Health and Social Care Scrutiny Sub-Committee AGENDA

DATE: **Wednesday 12 June 2019**

TIME: **7.30 pm**

VENUE: **Committee Rooms 1 & 2, Harrow Civic Centre, Station Road, Harrow, HA1 2XY**

MEMBERSHIP **(Quorum 3)**

Chair: **Councillor Mrs Rekha Shah**

Councillors:

Michael Borio	Vina Mithani
Natasha Proctor	Chris Mote

Reserve Members:

1. Niraj Dattani
2. Dan Anderson
3. Chloe Smith

1. Chetna Halai
2. Dr Lesline Lewinson

Advisers:

Julian Maw	Healthwatch Harrow
Dr N Merali	Harrow Local Medical Committee

Contact: **Daksha Ghelani, Senior Democratic Services Officer**
Tel: 020 8424 1881 E-mail: daksha.ghelani@harrow.gov.uk

Useful Information

Meeting details:

This meeting is open to the press and public.

Directions to the Civic Centre can be found at:
http://www.harrow.gov.uk/site/scripts/location.php.

Filming / recording of meetings

The Council will audio record Public and Councillor Questions. The audio recording will be placed on the Council's website.

Please note that proceedings at this meeting may be photographed, recorded or filmed. If you choose to attend, you will be deemed to have consented to being photographed, recorded and/or filmed.

When present in the meeting room, silent mode should be enabled for all mobile devices.

Meeting access / special requirements.

The Civic Centre is accessible to people with special needs. There are accessible toilets and lifts to meeting rooms. If you have special requirements, please contact the officer listed on the front page of this agenda.

An induction loop system for people with hearing difficulties is available. Please ask at the Security Desk on the Middlesex Floor.

Agenda publication date: Tuesday 4 June 2019

AGENDA - PART I

1. ATTENDANCE BY RESERVE MEMBERS

To note the attendance at this meeting of any duly appointed Reserve Members.

Reserve Members may attend meetings:-

(i) to take the place of an ordinary Member for whom they are a reserve;
(ii) where the ordinary Member will be absent for the whole of the meeting; and
(iii) the meeting notes at the start of the meeting at the item 'Reserves' that the Reserve Member is or will be attending as a reserve;
(iv) if a Reserve Member whose intention to attend has been noted arrives after the commencement of the meeting, then that Reserve Member can only act as a Member from the start of the next item of business on the agenda after his/her arrival.

2. DECLARATIONS OF INTEREST

To receive declarations of disclosable pecuniary or non pecuniary interests, arising from business to be transacted at this meeting, from:

(a) all Members of the Sub-Committee;
(b) all other Members present.

3. MINUTES (Pages 5 - 14)

That the minutes of the meeting held on 4 February 2019 be taken as read and signed as a correct record.

4. APPOINTMENT OF VICE CHAIR

To appoint a Vice-Chair of the Sub-Committee for the 2019/2020 Municipal Year.

5. APPOINTMENT OF (NON-VOTING) ADVISERS TO THE SUB-COMMITTEE 2019/20 (Pages 15 - 18)

Report of the Director of Legal and Governance Services.

6. PUBLIC QUESTIONS *

To receive any public questions received in accordance with Committee Procedure Rule 17 (Part 4B of the Constitution).

Questions will be asked in the order in which they were received. There will be a time limit of 15 minutes for the asking and answering of public questions.

[The deadline for receipt of public questions is 3.00 pm, 7 June 2019. Questions should be sent to publicquestions@harrow.gov.uk

No person may submit more than one question].

7. PETITIONS

To receive petitions (if any) submitted by members of the public/Councillors under the provisions of Committee Procedure Rule 15 (Part 4B of the Constitution).

8. REFERENCES FROM COUNCIL AND OTHER COMMITTEES/PANELS

To receive any references from Council and/or other Committees or Panels.

9. RNOH QUALITY ACCOUNT 2018-19 (Pages 19 - 112)

Report of the Director of Nursing, Royal National Orthopaedic Hospital.

10. QUALITY ACCOUNT TIMETABLE FOR IMPERIAL COLLEGE HEALTHCARE NHS TRUST (Pages 113 - 224)

Report of the Medical Director, Imperial College Healthcare NHS Trust.

11. LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST - QUALITY ACCOUNT 2018 TO 2019 (Pages 225 - 324)

Report of the NHS Trust.

12. UPDATE ON ALEXANDRA AVENUE GP ACCESS CENTRE - JUNE 2019 (Pages 325 - 328)

Report of the Assistant Managing Director, NHS Harrow CCG.

13. INFORMATION REPORT: PUBLIC HEALTH FORWARD PLAN (Pages 329 - 340)

Report of the Director of Public Health.

14. UPDATE FROM NW LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (Pages 341 - 346)

Report of the Director of Strategy.

15. ANY OTHER BUSINESS

Which cannot otherwise be dealt with.

AGENDA - PART II - Nil

*** DATA PROTECTION ACT NOTICE**

The Council will audio record item 4 (Public Questions) and will place the audio recording on the Council's website, which will be accessible to all.

[**Note:** The questions and answers will not be reproduced in the minutes.]

HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE

MINUTES

4 FEBRUARY 2019

Chair:	*	Councillor Mrs Rekha Shah		
Councillors:	*	Michael Borio	*	Vina Mithani
	*	Maxine Henson	*	Chris Mote
Advisers:	†	Julian Maw	-	Healthwatch Harrow
	*	Dr N Merali	-	Harrow Local Medical Committee

* Denotes Member present
† Denotes apologies received

25. Attendance by Reserve Members

RESOLVED: To note that there were no Reserve Members in attendance.

26. Declarations of Interest

RESOLVED: To note that the following interests were declared:

Agenda item 7 – CQC Progress Report including actions from the Quality Summit

Councillor Chris Mote, a member of the Sub-Committee, declared a non-pecuniary interest in that his daughter was employed at Northwick Park Hospital. He would remain in the room whilst the matter was considered and voted upon.

Agenda item 8 – Alexandra Avenue GP Access Centre – Changes to walk-in services and the impact of changes

Councillor Maxine Henson, a member of the Sub-Committee, declared a non-pecuniary interest in that Alexandra Avenue GP Access Centre was situated in Roxbourne Ward which she represented.

27. Minutes

RESOLVED: That the minutes of the meeting held on 16 October 2018, be taken as read and signed as a correct record.

28. Public Questions

RESOLVED: To note that no public questions were received.

29. Petitions

RESOLVED: To note that no petitions were received.

30. References from Council and Other Committees/Panels

None.

RESOLVED ITEMS

31. CQC Progress Report including Actions from the Quality Summit

The Forum noted that, at its meeting in October 2018, the Sub-Committee had received a report of the London North West University Healthcare NHS Trust setting out the response to the Inspection Report of the Care Quality Commission (CQC).

The report before Members at tonight's meeting (4 January 2019) provided an update on the following:

- the recent unannounced CQC visit on 10 January 2019;
- an update on the completion of the 'MUST DO' Action Plan;
- an overview of the developed Composite Improvement Plan;
- a progress update on the Actions from the Quality Summit;
- a proposal of the CQC Preparation Plan.

A representative of the Trust introduced the report and stated that, since the Inspection, a CQC Review Group had been set up to consider the Action Plan, which was attached to the report. Good progress had been made and the CQC had made an unannounced visit in January 2019 and their further report was awaited.

Another representative informed Members of the progress made following the CQC Inspection Report and the next steps for the Trust. She added that the Trust had made good progress towards the recommendations of the CQC. A

strong governance framework had been established to ensure that the progress made was sustainable. The visit by the CQC in January 2019 related to the 'Warning Notices' issued following the Inspection in 2018, which had mostly been technical in nature and had not compromised safety of patients. All the issues raised at both the Ealing Hospital and Northwick Park Hospital sites had been addressed. She re-iterated that a further report of the CQC was awaited.

The Sub-Committee was informed that since the receipt of the Inspection Report, the Trust had engaged with frontline staff and comprehensive measures had been put in place in relation to Maternity Services. The pledges following the Quality Summit were also being addressed.

Members asked the following questions:

- **Action Plan - which actions in the Plan had been completed? What was outstanding? How had the staff been involved in the implementation and had they taken ownership? Which actions in the Plan were proving particularly challenging to implement and why?**

  A representative of the Trust reported that engagement with staff had been positive. For example, in Maternity Services, a staff newsletter had been introduced to ensure that staff were kept informed of developments. Measures had been put in place to ensure that the progress made was sustainable. All Trusts faced difficulties in recruiting nursing staff and the Trust was working with NHS Improvement in this regard. Recruitment and retention measures were also being looked at, including that the Trust needed to be seen as an 'employer of choice'. International recruitment was being explored.

  Another representative stated that the majority of the recommendations in the Inspection Report related to compliance with training and stock management. He stated that additional staff training had been put in train, particularly in relation to the Bleep System(s) in Maternity Services. It was essential to embed practice and audits were undertaken to ensure that the measures put in place were working. He explained that dedicated time slots for testing had been introduced and staff had been informed on how to escalate issues. Follow up audits were also conducted by other departments.

- **Action Plan – what policies had been put in place for the management of medicines, including those where the date had expired?**

  A representative of the Trust stated that robust mechanisms had been put in place and the Trust was now compliant with its policies for the management and stock control for drugs at ward level. The CQC, as part of their unannounced visit in January 2019, had put this to test at Ealing Hospital and their report was awaited. It was noted that no patients had been harmed as a result of this issue. The Trust was not

complacent on this matter and would ensure that it remained fully compliant with the requirements.

Another representative added that Omnicell products to dispense medications had been purchased to help ensure patient safety. The products helped to ensure that medications were kept at the correct temperatures. The products allowed for stock control and dosage compliance. Checks against allergies were also made.

In response to a further question on how these products were being financed, the same representative stated that the costs were being met from existing budgets. He explained that whilst the Trust had received additional funding, the money was being used to fund, for example, the post of an Improvement Director and the appointment had been made from within the Trust for a fixed term of 1-year.

- **How had the feedback from service users and patient groups helped shape the action plan for improvements?**

  A representative of the Trust informed the Forum that various meetings/organisations, such as the Patient Experience Committee, Healthwatch, patient stories and complaints had helped capture key messages for the Trust to work on.

- **There would be a re-inspection in the first quarter of 2019/20 (i.e. summer). What can the Council do to help facilitate a successful inspection?**

  Representatives of the Trust stated that their attendance at meetings of the Council helped to provide feedback, including Member feedback from their constituents. Additionally, the following would help:

  - ensuring that there was sufficient access to placements when the Trust was in the process of discharging patients. There continued to be some challenges around provision in care homes and the Council could help with their improvements;

  - CQC would look at areas in which the Trust was languishing. An improved health/social care system together with collaborative working would help;

  - improved service delivery, supporting each other, positivity, transparency and integrated working between the Trust and the Council was also essential.

- **Budget - Who managed the audit? Were both internal and external audits carried out?**

  In response, a representative of the Trust stated that, for all action plans, audit was conducted within teams and by external teams. Internal audit would examine pathways (such as in the A&E), CQC would follow-up by carrying out further inspections, NHS Improvement

carried out reviews and the CCG would monitor on a monthly basis against the Plans and provide checks and balances. There were different tiers of scrutiny.

- **Risk Register – Was there an issue due to insufficient staff?**

  A representative from the Trust explained that new entries included Paediatric Anaesthetic cover at Ealing and Junior Doctors' compliance with mandatory training. Steps were being taken to ensure that all staff were trained and compliant.

- **Had winter pressures unduly impacted upon the Trust's ability to deliver the CQC action plan?**

  The Sub-Committee was informed that, since Christmas, the pressures on the emergency pathway had been extraordinary. Other areas of the Trust, such as the cardiology team, had to provide additional support to A&E Service. Such demands inevitably caused pressures on the Trust.

  Staff had fully engaged with the Action Plan. Some areas were challenging but, overall, engagement with staff had been positive and they remained engaged.

The Chair thanked representatives of the Trust for attending the meeting and answering their questions.

RESOLVED: That the report be noted.

32. Alexandra Avenue GP Access Centre - Changes to Walk-in Services and the impact of changes

The Sub-Committee received an information report of the Harrow Clinical Commissioning Group (CCG), which provided an update on the Alexandra Avenue GP Access Centre in relation to 'Changes to Walk-in Services' made in November 2018 and the impact of their implementation. The changes had been aligned with the Urgent Care Strategy which the CCG had adopted.

A representative of NHS Harrow CCG introduced the report and outlined how the implementation of the Alexandra Avenue Walk-in Centre to a GP Access Centre had been launched and promoted, the benefits the change offered to patients in Harrow, how the change had been marketed, how appointments could be booked through both GP Practices in Harrow and the NHS 111 Service, including other Walk-in Centres and the Urgent Care/Treatment Centre. He referred to the feedback received which had been included in the report. He added that individuals who had 'walked into' the Centre had had their clinical needs assessed and were briefed on how they could access medical care in the future as a result of the changes made.

The representative added that during the first two months, 85% of available appointments had been booked for Monday-Friday but the appointments during the weekends remained largely unused. The CCG was working with NHS 111 and the Urgent Care Centre to ensure that the capacity at the

Access Centre was effectively used and to help reduce the burden on the Urgent Care Centre and the A&E Services, particularly during the winter months.

The Sub-Committee was also informed that there was no evidence that the change to an Access Centre had had any material impact on the services provided both before and after the change. Data had shown that patients presenting themselves to the various medical services were presenting themselves to the correct service in light of their condition. It had been noted that there had been an increase in the number of younger patients presenting themselves to the A&E Service and that, year on year, there had been a 14% increase in Brent patients.

The representative from Harrow CCG added that recent data had shown that the usage at Alexandra Avenue GP Access Centre had gone up to 96% and the CCG was working to ensure maximum utilisation.

- **What had been the impact on the two Walk-in Centres in Harrow? Was it correct hat the CCG was looking to take out £1m from the medical centre budget? Would the Walk-in Centres in Harrow be changed to GP Access Centres?**

  The representative from the CCG stated that the situation at Belmont Walk-in and Pinn Medical Centres had remained static. In relation to the budget, he was not aware of any such information but undertook to provide details and clarification in this regard. A Medical Committee, as part of a PMS (Personal Medical Services) Contract Review (part of a wider development of primary care services), would ensure that matters were dealt with as equitably as possible and that patients were not disadvantaged.

  The Member concerned stated that he had heard different views regarding the budget and it was important that the correct information was shared with partners. The CCG representative stated that he would ask his colleague dealing with this area to provide a summary document in this regard as he did not want to mislead the Sub-Committee.

  An adviser referred to the PMS process and stated that not every General Practice in Harrow had applied for the contract. The PMS Contract (what GPs could do over and above the core services provided) was in addition to the GMS Contract. There had been a national drive to make the PMS process equitable and General Practices were being asked to return the extra payments and to re-apply. It was likely that the money added up to £1m. It was important to ensure that during the re-application stage, all General Practices were given an opportunity to apply to ensure that the money went to the primary care services rather than the CCG.

- **A large number of housing developments were taking place in Harrow and the population would increase. How was the CCG planning forward and addressing the issue of patient care when budgets were tight?**

  The infrastructure would include General Practice, which was the basis of delivering medical care. Funding from NHS England was directly linked to the population. Additionally, primary care was undergoing change. The CCG was looking at various housing development sites, such as the Kodak and Belmont sites, with a view to providing effective medical care in those areas. The CCG would also look at the overall growth in the population, including the growth in both the older and young populations to ensure that all had equal access to medical care.

  An adviser clarified that funding for General Practice was provided by the NHS England. He was of the view that patients, occasionally, inappropriately went to the Alexandra Avenue GP Access Centre as they were not triaged and continual care would not be followed up.

  Moreover, the Access Centre was not able to refer patients to other medical services, such as secondary care. He pointed out that patients still went to see their GP after attending the Alexandra Avenue Access Centre. He suggested an audit of patient care.

  He questioned why the CCG was adding money to GP Services which should be provided by General Practitioners. He suggested a study on what level of capacity each General Practice in Harrow provided and relate it to those who utilised the services.

  In response, the CCG representative stated that he would relay the point on carrying out a study on capacity back to his colleague. He acknowledged that NHS England funded the General Practices. The CCG would consider requests from 'courageous' General Practices that wanted to enhance services, thereby improving primary care service provision. The CCG would evaluate service models for quality. The provision of GP Access Centres was to start a journey for improved primary care provision and to manage demand.

  The Adviser was of the view that it would be better if services were devolved to General Practices rather than providing them at the Alexandra Avenue GP Access Centre. He questioned whether there had been a conflict of interest when decisions were made to change Alexandra Avenue from a Walk-in Centre to a GP Access Centre. In response, the CCG representative stated that conflicts of interests were managed and the relevant people would have 'excused' themselves from decision-making.

- **How many patients (ie those that were not registered with a Harrow GP) had been turned away from the Alexandra Avenue GP Access Centre? What was the year on year comparative data?**

The representative from the CCG undertook to provide the data separately. He added that the CCG was also tracking the number of patients presenting themselves to A&E but that the figure had not increased. He explained that the impact of change would be measured and year on year data would be provided. He undertook to share the previous year's figures. Additionally, the CCG would not look at the volume of patients but also which areas they were coming from. He informed Members that only one person arriving as a 'Walk-in patient' at the Alexandra Avenue GP Access Centre had been asked to leave and he explained the circumstances behind this.

- **What was the capacity at Alexandra Avenue GP Access Centre and did the Centre see enough patients? Were patients losing out due to the appointment only system and were they presenting themselves at Urgent Care Centre(s) or A&E instead?**

  Members were informed that further work was required on the appointments system, particularly relating to the weekend. A 100% utilisation was not expected and it was important to retain some gaps.

  A Member asked why the appointments were not being utilised. In response, the representative from the CCG reported that approximately 20-30 appointments were not being taken up and that these could be shifted to during the week when the take up rates were high. The representative added that the situation would be monitored as the weekend take up had improved in January 2019. He was of the view that it was important for the service to embed for six months and he would report back on the situation.

- **Alexandra Avenue Centre was a large building. How was it being utilised?**

  The representative from the CCG stated that the CCG would be using the building for other services. He reported that community clinics for outpatients were also held at the premises and it was intended to introduce ENT Clinics there in order to increase capacity. Other services were also being considered.

- **When scrutiny did its review of access to primary care in 2017, Members were alerted to the then new Harrow Health Now app that residents could use to assess their own health concerns in the first instance – had this been promoted any further to align with the changes to primary care access in the borough?**

  The NHS CCG representative undertook to report back.

- **The NHS Long Term Plan was published in January – how do the changes planned/implemented in Harrow fit the national strategies for primary care and urgent care?**

The representative from the CCG referred to the 10-year Plan, which his colleague was working on. He referred to the intervention programme for urgent care and referred to the services provided at Honeypot Medical Centre. He added that consideration had also been given to how best to help elderly patients. The CCG was testing out a number of theories with a view to expanding services.

The Chair thanked the representative from the CCG for attending the meeting and answering questions.

RESOLVED: That the report be noted and that a further written report capturing all the issues raised at the meeting, including how have these issues and the change at Alexandra Avenue GP Access Centre impacted on CCG's plans for primary care provision in the medium and longer term, be submitted to the June 2019 meeting of the Sub-Committee.

33. Update from NW London Joint Health Overview and Scrutiny Committee

The Sub-Committee received a report of the Divisional Director of Strategic Commissioning updating Members on the discussions held at the meeting of the North West London Joint Health and Overview and Scrutiny Committee (JHOSC) held on 4 December 2018.

The Chair reported that the JHOSC had extended its terms of reference to include scrutiny of regional Sustainability and Transformation Plans and the Council; had ratified the extended terms of reference in its own Constitution at its November 2018 full Council meeting.

The Chair reported that the next meeting of the JHOSC was scheduled to meeting on 12 March 2019 at 9.30 am and that it would be hosted by the Council. She added that the extraordinary meeting referred to in the report would not now meet in February 2019 as indicated in the officer report.

RESOLVED: That the report be noted.

34. Meeting Dates for Municipal Year 2019/20

RESOLVED: To note that, during the Municipal Year 2019/20, the Health and Social Care Scrutiny Sub-Committee was scheduled to meet on the dates set out below:

Wednesday 12 June 2019 at 7.30 pm, Harrow Civic Centre
Tuesday 5 November 2019 at 7.30 pm, Harrow Civic Centre
Monday 3 February 2020 at 7.30 pm, Harrow Civic Centre.

(Note: The meeting, having commenced at 7.30 pm, closed at 9.04 pm).

(Signed) COUNCILLOR REKHA SHAH
Chair

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REPORT FOR: HEALTH & SOCIAL CARE SCRUTINY SUB-COMMITTEE

Date of Meeting:	12 June 2019
Subject:	Appointment of (non-voting) Advisers to the Sub-Committee 2019/20
Responsible Officer:	Hugh Peart, Director of Legal and Governance Services
Scrutiny Lead Member area:	N/A
Exempt:	No
Wards affected:	None
Enclosures:	None

Section 1 – Summary and Recommendations

This report informs Members in relation to the appointment of two non-voting advisers to the Sub-Committee. Members are requested to consider and agree the appointment of the advisers to the Sub-Committee for the 2019/20 Municipal Year.

Recommendations:
That, in accordance with the Committee Procedure Rules (Part 4B of the Constitution - Rule 33.9) the nominees named in this report, be appointed as advisors to the Sub-Committee for the 2019/20 Municipal Year.

Section 2 – Report

2.1 Rule 33.9 of Committee Procedure Rules (Part 4B of the Council's Constitution) provides for a Scrutiny Sub-Committee to appoint non-voting advisers (to assist in the work of the Sub-Committee either generally or on specific matters).

2.2 The following advisers have confirmed that they wish to continue as advisers to the Sub-Committee for the 2019/20 Municipal Year:

Dr Nizar Merali (Local Medical Committee)
Mr Julian Maw (HealthWatch Harrow).

2.3 If appointed, the advisers will be required to comply with the Council's Protocol on Co-optees and Advisers (Part 5H of the Council's Constitution).

Ward Councillors' comments

Not applicable.

Financial/Legal Implications

There are no financial or legal implications arising from this report.

Performance Issues

None.

Environmental Impact

None.

Risk Management Implications

If not appointed, the Sub-Committee may not have access to expert external advice when conducting its business.

Equalities Implications / Public Sector Equality Duty

It is anticipated that appointing the proposed advisers will support the Council in meeting its Public Sector Equality Duty based on the advice they will be able to contribute.

Council Priorities

Promotes 'Protecting Vital Public Services' in a general sense by enabling scrutiny of health care services and that they meet the needs of Harrow residents.

Section 3 - Statutory Officer Clearance

Name: Sharon Daniels Date: 8 May 2019	x	on behalf of the Chief Financial Officer
Name: Paresh Mehta Date: 8 May 2019	x	on behalf of the Monitoring Officer

Ward Councillors notified: N/A

Section 4 - Contact Details and Background Papers

Contact: Daksha Ghelani, Senior Democratic Services Officer
Tel: 020 8424 1881

Background Papers: Council's Constitution
http://www.harrow.gov.uk/www2/ieListMeetings.aspx?CId=1092&Info=1&bcr=1

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Royal National Orthopaedic Hospital NHS Trust

REPORT FOR:	**HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE**
Date of Meeting:	12 June 2019
Subject:	Quality Account
Responsible Officer:	Paul Fish, Director of Nursing, RNOH
Exempt:	No
Enclosures:	Quality Account for Royal National Orthopaedics Hospital NHS Trust

Section 1 – Summary and Recommendations

This report sets out the Quality Account for Royal National Orthopaedics Hospital for 2018-19. It sets priorities for RNOH for 2019-20 and identifies the progress against the quality priorities set in 2017-18. It also identifies performance against key indicators set by NH Improvement.

Recommendations:
Require an assurance letter from the chair stating that draft Quality Account was reviewed by members of the sub-committee to their satisfaction.

Section 2 – Report

Background

Providers of NHS healthcare are required to publish a quality account each year as per the requirements by the Health Act 2009, and the National Health Service (Quality Accounts) Regulations 2010. Quality Accounts help trusts to improve public accountability for the quality of care they provide and engage the leaders in the quality improvement agenda. The requirements for quality accounts are confirmed in a letter published by NHS Improvement every year.

Current situation

Draft Quality Account is attached. The assurance letter from Health and Social Care Scrutiny Sub-Committee is required in order to finalise the document.

Financial Implications

N/A

Performance Issues

N/A

Environmental Impact

N/A

Risk Management Implications

N/A

Section 4 - Contact Details and Background Papers

Contact: Muhammad Kashif, Quality Manager, RNOH
Tel: 020 8909 5375

Background Papers: Quality Account 2017-18 (as per the enclosure)

ROYAL NATIONAL ORTHOPAEDIC HOSPITAL (RNOH) NHS TRUST

QUALITY ACCOUNT 2018/19

Contents

Part 5 Review of quality performance

5.1 Patient Safety Measures

5.1.1 Rate of admissions assessed for venous thromboembolism (VTE)
5.1.2 Clostridium difficile infection rate
5.1.3 Patient safety incident Reporting
5.1.4 Pressure ulcers

5.2 Clinical Effectiveness Measures

5.2.1 Summary hospital-level mortality indicator (SHMI)
5.2.2 Patient Reported Outcome Measures
5.2.3 Emergency readmissions within 28 days

5.3 Patient Experience Measures

5.3.1 Responsiveness to personal needs
5.3.2 Friends and Family Test (Patients)
5.3.3 Staff recommendation of the Trust as a provider of care to their family or friends
5.3.4 Complaints
5.3.5 PALS

5.4 Maintaining Continuous Quality Improvement

5.4.1 Learning from Deaths
5.4.2 Implementing Seven Day Hospital Services
5.4.3 Implementation of Duty of Candour
5.4.4 Details of ways in which staff can speak up
5.4.5 Our CQC results

APPENDIX 1: Statements from NHS England Specialist Commissioning, Harrow Healthwatch and Harrow Health watch & Harrow Health and Social Care Scrutiny Sub-Committee

APPENDIX 2: Statement of directors' responsibilities

APPENDIX 3: External audit limited assurance report

Glossary of terms and abbreviations

Part 1: Statement on quality from the chief executive

Delivering the best quality of patient care for all the RNOH patients remains the key focus and priority of the organisation. The values, dedication and professionalism of the staff at the RNOH are fundamental to this focus. Our staff work tirelessly to ensure that we make continuous improvements to our services and demonstrate learning from situations when we recognise that things have gone wrong.

We know that the highest quality of care is delivered by motivated and happy staff. We are committed to improving the experience of our staff at RNOH to ensure that they can improve the safety and experience of our patients. In 2018/19 we have continued to make real progress in improving the experience for our staff at the RNOH - our positive staff survey results to some of the best in the country.

We are thrilled to see the progress that continues to be made with the improvement in our infrastructure – particularly the redevelopment of the site, investment in equipment and our digital technology investments. The opening of the new Stanmore Building in December 2018 was a landmark moment for the organisation and for the quality of the facilities and supporting equipment and digital technology. The further phases of Redevelopment ahead will ensure that we are able to deliver high quality care in a setting that our patients and staff deserve.
The RNOH continues to make great strides in our aim to be a world leading learning centre of excellence - patient participation in research higher than ever before and research and our partnership projects with our academic partners, particularly University College London, continue to generate innovation and knowledge that translates into both a learning culture and improvements in the quality of patient care.

All of the above achievements and work in progress were recognised by the CQC when they visited the Trust this year and awarded us Good rating for the quality of care that we provide to patients. The RNOH, like many other NHS Trusts, continues to face significant financial challenges in the face of ever growing demand for our services in the years ahead. However, our vision remains to continue our vision to be a world leading Orthopaedic Hospital with the best patient care and staff experience in the NHS.

I confirm to the best of my knowledge that the information contained in this report is accurate.

Signature

Rob Hurd

Chief Executive,

THE STANMORE BUILDING

Construction of the new inpatient Stanmore Building is now complete; it was opened for patients in December 2018.

The brand new building means the RNOH are able to offer patients the very best ward facilities and allow staff to work in an environment that matches their skill and dedication. The major portion of the project was funded from a loan which is to be repaid by the capital receipt received when the Western Development Zone is sold.

The new Stanmore Building accommodates 119 beds in total, which includes a 27 bed Children's unit (Sir William Coxen Children and Young People's Unit) with embedded therapy and education functions and an external play area.

There are Adult Acute Wards comprising 64 beds over two floors, (London Irish Ward and the Duke of Gloucester Ward) with embedded therapies and socialisation spaces to replace several of the current outdated adult wards.

There is also a Private Patients Unit (Royal National Orthopaedic Hospital Private Care) accommodating 28 beds that includes 10 day case beds and a Therapy gym.

Alongside the clinical spaces, the new Stanmore Building includes a main entrance that will provide reception and waiting space, in addition to a refreshment and seating area adjacent to the children's activity centre which is fitted with interactive activities for our paediatric patients and visitors, funded from a charitable donation.

The new facility boasts a hanging sculpture in the atrium space as well as artwork within all the wards, donated by the RNOH Charity.

Part 2: Introduction

2.1 The Royal National Orthopaedic Hospital

The Royal National Orthopaedic Hospital is the UK's leading specialist Orthopaedic Hospital. We provide a comprehensive and unique range of Neuro-Musculoskeletal healthcare, ranging from acute spinal injuries to Orthopaedic Medicine and Specialist Rehabilitation for chronic back sufferers. As a National Centre of excellence, the RNOH treats patients from across the country, many of whom have been referred by other Hospital Consultants for second opinions or for treatment of complex or rare conditions.

Over 20% of all UK Orthopaedic Surgeons receive training at the RNOH, and our patients benefit from a team of highly Specialised Consultants many of whom are internationally recognised for their expertise.

The RNOH has a long track record of innovative research, and our research projects are pertinent to patient needs. Research is focused on musculoskeletal as well as Neuro-Musculoskeletal conditions, Rehabilitation, Peripheral Nerve Injury Repair, Sarcoma Detection, Surgical Treatments and much more. Together with our research partner, University College London's Institute of Orthopaedic and Musculoskeletal Science, our work has led to new devices and treatments for some of the most complex orthopaedic and musculoskeletal conditions.

2.2 What is Quality?

High quality care in the NHS means that patients have a good overall experience of care which is clinically effective and delivered safely. An organisation committed to delivering high quality care is one which is always striving to be even better. The RNOH is committed to being a world leading Orthopaedic Hospital with the best patient care and staff experience in the NHS.

This means:

- Achieving even better clinical outcomes
- Providing even safer care
- Exceeding the expectations of our patients and their families

Knowing that we are delivering the best care requires continuous measurement. We do this in many different ways including comparison with our peers through participation in National Audits and benchmarking our practice against guidance from the National Institute for Health and Care Excellence (NICE). We also undertake many local clinical audits based on best practice guidelines. This helps us understand more clearly what we do really well and what we could improve. We are also able to understand the impact of our Clinical Interventions from our patient's perspective through our Patient Reported Outcome Measures (PROMS) and Patient Outcome Data (POD).

Safe care is care in which avoidable error and harm has been effectively removed. Safe care can be measured by looking at our rates of hospital acquired infections, thrombosis, pressure damage and falls. It can also be analysed in relation to the rates of incident reporting within the hospital. We know that when staff is focussed on improving the safety of care provided, we can expect to see high levels of incident reporting. Each incident report provides further opportunity for quality improvement and learning within the hospital.

Ensuring that patients and their families have a good experience while at the RNOH is incredibly important to us. We continue to work to find better ways of enabling our patients to give us feedback in order to improve the services that we provide. We were really pleased to be identified in the 2016 National Inpatient Survey as the best Trust in the country for seeking view from our patients.

Delivering high quality care means being able to recognise that in the provision of complex specialist services we do not always get it right. Being open and honest with our patients, our regulators and ourselves when we get things wrong is the most important step we can take to improving the quality of our care and being even better.

2.3 The Quality Account

Every year the Trust is required to produce an account of the quality of the services it provides. This is an important way for NHS services to provide information to the public about the quality of care it provides as well as demonstrating what work it being undertaken to improve services.

The RNOH is committed to continuously reviewing and improving the quality of its services to ensure our patients have the very best experience of care and successful clinical outcomes. Within this document the Trust provides information about how we have performed against National Quality Indicators for Patient Safety, Clinical Effectiveness, and Patient Experience. We also outline our

Quality Improvement Priorities for 2019/20 as well as reviewing our progress against last year's priorities.

2.4 Quality Highlights of 2018/19

Over the past year, work has gone on around the Trust to improve the quality of our care and services. This section takes a look at some notable highlights in our quality improvement work in 2018/19:

- Care of the dying in the last days of life
  RNOH puts the needs of individual and families at the centre of the care we provide to our patients. Although the RNOH have less than 20 deaths per year it is important that staff feel supported to deliver high quality care. In 2018/19, we focused on improving the care and treatment of people in their last days of life. We worked with partners to develop a resource folder to support colleagues in providing care for patients in the last days of life. The folder includes care plans, symptom control flow charts and information leaflets for patients, their family and friends. Since the introduction of the resources folder staff have reported how valuable to resource folder is. The resource folder will be formally evaluated in the June 2019.

  We purchased necessary equipment and trained a variety of staff members on the use. We also introduced a bereavement booklet in order to provide our patients with useful information.

  RNOH is now fully compliant with the recommendations of NICE published guidelines on Care of the dying adults in the last days of life (NG31) and End of life care for Adults (QS13).

- Friends and Family Test Performance
  We have maintained a high level of approval from both our inpatients and outpatients. **95%** of our patients would recommend our services to their family and friends.

- New build
  The introduction of New Stanmore Building has highlighted the significance of the environment in achieving good patient and staff experience. Patient and Staff experience has significantly improved since it was opened in December 2018.

  The new building offers an increase in the number of single rooms. The facilities in the single rooms include sofa beds which allow carers/relatives to stay overnight with patients.

- Clinical Pocket Reference Book
  The education team has written and published a clinical pocket reference book, covering a wide range of Orthopaedic nursing care including managing deteriorating patients.
  This provides a quick-reference, easy-to-read guide for nurses.

  This exceptionally useful and popular resource has been adapted and updated by the team of nurse educators for use by nurses caring for orthopaedic patients. Nurses caring for orthopaedic patients and the rest of the team on the orthopaedic wards have found this resource very useful.

- Length of Stay

  The Trust participated in an AHP supporting patient flow improvement collaborative which was facilitated by NHSI to identify reasons for delay in discharges. It was identified that up to 22% of patients were overstaying their estimated discharge date by 50%. We introduced a weekly meeting "Get Me Home" to facilitate timely discharge.

  Get Me Home is a multidisciplinary meeting chaired by Head of Nursing and attended by Medical, Clinical and AHP staff. The main focus of the meeting is to discuss and address the needs of the complex patients to facilitate a timely discharge.

- Pepper The Robot

  Thanks to the funding from RNOH Charity, we have introduced Pepper The Robot to the Sir William Coxen ward.

  Pepper is a 4-foot tall, interactive robot who is able to converse with people, take instructions and play games. Research has shown that robots, like Pepper, can help relieve anxiety, develop social skills and improve communication skills of the cognitively impaired.

  Pepper is used to both entertain and educate the patients, through a variety of custom build programs for the ward, including:

  - Greeting patients and visitors at reception
  - Giving patients and parents their ward introductions
  - Completing Friends & Family questionnaires
  - Educational games, videos and activities

- Improved Theatre Utilisation

  Theatre Utilisation project was undertaken to increase efficiency and through put of valuable Theatre resources in order to improve patient access. The project resulted in improving team performance, increasing the patient's access, patient experience and staff well-being. The project also improved the safety and reliability.

- Paediatric Golden Patients

  This project, as part of Theatre Productivity Programme, was undertaken to improve patient access, outcomes and experience. A group was established to ensure timely arrival of paediatric patients in theatre (for their operation) at the start of a list. The group explored the main issues that prevent paediatric patients being ready for theatre. This led to the Divisional Head of Nursing agreeing to convert a current nursing vacant post into an admissions nursing post. Once appointed to, the nurse will be solely responsible for preparing paediatric patients for theatre.

- Improved CQC rating

  Care Quality Commission visited us in 2018 to check the quality of services RNOH provided. CQC also looked specifically at management and leadership to ensure the trust was well-led. Overall, the trust has significantly improved from a 'Requires Improvement' to a 'Good' rating. CQC acknowledged that there had been a number of significant improvements since their last inspection. We are proud of the progress made in many of the areas including

positive changes to organisational culture, quality improvement initiatives and innovative research projects. This is one major step forward in our aim to not only maintain the RNOH's position as the country's leading specialist musculoskeletal centre, but also to become the best place to work in the NHS.

- Anti-embolism stockings compliance after joint replacement surgery

  Venous thromboembolism is a recognised complication of lower limb joint replacement surgery. It is a leading cause of death and disability worldwide. Anti-embolism stockings are used to increase the blood flow and reduce the risk of blood clots. New NICE guidelines implemented in October 2018 require stockings to be worn as an in-patient as a standard for hip and knee joint replacement surgery.

  A quality improvement initiative reviewed the proportion of patients wearing anti-embolism stockings after hip and knee joint replacement surgery. Gaps were identified in patient's compliance with the recommendation to wear them for 6 weeks. The main themes for not wearing the stockings were discomfort, perception of need, information and attitudes. Further work is underway to address patients concerns in order to improve patient's compliance.

- Use of an app to support the rehabilitation needs of people with spinal cord injury

  Following a service evaluation of the patient education provided at the London spinal cord injury centre the results highlighted the need for education and information to be delivered via e learning/app. Several focus groups have been conducted to explore stakeholder's views specifically for people with spinal cord injury. There was a lot of support for an app which highlighted a great deal of potential function. The data collected from focus group is being analysed to develop a prototype for testing.

  This is a very exciting project for the London Spinal Cord Injury Centre and it is hoped that the app will increase independence and decrease post injury complications.

- EACH (empathy in action in healthcare)

  RNOH continues its focus on better patient experience and higher satisfactions. Studies show that patient experience has a direct impact on patient outcomes. Studies carried out on patient's perception of healthcare delivery identify the two important aspects of care delivered i.e. relational aspects and functional aspects. Empathy is one of the elements of relational aspects of care. Being able to feel a patient's emotions helps to deliver a more compassionate care and makes the patient feel more comfortable during their treatment. A study was carried out to investigate the empathy of nursing and therapist staff and its impact on clinical decision making.

  This project involved nurses and therapists assessing self-rated empathy using a validated scale and exploring its impact on clinical care delivery. Results of the study showed variations in empathy levels between staff groups. The findings identify both positive and negative impacts of empathy, and are being used to determine ways to encourage its positive use in improving patient health outcomes and experience.

- Exploring nurses' views and experiences of research
  Having research active staff is important to improving patient health outcomes and experience. It is also a key to embed the culture of learning, continuous improvement and innovation as per the CQC well led domain. This study sought to explore our nurses' experience of research and ways to support their future engagement. This study has now been published in the International Journal of Trauma and Orthopaedic Nursing and the findings are being used to help nurses engage in research and improvement activities.

- Always events
  NHS England's 'Always Event' co design methodology was utilised to undertake a service improvement within the children's and Young person's out-patient (CYO) department, Stanmore. A feedback tree was designed and utilised to receive feedback from patients and their careers / parents to look at 'what could have improved your experience of the CYP department?' The theme of signage from the hospital car park was found to be a challenge and staying with the Always Event ethos the question was possessed as to how the signage could be improved and a suggestion of little bones from the car park to the CYP department was given. The trust has since run cooperation within the CYP department to design the stencil for the bone pictures. The 'RNOH little bones Always Event' has been shared at a number of NHS England Always Events.

- Perioperative Quality Improvement Programme (PQIP)
  We joined Perioperative Quality Improvement Programme in March 2018 and we have recruited 222 patients to date at RNOH. PQIP is a multidisciplinary initiative supporting local quality improvement to benefit patients undergoing major surgery. At this site we recruit patients having lower limb revision surgery, spinal surgery or sarcoma surgery. This initiative uses questionnaires to find out how patients are feeling and managing activities of daily living (ADLs) before surgery, on day 1 and day 3 post-operatively. Patients are also contacted at 6 and 12 months post op and the information gathered is used to better understand what happens to patients after they leave hospital after major surgery and whether the surgery has had a beneficial effect on their longer term health. This helps establish if any changes or improvements benefit patients. Part of the PQIP methodology is to really support clinicians and managers with how to use data for improvement.

- Optimising Nurtritional status of patients using supplements
  The nutritional status of a patient has a direct impact not only on their mood and wellbeing but also on the success of surgery. Malnutrition (poor nutritional status) may increase the length of hospital stay, likelihood of infection and wound breakdown. Pre-operative carbohydrate loading has improved outcomes in our complex ileocystoplasty patients.

  We are one of only a few centres to use bioelectrical impedance advanced body measurement to assess the body stores of patients with unusual body types and will use this data to tailor the nutrition interventions.

  The fasting practices in the hospital have been scrutinised to avoid prolonged periods without food or drink. Collaboration between anaesthetics, dietetics and Surgeons has led to reduced fasting times so that patients are more comfortable, less anxious, with better fluid-balanced and normoglycaemia.

- The use of game technology in rehabilitation

  We have trialled the MIRA, an X-box system that allows physiotherapists to prescribe exercises to patients using games, this can help to motivate, distract and make therapy sessions fun for patients. There has been positive feedback from paediatric patients who have used it to treat their painful and unstable shoulders. The system is now being used by other clinical teams such as in the post-operative total knee replacement classes.

- The use of a 'Physio Exerciser' APP in prescribing exercises to patients presenting with musculoskeletal conditions

  This project has been done in collaboration with an APP developer to look at usability and acceptability of an exerciser APP. The APP allows a physiotherapist to prescribe exercises and upload videos of the exercises on the patient's own phone. It also uses motion sensors on the phone to help guide the patient they are doing the exercises correctly and accurately as well as sending them reminders and emails to motivate them to do their exercises. Currently the APP is being tested on both iPhone and android. If successful it is hoped the App will be properly trialled at other NHS settings with support of a further grant.

- The Volunteer Patient Buggy Service

  Amongst many fantastic interventions to improve patient experience at RNOH, 'Buggy Service', and its intrepid team of drivers, who are out in all weathers, transport patients around some incredible difficult terrain. The visitor numbers continue to increase month on month. Averaging 2000 visitors a month, many of whom suffer from mobility problems, it is hard to recall how we ever managed without them!

- Equipment ordering review

  This project was undertaken to improve patient experience, patient access and patient outcomes. Unavailability of right equipment may result in a delay in starting the theatre list as well as cancelling the patients.

  The project involved process mapping the current process of ordering equipment for 4 surgeons. All aspects of the ordering process and communication of information were considered. This lead to developing an electronic requisition form which will be tested by some surgeons. If the trial is successful we will publicise its use to other consultants for adoption.

- ‘I delivered great care’ Gold badge award

  “I delivered great care” badge is part of the RNOH patient Welcome Pack and is awarded by the patient to member of staff who they feel have delivered great care to them during their stay.

  To receive a bronze badge, staff must receive five ‘I Delivered Great Care’ badges from patients. Five bronze badges results in one silver, and five silver badges gain a gold award. So that's 125 in total!

  This initiative was started in 2016 and continues to motivate staff to deliver the best care to our patients.

- RNOH Val-You charter

  Evidence suggests that a positive staff experience benefits staff as well as patients through positive patient experience and improved outcomes.

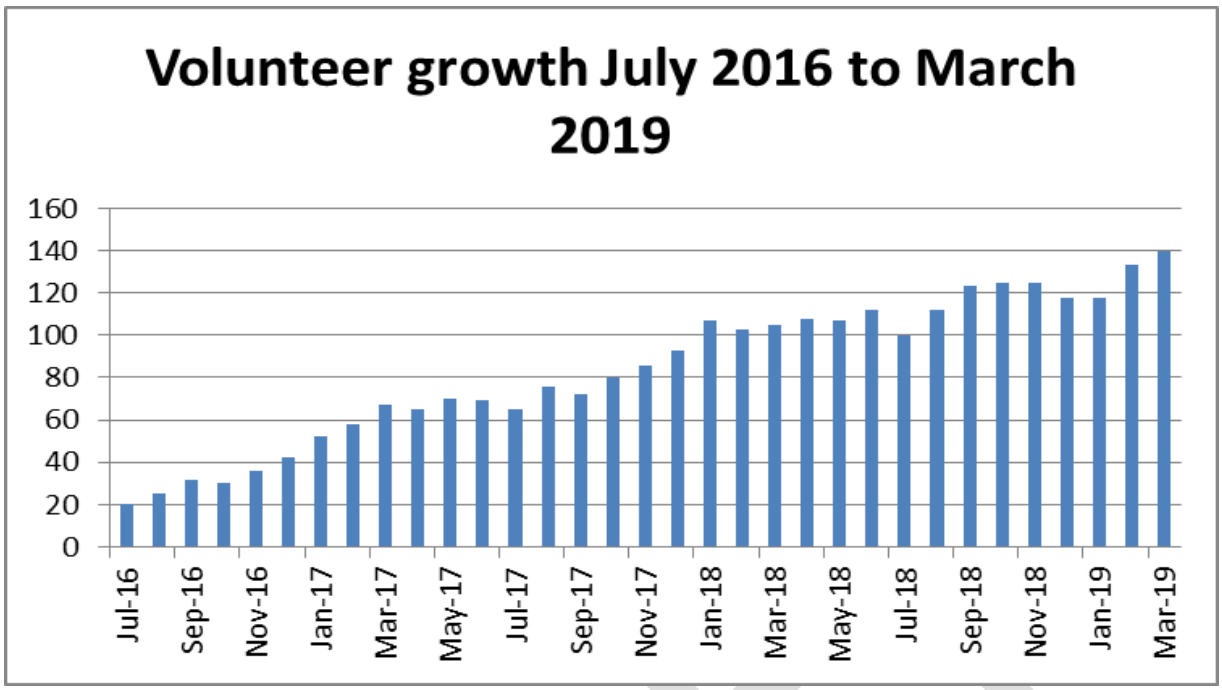
  In 2016 the RNOH made a commitment to focus on staff experience and to become the best place to work in the NHS within five years.

  Following the creation of the RNOH VAL-YOU programme, staff experience within the Trust has continued to be a priority. By embedding our Values: Patient First *always*, Excellence *in all we do,* Trust, honesty and Respect *for each other*, and Equality *for all*, we continue to develop the culture within the organisation to help us reach our goal of becoming the best place to work in the NHS, as detailed in our vision.

2.5 Volunteer Service

This year has seen another increase in the numbers of people applying to become volunteers at RNOH. The team now manages 140 volunteers who wear our distinctive yellow uniform and can be seen in all patient areas of the Trust. With additional responsibility for Radio Brockley, The Disability Foundation and our own Patient Group we support a total of 178 volunteers across the hospital.

- 10% of volunteers undertake more than one role
- We have five married couples. We are doing something right!



Graph 2.5

Corporate Volunteering

Our plan this year was to focus on the resources offered to the Trust from the corporate world wanting to undertake some social responsibility and team building. Our links to Lloyds bank have become increasingly well-established over the last 3 years. This year we have been able to accommodate the multi-faith team (from the local Synagogue and Temple), Network rail, Cincera publicity and four teams from Lloyds banking group. All of these teams have been encouraged to either donate items such as plants for the garden or take advantage of our hospitality packages.

Projects undertaken have been:

- decorating nurses flat,
- planting £100 worth of donated plants,
- window cleaning,
- painting Orthotics reception,
- decorating the nurse education centre
- substantial garden maintenance projects
- redecorating visitor's side room in the restaurant.

ISS South East Division Management Team

Impact of Corporate Volunteering on RNOH Staff

"I would really like to express my appreciation to you and the team of volunteers who did a fantastic job in painting the educators' office.
Kindly convey our gratitude to the volunteers and also not forgetting the gentlemen who removed all the redundant bits from the walls and did the prep for the painters.
Every little that was done has gone a long way to make the space more habitable. "

Thanks received from the Clinical Nurse Educators team.

Buggy Poster Winner!

The volunteer service team are the proud recipients of the National Association of Volunteer Service Managers (NAVSM) poster award. Entrants were asked to submit a poster for a service that enhances patient experience, along with a 500 word essay on the project.

The volunteer buggy service team along with the representative of The Forrester Corporation, who helped create the winning poster, were there to receive the NAVSM award from the Chairperson.

Haberdasher's school successful pilot 16-18 year old volunteers

Following the immensely successful pilot scheme with Haberdashers girls school we have developed a further full years volunteering experience for a cohort of 12 girls. The school have embedded this into their curriculum and provide transport to the hospital weekly. The girls undertake ward visits, support therapies and histopathology.

After the completion of the pilot, three students continued to volunteer with us at the weekend. Our young volunteers are able to undertake shifts in the evenings and weekend; previously a difficult time for us to fill and this need has increased since we moved into our new building in December 2018.

Improving the Patient Experience

Improving the patient experience is at the heart of all we do in volunteer services. The Involvement lead facilitated a series of training events for existing staff on improving the patient experience and how to enhance customer care including the Strategic Nurse Leadership course. This also has given us the opportunity to speak to members of teams that have, as yet, not taken on a volunteer within their department and how this addition to their departments can enhance the patient experience.

Patient buggy service

Our highly successful patient buggy service which transports patients around our challenging site reached its milestone 55,000 passengers since its inception in July 2016. The service runs from 9.00am – 4.00pm 5 days a week by a team of fifteen volunteers who maintain the service in all weathers.

> *'comfortable and efficient but the driver was particularly nice and most helpful in getting me back to my parked car.' (Patient)*

Buggy driver Sep.

Nutrition volunteer

Working with the teams from dietetics and speech and language, 6 hand-picked meal time buddies received further training to become our first nutrition support volunteers. They offer nutritional support to patients which in turn helps supports the nursing staff team.

Meal time buddies successfully support patients across all wards over lunch time, dinner time and weekends.

Volunteers Week

We feel it is important to nurture and support our volunteers throughout the year and not just during volunteer's week. All our volunteers have regular support meetings with the team, have birthday cards sent to them, are awarded a badge after one and three years with us and feel they are able to call the office at any time. Saying thank you and feeling supported is why our retention rate consistently remains so high.

In addition, volunteers' week allowed the trust executive team to also show their appreciation, CEO, Director of Workforce, Chief Operating Officer and Director of Redevelopment all took half a day to personally visit volunteers and thank them for the roles and input they have. This was greatly appreciated by the volunteers and demonstrated the great support from the executive team for the Volunteering force.

We organised an outing to the Lido and had cream teas under the new gazebo. The weather was glorious as we took the train, driven by one of our volunteers, to the beach side venue for an ice cream and then back again to exchange stories and meet other volunteers in a relaxed and friendly manner.

Furthermore, we hold a biannual volunteers forum to exchange information and developments within the Trust and ideas the volunteers have for new roles and improvements to the services we offer**.**

Promoting Equality and Diversity

Working closely with Langdon UK we have been able to provide volunteer places for members of the public with learning disability to undertake volunteering roles around the Trust to enhance and develop their existing skills and to offer diversity and equality throughout our volunteering network.

Mother and Daughter dynamic duo; Sona and Vasha on their weekly trolley volunteer round. The trolley visits all wards including theatres, taking over £7,000 per year and serving 320 patients/staff a week.

'The volunteers are all angels –
Even if I don't want anything, it's always
great to see the volunteers' (Patient)

NHS@70

The Buttercup singers were formed by the volunteering department and named in honour of the RNOH Charities long association with buttercups. The singers were asked to take part in the NHS@70 celebrations on 5th July. A marque on "Matrons lawn" was festooned with bunting and balloons on a beautiful summers evening. The singers undertook a rendition of the Kool and the Gang's classic "celebration". NHS at 70, the new build and the RNOH were cleverly woven into the lyrics.

Some of the Buttercup Singers

Involvement

This year has seen the growth of patient involvement within the Trust including

- Patient Group
- Always Events
- What Matters to you day
- Focus group for the innovations team
- Patient Involvement Volunteer role

Patient Group - Second Observations

Patient Group, in addition to their ongoing ward visits and attendance at meetings such as safety and cognitive impairment, out-patients undertook a follow up to their report First Impressions. Second Observations looked at navigating around the hospital, including signage, litter, and inappropriate parking around the Trust and how this impacts on patient experience. The Trust has worked closely with Patient Group to improve all these aspects for our patients.

Always Event

The Trust has signed up to take part in NHS-England Always Events, a method of co-producing services with our patients. The Involvement Lead is part of the management steering group.

The Always Event asks patients what they would always like to happen and how to improve services. From experience these ideas are often small and inexpensive however have significant impacts for the patients.

A feedback tree has been designed and uses acorns for the anonymous feedback. The initial pilot focused on signage to Children's Outpatient department.

Patient Involvement Lead and Senior Project Nurse presented the initiative to the Always Event Conference which was attended by a mixed audience of patient experience managers, clinicians, quality leads and members of patient group. Findings from this pilot study were highlighted as well as the challenges and interventions to overcome those challenges. Collaborative work with outpatient department is underway to implement feedback in order to complete the first Always Event cycle before moving on to our next project.

2.6 VAL-YOU

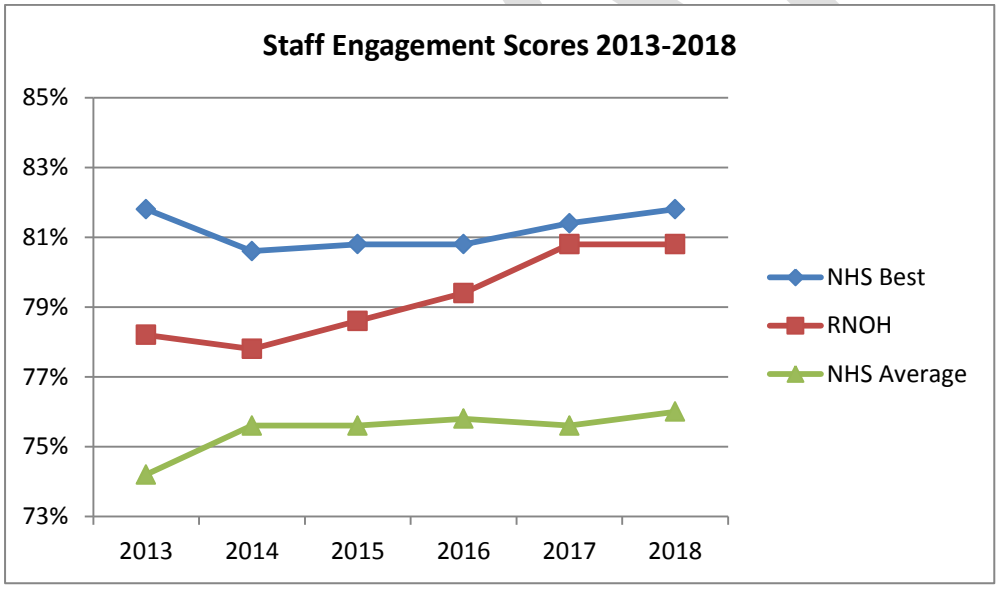
In 2016 the RNOH made a commitment to focus on staff experience and to become the best place to work in the NHS within five years. Evidence tells us that not only does a positive staff experience benefit staff; it also benefits patients through positive patient experience and improved outcomes.

Following the creation of the RNOH VAL-YOU programme, staff experience within the Trust has continued to be a priority.

By embedding our Values:
Patient First *always*,
Excellence *in all we do,*
Trust, honesty and Respect *for each other*, and
Equality *for all*,

we continue to develop the culture within the organisation to help us reach our goal of becoming the best place to work in the NHS, as detailed in our vision.

We are proud of the progress we have made, demonstrating improvement on our NHS Staff Survey staff engagement scores, against a background of no improvement in the broader NHS as illustrated in the chart below, and achieving the best scores amongst Acute Specialist Trusts for Quality of Care for the second year.



Graph 2.6

This year, based on feedback through various channels including Staff Survey and a number of Focus Groups, the primary focus within the last 12 months for the Val-You team has been to develop a culture of healthy conflict resolution and speaking up. This has consisted of;

- Creating an internal mediation scheme
- Delivery of team based, Forum Theatre sessions addressing values, behaviours and inclusivity

- Creation of a Resolution Policy, to replace our Bullying & Harassment and Grievance Policies encouraging and supporting a solution focused approach to resolving conflict
- Raising awareness of our Freedom to Speak up Guardians
- Continued provision of leadership development including a regular Leadership Forum, supporting staff to access national NHS Leadership programmes and providing bespoke Leadership programmes for staff at all levels
- The introduction of staff wellbeing workshops
- Launch of a reverse mentoring programme focused on diversity and inclusivity
- Delivery of a very successful Diversity Festival

For more information about RNOH VAL-YOU and our work to become the best place to work in the NHS please visit the RNOH's website, internal grapevine page (for staff only) or email rnoh.valyou@nhs.net.

2.7 Pharmacy and Medicines Optimisation 2018/19

The RNOH Pharmacy continues to ensure high quality medicines optimisation for patients. Medicines optimisation is about supporting patients to get the right choice of medicine at the right time. This helps to improve patient outcomes, support patients in taking their medicines, avoid taking unnecessary medicines, reduce medicines wastage and improve patient safety.

Some of the ways in which this continues to happen is through:

RNOH Formulary

A list of medicines that have been approved for use at RNOH is available for patients and staff alike to access. It is web-based, and can be accessed at www.rnohformulary.nhs.uk

RNOH is a member of the North Central London Joint Formulary Committee (NCL JFC) and the Hertfordshire Medicines Management Committee (HMMC). The medicines available for prescribing at RNOH (i.e. the RNOH Formulary) and the pathways for using these medicines are based on recommendations made by the NCL JFC and HMMC, as well as national and regional guidance.

In the first quarter of 2019, the RNOH formulary will be hosted by the North Central London Medicines Optimisation Network as part of a web-based 'joint' formulary across multiple NHS Trusts. This will help increase the number of medicines RNOH clinicians can access to treat their patients, as well as creating uniformity of access to medicines within the local region (North Central London) that RNOH works in (in partnership with other NHS Trusts and CCGs).

Clinical audits

The Pharmacy department clinical audit lead works closely with the Trust's clinical audit department in undertaking audits to identify opportunities for ongoing change in practice and improvement of care and services provided by the pharmacy department.

Priority audits have also been presented to the Trust at the Trust-wide clinical audit presentations which have been well received. Audits help us to ensure that staff adhere to recommendations made in local and national guidelines and policies, and therefore practice medicines optimisation by

ensuring evidence-based practice. All audits are registered with the audit department and a dedicated pharmacist helps maintain the department audit database to ensure audits are carried out, reports generated and action plans completed in a timely manner.

Medicines Safety

Globally, medicines have the potential to cause harm to patients, and thus the main medicines optimisation aim is to improve medicines safety. In the unfortunate event that mistakes have been made by staff, patients are informed of the learning that has been undertaken and an apology is offered, thus fulfilling the RNOH Duty of candour.

The RNOH has an Incident Review Group (IRG) that meets weekly and a Medicines Safety Committee (MSC) which meets 6 times a year, with a multi-disciplinary representation on both forums. The purpose of the RNOH MSC is to discuss medicines-related incidences, monitor and track trends over the last couple of months, and take steps to implement change to prevent such incidents recurring. Whereas, the RNOH IRG focuses on incidents that have occurred that past week (whether medicines related or not) and similarly discuss what has happened with the aim of expediting the investigation and closing off the incidents so that learning can be disseminated in a timely manner. Both the RNOH MSC and IRG comprise of pharmacists, doctors, nurses and the patient safety team, and the MSC has the addition of a patient representative as well. This complementary approach to working adds value immediately and in a sustainable manner to the care RNOH patients receive with regards to their medicines.

The RNOH has implemented a new Pharmacy stock management system that allows them to now electronically document and thus audit medication ordering/supply; record the time stamp of when a medicine was ordered, dispensed, and checked and also by whom; state the indication for an antibiotic when ordering so that its documented and thus can be reported upon; record a patients allergy status so that the system warns you if you try to issue out medicines that you've listed on their allergy list; flags up the BNF drug interactions if present, and so on. This list is not exhaustive but the patent/medicines safety benefits are numerous.

Furthermore, in the last year the RNOH has been able to identify trends in medicines-related incidents involving controlled drugs and have reviewed the use of some controlled drugs and also put additional training into place for their doctors, nurses and pharmacy staff. This has led to the RNOH noticing a reduction in these types of incidents occurring. Venous thromboembolism (VTE) is known to be fatal in hospitalised patients who have had surgery. Pharmacists at the RNOH routinely complete majority of 24 hour VTE re-assessments for all inpatients, which is an innovative practice in the NHS and aims to ensure patients receive evidence based VTE prevention in accordance with national guidelines.

As a national centre, the RNOH sees patients from all over the country, and abroad. There have been instances where patients have had medicines incorrectly prescribed and supplied when at home, and these instances have been picked up when the pharmacy staff undertake medicines reconciliation between the hospital prescription, GP prescription, and the medicines the patient brings in. This has led to further harm being prevented to patients, and improvements in their health and well-being. Patient safety is paramount to all RNOH staff, and this is one example where the RNOH pharmacy staff contribute to improving patient safety and the quality of care our patients continue to receive.

Medicines optimisation clinics and telemedicine clinics

Pharmacy work closely with the rheumatology doctors and nurses in ensuring medicines optimisation for patients referred into the rheumatology and metabolic bone disease service. These are expensive and complex medicines. Once the rheumatologist has seen the patient and recommended treatment, the pharmacist will have a face to face consultation with the patient to ensure the patient understands what side effects to look out for, how to administer the medicine and how to store it. This discussion also involves the provision of ongoing support patients once treatment has started through homecare. We have received positive feedback from patients who now call and speak directly to the pharmacist about any problems or concerns they have. These clinics have seen improved outcomes for patients and enabled closer working relationships between the rheumatology department and pharmacy in ensuring safe and improved patient care.

Pharmacists and pharmacy technicians are routinely providing ongoing access to medicines and advice, monitoring for adverse effects through telephone clinics to specialist clinical services e.g. bone and joint infection and long-term pain. These telephone clinics take place on a weekly basis. In long-term pain clinics, a pharmacist also facilitates trial of analgesics to determine their usefulness in individual patients and deprescribing as appropriate. Deprescribing of medicines is just as important as prescribing of medicines; often patients simply continue to increase the number of medicines they take, and the process of deprescribing means reviewing and stopping medicines that do not provide positive outcomes to patients' health and wellbeing. These telephone clinics have received positive feedback from patients and clinical staff.

Pharmacy staff also contact patients two weeks in advance of their surgery dates to confirm the medicines the patient takes, and discuss which medicines to stop and which are appropriate to continue. Prescriptions are written in advance of the patient arriving at RNOH, thereby enabling doctors to spend more time discussing any other issues the patients want to discuss on the day of their procedure.

In 2018 we implemented our plans to have a dedicated medicines helpline. This is accessible to all our patients through switchboard and is a reliable source of medicines-related advice. Queries are received and forwarded on to the most appropriate pharmacist to manage the enquiry. Patients' feedback is that they have found this service to be helpful and timely in terms of response.

Antimicrobial stewardship

The Department of Health considers antimicrobial resistance to be the single biggest threat to patients currently. As the RNOH is a national and international tertiary treatment centre, patients have been treated elsewhere before they are treated here. This means most of the time patients have become resistant to routine and conventional antimicrobials that are used to treat infections.

Specific expertise is required to help address such issues. The RNOH has a specialist antimicrobial pharmacist who provides clinical expertise as regards the use of antimicrobials. This role includes a range of activities to support the optimal prescribing, administration and supply of antimicrobials. This is in order to achieve the optimal clinical outcome and minimise the risk of Clostridium difficile infection and antimicrobial resistance. This also includes clinical leadership to the antimicrobial stewardship committee which is a multidisciplinary group that leads on a program of education and

training, audit and feedback, quality improvement and updating of the RNOH Microguide Application (this is a web based tool that guides clinicians in prescribing the most appropriate antimicrobials for patients for specific infections). It is accessible to all clinical staff and is widely used. In 2018/19 the range of local antimicrobial guidelines was broadened to include the prudent use of antimicrobials in children.

Reducing the impact of severe infections CQUIN

Antimicrobial resistance (AMR) is the single biggest threat to public health. The UK Government has taken strong leadership, by making AMR a national priority with the aim of reducing specific drug-resistant infections by 10% by 2025 and antimicrobial usage in people by 15% by 2024. This is important for the RNOH, as AMR complicates the prevention and treatment of orthopaedic infection. This has led to the safe reduction in total antimicrobial usage to achieve national CQUIN targets.

The RNOH is also actively promoting patients to become antibiotic guardians. Please sign up to this national campaign by logging on to www.antibioticguardian.com/public/

Please also support the national antibiotic awareness week which is usually held each November.

Outpatient Parenteral Antibiotic Therapy Service (OPAT)

The RNOH offers an outpatient parenteral antibiotic therapy (OPAT) service to permit intravenous antibiotics to be given safely outside the hospital setting, for up to several weeks. The pharmacy team supports this service by working within a multidisciplinary team including microbiologists, bone infection clinical nurse specialists and administration staff.

Feedback from the OPAT patient survey has shown that patients prefer OPAT treatment and evidence demonstrates that there is less risk of developing complications associated with a prolonged hospital stay.

The OPAT patient survey result for 2018/19 shows that:

100% of patients were confident to be discharged on OPAT.
96% of patients thought OPAT was preferable to in-patient treatment.
100% of patients were likely or extremely likely to recommend OPAT to their friends & family.

Although the RNOH complication rates from the vascular access devices are low, they have been reduced further by the introduction of a patient held booklet, better patient education and changing the line fixation devices as demonstrated on the graph overleaf.

The RNOH continuously reviews the clinical outcomes of patient treated in the service. In 2018/19, 93% of patients with bone infection were successfully treated. This high success rate has been maintained over the previous 4 years since 2013/14. Intravenous antibiotics have long been considered the gold standard for treatment of bone infection despite little evidence to support this. The Oxford Bone Infection team led the Oral Versus IV Antibiotic (OVIVA) trial. This was a randomised control trial that showed that oral (by mouth) antibiotics were non-inferior to intravenous antibiotics for treatment of bone infection. The RNOH was the largest recruiter for this

study outside of Oxford. The OPAT team have implemented the findings of this study and has shown that approximately two thirds of patients can now be safely and effectively treated with oral (by mouth) antibiotics. This improves the patient's quality of life by avoiding the need for long term intravenous access for antibiotic treatment.

Pre-assessment medicines optimisation

The pharmacists work with clinical staff in pre-assessment to agree treatment plans for patients in advance of their surgery. This helps to ensure patients are provided with the right advice relating to stopping and starting medicines prior to surgery (e.g. anticoagulants, antidiabetic medicines, oral contraception, hormone replacement therapy etc.) and provides an opportunity for patients to share preferences and concerns regarding their medicines in the perioperative period. The pre-assessment pharmacists are also prescribers who can write up the inpatient prescription chart to reflect an agreed treatment plan.

The pre-assessment team actively promotes and encourages patients to bring their medicines with them for their hospital admission, and use the 'green bag scheme' which has shown to save time and money, reduce drug wastage and minimise errors and missed doses. Research demonstrates that one of the biggest 'let-downs' for patients and medicines is in the 'interface' between hospital and primary care (GPs and community pharmacies). The pharmacist in the pre-assessment clinic aims to bridge this gap by enabling proactive communication between the hospital and primary care, thereby minimising the impact of any medicines-related 'interface' issues that may occur after our patients are discharged from hospital.

Medicines optimisation by patients' bedsides

For patients who are admitted into hospital, pharmacists and pharmacy technicians are available on the wards to discuss any issues and concerns patients have as regards their medicines. For those patients who are staying overnight, the pharmacy staff reconcile the information between the GP, community pharmacy and patient/carer, in ensuring that patients have the correct medicines prescribed, such that nurses can administer medicines to patients. They also make use of the 'green bag scheme' in ensuring that if a patient is moved from one ward to another then the patients' medicines are also moved. This helps ensure that medicines are available for patients to take as intended, and therefore optimise recovery time after their operation.

During 2019, RNOH plans to expand the role of Pharmacy technicians to enable them to administer medicines on wards to increase engagement with patients. Pharmacy technicians will undertake medicine rounds with an opportunity to engage with patients, assess the patient's understanding of their medicines, identify any barriers to adherence and be actively involved in the medicines optimisation process.

Self-administration of medicines

Patients most commonly take their medicines by themselves before and after they come into hospital. So why do we not empower patients to take their medicines by themselves when they are in hospital? The RNOH answered this question by evaluating a pilot involving 'self-administration' of medicines on the Jubilee Rehabilitation ward. Patients and nursing staff found this to be preferable to tradition hospital medicines rounds. In 2017 – 18, this was commenced to roll this out to other wards where patients are able to, want to, and can self-administer their own medicines. In 2018 the RNOH has continued this work in the New Stanmore Ward block, where there is more space for patients to hold their medicines by their bedsides.

The impact of this change will be measured during 2019.

Improving the patient experience

Research, patient surveys and patient feedback all tell us that patients do not like to have to wait around in hospital after being declared fit for discharge. We know that some of the delays are due prescriptions not being written up on a timely basis, which then leads to delays in the dispensing of medicines to patients. In order to improve the patient experience around discharge, where possible, working closely with the doctors and nurses we have:

1. Implemented pharmacist prescribers in clinical areas to prescribe discharge medicines at least 24hours before discharge. This provides an opportunity for patients to discuss the options for analgesics 'to take away' with a pharmacist and enables the medicines to be available on the ward before discharge
2. The Pharmacy team dispenses 'to take away' medicines in clinical areas to minimise delays. To enable this there are designated spaces in treatment rooms that are fitted with computers and labellers
3. Pharmacy continue to work with the volunteering service to try and reduce the time it takes for medication to transport from the pharmacy dispensary to the clinical areas

We have received feedback from patients about having to wait inside the pharmacy reception area for their prescriptions. In response, we have worked with RNOH charity to improve patients' experience by issuing vouchers for all patients waiting for their outpatient medicines so that they can receive a complimentary cup of tea / coffee in the hospital restaurant.
Pharmacists actively contribute to joint school sessions for elective joint arthroplasty patients. The overall aim of these sessions is to prepare patients for their admission, providing insight into what they should expect and empowering patients to be involved in decisions around their care and treatment at the RNOH.

Education and Training

RNOH, in association with the Royal Free Hospital Pharmacy Department have put together a KPI database to track formalised education and training within the pharmacy department. We also conduct regular pharmacist group and technician group meetings, as well as departmental meetings where specialist clinicians are sought to provide education on specific topics. These have been very well received and feedback has been positive. As of 2019, all specialist pharmacists will be qualified non-medical prescribers and one pharmacist is currently on the enhanced clinical independent

prescribing course, as all future trainees will also be. We currently have 3 pre-registration pharmacy technicians, one of whom is ahead of schedule to complete by June 2019. Three pharmacists are currently undertaking the clinical pharmacist diploma. These areas of training are imperative to the efficient running of not only the department, but all in providing excellence in care and putting our patients first.

Our specialist pharmacist in antimicrobials will be commencing a PhD in antimicrobial resistance, which will help the RNOH best manage patients with the limited range of antimicrobials we have presently, whilst the NHS and the world awaits the pharmaceutical industry to develop novel antimicrobials.

Specialised services with NHSE

The Pharmacy department has proactively supported colleagues at RNOH to setup and establish specialised services to treat rare and complex conditions. This includes the use of asfotase alfa for treating paediatric-onset hypophosphatasia and burosumab for treating X-linked hypophosphataemia in children and young people. RNOH continues to be recognised by NHSE as a designated centre for the use of dibotermin alfa for complex spinal fusion surgery.

Clinical trials

Since 2015, the Pharmacy department has been actively collaborating with consultants at RNOH to increase research capacity and undertake clinical trials for new medicines. To date we have started eleven new clinical trials with plans to initiate further studies in 2019. The majority of clinical trials have been for investigative medicines used for the treatment of rare bone diseases in children and adults, further establishing our national and international reputation as a specialist centre in this therapy area. To accommodate this high intensity workload, the Pharmacy workforce has continued ongoing training to meet the requirements of the regulatory authorities and our clinical trial sponsors.

NHS Benchmarking

Since 2017, the Pharmacy department has been submitting data to the annual Pharmacy and Medicines Optimisation benchmarking project. This has enabled the pharmacy to review the services it provides to patients and learn what the team is doing well and where improvement needs to happen. Aligned with the outcomes of the Carter Report, benchmarking measures include patient-facing services such as:

- % of Pharmacists' time spent undertaking clinical activities – as a result of the data demonstrated, changes have been made to the daily work-plan and an increase in pharmacist time spent by patients' bedsides has been noticed
- % of Pharmacy technicians' time on ward-based activities – the RNOH has gone from having no pharmacy technician input to having 5 members of staff providing pharmacy technical input into patients' care in clinical areas
- % of inpatient beds visited daily by a clinical pharmacist – each weekday, every patient is seen at least once by a pharmacist
- Medicines reconciliation by pharmacy team within 24 hours of admission – the aim is to endure every patient who is admitted for longer than a day has their medicines reconciled

within 24 hours, and the benchmarking data demonstrates RNOH pharmacy will need to continue to work

- % of patients experiencing an omission of critical medicines – audit data has demonstrated a reduction in this, which is a positive step in the right direction; the focus on this will continue through 2019 to further improve to 0% omission of critical medicines
- Percentage of qualified pharmacist prescribers routinely prescribing – using the benchmarking data, RNOH has increased its pharmacist prescribers from 1 to 6 in the last few years, and this trend is set to continue.

Electronic Prescribing and Medicines Administration (ePMA)

The Pharmacy department will be integral to the Trust's plan in launching an ePMA system during 2019/20. This is a core missing element in the Trust's journey to deliver its Electronic Patient Record strategy.

Part 3: Progress against 2018/19 Quality Priorities

3.1 Priority 1: Improving Length of Stay

The RNOH agreed that improving the length of stay (specifically for patients who have a primary hip or knee replacement) was an important quality improvement initiative. Over the past 15 months the Trust has implemented opportunities to reduce inappropriate adult inpatient hospital stays, whilst maintaining safe, risk assessed and high quality patient care.

As part of this work, the Trust has set itself a SMART (Specific, Measureable, Achievable, Realistic and Timely) objective for reducing the length of stay for all adult inpatients having a primary total hip/knee replacement by March 2019 and reduce the average length of stay by increasing the number of patients discharged on or before their target discharge date, from the 4 surgical wards.

This initiative also involves reducing the proportion of adult inpatients admitted the day before elective surgery from Joint Replacement Unit (JRU), Spinal and Sarcoma specialities and introducing On the MEND principles on wards.

The 'On The MEND' initiative has been rolled out to all adult wards and a programme of audit commenced to measure the effectiveness. This initiative aims to support patients in 4 main areas to aid post-operative recovery: **M**edicines, **E**xercise, **N**utrition, and **D**aily Activities.

The Trust has been measuring progress through the following key performance indicators:

- Target Discharge Date
- Overall average length of Inpatient Spell (on the Mend group)
- Admission the day before surgery

The progress against this quality priority is being monitored via monthly update reports to Length of Stay Steering Group. The progress against each priority is also reported to the Trust Board on a Monthly basis through the Improvement Programme Board update.

During 2018/19 the Trust made progress in the following areas:

- A statistically significant improvement was observed for admissions on the day of surgery in our joint reconstruction unit and in our sarcoma service
- A patient education video has been scripted and commissioned for our joint reconstruction patients. This was developed in conjunction with our patients
- A comprehensive evaluation was performed on the programme's overall outcomes, which will inform the priorities for 2019/20
- The On the MEND project was launched on our surgical wards to encourage patients to mobilise as soon as is clinically safe to do so post operatively.

3.2 Priority 2: Theatre Utilisation Project

RNOH recognises that the patient's surgical journey is complex and crosses many boundaries. Services to patients can only be improved if operating theatres are seen as part of a wider more complex system.

The overarching strategic aim of this initiative was to facilitate a step change in performance of theatre productivity at the RNOH for the benefit of patients and staff. This initiative involved consistent improvements in various areas affecting theatre productivity, with a particular focus on intra-session utilisation and list pick up rates.

The Trust has been measuring the progress through the following key performance indicators:

- List order changes
- Late starts
- Early finishes
- % Utilisation
- Weekend operating
- Empty lists
- Cancellations on the day
- Booking rate (%) (booking efficiency)

The progress against this quality priority is being monitored via monthly update reports to the Theatre Action Group. Progress is also reported to the Improvement Programme Board once every two months and monthly to the Trust Board via the Improvement Programme Update report.

During 2018/19 the Trust made progress in the following areas:

- Statistically significant improvements were observed for:
  - Intra-session utilisation
  - On time starts
  - Booking fill rates
- Recognised by NHS Improvement for being in the top tier group for theatre improvement amongst London trusts. NHS Improvement has invited the RNOH to share its experience and good practice with others
- The Trust has committed, in principle, to develop a Theatre Admission and Day Case Unit in the coming years. This is subject to capital funding being available
- The programme has transitioned into business as usual and it is therefore unlikely that there will be any new priorities set for 2019/20.

3.3 Priority 3: Safer Staffing

Implementing a safer clinical staffing model for the RNOH underpinned by equitable contractual arrangements and effective systems and processes was a key priority for 2018-19. Assessing the care needs of patients is paramount when making decisions about safe staff requirements for RNOH. RNOH recognises that assessment of patients' care needs should take into account individual preferences and the need for holistic care and patient contact time.

The Trust had set itself some SMART objectives around Safer Staffing Improvement Project which included implementing revised job planning, updating the leave policy for medical workforce, implementing consistent rates of pay for additional sessions, implementing consultant-led weekend ward rounds, implementing on-call supplement rates of pay for medical staff, implementing a sustainable non-consultant doctor workforce and implementing a sustainable medical physician consultant workforce to deliver high quality patient care.

The Trust has been measuring the progress through the following key performance indicators:

- Job plans
- Additional sessions arranged
- Consultant leave
- On-call arrangements
- Development of the Sustainable Safer Medical Staffing Models

The progress against this quality priority is being monitored via monthly update report to the Medical Management Meeting / Safer Staffing steering Group. Progress is also reported to the Improvement Programme Board once every two months and monthly to the Trust Board via the Improvement Programme Update report.

During 2018/19 the Trust made progress in the following areas:

- Formally established a programme to deliver the key projects
- Undertook a detailed review of current projects and prioritised key projects and ceased others. The key projects for 2018/19 were:
    - Tendering for a Register Medical Officer service (ongoing)
    - Formally reviewing all clinical service level agreements with other Trusts (ongoing)
    - Addressing urgent handover and escalation processes and policies (ongoing)
    - Piloting independent prescribing pharmacists (complete and further roll out is under review)
    - Assessing the role of Advance Nurse Practitioners (ongoing)
    - Good progress is being made in all projects
- Transitioned job planning management to business as usual following good progress on job planning for all consultant staff
- Transitioned the Medical Emergency Team to be managed by business as usual following completion of this project.

3.4 Priority 4: Developing Capability and Capacity of Staff in Quality Improvement Methodology

Developing Capability and Capacity of staff in Quality Improvement Methodology was one of the Trusts key quality priorities for 2018-19. It is important for staff to build the skills set, knowledge and experience required to meet the future needs of the service.

In time this should lead to a culture or way of delivering improvement that is consistent amongst all staff delivering any type of improvement whether it is quality or service improvements, small scale change or complex transformation.

A bespoke training programme was developed and delivered by University College London Partners.

The aim of the programme was to provide staff with the ability to increase their knowledge in building capability and capacity to improve quality, patient outcomes and experience, alongside increasing efficiency. It offered time and space to plan and have open dialogue in a safe environment, away from the usual workplace. It also provided staff with opportunity for more tangible learning and benefits that would enable us to develop quality improvement work which delivers better results for patients and populations.

The progress against this quality priority was monitored via monthly update report to the Improvement Programme Board and Trust Board.

During 2018/19 the Trust made progress in the following areas:

- UCLP bespoke Improvement Leaders training delivered for over 30 staff in leadership and management positions
- Developed, agreed and delivered Year 1Improvement Strategy
- Developed and agreed a 'dosing' model for improvement training for all staff
- Began developing measurements to monitor delivery of strategy and impact on staff culture
- Using staff representatives to develop year 2 and beyond Improvement Strategy
- Created a Senior Improvement Advisor post
- Secured non-executive director support for the improvement agenda and trained non-executive directors
- Planned for a Trust Board Development session to further educate Trust Board and build consensus and support for Improvement Strategy

Part 4: Quality Priorities for 2019/20 and statement of assurance from the Board

4.1 Quality Priorities for 2019/20

4.1.1 Priority 1 – Develop and embed safety huddles across all in-patient areas

Safety huddles provide an opportunity for daily learning from recent safety incidents and feedback relating to patient experience. They also provide an opportunity to identify patients at risk of deterioration and harm to prevent this from occurring. Safety huddles are seen in many high reliability organisations.

A project lead has been identified to develop the RNOH safety huddle model, looking at evidence of existing frameworks and undertaking visits to organisations where these are embedded.

Key milestones for this project, which will be monitored via the Clinical Quality & Governance Sub-Committee (CQGC), are:

- Development the RNOH model (31st May 2019)
- Design & instillation of new RNOH Quality boards in ward areas (31st May 2019)
- Small scale tests of change to the model utilising the IHI improvement model (28th June 2019)
- Training programme for staff in the use of the model & awareness raising campaign (31st July 2019)
- Clinical audit of the use of safety huddles to test these are embedded (monthly from 30th August & reported via CQGC)

4.1.2 Priority 2 – Develop and fully implement a Ward Accreditation Programme

Ward Accreditation programmes ensure that high standards of clinical care are consistently delivered, using a framework of continual assessment, quality improvement and a system of recognition.

A project lead has been identified to develop the RNOH accreditation model, looking at evidence of existing models and undertaking visits to organisations where these are embedded.

Key milestones for this project, which will be monitored via the Strategic Nursing Committee, are:

- Development of the RNOH accreditation model (28th June 2019)
- Development of data collection and reporting tools (28th June 2019)
- Training programme for staff involved in data collection (31st July 2019)
- Internal communications to raise awareness of ward accreditation (31st July 2019)
- Launch of ward accreditation (1st October 2019)

4.1.3 Priority 3 – Procure, develop and roll-out Electronic Prescribing and Medicines Administration (EPMA)

EMPA systems have the opportunity to reduce the number of prescribing, dispensing and administration errors. The trust will seek capital funding to enable procurement and roll out of an EPMA system.

Key milestones for this project, which will be monitored via the IM&T committee, are:

- Secure capital funding for the system (April 2019)
- Procure the EMPA system (June 2019)
- Integrate the EMPA system into the Trust IT infrastructure (Dec 2020)
- Undertake training of clinical staff in the use of the system (Dec 2020)
- EMPA project completed with full roll out within the trust (Jan 2021)

4.2 Statements of assurance from the Board

All providers of NHS services are required to provide certain mandatory reporting elements within their annual Quality Account. This section of the account contains the required mandatory information and, where necessary, an explanation of our quality governance arrangements relating to these indicators.

4.2.1 Review of services

During 2018/19, the RNOH provided 24 NHS services. The RNOH has reviewed all the data available to them on the quality of care in all of these NHS services.

The 24 clinical services provided by the RNOH are:

- Anaesthesia
- Bone Infection Unit
- Clinical Neurophysiology
- Clinical pharmacy and Medicines Optimisation
- Foot and Ankle
- Functional Assessment and Restoration (FARs)
- Histopathology and Pathology
- Joint Reconstruction
- London Sarcoma Unit
- London Spinal Cord Injury Centre
- Orthopaedic Medicine
- Orthotics and Prosthetics
- Paediatric and Adolescents
- Pain Management Services
- Peripheral Nerve Injury Unit
- Plastics
- Radiology
- Rehabilitation and Therapy
- Rheumatology
- Shoulder and Upper Limb
- Spinal Surgical Unit
- Urology
- Psychiatry
- Clinical Psychology

The NHS income generated by the relevant health services reviewed in 2018/19 represents 91% of the total income generated from the provision of relevant health services by the RNOH for 2018/19.

4.2.2 Participation in Clinical Audits

Participation in National Clinical Audits
In 2018/19, the RNOH was eligible to and did participate in 100% (8) National Clinical Audits and 100% (1) National Confidential Enquiry.

The National Clinical Audits and National Confidential Enquiry that the RNOH was eligible to participate in are listed below, alongside the number of cases submitted compared to the requirements set out by the enquiry/audit.

National clinical audits and National Confidential Enquiries	Number of eligible cases required by the audit	Percentage submitted
National Joint Registry: Hip, Knee Primary and Revision procedures (2018/19) Hip and Knee Primary and Revision procedures (2017/18)	1048 987	In Progress (87.2%) 99.4%
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis	49	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	1	100%
National Comparative Audit of Blood Transfusion - FFP and Cryo use in neonates and children 2018	3	100%
National Comparative Audit of Blood Transfusion - Management of massive haemorrhage	0 (No haemorrhage met the criteria in the audit period).	N/A
BAUS Urology Audit – Female Stress Urinary Incontinence (SUI)	2	100%
Case Mix Programme (ICNARC)	680 (Q1 -3)	100%
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	12	100%

Table 4.2.2A

The National Joint Registry (NJR) was set up by the Department of Health and Welsh Government in 2002 to collect information on all hip, knee, ankle, elbow and shoulder replacement operations, to

monitor the performance of joint replacement implants and the effectiveness of different types of surgery, improving clinical standards and benefiting patients, clinicians and the orthopaedic sector as a whole. The Trust continues to contribute to the National Joint Registry (NJR). The compliance rate for submission of Hip and Knee replacement operations is currently being analysed. Continuous work is being undertaken to ensure compliance is in alignment with the benchmark figure of 95%.

The Trust participates in Serious Hazards of Transfusion (SHOT) scheme. SHOT is the United Kingdom independent, professionally-led haemovigilance scheme. Since 1996 SHOT has been collecting information on adverse events and reactions in blood transfusion from all healthcare organisations that are involved in the transfusion of blood and blood components in the United Kingdom. RNOH submitted 1 eligible case in 2018/19.

The Trust participated in National Comparative Audit of Blood Transfusion- Frozen Plasma and Cryoprecipitate in neonates and children 2018. This audit was designed by National Comparative Audit Team to determine appropriate use of frozen plasma and Cryoprecipitate in neonates and children against current British Society of Haematology guidelines. RNOH do not care for neonates and only children were audited. The RNOH submitted 3 cases which met the criteria (100%).

The Trust participated in National Comparative Audit of Blood Transfusion- Management of massive haemorrhage. RNOH submitted 0 cases (no haemorrhage which met the audit criteria in the audit period in 2018/19).

The reports of 5 relevant national clinical audits were published in 2018/19. These reports were reviewed and we intend to take the following actions to improve the quality of healthcare provided:

National clinical audits	Details of actions taken/planned following review

National Joint Registry: Hip, Knee and Ankle Replacements	• To continue to participate in the Registry to monitor the performance of joint replacement implants and the effectiveness of different types of surgery, improving clinical standards; benefiting patients including outcomes and clinicians
	• All historical data backlog has now been taken over and cleared by Theatre Admin and clinical teams
	• New monthly compliance check report has been established to avoid backlog re-occurrence going forward; this has been proposed to the NJR who are considering rolling this methodology out National wide.
	• Improved clinical engagement seen across all specialties
	• NJR process was fully reviewed by the CSSD Senior team to ensure that:
	  ○ Robust system is now in place to ensure that all MDS forms are generated for all eligible NJR procedures. A monthly checking process is in place to ensure a cleansing processing picks up any remaining items
	  ○ All staff are aware of the NJR process, and reminder communications are regularly sent out to Divisions

	○ All completed NJR forms reach the member(s) of staff responsible for inputting NJR data. All Surgeons submit forms to single point of contact in Theatres admin team ○ Data is now input is completed daily. And team working on a e-system to provide bulk direct upload to NJR system • NJR audit now included in the hospital annual audit plan.
National Confidential Enquiry- Chronic Neuro-disability in Children, Young People and Young Adults	• Audit data presented at MDT to raise importance and improve compliance with weight and nutrition status assessment. Discussion included clearly documenting the patient's learning disability in addition to neurodisabling condition • RNOH have put in place specific policies and procedures for children and young persons (CYP). There is specific Children and Adolescent Ward (Sir William Coxen Ward) and a dedicated CYP outpatient department. However some CYP are still seen in the main outpatient department as the surgeons see both adults and children. There are however separate waiting areas for CYP. This is currently being looked at • Patients with a cerebral palsy or other chronic neurodisability have very specialised care. This is discussed on an individual basis • Audit underway by therapies to look at pre-assessment pathway and referral.
National Comparative Audit of Blood Transfusion - 2017 Audit of Transfusion Associated Circulatory Overload (TACO)	• TACO checklist added to Transfusion Policy • Checklist added to Nursing care plan • Checklist added to clinical and medical induction and annual update • Only 2 out of the 20 patients audited had a significant risk factor • Education for prescribers to document any risks and treatment discussed with the patient • Patients routinely have Haemoglobin reassessed 24hrs post transfusion (lab test) by medical teams • The person authorising/prescribing the blood must review the patient. We recommend this is within the preceding 24 hours (at most) if the patient is an inpatient: This however may not be the prescriber due to timing of prescription. The reassessment will usually be done by the surgical teams on their ward rounds. • Currently trialling a non-invasive device • Re-audit to be undertaken in 2019.

Serious Hazards of Transfusion (SHOT) 2017	• Training in A, B, O and D blood group principles is included in annual update training and competency assessment • Monitor risk and safeguard reports for trends and report to SHOT as required • Blood track for blood fridge access and tracking in place since 2014 • Current service provider LIMS cannot support further electronic management systems. This will be considered in future with LIMS upgrade • TACO checklist was added to Transfusion Policy in November 2017 • Checklist added to Nursing care plan (on shared drive) • Checklist added to clinical and medical induction and annual update training • National Audit was completed in 2017 - action plan has been completed
NCEPOD: Peri-operatives Management of Surgical Patients with Diabetes Study	• Ongoing review of Trust diabetes patients' admission criteria, pre-operative patient information booklet and pre-operative diabetes referral pathway • Preoperative Assessment currently looking to increase admin staff as part of current Business Case • Diabetes team is considering to include glucose monitoring into WHO Checklist and addition of a diabetes page into the green consent and surgical monitoring booklet • Plan for auditing the preoperative Assessment Diabetes referral pathway • Plan for including specific diabetes section in Pre-operative assessment booklet • Upskilling of nursing staff at ward level by providing educational opportunities. • Diabetes Specialist Nurse will review complex appropriate diabetes cases • Annual audit of prioritisation of patients with diabetes on operating lists

Participation in Local Clinical Audits

For the year 2018/19, a total of 113 local Clinical Audits were registered which are specific to RNOH. The reports of 67 completed audits have been reviewed during the year. This includes regular monthly audits to check the standards to which we should be operating at, assessing our current practice and then implementing actions (if required) to ensure that we provide safer and more effective care.

Local Clinical Audits	Details
The NHS Safety Thermometer	For 2018/19 the highest recorded harm free percentage has 98.3%. We have consistent low percentage of RNOH acquired harms which includes Falls with Harm, New VTEs, New Pressure Ulcers and New UTIs. If any new harm is identified, actions are put into place immediately by the ward. All harms are reported via the web incident reporting system and All PU's reported are escalated to the Lead TVN.
Hand Hygiene	Hand Hygiene audit is carried out to measure compliance against the National guidance by World Health Organisation (WHO) 5 Moments for Hand Hygiene approach. Devised by the World Health Organisation (WHO) it defines the key moments when health-care workers should perform hand hygiene. **We are undertaking the following actions to improve compliance:** • Infection Prevention and Control Team (IPCT) has been raising awareness of Hand Hygiene via periodic training and ward level monitoring • IPCT will continue monitoring hand hygiene compliance across the trust and publish audit findings to ensure awareness and encourage ownership of hand hygiene practices.
Vascular Access Management Audit	The purpose of this audit was to reduce the risk of infection by improving the use and management of vascular access devices. NICE Clinical Guidance CG139, Prevention and control of healthcare-associated infections in primary and community care (published in March 2012) contains standards for Vascular access device site care. These devices are one of the main causes of healthcare-associated infections, and bloodstream infections associated with central venous device insertion are a major cause of morbidity. **We are undertaking the following actions to improve compliance:** • Anaesthetic charts used in Theatres are reprinted to cover vascular access insertion criteria • Awareness through education and posters are being implemented by IPCT in coordination with Clinical Educators and Theatre Link Nurse to ensure compliance to these criteria

Local Clinical Audits	Details
	• Increased training will be delivered via workshops and ward rounds regarding vascular access.
Environmental Ward Spot-check **and** **Full Compliance Audits**	Monthly spot-checks are done by the Infection Control Nurse and through peer audit. The checks are completed for all wards. Compliance is monitored by the Infection Control team. A further full compliance audit is completed twice yearly for all areas, once by the Matron for the area and once by the (IPC) team. **We are undertaking the following actions to improve compliance:** • Issues are immediately addressed with further monitoring done through the full compliance audit • Senior Nurses in Wards carry out continuous education and equipment cleaning audit in Clinical Areas • Minimise clutter given the lack of storage space and continue environmental cleaning • Continuous observation and inspection by team composed of Estates & Facilities Administrator, ISS Domestic Manager and IPC Nurse is conducted every first Friday of the month to a specific ward/area/ department.
Combined Nursing Audit	Combined Nursing audit is conducted on monthly basis to identify current practice of completing various aspects of Nursing practice. The audit is designed to monitor nursing documentation, slips trips & falls assessments, Pressure Ulcers, Nutritional Assessment and Care Planning. **We are undertaking the following actions to improve compliance:** • Progress is monitored via clinical audit software "AuditR" and shortfalls are addressed on monthly basis via AuditR alerts to identified leads • National Early Warning Score (NEWS) app has been trialled across certain wards. It will be fully implemented across all wards to improve compliance • New reporting system for Combined Nursing had been introduced on AuditR to improve monitoring.
World Health Organisation (WHO) Safety Checklist Audit: - **Imaging** - **PPU** - **Surgical**	The Safer Surgery Saves Lives initiative was launched by the World Health Organisation (WHO) in 2008 to develop patient safety throughout the perioperative phase of care through a reduction in the number of surgical errors; which could lead to patient death. WHO checklist audit is completed in real-time for all the procedures carried out in theatres and interventional procedures carried out in Imaging. **We are undertaking the following actions to improve compliance:** • An ongoing observational audit has been introduced to capture adherence to WHO Checklist completion policy. This will focus on the

Local Clinical Audits	Details
	quality of the checks conducted • Policy has been updated with the new WHO reporting process and updated WHO charts • Locally WHO safer surgery checklist data is analysed on monthly basis to identify any areas of improvement • WHO checklist has been updated on AuditR • Chart identifying any missing elements / sections are provided to Head of Nursing for Critical Support Services Division. This is displayed in the Theatres notice board • Areas of low compliance are addressed at team meeting.
Audit of anaemia and transfusion in 2 stage spinal surgery (NICE Guidance NG24)	The audit evaluated the prevalence of anaemia in undergoing multi-stage surgery patients at different stages of their surgery and at discharge, prior to the implementation of strategies to treat the anaemia including the use of intravenous iron to improve patient recovery and outcome post-operatively. **We are undertaking the following actions to improve compliance:** • Data shared with Anaesthetic Department and pan-Trust • Audit submitted to international NATA meeting to gain further recommendations • Recommend routine commencement of oral iron post 2 stage spinal surgeries for patients diagnosed with anaemia, and followed up in community by GPs • A service evaluation of intravenous iron to treat anaemia in 2 stage spinal surgery should be considered in discussion with the DTC.
Medicines Reconciliation Review (NICE Guidance NG5)	The audit evaluated the number of patients that have medicines reconciliation completed within 24 hours of admission. **We are undertaking the following actions to improve compliance:** • All ward pharmacists reminded of Trust's Medicines Reconciliation Policy and to accurately document completed reconciliation on the drug chart • Audit results presented in clinical pharmacist meeting to discuss reconciliation not being completed in a timely manner • Line managers monitor documentation of reconciliations during ward visits.
An audit of the Shoulder and Elbow Unit (SEU)/ Peripheral Nerve Injury (PNI) in-patient rehabilitation standards	To evaluate if consistent approach to the admission and treatment of every admission to the PNI / SEU in-patient programme is adopted across the team. **We are undertaking the following actions to improve compliance:** • Quality of patient information was improved. • Establish formal SEU referral criteria and clarify pre-admission requisites for each service

Local Clinical Audits	Details
	• Assessment on day 1 is being considered • Psychology screening was included on assessment forms • Liaise with Psychology about electronic referrals for psychology input • Patient pathway was reviewed and standards rephrases.
An audit on the effectiveness of the green bag scheme	The audit evaluated if the proportion of patients bringing in their regular medicines has increased from 79% following the introduction of the green bag scheme in 2013. Initially, green bags were only given to patients who were attending for face to face pre-assessment appointments. Recently, green bags are now posted to patients who have telephone pre-assessment appointments. **We are undertaking the following actions to improve compliance:** • The green bag scheme was re-advertised by putting up posters in main patient areas. Green bags made more visible and available in pre-assessment, in all consultation rooms, and at reception • Scheme expanded to patients not attending for face to face appointments by posting to patients with appointment letter for telephone assessments • Green bag scheme introduced to private patient and children's' pre-assessment unit • Pharmacy telephone clinics continued to remind patients to bring in their medicines 1-2 weeks before their admission Telephone text reminder service implementation for patients being admitted for surgery to bring in their medicines.
An audit on the pharmacy endorsements on drug charts	The audit evaluated the standards of endorsements by Pharmacy staff on drug charts to establish if the clinical pharmacy endorsements standards are being followed consistently across the Trust. **We are undertaking the following actions to improve compliance:** • Clinical Endorsement standards reviewed and updated, and require all staff refreshed their knowledge and understanding of these standards • Electronic prescribing being implemented to reduce inconsistency in endorsements and clarity of prescriptions.
Audit of patient consent for Human Tissue in Orthopaedics Surgeries	The audit evaluated the quality of care provided to patients by ensuring blood product transfusion and Human Tissue Consent policies / guidelines are available, appropriate, understood and practised within the Trust. **We are undertaking the following actions to improve compliance:** • Patients are consented in Pre-op clinic, giving them opportunity to discuss proposed surgery in more relaxed environment on the day of planned procedure • Information leaflet is distributed in Outpatients and Pre Op clinic

Local Clinical Audits	Details
	• Consent Form made more visible and revised to require service user confirm risk and benefits have been discussed.
Audit of Untoward Events in a Multidisciplinary Chronic Musculoskeletal Pain Centre	The audit evaluated if policy on managing untoward events is being followed. **We are undertaking the following actions to improve compliance:** • To continue the current format of meetings with enough documentation for future audits • To discuss at Departmental strategy meeting the need for Duty of Candour.
Catheter Care Audit	Annual audit to assure Infection Control Committee that care of patients with catheter comply with NICE Quality Standard (QS61), statement 4: "Urinary Catheters" and Clinical Guideline (CG139) "Healthcare-associated infections: prevention and control in primary and community care", catheter care plan / policy, and as part of infection control annual work plan for reducing Gram Negative bacteraemia infection. **We are undertaking the following actions to improve compliance:** • Trust wide awareness sessions by the Infection Control / Urology specialist nurses.
Clinical Notes Audit for Private Patient Unit (PPU) Therapy Staff	The audit evaluated the documentation of staff members working on the PPU. Monitoring this regularly (every 6 months) helps to ensure a safe mode of practice and notes are of satisfactory quality and manage the risk from new, rotational locum and temporary staff. **We are undertaking the following actions to improve compliance:** • In-service training with team to ensure notes are legible • Send team list of trusts abbreviations • Relay areas of low compliance identified to the team
Clinical Notes Audit for PPU therapy staff: Re-audit	The re-audit evaluated if there had been an improvement in clinical notes. **We are undertaking the following actions to improve compliance:** • In-service training with team to ensure awareness and adherence to professional body guidance • Exclude standards inapplicable to the next audit tool
Complaints Policy and Associated Learning Outcomes	The audit evaluate compliance with following CQC regulations: making sure appropriate investigations are carried out to identify what might have caused the complaint and the actions required to prevent similar complaints and providers should monitor complaints over time, looking for trends and areas of risk that may be addressed.

Local Clinical Audits	Details
	We are undertaking the following actions to improve compliance: • Clinical Directors from each division to appoint a Quality Facilitator • Clinical Directors from each division to share their learning outcome actions at regular governance meetings and shared at Quality Improvement and Lessons Learnt Review Panel • For staff who have complaints upheld / partially upheld regarding the communication / behaviour / attitude should be held accountable and receive development where appropriate e.g. training, monitoring etc.
Consent in Children and Young People	The audit evaluated the consent process in children and young persons with a focus on involving children and young persons as appropriate for their age. **We are undertaking the following actions to improve compliance:** • Present findings to multi-disciplinary team including Nursing, Surgical and Anaesthesia teams. Provide teaching sessions about policies and laws • Develop a Mental Capacity Assessment (MCA) form for young persons on the Adolescent Unit. Develop posters about procedures and MCAs • Insert Consent Form 1 in folders of all young person's ages 16-17 • Develop leaflets for patients in all children over 10 years old and encourage competent children up to age 16 to participate in their own consent • Applaud Nursing staff for high rate of young person's signing their own consent
Continuity of care in orthotics outpatients	The audit evaluated patient experience and outcomes by assessing if patients see the same member of staff while being treated for the same orthotic condition wherever possible. **We are undertaking the following actions to improve compliance:** • Record reasons in patients' clinical notes if they are booked in with different orthotists. This will be discussed with admin team to try to ensure this happens when appointments are booked • It will be difficult to prevent patients from seeing different orthotists if they attend as walk-ins so these patients should be excluded from future audits • Re-audit in 6 months (April 2019) after asking admin team to record reasons in the notes if patients are booked in with other orthotists.
Quarterly Controlled Drugs Audit	This audit evaluated if wards and theatres are compliant with the Medicines Policy (MP10) and Controlled Drugs legislations. **We are undertaking the following actions to improve compliance:** • Quarterly CD checks to be conducted with ward pharmacist and senior

Local Clinical Audits	Details
	ward staff, review ADIoS monthly. CD stock list for the clinical area to be reviewed by ward pharmacist and ward manager/senior staff nurse • All heads of nursing and ward managers (and other senior ward staff) to obtain administration rights for managing nursing signatory lists. Obtain training on use from IT if required. Perform appropriate and timely review and updating of nurses' signatures • Education and training for nurses and ODPs in relation to documentation • Incident reporting of all CD related events – including breakages and spillages, missing signatures • Twice weekly CD stock ordering to be completed in the timely manner. Return unwanted, expired or close to expiry, unrequired PODs/TTAs in a timely manner.
Documentation of Tourniquet	This audit evaluated how well Health Care Professionals in the Upper Limb and Foot Ankle Unit are documenting tourniquet use during surgery. There are no standardised guidelines that exist and this audit will assist in establishing some local ones that can be implemented. **We are undertaking the following actions to improve compliance:** • Standardised section in operation notes to document all 5 standards • Allocating a nursing staff to complete the admissions booklet with all the information.
Re-Audit: Documentation of Tourniquet	This re-audit evaluated if actions implemented from the initial audit had improved the documentation of Tourniquet. Five documentation standards were established from the initial audit. **We are undertaking the following actions to improve compliance:** • Standardised section in operations notes to document all 5 standards • Allocate a nursing staff to complete the admissions booklet • New admission booklets with sections to document: Padding use & type and Fluid shield use • Laminate copy of what to document on the Tourniquet machines • Use of micro tape.
Effectiveness of Foot & Ankle Telephone Clinic	The audit evaluated the outcomes of the foot and ankle telephone clinics and the use of resources. **We are undertaking the following actions to improve compliance:** • Educate new medical team at unit induction on role of Tele clinic every 6 months by Clinical Lead / Clinical Nurse Specialist • Re audit 12 - 24 months by Clinical Nurse Specialists.
Ensuring safer practice with high doses	The audit evaluated current practice with regard to ensuring safer practice with high dose ampoules of diamorphine and morphine by comparing current practice against the standards set by the NPSA.

Local Clinical Audits	Details
ampoules of diamorphine and morphine	**We are undertaking the following actions to improve compliance:** • All nurses have to complete IV assessment book and part of the workbook the nurses have to choose six IV medicines which have to be supervised • Make morphine as one of the drugs of choice where they would learn what the adverse effects and the monitoring requirements for morphine are • All nurses to attend the Pain study day, Epidurals and Patient controlled analgesia study day.
Compliance against NICE Interventional Procedures Guidance (IPG311 & IPG571)	These two audits evaluated the use of Extracorporeal Radial Shockwave Therapy (ESWT) in the foot & ankle shockwave clinic at RNOH adheres to NICE guidelines for ESWT for Plantar Fasciitis and for insertional and non-insertional Achilles Tendinopathy. The audit also looks at monitoring the effectiveness of ESWT as an intervention by ensuring data is collected regarding outcomes and any adverse effects. **We are undertaking the following actions to improve compliance:** • Development of a shockwave patient information leaflet • Team meeting to address Consent issues, agreed that verbal consent was satisfactory for both plantar fasciitis and Achilles tendinopathy patients, and that written consent not required • Discussed and agreed with all consultants in MDT in February 2017 Achilles tendinopathy NICE guidelines were updated in December 2016 and now just say "consent" and do not specify that this has to be written. For future audits, standard will just say consent for both plantar fasciitis and Achilles tendinopathy and will not specify written or verbal.
Fasting times audit for adults and paediatrics (Fasting Policy Audit)	The audit evaluated the length of time fasting for fluids and solids that occur compared to the RNOH fasting policy. **We are undertaking the following actions to improve compliance:** • Patient leaflet in use by anaesthetists • Anaesthetic room observation by dietitian • Share findings at the relevant forums • Re-audit.
How well do operation notes in Sarcoma/BTU comply with 'Good surgical practice' outlined by the Royal College of Surgeons	The audit evaluated the Sarcoma / Bone Tumour Unit compliance with the Royal College of Surgeons (RCS) guidance on keeping clear and comprehensive operation notes in order to improve patient safety post-operatively, communication between doctors working on the ward with those in theatre, and efficient handover to medical and allied health professionals. **We are undertaking the following actions to improve compliance:**

Local Clinical Audits	Details
England	• Developed a pro-forma for surgeons to fill out and ensure all the criteria of the RCS are being met as well as some adjuncts relating to the Unit.
Improving Compliance with Oral Methotrexate Guidelines NPSA/2006/PSA13	The audit evaluated whether the Royal National Orthopaedic Hospital adhered to the recommendations set out in NPSA Patient Safety Alert 13: *Improving compliance with oral methotrexate guidelines*. **We are undertaking the following actions to improve compliance:** • All pharmacists reminded of requirements for managing inpatients on Methotrexate • Clinical Nurse Specialist / doctors to identify patients less likely to carry monitoring booklets and advised them of the importance these. Pharmacists/Medicines Management Technicians to review monitoring booklets upon discharge planning • Prescribing and dispensing software programmes updated with risk management specifications • Pharmacy team develop method of differentiating between Folic Acid and Methotrexate packed down boxes.
Identification and accuracy of allergy-status documentation of adult inpatients at RNOH	The audit evaluated if allergy status is correctly and accurately documented for adult inpatients, if documented allergies are true allergies and distinguish between true allergic reactions or other adverse reactions, and to identify best practice of documenting highlighting patient's allergies. **We are undertaking the following actions to improve compliance:** • Promote awareness and improve training for multi-disciplinary staff about dangers of recording incomplete or incorrect allergy information • Formulation of a trust wide policy / guideline on drug allergies to include information such as the structured assessment guide recommended by NICE • Use the iCS risk flags to identify true allergies.
Is the current Foot and Ankle MDT clinic orthotic outreach model an effective use of available Orthotic clinic time?	The audit evaluated if the current model of Orthotists formally providing input alongside the Orthopaedic Foot and Ankle Consultants (under the standard of care: that sufficient numbers of complex patients will benefit from multidisciplinary planning at the time of surgical team assessment). **We are undertaking the following actions to improve compliance:** • Train other healthcare professionals to fit simple off the shelf, Consultant prescribed orthotic devices • To change clinic set up to utilise appointment times more efficiently • Re-audit.
MDT Record Keeping	The audit evaluated the results with the previous year's compliance rate, and reviewed the RNOH medical record documentation against National and

Local Clinical Audits	Details
Audit	Local standards in order to verify that the Trust is providing high quality and safe care. **We are undertaking the following actions to improve compliance:** • Audit findings to be highlighted at different disciplinary teaching sessions and to different staff groups (from ward clerks to Trust executives) • SHOs and therapists to use a stamp with their name for printing names in patient notes • Update adult admission booklets containing consent to share information, and discard old ones • E-medical records team to test and confirm if alerts on NoteOn.
Medicines optimisation – Delayed/missed doses	The audit evaluated the number of omitted and delayed doses, which therapeutic drug had the highest omitted and delayed doses, how many critical medicines were omitted/delayed, the most common reason behind the omitted and delayed doses, and the wards with the most omitted and delayed doses. **We are undertaking the following actions to improve compliance:** • Doctors/Nurses/Pharmacists to review medication that the patient is refusing regularly • Ward pharmacists to inform doctors and non-medical prescribers on wards about standardising timings when prescribing medicines. Educate nursing staff about how to obtain medicines out of hours to avoid missed/delayed doses • Ward managers to have meeting with their nursing staff to reinforce the importance of documenting reasons for omitted or delayed medicines • Incident reports on omitted and delayed medication should be reviewed regularly.
MRSA Screening Compliance Audit	This audit was conducted to assure the Infection Control Committee and Trust Board that the RNOH patients are being screened for MRSA. The MRSA compliance audit is carried out bi-annually for all in- patients at RNOH as a point prevalence audit to ascertain that all patients are being screened for MRSA pre admission or on the day of surgery. **We are undertaking the following actions to improve compliance:** • Any non-compliance is followed up by appropriate infection control/awareness raising action in any department where gap in compliance is identified • Reminder to all wards that patients need to be screened for MRSA.
NICE: QS131 Intravenous	The audit evaluated the compliance of prescribers with local and National Institute for Health and Care Excellence (NICE) guidelines on prescribing IV

Local Clinical Audits	Details
fluid therapy for children in RNOH	fluids in paediatric patients. **We are undertaking the following actions to improve compliance:** • Promote the presentation of the key findings of this audit to all relevant staff to support implementation of the recommendations • Fluid calculations for bolus, maintenance, deficit and on-going loss replacement must be made and documented, preferably on the fluid charts or in the notes • Publish this report and seek widespread circulation to all staff involved in administering of IV fluids in children • Discuss during the induction with paediatric and anaesthetic registrars • Present audit to paediatric MDT.

Notes Audit (Orthotics Department)	The audit evaluated the record keeping process to assess if clinical notes adhered to the required standards to provide the correct and relevant information related to each patient's treatment.
	
	We are undertaking the following actions to improve compliance:
	• Request admin staff ensure this documentation (current discharge summary or referral) is present when booking appointments
	• Educate staff members in training sessions on the importance of recording the following information:
	  ○ Patient diagnosis stated
	  ○ Initial assessment documented
	  ○ Clear treatment plan documented.

Paediatric Medicines Safety Qualitative & Quantitative Audit	The audit evaluated compliance with standards to ensure safe prescribing. **We are undertaking the following actions to improve compliance:** • Paediatric MDT Teaching session to go through common drug doses and what should be round down/up so as to facilitate easy administration for nurses • Education and training for nurses surrounding good documentation practice on drug charts. Can be delivered by ward pharmacist via 5-10min "Drug huddle or Druggles" session • Implement 2x 15 mins slots for nurses for dedicated medication-related documentation in the medical notes • Education and training with competence assessments - to encourage good prescribing practice • For anaesthetic team to review pain score chart/NEWS chart to address this.
Pain Outcomes Diary Audit in Radiology	The audit evaluated the effectiveness of diagnostic & therapeutic image guided injections for patients undertaken in the radiology department.

Local Clinical Audits	Details
	We are undertaking the following actions to improve compliance: • First part of diary completed with RDA at sign out • Information leaflet produced with instructions • Liaise with communications team to have reminder prompts sent to patients 6 weeks post op.
Perioperative experiences of anaesthesia reported by children and parents	This was followed by a recent paper from Great Ormond Street Hospital, "Perioperative experiences of anaesthesia reported by children and parents" the experiences of children from The Royal National Orthopaedic Hospital with those from Great Ormond Street (see paper from Great Ormond Street Hospital, "Perioperative experiences of anaesthesia reported by children and parents"). **We are undertaking the following actions to improve compliance:** • Document the offer to parents to ask any further questions • Ensure preparation for general anaesthesia is done prior to arrival of child. • Alternative fluids for children who do not like water • PCA/ NCA prepared in advance. • Further toys for children in the recovery room.
Pharmacy Porter Workload	The audit evaluated if the Pharmacy porter is able to manage with the current work load and will have the capacity to manage additional deliveries when making deliveries to the new build hospital. **We are undertaking the following actions to improve compliance:** • Increased support to Pharmacy portering service, particularly at identified time pinch points and in anticipation of an increase in distance for transport of medication when the NIWB opens • RNOH ISS contracts manager and Pharmacy Department reviewed purchase of buggy with lockable component • Pharmacy porters use Vocera communication system.
Post-operative wound healing	The audit evaluated the reasons for post-operative wound complications. **We are undertaking the following actions to improve compliance:** • Clinicians identify on operation notes that patients with associated co-morbidities have their skin checked at one week post-surgery • Review suture closure by the medical team looking at types of material and suturing techniques • Education of wound care and suturing included in induction of rotational medical team.
Promoting safer	The audit evaluated whether the actions from the previous audit with regards to promoting safer measurement and administration of oral liquid

Local Clinical Audits	Details
measurement and administration of oral liquid medicines - NPSA/2007/19	medicines which was audited in 2016 have been completed. The results of the audit showed that all of the standards are now met and the Trust is compliant with the NPSA audit recommendations where Trust policies and certain devices are concerned.
Re audit of fridges and snacks available on all wards	The audit re-audited compliance with the Trust's Nutrition Policy. **We are undertaking the following actions to improve compliance:** • Communication team signpost patients to guidance on food from home • Ward managers check that fridge operating procedure being completed by their dedicated staff member, and reported back to Nutrition Steering Committee • Matrons/Clinical Leads disseminate consistent messages about food from home to all ward staff • ISS responsible for ensuring adequate snacks available at all times • Educated Ward Host on appropriate storage of opened items.
Re-audit of Compliance with Metastatic Spinal Cord Compression (MSCC) guidelines	The re-audit evaluated if patients coming in on the MSCC pathway get the assessment and rehabilitation as outlined in the Guidelines and Audit Implementation Network (GAIN) guidelines. **We are undertaking the following actions to improve compliance:** • Continue with relevant training as part of induction process • Developing integrated care pathway (ICP), and embedding a clear communication pathway open between the MDT to ensure patients are assessed in a timely manner • Improved documentation e.g. fatigue management discussions, drug history, outcomes of MDT meetings • Although psychological wellbeing has been documented, a relevant screening tool for use where appropriate being considered.
Re-audit of Inpatient Therapy Standards Following Posterior Spinal Fusion in Adolescents	The re-audit establish a benchmark of therapy intervention for adolescent patients scheduled for posterior spinal fusion for scoliosis corrective surgery at RNOH as set out in the original Audit. **We are undertaking the following actions to improve compliance:** • The day of therapy discharge and whether standards were achieved at day 5 for future reference are documented clearly in the medical notes • Embedding the prioritization of AIS patients at weekends to ensure standards are achieved. Preliminary meeting held in February 2019 and invited AHP'S working with AIS to share thoughts and see if consensus about standards is possible nationally.
Reducing dosing errors	The audit evaluated compliance against standards set by National Patient Safety Alerts (NSPA) to ensure clinicians are administrating the correct and

Local Clinical Audits	Details
with Opioids medicines	safe dose of opioids to patients. **We are undertaking the following actions to improve compliance:** • Acute pain team presented the findings in a Senior House Officer teaching session • The Acute pain team delivers training for all clinicians at medical induction to improve the way opioids are prescribed for adults at the RNOH • NPSA algorithm will be included in the Acute Pain Policy • Prescribers are directed to the Acute Pain Policy at induction.
Resources to support the safety of girls and women who are being treated with valproate NHS/PSA/RE/2017/002	The audit evaluated compliance with recommendations in Patient Safety Alert regarding the resources to support the safety of girls and women who are being treated with Valproate. **We are undertaking the following actions to improve compliance:** • Patient safety cards on Valproate kept in the dispensary • The lead educators for doctors, clinical nurse educators for adult and children, and pharmacist training voice sent this alert for them to action the relevant points of the alert (and embed training into clinical practice).
Risky Behaviours (CQUIN)	The audit evaluated if patients admitted to the hospital have an admissions booklet completed including 'healthy lifestyle' section as required by National CQUIN 18/19. **We are undertaking the following actions to improve compliance:** • Regular teaching sessions • DOH updated patient information.
Safeguarding Children Process	The audit evaluated if safeguarding processes are being followed in accordance to the RNOH Safeguarding Children Child Protection Policy. **We are undertaking the following actions to improve compliance:** • Review Pre-Op Admission Clerking form to lend itself to the questions required as per Recommendation 12 of the Victoria Climbie Inquiry • Consider introduction of the use of genograms during the clerking process • Safeguarding team to document in multi-disciplinary history sheets their involvement with an in-patient child and any support or advice given • The Safeguarding Office to complete monthly checks of the office VC log • Save to skinny file referrals made to Local Authority for each inpatient children.

Local Clinical Audits	Details
Screening for Depression and Anxiety in Patient to come in for Surgery	The audit evaluated if a history of mental illness affects the length of stay for the 12 most common surgeries conducted at the RNOH and to identify if the proportion of patients booked to come to RNOH who screen positive for a common mental disorder (anxiety or depression) are receiving treatment for it. **We are undertaking the following actions to improve compliance:** • Information shared with executive board and medical director • Business planning committee/executive are considering if viable service models can be implemented.
Temperature/ Thermal Blanket Audit	The audit evaluated patients' surgical pathway by ensuring maintenance of normothermia throughout the three surgical phases (pre, intra and post operatively) as recommended by NICE guidelines QS 49 to reduce the risk of surgical site infection. **We are undertaking the following actions to improve compliance:** • Normothermia should continue to be measured and documented before patient goes to theatres as it has improved according to the audit taken • Estates department to review the warming system so that theatres rooms' temperatures become easily warmed up accordingly • Patients temperature should be taken one hour or just before the patient leaves the ward otherwise theatre list can be delayed • Controlling long time operation procedures are difficult but patients should be warmed also with electric mattresses where it is applicable.
The adult patient's passport to safer use of insulin NPSA/2011/Alert 3	The audit evaluated if the actions from the previous audit of the safe use of insulin (2016) have been completed. **We are undertaking the following actions to improve compliance:** • Availability of blood glucose monitors on the wards has been reviewed with view to increase the numbers • Insulin passports added to Emis System so they can be booked out as zero stock.
Theatre Last Date of Menstrual Period (LMP) Documentation Compliance Re-audit	The audit evaluated the Trust's compliance against the required standard (95%) for the LMP part of the consent form to be completed, signed and scanned onto documents of the corresponding CRIS event. **We are undertaking the following actions to improve compliance:** • Nurses complete the LMP part of consent and sign and date the form • Radiographers check the form is completed before using it in theatres • WHO safety checklist amended to include LMP check in 'sign in' section. Theatre staff ensure this is completed during 'sign in.'

Local Clinical Audits	Details
An Audit of Histopathology Reporting of Uterine Sarcomas	The audit evaluated if histopathology reports for uterine sarcomas contain 100% of the core data items, as specified by the RCPath dataset. **We are undertaking the following actions to improve compliance:** • Use of a specific proforma or template for reporting uterine sarcomas.
To improve clinical care in the referral of orthopaedic oncology	To evaluate if patients are receiving optimal access to timely services to ensure good functional outcomes. **We are undertaking the following actions to improve compliance:** • Timely discharge reports are imperative • Consideration of rehabilitation pathway for those undergoing chemotherapy • Empowerment of people to follow up own referrals by providing contact details and a copy of the referral to the patient before discharge.
Improving scar care in adult post-surgical peripheral nerve injury (PNI) outpatients seen by occupational therapists in Bolsover Street	The audit evaluated if scar care advice is provided to patients and if post-surgical wounds/scars are assessed at the first Occupational Therapist (OT) appointment. **We are undertaking the following actions to improve compliance:** • Complete Multi-Disciplinary Team (MDT) liaison • Document reasons for advice not given • Consider wider role of MDT in scar advice to ensure timely provision • Team discussion and review of OT/PNI documentation of scar care advice and advice given • Liaison and review within Therapies, PNI unit and other RNOH clinical units regarding scar advice, provision of patient information including when advice provided, by whom and in what format.
To improve Speech and Language Therapy (SLP) management in spinal cord injured patients at the RNOH	The audit evaluated if current management of dysphagia and communication in spinal cord injury patients meets national standards for SLT role in rehabilitation and critical care settings and to identify any areas which need improvement. **We are undertaking the following actions to improve compliance:** • Documenting advice and assessment of mouth care on tracheostomy ward round stickers • Joint working with nursing staff, currently a nurse on ITU is leading on mouth care matters, a Health Education England initiative to improve mouth care on the wards • Benchmark against other SCI units for SLT input.
Tristel Wipes Annual	The audit evaluated adherence to cleaning of the flexible nasendoscope (FNE) as per manufactures standards and that the tracing book is completed

Local Clinical Audits	Details
Audit	fully for each procedure. **We are undertaking the following actions to improve compliance:** • Record the serial number in the Tristel book and/or highlighting the serial number of the one scope we have for this procedure at the front of each Tristel audit book • Ensure leak testing is always documented. Findings to be disseminated with adult SLT team and report sent to the trust audit team.
Uniform Audit for Adult Orthopaedic Inpatient Therapy Team	The audit evaluated if staff are adhering to wearing the correct uniform which is clean and fit for purpose (as per Trust Uniform Policy). **We are undertaking the following actions to improve compliance:** • Areas of low compliance around RNOH dress code, particularly around footwear has been discussed in team meetings with all staff agreeing to the proposal regarding the purchase of footwear.
Upper Limb Annual Notes Audit	The audit evaluated if the Upper Limb Therapy Team comply with record keeping guidelines as per the professional standards. **We are undertaking the following actions to improve compliance:** • Results discussed within 1:1 supervision sessions and subsequent and individual action plans developed between supervisor and supervisee • There is an ongoing project to develop the Therapies electronic notes system and it is anticipated this will reduce significantly the volume of uploaded documents.
Use of antimicrobial prophylaxis in urinary catheter removal	The audit evaluated the use of antimicrobial prophylaxis in urinary catheter removal at RNOH and assesses the usefulness of staff education in promoting good antibiotic stewardship. **We are undertaking the following actions to improve compliance:** • Teaching sessions given to Junior Doctors, Nurses and Pharmacist to reiterate standard as per Trust Policy • Present findings at Trust Quality Improvement and Audit Day in November 2018.
Use of tranexamic acid in primary knee replacement	The audit evaluated the use of tranexamic acid (TXA) and autologous drain transfusions and what effect if any this had on post-operative haemoglobin (Hb). **We are undertaking the following actions to improve compliance:** • For all primary knee replacements consideration should be given to the use of tranexamic acid provided there are no contraindications • For all primary knee replacements surgeons should consider their reason

Local Clinical Audits	Details
	for using a drain, with the understanding that the use of autologous drain blood does not make a statistically significant difference to post-operative Hb.
Written information for patients requiring surgery	The audit evaluated the written information provided in the clinic letter to patients with Royal College of Surgeons standards. The audit also assessed if patients wanted further information and determine what they would like. **We are undertaking the following actions to improve compliance:** • Highlight the findings regarding diagnosis and risk discussion at the departmental audit meeting • Introduce patient information leaflets for common conditions (Schwannoma, brachial plexus injuries and injury to the common peroneal nerve).

Table 4.2.2B

4.2.3 Participation in Clinical Research

Clinical research is essential for continuous improvement in healthcare delivery. Its importance has been recognised by the Care Quality Commission (CQC) and has been added to the inspection schedules. Each year thousands of patients take part in clinical studies in the NHS. The Royal National Orthopaedic Hospital NHS Trust together with our academic and commercial partners contributes to the development of new projects as well as contributing to recruitment of studies and trials from other centres. In 2018/19 our recruitment into NIHR Portfolio studies have exceeded 700 patients. Our studies are reviewed by research ethics committee (REC) as well as the Health Research Authority (HRA).

We provide opportunities for clinical research participation to our patients, and provide access to cutting edge treatments; this includes patients with rare conditions for whom treatments are currently limited. We provide individual patient solutions as part of innovative treatment, and support international studies for patients with extremely rare conditions.

Participation in clinical research demonstrates The Royal National Orthopaedic Hospital NHS Trust's 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. We work closely with our university partners to develop new treatments for our patients and our collaborations have produced impact on patient care locally and beyond. We're committed to producing new ideas across all staff groups to deliver research, which has a potential to change the way we treat our patients. Involving staff and patients in developing and delivering is essential for gaining the benefit associated with being a research active organisation.

The Royal National Orthopaedic Hospital NHS Trust was involved in conducting 65 clinical research studies of which 24 were initiated during the past year in the neuro- musculoskeletal specialities.

There were over 100 members of clinical staff participating in research approved by a national research ethics committee at The Royal National Orthopaedic NHS Trust, and support for clinical research continues to grow.

Our engagement with clinical research also demonstrates The Royal National Orthopaedic Hospital NHS Trust commitment to testing the latest medical treatments and techniques. RNOH collaborates with universities as well as industry partners in delivering cutting edge technology to everyday care. Our engagement with clinical research also demonstrates The Royal National Orthopaedic NHS Trust commitment to testing the latest medical treatments and techniques. Our collaborations include international projects with EU funding, and we also contributed to national projects such as the Genome 100,000, which aims to change care delivery in the UK.

Case studies:

Short title: The Connect Project
Title: The CONNECT Project, Phase 2: burdeN of treatmeNt

Lead: Mr Anthony Gilbert

Project: This is an NIHR funded project as part of Clinical Doctoral Research Fellowship (CDRF). The project explores patient preferences for the use of communication technology (for example, telephone, SKYPE or FaceTime) in orthopaedic physiotherapy and occupational therapy consultations. The project will help to shape future delivery of specific consultations using communication technology.

Short title: MUNEFlex
Title: A study of the application of Motor unit number estimation as a valid tool in assessing muscle re-innervation.

Lead: Mr Tom Quick

Project: The Motor Unit Number Estimation MUNE Flex study aims to assess the validity and application of this recognised neurophysiologic assessment to the process of nerve transfer to reanimate elbow flexion. This is a pilot study to inform the use of this technology in monitoring the return of axons to a re-innervated muscle. This is an important study, which will help to provide validated outcomes for future clinical trials in this area.

4.2.4 Commissioning for Quality and Innovation (CQUIN) payment framework

During 2017/19 the Trust signed up to CQUINs with both Clinical Commissioning Groups (CCGs) and NHS England (Specialised Commissioning).

The Trust overall income target associated with 2017/19 CQUIN schemes was approximately £2.5 million per annum. Details of the agreed CQUIN schemes for 2017/19 are provided in the table below.

For NHSE CQUINs the Trust is on target to achieve 100% for our CQUINS to date for 2018/19, which should equate to £955,935 to date.

Monthly monitoring both within the Trust and with the commissioners continues to take place to assess progress against each of the milestones. In our second year for these CQUINs the trust has again fully achieved all Specialised Commissioning CQUINs.

The trust is also on target to achieve all Non-specialised Commissioning CQUINs. Currently the Trust has 5 Fully Achieved and 1 partially achieved CQUIN. The Trust agreed 4 CQUIN schemes with NHS England for Specialised commissioners and 6 CQUIN schemes with Non-Specialised Commissioner CCG's.

For Specialised Commissioning: Out of 4 schemes the outcome was as follows:

1. All CQUINs Q1: Fully Achieved
2. All CQUINs Q2: Fully Achieved
3. All CQUINs Q3: Fully Achieved
4. All CQUINs Q4: Submission only on 30th April 2019

For the CCG schemes: Out of 6 schemes the outcome was as follows:

1. All CQUINs Q1: Fully Achieved
2. All CQUINs Q2:5 Fully Achieved / 1 partially achieved
3. All CQUINs Q3: Still to Be confirmed
4. All CQUINs Q4: Submission only on 30th April 2019

CQUIN Schemes Achievements

NHSE	Q1 Achievement	Q2 Achievement	Q3 Achievement	Q4 Achievement	Q1-4 Averaged %	M12 Forecasted Achievement	Total value of CQUIN Available if 100% was achieved
	Achieved	Achieved	Achieved	Estimated			
TR3 Spinal Surgery	100%	100%	100%	100%	100%	£ 348,916	£ 348,916
Service Redesign	100%	100%	100%	100%	100%	£ 253,323	£ 253,323
Telemedicine	100%	100%	100%	100%	100%	£ 148,170	£ 148,170
Anti microbials	100%	100%	100%	100%	100%	£ 205,526	£ 205,526
					100%	**£ 955,935**	**£ 955,935**

Table 4.2.4A

CCG	Q1 Achievement	Q2 Achievement	Q3 Achievement	Q4 Achievement	M12 Forecasted Achievement	Total value of CQUIN Available if 100% was achieved
	Estimated	Estimated	Estimated	Estimated		
1. Improvements of Health	100%	100%	100%	100%	£ 172,358	£ 172,358
2. Timely Identification	100%	100%	100%	100%	£ 172,358	£ 172,358
6.Advice & Guidance	100%	100%	100%	100%	£ 172,358	£ 172,358
9. Risky Behaviours (tobacco & Alcohol)	100%	100%	100%	100%	£ 172,358	£ 172,358
STP Engagement	100%	100%	100%	100%	£ 287,264	£ 287,264
Financial Control	100%	100%	100%	100%	£ 287,264	£ 287,264
Total					**£ 1,263,960**	**£ 1,263,960**

Table 4.2.4B

The achievement of these CQUINs has been once again been underpinned by the continuous engagement and work between Finance/Commissioning and CQUIN leads, which was embedded in 2017/18 when these CQUINs first started. RNOH has now standardised this approach with regards the management of CQUINs for 2018/19 and when the new round of CQUINs begins in 2019/20.

As a result of the CQUINs programme, improvements have continued to be made in the following:

- Establishment and operation of regional spinal surgery networks, GIRFT, data flows and MDT for surgery patients
- The Pharmacy team have worked incredibly hard to embed the timely identification of sepsis Antimicrobial resistance (AMR) across the Trust in 2018-19, which is reflected in the Trust expecting to achieve 100% for this CQUIN
- Telemedicine services in chronic pain and urology were implemented and further developed. This CQUIN has continued to achieve 100% during 2018-19
- There has been a continued focus on Flu Vaccination within the Trust in 2018/19, and the Trust is expecting to achieve our CQUIN target of 75% coverage for frontline clinical staff flu vaccinations
- Critical care service redesign CQUIN has continued to be embedded and rolled out successfully. Acute intervention team, transfer of zero organ supported patients to ward care rather than critical care and new Integrated care pathways have made the full achievement of this CQUIN in 2018-19 possible

- Development & implementation of Advice and Guidance service, with additional services coming on line throughout 2018-19. New services now offering Advice and Guidance include:
  - Upper Limb
  - Rheumatology
  - Paediatric Surgery.

4.2.5 CQC registration and compliance

All NHS hospitals are required to be registered with the Care Quality Commission (CQC) in order to provide services and are required to maintain high quality care in order to retain their registration. RNOH is required to register with the CQC and its current registration status is 'without conditions'. The Trust underwent a CQC Inspection in 2018/19 and received an "overall good" rating. CQC has not taken any enforcement actions against RNOH in 2018/19.

4.2.6 Data Quality

The oversight of data quality and its assurance falls within the remit of the Information Quality and Governance Steering Subcommittee. The Information Governance team work to ensure that high quality data flows are in place to provide better patient care and patient safety. The data flows play a key part in improving services through informed decision making and can be used to identify trends and patterns, draw comparisons, predict future events and outcomes, and evaluate services. RNOH will be taking the following actions to improve data quality:

- Consistent and comprehensive use of the NHS Number
- Quality assurances of data pre-submission
- Sign off data pre-submission
- Effective tracing of patients on the Personal Demographics Service (PDS) pre-submission
- Developing Data Quality Improvement Plans
- Reporting of data quality
- Routine audit and management of clinical & corporate records
- Audit clinical coding
- Comprehensive clinical coding training
- Incorporate national data definitions, standards, values and validation programs. Local documentation should be updated, as national standards develop
- The use of local and national benchmarking to identify data quality issues and analyse trends.

4.2.7 NHS number and General Medical Practice Code Validity

RNOH submitted records during 2018/19 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

- 98.9% for admitted patient care
- 99.2% for outpatient care

The percentage of records in the published data which included the patient's valid general medical practice code was:

- 100% for admitted patient care
- 99.9% for outpatient care

(Source: SUS+ Data Quality Dashboard as at month 11)

4.2.8 Data Security and Protection Toolkit attainment levels

From April 2018 the new Data Security and Protection Toolkit (DSP Toolkit) replaces the Information Governance Toolkit (IG Toolkit). It forms part of a new framework for assuring that the Trust are implementing the ten data security standards and meeting their statutory obligations on data protection and data security in line with the General Data Protection Regulation (GDPR).

Organisations contracted to provide services under the NHS Standard Contract (NHS providers) must comply with the requirements set out by Department of Health, NHS England and NHS Improvement, as part of the data security and protection requirements. The ten data security and protection standards are grouped: people, process and technology and include;

- **Leadership – People**

1. Senior Level Responsibility - Senior Information Risk Owner (SIRO) for data and cyber security
2. Completing the DSP Toolkit
3. Continue compliance to General Data Protection Regulation (GDPR)
4. Training staff

- **Leadership – Processes**

5. Acting on CareCERT advisories
6. Continuity planning in place to respond to data and cyber security incidents
7. Reporting incidents across the organisation

- **Leadership – Technology**

8. Identify unsupported systems
9. On-Site Assessments
10. Checking Supplier Certification

RNOH self-assessment submission for the DSP 2018/19 was submitted on time with all mandatory items completed by the deadline 31st March 2019 and the result was a pass.

4.2.9 Clinical coding error rate

RNOH was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission. However an internal formal clinical coding data quality audit was completed to NHS Digital and Data Security and Protection Toolkit standards in January 2019. A total number of 200 Finished Consultant Episodes (FCEs) were audited. The sample was randomly selected from the spells that occurred between the months of September, October and November 2018.

The audit was undertaken by NHS Digital Terminology and Classifications Delivery Service Approved Clinical Coding Auditor.

DATA SECURITY AND PROTECTION TOOLKIT LEVEL

Data Security & Protection Toolkit Requirements

	Level of attainment	
	Mandatory	**Advisory**
Primary diagnosis	>= 90%	>= 95%
Secondary diagnosis	>= 80%	>= 90%
Primary procedure	>= 90%	>= 95%
Secondary procedure	>= 80%	>= 90%

Overall results – Coder and Non-Coder errors

Year	Primary Diagnosis Accuracy	Secondary Diagnosis Accuracy	Primary Procedure Accuracy	Secondary Procedure Accuracy
2018/19	95%	98.7%	95.4%	93.4%
2017/18	96.5%	98.1%	96.3%	93.5%

Table 4.2.9 - RNOH-Data Security and Protection Toolkit Clinical Coding Data Quality Audit 2018-19

The audit report demonstrates that the RNOH has maintained its high standard of coding quality and has achieved excellent coding accuracy. Data quality coding audit percentages achieved correspond to an advisory level attainment on the data security and protection toolkit requirement in Table 1.

The income variance for the audited sample was (variance = 0.1% for a sample total value of £739,677). Most errors were made by omitting secondary codes for method of operation and site codes with minimal impact on income. Overall clinical coding audit findings show a high level of coding and income accuracy.

4.2.10 NHSE Emergency Planning Resilience and Response Assurance

The annual EPRR assurance process is used in order to be assured that NHS organisations in London are prepared to respond to an emergency, and have the resilience in place to continue to provide safe patient care during a major incident or business continuity event.

All organisations were required to carry out a RAG rated self-assessment against the NHS Core Standards for EPRR; this included the organisation's 2017-18 scores as a baseline to assess the 2018-19 position. Compliance was assessed against 77 applicable EPRR and Hazmat Standards.

RNOH demonstrated full compliance against all applicable standards i.e. all the standards relating to Governance, Duty to maintain plans, Command & Control, Training and Deep dive. RNOH was commended by NHS England for maintaining high compliance across all areas.

Part 5: Review of quality performance

Quality Account regulations from the Department of Health require trusts to report performance against a core set of indicators, using data made available to the Trust by the NHS Digital where available. The RNOH has added a number of other quality indicators that form part of our quality agenda.

5.1 Patient Safety Measures

5.1.1 Rate of admissions assessed for venous thromboembolism (VTE) – CORE INDICATOR

The RNOH considers that this data is as described for the following reasons. The data is collected regularly and is overseen by the multidisciplinary VTE Group.

VTE group works to:

- Ensure that the hospital follows national guidance on VTE and meets the requirements of the All Party Parliamentary Thrombosis Group
- Keep VTE related policies and processes up to date
- Implement and review mechanisms for VTE related clinical audits
- Complete root cause analysis investigations of all cases of VTE as nationally recommended
- Collate and analyse data on VTE risk assessment, prophylaxis and events including in-depth trend analysis using RCAs finding
- Set up training and education for staff including medical doctors, pharmacists, and ward staff on VTE prevention, recognition, and treatment

Indicator	2016/17	2017/18	2018/19
% patients admitted who were risk assessed for VTE	**99.8**	**98.5%**	**96.6***

Table 5.1.1: NHS England published data except *provisional internal data

The Trust has taken the following actions to improve the rate of risk assessments and so the quality of its services:

- A clinical audit is being planned against the VTE policy and NICE guidance Quality Standard
- An up to date policy on VTE is available to all members of staff via intranet. The policy is based on the latest NICE guidance and is actively being followed by the clinicians
- VTE committee is working closely with Surgeons, Cardiologists and Haematologists to develop action plan in order to fully implement the NICE guidance on VTE.

5.1.2 Clostridium difficile infection rate - CORE INDICATOR

The Royal National Orthopaedic Hospital NHS Trust considers that the rate per 100,000 bed days of cases of Clostridium difficile infection is as described for the following reasons: the Trust complies with the Department of Health guidance for mandatory reporting and management of positive cases of C. difficile infections acquired in the Trust. The data is submitted to Public Health England and it is benchmarked nationally against other Trusts. The RNOH board subjects outs C. difficile data to external audit for assurance purposes.

For the financial year 2018/19, the Trust had 2 cases of C. difficile infections against a target limit of 1 (i.e. CDI incidents/100,000 bed days is 4.1) set by NHS England. Within the year, the Trust also recorded 1 case where the patient was identified as a C. difficile antigen carrier but toxin negative in its inpatient group. The target limit is held against the number of incidents that are deemed as resulting to lapses in care. For the above financial year none of the two cases were regarded as a lapse in care following review by a representative of NHS England based on root cause analysis findings. All C. difficile infections were promptly identified resulting to patients having appropriate treatment, prompt recovery and enhanced experience.

Good practices, areas needing improvement and actions generated by the RCA are communicated to the multi-disciplinary team and the patient accordingly following duty of candour principles. The infection control team on behalf of the Trust continues to embed the following actions targeted at reducing its rate of C. difficile infection in order to improve the quality of its services and patient experience by:

- Maintaining and monitoring standards of cleanliness in the hospital and patient's surroundings.
- Continuous education on C. difficile infection among staff with emphasis on the following; its causes/pathway, identification, appropriate sampling, prompt treatment, isolation precautions, handwashing and other preventive measures.
- Maintaining and monitoring compliance of good infection control practices across the Trust including good hand hygiene, isolation protocols and cleaning of clinical equipment among others.
- Networking with other hospitals, professional groups and public sector stakeholders by sharing and implementing best practice in relation to management of C. difficile infection and updating local Trust policy as appropriate.
- Ensuring robust root cause analyses of C. difficile infection incidents in the hospital with the aim of identifying good practice, areas for improvement and identifying whether there are lapses in patient care. These are all taken into consideration for a learning curve leading to better patient outcomes.
- Maintenance of the Outpatient Parenteral Antimicrobial Therapy (OPAT) service, patient monitoring via the outpatient clinics and assurance through the Antibiotic Stewardship group and Infection Control Committee.
- Strengthening antibiotic stewardship within the Trust via consistent review of antibiotic prescribing, assessment and management of patients who are at risk of C. difficile infection in line current trends and best practice.

The table below provides comparison of the number of C. difficile infections in the Trust last 4 years versus allocated target limits by NHS England. The target limit score is a yearly figure calculated by NHS England and is based on performance indicators of the previous year. (https://improvement.nhs.uk/resources/clostridium-difficile-infection-objectives/)

	2014/15	2015/16	2016/17	2017/18	2018/19
C. diff Infections	3	2	2	5	2
Target Limit	13	2	2	2	1

Table 5.1.2: Confirmed data – Public Heath England – HCAI Data Collection System 2018/19

5.1.3 Patient Safety Incident Reporting - CORE INDICATOR

The RNOH considers that the rate of patient safety incidents reported and the number and percentage of such incidents that resulted in severe harm or death are as described for the following reasons:

- The Trust actively promotes an open and fair culture that encourages the honest and timely reporting of adverse events and near misses to ensure learning and improvement actions are taken
- The Trust submits patient safety incident data to the National Reporting Learning System. We are ranked against other Trusts in respect of the rate of reporting and category of harm

Incident Reporting							
Indicator	**2015/16**		**2016/17**		**2017/18**		**2018/19**
	Apr 2015 Sep 2015	Oct 2015 Mar 2016	Apr 2016 Sep 2016	Oct 2016 Mar 2017	Apr 2017 Sep 2017	Oct 2017 Mar 2018	Apr 2018 Sep 2018
Number of patient safety incidents reported[1]	347	334	343	428	633	779	776
Rate of patient safety incidents reported, per 100 admissions (as of 14/15 per 1000 bed days)	15.9	16.05	16.3	21.37	31.76	40.65	39.4
% incidents that resulted in severe harm (or death)	0.60%	0.30%	0%	0%	1.60%	0.3%	0.1%
% incidents that resulted in death	0%	0%	0.30%	0.50%	0.20%	-	0.3%
Lowest Performing Trust *wrt Bed days	16.34	16.05	16.3	13.67	14.82	17.6	19.0
Highest Performing Trust *wrt Bed days	150.63	141.94	150.6	149.7	174.59	158.25	142.8

Table 5.1.3: (Source: NRLS Organisation data for Acute Specialist Hospitals)

The Royal National Orthopaedic Hospital recognises that although serious incidents in health and social care are relatively uncommon, from time to time things can and do go wrong in the delivery of complex healthcare. When adverse incidents do occur the Trust has a responsibility to investigate & ensure that there are systematic measures in place for safeguarding people, property, Trust resources and reputation. This includes responsibility to learn from these incidents in order to minimise the risk of these happening again.

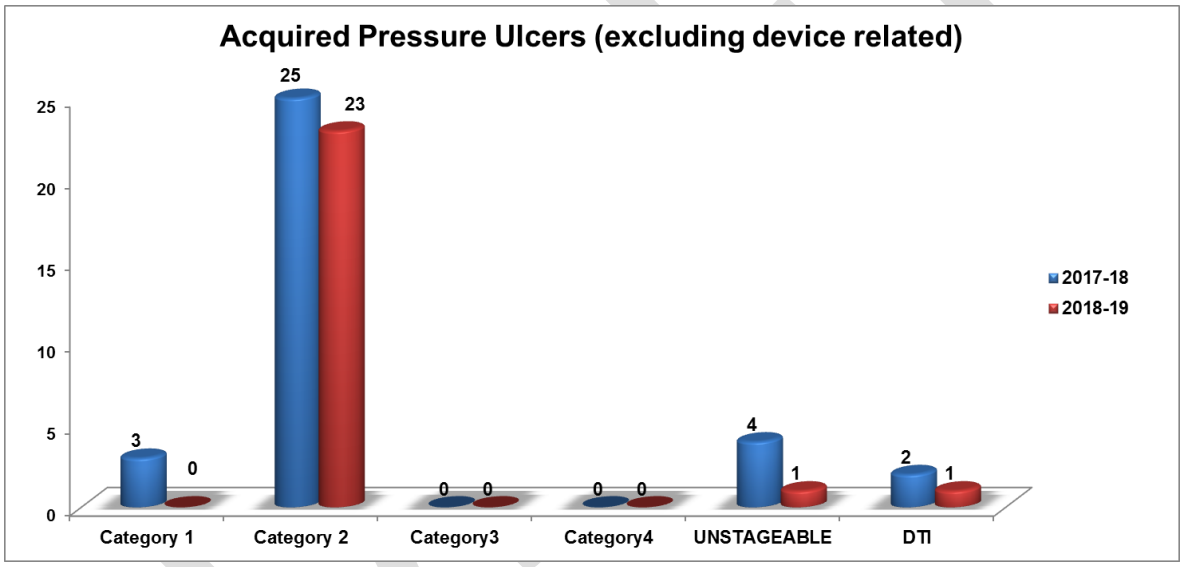
A combined incident and serious incident policy was approved in 2016. This policy is supported by the Complaints Policy and Being Open and Duty of Candour Policy which helps the organisation to understand why things went wrong, how we can prevent or minimise similar incidents and how we can share that learning across the organisation and externally. Serious incidents are investigated by a nominated multidisciplinary panel using the root cause methodology. Monthly reports are submitted to the Quality Improvement and Lessons Learnt (QUILL) Committee as part of the Quality Report.

5.1.4 Pressure Ulcers

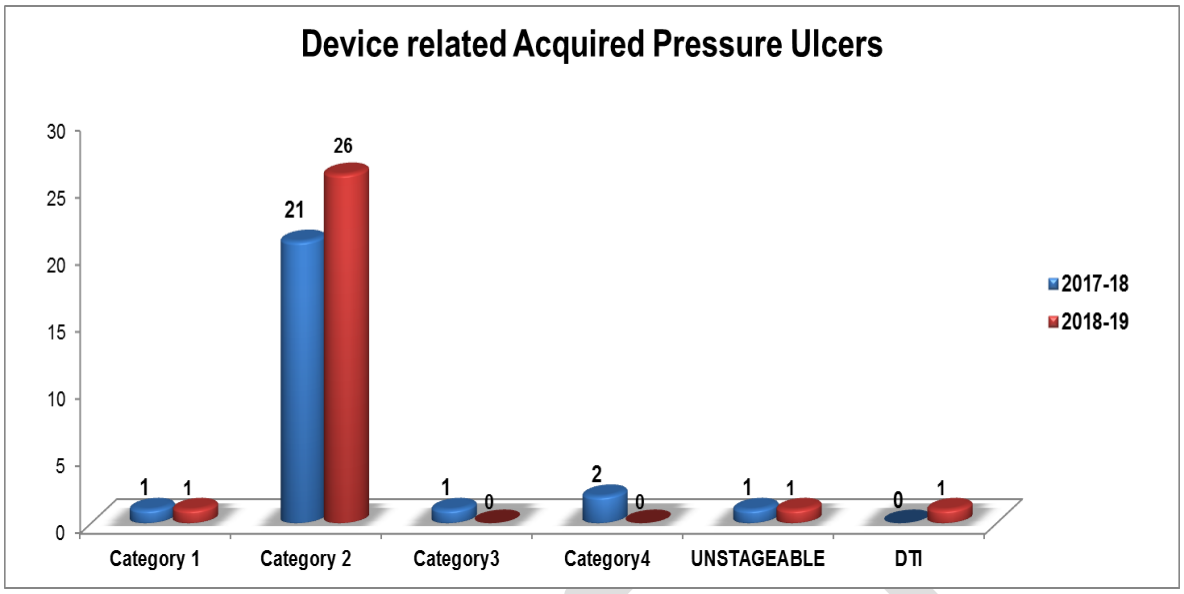
The Royal National Orthopaedic Hospital NHS Trust continues to commit to a zero tolerance towards pressure ulcer development with recognition of the risk levels posed to our client group due to the complexity of musculoskeletal conditions. Validation and investigations are led by the Tissue viability team along with the Senior Leadership team to determine the areas of learning from the patient's episode of care. Learning from the investigations is cascaded to multi- disciplinary teams and changes to care implemented to avoid future pressure ulcer development.

This financial year (2018-2019) has observed an increase in skin incidents being reported enabling early action and intervention which has seen a reduction in the severity of pressure ulcer formation compared to 2017-2018. In 2018 -2019 there were no validated category 3 or 4 pressure ulcer developments.

In 2018-2019, a total of 54 acquired pressure ulcers were identified whilst patients received care in the Royal National Orthopaedic Hospital NHS Trust. It is a 10% improvement from the previous year.

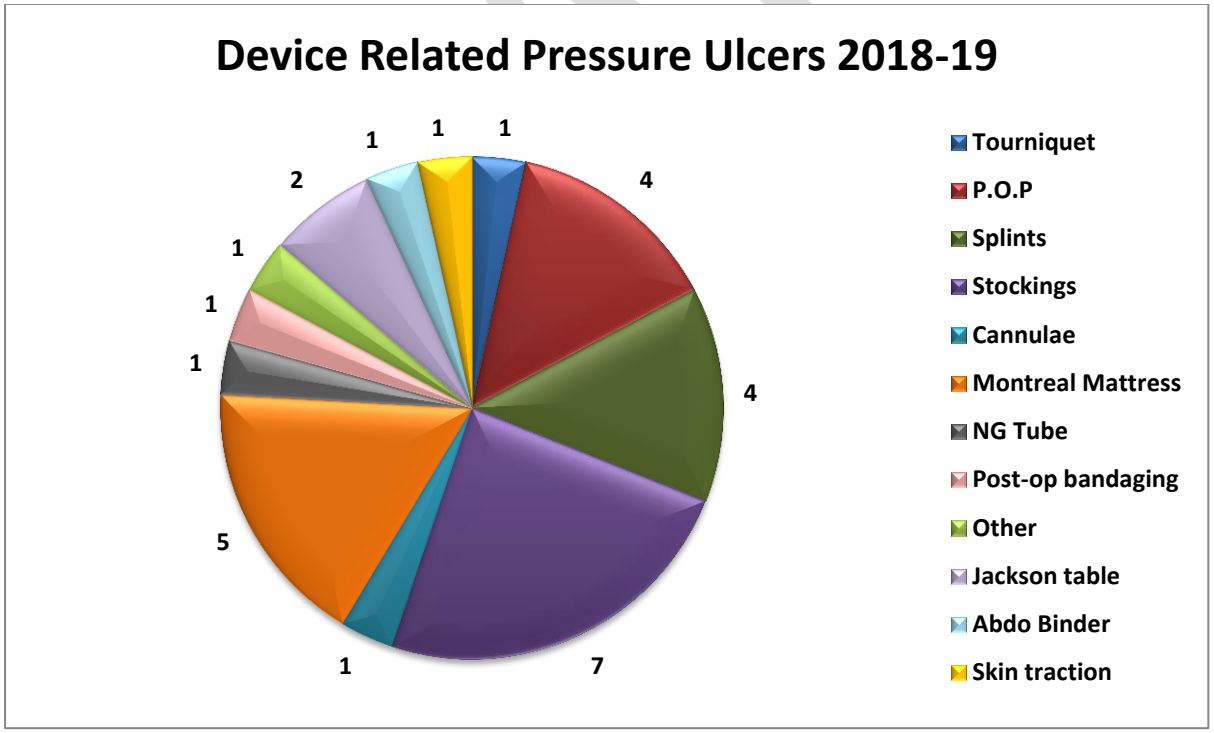


Graph 5.1.4A



Graph 5.1.4B

There was a slight increase in the device related pressure ulcers since last year i.e. from 26 to 29. The cause groups remain unchanged from previous years. Further audit and education are being implemented.



Graph 5.1.4C

In 2018-2019 mandatory training on pressure ulcer prevention has been implemented as an e-learning application for all clinical staff to perform and STOP pressure ulcer campaign continues to engage all members of staff, patients and carers to provide prevention.

Training programs have been designed and introduced at all clinical levels to enhance each individual's knowledge and provide best practice.

The Royal National Orthopaedic Hospital NHS Trust recognises the NHS improvement guidance; Pressure ulcers: revised definition and measurement framework (2018). It has been implemented across the Trust in April 2019.

5.2 Clinical Effectiveness Measures

5.2.1 Summary hospital-level mortality indicator (SHMI) - CORE INDICATOR

The measure for Summary Hospital-level Mortality Indicator (SHMI) is not applicable to the Trust.

5.2.2 Patient Reported Outcome Measures - CORE INDICATOR

RNOH considers that the Patient Reported Outcomes Measures (PROMS) are as described for the following reasons: RNOH has a process in place to ensure that relevant patients are given questionnaires to complete and that patients are encouraged to do so. It is important to note that the Trust has no control over the completion and return of these forms.

PROMs are designed to allow patients to assess improvements to their health following surgical treatment. Patients answer questions about their quality of life before surgery and again after surgery. The two scores are compared and the difference is regarded as a health gain (or loss). These results provide an indication of the success and benefit of their surgery on their health. The responses are analysed independently by NHS digital and benchmarked against other trusts.

PROMS use three different measures to assess improvements to health following surgery. Although each measure is slightly different, a positive number means the patient has experienced an improvement to their health. The greater the number, the greater the patient reported improvement to their health.

Six procedures currently subject to PROMs are carried out at the RNOH and the table below provides RNOH performance against the three measures: EQ-5D, EQ-VAS, and the Oxford Hip and Knee Scores. EQ-5D asks questions about mobility, ability to self-care, ability to carry out usual activities, pain and discomfort, and anxiety and depression. EQ-VAS asks patients to rate their overall health on a scale (VAS = visual analogue scale). The Oxford Score is a short questionnaire designed to assess function and pain.

PROMS - Casemix Adjusted Average Health Gains:

Total Hip Replacement	National average 2017-18	RNOH 2017-18	RNOH 2016-17	RNOH 2015-16
EQ-5D	0.458	0.405	0.385	X
EQ VAS	13.877	11.654	12.667	X
Oxford Hip Score	22.210	19.174	18.183	X

Hip Replacement - Primary	National average 2017-18	RNOH 2017-18	RNOH 2016-17	RNOH 2015-16
EQ-5D	0.468	0.445	0.409	0.468
EQ VAS	14.231	11.796	12.831	11.151
Oxford Hip Score	22.680	21.044	20.271	22.312

Hip replacement - Revision	National average 2017-18	RNOH 2017-18	RNOH 2016-17	RNOH 2015-16
EQ-5D	0.289	0.244	X	0.243
EQ VAS	7.654	8.263	X	4.261
Oxford Hip Score	13.901	12.321	X	9.647

Total Knee Replacement	National average 2017-18	RNOH 2017-18	RNOH 2016-17	RNOH 2015-16
EQ-5D	0.337	0.296	0.275	X
EQ VAS	8.153	6.654	4.701	X
Oxford Knee Score	17.102	12.899	12.165	X

Knee Replacement - Primary	National average 2017-18	RNOH 2017-18	RNOH 2016-17	RNOH 2015-16
EQ-5D	0.338	0.247	0.247	0.289
EQ VAS	8.280	2.635	2.735	4.175
Oxford Knee Score	17.259	13.156	12.335	14.664

Knee replacement - Revision	National average 2017-18	RNOH 2017-18	RNOH 2016-17	RNOH 2015-16
EQ-5D	0.292	0.313	0.293	X
EQ VAS	4.892	7.344	4.557	X
Oxford Knee Score	13.124	10.238	10.863	X

Table 5.2.2: NHS Digital latest published data (Accessed May 2019)
X = low sample size, results not available

5.2.3 Emergency readmissions within 28 days - CORE INDICATOR

The Royal National Orthopaedic Hospital NHS Trust considers that the percentage of emergency readmissions within 28 days of discharge from hospital is as described for the following reasons:

Every time a patient is discharged and readmitted to hospital the episode of care is coded. The Information Team continually monitors and audits data quality locally and the Trust participates in external audit which enables the Trust to benchmark its performance against other Trust.

The Royal National Orthopaedic Hospital NHS Trust admitted 16085 (April 2018- date) NHS patients in 2018/19. Of these 74 were emergency readmissions within 28 days of discharge.

Percentage of emergency readmissions within 28 days of discharge from hospital of patients:	2015/16	2016/17	2017/18	2018/19
i) 0 to 14 year olds (indicator up until 2016/17)	0.04%	0.04%	-	-
0 to 15 years (**indicator from 2017/18 onwards**)	-	-	0.74%	0.59%
ii) 15 or over (indicator up until 2016/17)	0.52%	0.43%	-	-
16 and Over (**indicator from 2017/18 onwards**)	-	-	0.46%	0.45%

Table 5.2.3: Trust Data

The Royal National Orthopaedic Hospital NHS Trust intends to take the following actions to reduce readmissions to improve the quality of its services by working to implement a process of exemplar discharge, while continuing to monitor those patients discharged from the Royal National Orthopaedic Hospital NHS Trust and readmitted to other hospitals to ensure accurate readmission rates and appropriate clinical review of any readmissions within 28 days.

5.3 Patient Experience Measures

5.3.1 Responsiveness to personal needs - CORE INDICATOR

The Royal National Orthopaedic Hospital NHS Trust considers that the mean score of responsiveness to inpatient personal needs is as described:

- Each year the Trust participates in the National Inpatient Survey. For year 2017/18, 1250 patients were randomly selected and sent a nationally agreed questionnaire. A total of 679 patients responded to the survey.
- The indicator shows the average weighted score of 5 questions relating to responsiveness to inpatients' personal needs (Score out of 100).
- The five questions are:
  i) Were you involved as much as you wanted to be in decisions about your care and treatment?
  ii) Did you find someone on the hospital staff to talk to about worries and fears?
  iii) Were you given enough privacy when discussing your condition or treatment?
  iv) Did a member of staff tell you about medication side effects to watch for when you went home?
  v) Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?
- For the year 2017/18, the Trust was 13th out of 148 trusts for responsiveness to patient needs. This is however a comparison for all Trusts and not just specialists NHS Trusts.

Year	Indicator Score	Highest performing trust	Lowest performing Trust	National Average
RNOH 2017/18	74.3	85.0	60.5	68.6
RNOH 2016/17	75.9	85.2	60.0	68.1
RNOH 2015/16	74.4	86.2	58.9	69.6
RNOH 2014/15	78.7	86.1	59.1	68.9

Table 5.3.1: NHS Digital (2017) National Inpatient Survey Official Statistics – Data published August 2017

The Royal National Orthopaedic Hospital NHS Trust has taken the following actions to improve this rate and so the quality of its services:

- Recognised that although it is performing above national average and in the top 13 Trusts nationally, work to improve patient experience needs to continue
- Continue to publish monthly Quality Report that provides each ward and service a breakdown of patient feedback scores and comments
- Continue to use Trust's Balanced Scorecard indicators specific to patient experience and patient needs. These include measures of length of stay, patient experience of the discharge process, staffing levels, and patient perception of staffing levels
- The Trust continues to look to improve its engagement and involvement of patients in the development of its services, ensuring that patient voices are heard and acted on.

5.3.2 Friends and Family Test - CORE INDICATOR

The Friends and Family Test (FFT) is a single question which asks patients whether they would recommend the NHS service they have used to friends and family who need similar treatment or care. At the RNOH, the FFT question is asked in all inpatient wards, outpatients, and in therapies.

For inpatients, the FFT question is part of a longer real-time patient survey in which we ask patients to tell us about their experience of our care, services, and hospital environment.

In 2018/19, the RNOH was one of the high performing trusts nationally for inpatient response rate (see NHSE published FFT data). The national average was 24.2% for the year 2018/19, however, the Trust had a response rate of 35.8%, which is above the national average (April 2018 – March 2019).

Patients also left many thousands of free text comments during the year, and these are analysed and reported back to wards to allow improvements to be made.

Our results

Inpatients

Inpatients	Responses	Response Rate	Would recommend	Would not recommend
2018/19*	3075	35.8%	95.0%	1.0%
2017/18	4671	48.0%	95.1%	0.9%
2016/17	5907	55.1%	96.3%	0.8%
2015/16	5536	56.6%	96.0%	1.1%
2014/15	4422	52.4%	96.0%	1.0%

Table 5.3.2A: *NHS England published data

Outpatients

Outpatients	Responses	Response Rate	Would recommend	Would not recommend
2018/19*	9882	17%	98.0%	1.0%
2017/18	3180	4.1%	95.4%	1.9%
2016/17	4470	5.9%	94.5%	2.1%
2015/16	3442	4.7%	93.8%	2.0%

Table 5.3.2B: *NHS England published data

The RNOH has taken the following actions to improve our patient feedback and so the quality of patient experience we deliver:
Inpatient wards regularly receive patient feedback report and quarterly posters that provide staff with all of the good comments patients have made about the ward. These reports are discussed at team meetings and also displayed on the ward for patients and visitors to see. This reinforces not only the Trust's high standards of care but also allows staff to see that patients recognise and value their efforts.

When we don't get it right and fail to deliver the experience of care our patients expect, it is important that we listen to patients to learn what we could have done to improve their experience. Senior nurses and ward managers receive a regular report on all of the less positive feedback. These reports establish common themes, and senior nurses and managers can use this feedback to formulate a plan of action to ensure issues are addressed. Each division receives a monthly Quality Report that contains the performance in the Friends & Family Test for all divisional services and wards. This helps to provide quality performance monitoring and to identify any trends or issues developing over time.

Our patient experience strategy

We have made significant progress across all our services to enhance patient experience. However, there is more we can do to strengthen our approach to listening and responding to patient's feedback.

Our vision for patient experience is one that requires all staff to provide compassionate care, so that when people access our services – as a patient or a carer – they can be confident that the care they receive will be kind, sensitive and compassionate.

Following analysis from the national inpatient survey and our local FFT we are working to improve our discharge process through a variety of means including patient participation and involvement. In addition we are working closely with our patients to actively improve service and implement their feedback including using NHS Improvement Always Events.

We have high expectations around the improvements required in patient experience, both in terms of receiving real time feedback and on achieving measurable improvements in our results in the national surveys. We are committed to improving and enhancing patient experience and expect to see significant improvements in the experiences of patients receiving care.

Patient Feedback & Suggestions

RNOH continues to be committed to improving all communication with patients and carers, and we are well on the way to reaching our aim that all patients should feel safe, involved and able to make informed choices about their treatment and care.

Patient feedback & suggestions inpatients	
Rehab Ward	'All the staff team went above and beyond to ensure that decisions were made with you. Care was taken and you felt safe.''
The Coleman Unit	'The care and attention I received has been second to none! Excellent. The staff are so kind and nothing is too much trouble.'
Duke of Gloucester	'I was very happy with the staff. They treated me nicely. It was a wonderful experience. I felt 'at home''
London Irish	'RNOH is a very good hospital. I would recommend to friends and family. Staff were really lovely.'

Table 5.3.2C: Trust data

Patient feedback about Outpatients service	
OPD Stanmore	'I was able to ask questions where needed, the doctor explained very clearly my results, staff very polite.'
OPD Bolsover	'Promptly seen, even though I was early. Everyone was helpful and welcoming. Very pleased with the consultation. Many Thanks.'
OPD Stanmore	'Staff Efficient and helpful and friendly. Thank goodness for free parking.'
OPD Bolsover	'Totally professional, great communication. Excellent result.'
OPD Stanmore	'Stanmore orthopaedic is an amazing hospital, they offer exceptional care and attention to patients - fantastic service.'
OPD Bolsover	'You are looked after very well. You have changed my life for the better and pretty much saved my life.'
OPD Stanmore	'Efficient, friendly, not rushed, comfortable environment. Consultant excellent unique expertise. Feels like private hospital.'
OPD Bolsover	'Friendly, communication is good. I trust them and my experience has always been great.'

Table 5.3.2D: Trust data

5.3.3 Staff recommendation of the Trust as a provider of care to their family or friends - CORE INDICATOR

The RNOH considers that this data is as described for the following reasons: annual national staff survey is carried by an independent organisation.

	RNOH 2016/17	RNOH 2017/18	RNOH 2018/19	National Average for Specialist acute trusts 2018/19	Highest specialist acute trust performance Trust 2018/19	Lowest specialist acute trust performance Trust 2018/19
The percentage of staff employed by, or under contract to, the Trust during the reporting period would recommend the trust as a provider of care to their family or friends	**87%**	**88%**	**86%**	**90%**	**95%**	**78%**

Table 5.3.3: Picker NHS Staff Survey 2018

847 staff members completed the 2018 National Staff Survey at RNOH. This is an increase since 2017 and accounts for a response rate of 56%. We can therefore be assured that the feedback is representative of the views of our staff.

Overall the Trust achieved a fourth year of positive results. The Royal National Orthopaedic Hospital also achieved the best score nationally for positive work experience, providing excellent care, feeling well at work, able to make improvements and have helpful, values based appraisals.

5.3.4 Complaints

Patients are encouraged to raise PALS or Complaints in order to provide feedback so lessons can be learnt from investigating complaints, as well as resolving issues and concerns. This plays a key role in improving service quality and patient experience. This year we report on performance, activity and on the many policy and service changes we have implemented to ensure all our patients and service users have access to prompt local resolution and an effective complaints process if they wish to make a complaint.

In 2018/19 the RNOH received 142 formal complaints compared with 134 in the previous year.
There has been a steady rise in the number of complaints we have received each month with the average number of complaints being around 12 a month. The Trust continues to encourage patients to highlight their concerns to us.

5.3.5 PALS

During the last year, our Patient Advice and Liaison Service (PALS) Team has continued ensure that individual concerns - whether from patients, relatives or their representative - are addressed promptly and effectively and the appropriate actions are taken by Trust staff to resolve those concerns and improve services for the future. PALS provide a confidential advice and local resolution service. The team The PALS team and the central complaints team work alongside the governance staff in each of our divisions to ensure that patient concerns are heard and responded to.

During 2018/19, the PALS team dealt with 855 PALS enquires. This number is considerably lower than 2017/18, which was 1,149 and 1,854 the year before. This illustrates that the number of PALS reduces each year, hence lessons are being learnt.

5.4 Maintaining continuous quality improvement

The RNOH is committed to improving the quality of its services. This section details some of the quality improvement work currently underway at the Trust, including work addressing particular issues and concerns. Additionally, NHS England has requested each trust's 2018/19 Quality Accounts contain information on:

- Statement regarding progress in implementing the priority clinical standards for seven day hospital services
- Details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment. This disclosure should explain the different ways in which staff can speak up if they have concerns over quality of care, patient safety or bullying and harassment within the trust.

These are detailed below.

5.4.1 Learning From Deaths

During 2018/19, 20 RNOH patients died. These comprised of one paediatric patient, and no neonatal deaths, no deaths of patients with learning difficulties, and no deaths of patients with severe mental illness. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 4 in the first quarter, including one paediatric death
- 8 in the second quarter
- 6 in the third quarter
- 2 in the fourth quarter

All patients who have died within 30 days of attending the RNOH for a procedure have been subjected to a formal notes review. The data for deaths have been taken from the hospital reporting system, called Insight, which itself is fed data via the NHS Spine. This represents the most accurate source of data in RNOH. Since February 2018 cases were assessed using the structured judgment review method (Royal College of Physicians). All of these patients have been (or will be) presented and discussed at either the regular bi-monthly M&M MDT meeting or local M&M meeting. There can be a difference in the numbers of deaths reported in a quarter and the deaths reviewed or

reported due to the timings of the bi-monthly meetings. The bi-monthly meeting is hospital wide and multidisciplinary, with comments accepted from all members of staff. When issues have been raised at the M&M MDT meetings, the cases were then proposed for a case review if this was deemed appropriate by the M&M MDT meeting.

By March 2019, 17 case record reviews and 2 investigations have been carried out in relation to 20 of the deaths. In 6 cases, a death was subjected to both a case record review and either an investigation or discussion at weekly incident meeting. This is in addition to presentation at the M&M MDT meeting.

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 4 in the first quarter
- 8 in the second quarter
- 6 in the third quarter
- 1 in the fourth quarter

None of the patient deaths during the reporting period is judged to be more likely than not to have been due to problems in the care provided to the patient.

Key Learning:
A summary of key learnings from case record reviews and investigations conducted in relation to the deaths identified:

Actions taken in 2018/19

- Improved guidelines in relation to administration of preoperative medicines
- Heightened awareness for anaemic management pathway
- Improved documentation of patient vascular access when patients are managed in the prone position
- Communication of list order changes or changes in surgical plans with the theatre coordinator
- Improved planning of vascular surgeon support
- Acute Intervention Team (AIT) formally known as outreach, increased from 4 WTE to 7 WTE (Band 7s) plus a band 8a lead
- Increased senior nursing staff presence by separating site management role and AIT role into two posts
- Process of MDT handover at 0800 and at 2000 changed
- Changes within AIT as to how patients are picked up, reviewed and recorded.

Duty of candour meetings have been undertaken where necessary. This has included sharing learning from reviews with relatives and discussion of actions which the trust has taken.

An assessment of the impact of the actions undertaken in 2018/19

- Ensuring that anaemia is effectively identified by reviewing all correspondence pre-operatively and that anaemia is treated prior to surgery to optimise patient outcomes.
- Improved awareness of cases occurring in theatre, changes to lists, and staff availability, should improve availability of specialist staff members for complex cases.
- Increased senior nursing staff presence, separating roles of site management and acute intervention team, will improved safety at busy times.
- Process change at handover will improve resilience of handover and improve patient care.
- Improvements within AIT team structure should ensure patients are not able to 'slip through the safety net'.

Actions to be taken going forward

RNOH carried out 4 case record reviews after April 2018 which related to deaths which took place before the start of the reporting period 2018/19. This is in addition to the case reviews for deaths in 2018/19.

None of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the structured judgement review process and via review of deaths presented at the morbidity and mortality meeting.

One, representing 5%, of the patient deaths during 2017-18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

5.4.2 Implementing Seven Day Hospital Services

Seven Day Services Clinical Standards have been introduced in the NHS to improve outcomes of patients who are admitted to hospital as emergencies at weekends. Ten clinical standards were developed by Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. These standards define what seven day services should achieve, no matter when or where patients are admitted, with an aim to end the variation in outcomes.

In response to these clinical standards, the RNOH has designed a pathway in collaboration with medical, nursing, AHP and operational staff. The aim is for patients to be able to access hospital services in a timely fashion.

With the support of the Academy of Medical Royal Colleges (AoMRC), four of the 10 clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes. These are:

- Standard 2 – Time to first consultant review
- Standard 5 – Access to diagnostic tests
- Standard 6 – Access to consultant-directed interventions
- Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others

Outlined below is the progress RNOH has made to achieve these priority standards:

Standard 2 – Time to first consultant review:

This standard states that all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.

RNOH has very few emergency transfers but accepts emergency admissions for:

1. Spinal trauma
2. Spinal Infection
3. Metastatic Spinal cord compression
4. Admissions from outpatient clinic
5. Urgent inter-hospital transfers

All emergency admissions are accepted/transferred to RNOH under a named consultant. Risk factors for emergency admissions are triaged prior to acceptance by admitting consultant and ITU - site/outreach team.

Critically unwell patients are rarely transferred to RNOH as most would be managed at local referring hospitals. Patients with significant risk factors are discussed with the on-call ITU/anaesthetic consultants and consequently transferred to a clinical setting capable of delivering appropriate care. All patients with significant risk factors are admitted/transferred to ITU. The condition and location of all emergency admissions are kept under continuous review by the acute outreach team. Critically unwell inpatients are triaged for emergency admission to on-site HDU/ITU.
RNOH has 24/7 Consultant on call for ITU (both Adult and Children) with provision to attend the patient within 14 hours of their admission to ITU/CHDU. Consultant Anaesthetist for Intensive Care are on site between 0800 & 2000 on Monday to Friday and 0900 to 1500 on Saturdays and Sundays. They would attend the site within half an hour for any emergencies outside those hours whilst senior registrar is on site 24 hours. Theatre got another consultant on call for any theatre emergencies 24/7, again with the provision of attending within half an hour.

There is another on call rota for paediatric Anaesthetists, who would provide either telephonic advice or attend in person for any paediatric emergencies in theatre as additional help to theatre on call consultant. Consultant job plans make provision for the above working patterns.

All transfers are seen by the appropriate non ITU consultant within 14 hours of admission - an integrated management plan and estimated discharge are set.

Clinical on-call rotas are managed for:

- Orthopaedics
- Spinal surgery
- Sarcoma
- HDU/ITU/Anaesthetics
- Paediatrics
- Pharmacy
- Physiotherapy and
- Occupational Therapy

RNOH provides dedicated, named, 24/7 consultant on-call cover including out of hours and at weekends. Consultant job plans for all required specialities include appropriate time for on-call working, including cover at weekends and out of hours.

All emergency admissions are reviewed by therapy teams within 14 hours of admission. Baseline function is assessed and functional criteria for discharge are set. Medicines reconciliation is undertaken and completed by a pharmacist within 24 hours of admission. Appropriate staff are available to facilitate the treatment/management plans relating to emergency admissions including, but not limited to anaesthetists, theatre staff, ODPs, neurophysiology/spinal cord monitoring, theatre staff and on-call pharmacy.

RNOH has a 24 hour Medical Emergency Team that can be called in case of deteriorating patients with low NEWS scores. The team consists of an ITU consultant (day time only), ITU registrar, Orthopaedic SHO, Paediatric SHO/SpR for children and a Critical Care Outreach nurse. There is an Outreach team from the nursing staff from ITU/HDU who proactively attend wards out-of-hours.

RNOH has instituted consultant led weekend ward rounds for all surgical patients including named, dedicated consultants contributing to the General Orthopaedic on-call rota in addition to the specialist Spinal Consultant on-call rota and Sarcoma Consultant on-call rota. Similar provision exists for other specialist units including Peripheral Nerve Injury, Upper Limb, Urology, Spinal Rehabilitation though these specialties do not conduct weekend consultant led ward rounds.

ICNARC data (submitted quarterly) confirms that 100% of patients admitted to ITU are discussed with the on-call ITU consultant. Furthermore, all patients admitted to ITU are seen twice daily by the ITU consultant. This facilitates timely review of all patients admitted to HDU/ITU out of hours and at weekends.

Weekday and weekend ratio data in mortality, length of stay and readmissions confirms good performance with respect to non-elective cases admitted on weekends. In the period from July 2017 - Dec 2018, there were 428 weekday admissions as compared with 52 weekend admissions. Weekday Length of Stay was measured as 32.9 whereas weekend Length of Stay was 18.9. In terms of in hospital mortality, 5 on weekdays as compared with none at the weekends. For the same period there were 7 weekday readmissions as compared with no readmission for the weekends.

GMC survey data for doctors in training confirms trainees feel well supported in terms of out of hours supervision from both orthopaedic and anaesthetic trainees. Wider performance and experience measures show good ratings from both groups overall

Score:
Standard met.

Standard 5 – Access to diagnostic tests

This standard states that hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:

- Within 1 hour for critical patients
- Within 12 hours for urgent patients
- Within 24 hours for non-urgent patients

The RNOH currently offers 24/7 access to the following consultant directed MSK diagnostic imaging services; Ultrasound, CT, MRI and urgent interventional procedures under imaging guidance. This arrangement is supported by 24/7 radiographer cover. A Consultant Radiologist is on call 24/7 and accessible through switchboard.

Urgent Non MSK scans/ opinions are currently reported via outsourcing to external companies.

Microbiology - is provided via the Royal Free Hospital and is a 24/7 service.

Echocardiography - is provided via the Royal Free Hospital and is a 24/7 service.

Score:
Standard met.

Standard 6 – Access to consultant-directed interventions

This standard states that hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.

RNOH is a tertiary, primarily elective orthopaedic centre. We have on-site provision for the emergency services required on a regular basis.

RNOH maintains a number of formal service level agreements with outside providers for services where we require a regular on-site component or where the provision of services differs from the provider's usual referral pathway. Where emergency services are required (that are not provided on-site or covered by a formal arrangement) RNOH has preferred, local providers through which informal arrangements are made for the provision of services as required.

With respect to emergent cases requiring interventional endoscopy, renal replacement therapy, stroke thrombolysis, percutaneous coronary intervention or cardiac pacing; RNOH makes onward emergency referrals to outside providers through their usual emergency referral pathways. This could include emergency assessment and transfer utilising the London Ambulance Service.

The above arrangements have served our patients well. In addition we continue to review our outside provider contractual arrangements and have a dedicated working group which proactively reviews our supplementary clinical services to continuously improve the governance framework around the services we formally contract. The Supplementary Clinical Services Governance Group

also works to improve access to outside medical services for all staff by defining preferred providers and routes of escalation for commonly required services.

Score:
Standard not met.

Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others

This standard states that all patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

All patients with high dependency needs at RNOH are managed in an appropriate setting or are transferred to HDU/ITU when clinically appropriate. All patients on HDU/ITU are seen on twice daily consultant ward rounds which take place during weekdays and at weekends.

All patients discharged from critical care are done so when it is felt appropriate by the ITU consultant and this implies that they do not need daily consultant review but if there are any concerns, then they will be reviewed by an outreach nurse who has direct access to both the ITU SpR and Consultant if they wish to escalate the level of care or seniority of review. There is an outreach system from HDU to review any potential at risk patient led by medical and nursing team daily and weekends.

A Consultant Paediatrician is on call 24/7 and accessible through switchboard. A physical ward round takes place every week day and at least once over the weekend. Additionally, a paediatric registrar is on site 8am-8pm every day. An anaesthetic registrar provides cover from 8pm-8am.

Patients with significant risk factors are discussed with the on-call ITU/Anaesthetic consultants and consequently transferred to a clinical setting capable of delivering appropriate care. All patients with significant risk factors are admitted / transferred to ITU. The condition and location of all emergency admissions are kept under continuous review by the acute outreach team. Critically unwell inpatients are triaged for emergency admission to on-site HDU/ITU.

RNOH has 24/7 Consultant on call for ITU (both Adult and Children) with provision to attend the patient within 14 hours of their admission to ITU/CHDU. Consultant Anaesthetist for Intensive Care is on site between 0800 & 2000 on Monday to Friday and 0900 to 1500 on Saturday and Sundays. They would attend the site within half an hour for any emergencies outside those hours whilst senior registrar is on site 24 hours. Theatre has another consultant on call for any theatre emergencies 24/7, again with the provision of attending within half an hour.

There is another on call rota for paediatric Anaesthetists, who would provide either telephonic advice or attend in person for any paediatric emergencies in theatre as additional help to theatre on call consultant. Consultant job plans make provision for the above working patterns.
RNOH has adopted an electronic near side patient monitoring system. Observations are taken by the nursing staff; this is recorded on the 'nurses app', which assigns a numerical score. This is based on

the National Early Warning System (https://www.england.nhs.uk/ourwork/clinical-policy/sepsis/nationalearlywarningscore/). Any score of 5 or greater warrants consideration for referral to the Acute Intervention Team (AIT). A score of 7 or above warrants an urgent referral to the Medical Emergency Team (MET). The clinical practitioner for the AIT will look at the nurses app periodically and will either phone or visit those patients with high NEWs who have not been referred.

Over the next few months (to Q2 2019), we will be introducing NEWs 2. We shall also upgrade the software on the nurses app in this process. This will enable the user to also complete a fluid balance, have online access to specific forms and protocols such as the sepsis 6 and delirium assessment. In addition, the AIT will be notified via the app if there is a score above 5, thus adding in another safety layer into the system. In addition, RNOH has twice daily Medical Emergency Team meetings in line with the wider on-call handover meetings. These also constitute board rounds for the patients under MET Team/Acute Intervention Team review.

RNOH plans further prospective audit of relevant practice in this area which will also support future 7 Day Service board assurance submissions. GMC survey data for doctors in training confirms trainees feel well supported in terms of out of hours supervision from both orthopaedic and anaesthetic trainees. Wider performance and experience measures show good ratings from both groups overall.

Score:
Standard met.

5.4.3 Implementation of Duty of Candour

The Duty of Candour requirements follows Sir Robert Francis' QC's call for a more open and transparent culture following the failures in patient care at Mid Staffordshire NHS Foundation Trust. From October 2014 NHS providers are required to comply with the Duty of Candour. Providers must be open and transparent with service users about their care and treatment, including when it goes wrong. Compliance with Duty of Candour is a legal requirement and the Care Quality Commission is able to take enforcement action when it finds breaches.

Under the Duty of Candour requirements clinical professionals should:

- speak to a patient, or those close to them, as soon as possible after they realise something has gone wrong with their care that appears to have caused or has the potential to cause moderate/significant harm
- apologise to the patient – explain what happened, what can be done if they have suffered harm and what will be done to prevent someone else being harmed in the future
- provide an account of the incident which, to the best of the provider's knowledge, is true of all the facts the body knows about the incident as at the date of the notification
- advise the relevant person what further enquiries the provider believes are appropriate
- Follow up the apology by giving the same information in writing, and providing an update on the enquiries
- Keep a written record of all communication with the relevant person

Our Duty of Candour Compliance research has revealed that RNOH Clinicians are exemplary at having Duty of Candour discussions with patients who have suffered levels of harm. However, that

there is room for improvement with compliance in sending written Duty of Candour letters to patients and their families, where appropriate, identifying the fact that a full investigation into the circumstances of the harm occurring will take place and that they will be sent a copy of the report when it is completed.

The Patient Safety team are progressing work with Divisions under the auspices of the Divisional Performance Reviews to provide written updates, as per the Duty of Candour requirements, to patients / families.

5.4.4 Details of ways in which staff can speak up

RNOH is committed to supporting a robust Speaking Up culture. In 2017 the Trust recruited 3 Freedom to Speak Up Guardians (FTSUG). Whilst the primary responsibility of the FTSUG is to provide a safe space for staff to talk through and raise concerns relating to patient safety, staff experience and/or bullying and harassment, they also have a number of additional responsibilities. These include:

- raising awareness about and actively encouraging the development of a speaking up culture
- meeting regularly with senior leaders; in particular the Board Speaking Up representative, CEO and appropriate Non-Executive Directors, to share trends and ensure issues are responded to
- building relationships with key stakeholders
- understanding and as appropriate, participating in speaking up pathways
- providing at least 6 monthly reports to the Board and
- providing quarterly activity data to the National Guardian Office.

The FTSUG's have been in post for the last 18 months. During that time they have been highly successful in raising the visibility of the FTSUG and building credibility in the role. The team have undertaken more than 40 individual cases providing support, sign posting, and on occasion, advocacy. They have participated in numerous walkabouts with members of the executive team and supporting functions such as counter fraud. The team provides support to the induction programme, driving visibility of the FTSUG and advocating the importance of a speaking up culture amongst new starters to the organisation. Communications materials have been developed, including a guide to speaking up pathways.

The purpose of the FTSUG is to help support and protect the individual raising a concern. Where possible the FTSUG will maintain confidentiality to give the individual anonymity.

Staff can also raise concerns by:

- Speaking to their line manager or another senior manager
- Raising an incident form
- Speaking to members of the Workforce Directorate
- Speaking to a Union representative
- Through the whistleblowing helpline

5.4.5 Our CQC Results

The Care Quality Commission (CQC) monitors, inspects and regulates health and social care services in England to ensure they meet fundamental standards of quality and safety. Performance ratings and findings from the CQC on the quality and safety of services are published regularly. The CQC asks a number of key questions to inform their view on the quality and safety of services:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

All NHS hospitals are required to be registered with the CQC in order to provide services and are required to maintain high quality care in order to retain their registration. RNOH is required to register with the CQC and its current registration status is 'without conditions'.

RNOH was inspected by the CQC in October 2019, with subsequent inspection report published in March 2019

Overall, the Trust was rated as 'Good'. The ratings for each of the Trust's service areas are shown below.

Overall rating for this hospital	Good
Medical care (including older people's care)	Good
Surgery	Good
Critical care	Good
Services for Children and young people	Good
Outpatients and Diagnostic imaging	Requires improvement

Table 5.4.6: CQC website

In response to the CQC inspection report, the Trust has in place an action plan to address the conclusions reported by the CQC.

APPENDIX 1

Statements from NHS England Specialist Commissioners and Healthwatch Harrow

The Quality Account has been developed by the Trust with input, involvement, and consultation from a range of stakeholders. This has included:

- Consultation on the Trust website, seeking views of proposed quality priorities
- Presentation of quality priorities with the RNOH Patient Group
- Discussion of our quality priorities with commissioners through the Clinical Quality Review Group
- Internal discussions of the Quality Account at the Clinical Quality and Governance Committee
- Presentation of draft and final Quality Account to Healthwatch Harrow
- Presentation of the Quality Account to Harrow Health and Social Care Scrutiny

Statement from the Director of Nursing and Quality, Specialised Commissioning on behalf of NHS England – London Region

Statement from Chair of Enterprise Wellness Ltd. (Accountable body of Healthwatch Harrow)

APPENDIX 2

Statement of directors' responsibilities in Respect of the Quality Accounts

Joint Statement from Chairman and CEO to be included once finalised

By order of the Board.

Professor Anthony Goldstone CBE
Chairman

Rob Hurd
Chief Executive Officer

APPENDIX 3

External Audit Limited Assurance Report

Glossary

AHP .....Allied Healthcare Professionals
C. difficile .....Clostridium difficile
CCG .....Clinical Commissioning Group
CQC .....Care Quality Commission
CQRG .....Clinical Quality Review Group
CQUIN .....Commissioning for Quality and Innovation
DoLS .....Deprivation of Liberties Safeguarding
EQ5D ..... A standardised measure of patient reported health outcome for hip and knee operations
FARs .....Functional Assessment and Restoration
FFT .....Friends and Family Test
GIRFT .....Getting it Right First Time programme
HAPU .....Hospital Acquired Pressure Ulcers
HES .....Hospital Episode Statistics
IG .....Information Governance
IOMS .....Institute of Orthopaedic and Musculoskeletal Science
KPI .....Key performance indicators
LCRN .....Local Clinical Research Network
MCA .....Mental Capacity Act
MRSA .....Methicillin-resistant Staphylococcus aureus
NEWS .....National Early Warning System
NHSI .....NHS Improvement
NICE .....National Institute for Health and Clinical Excellence
NIHR .....National Institute for Health Research
NJR .....National Joint Registry
PALS .....Patient Advice Liaison Service
POD .....Patient Outcomes Data
PROMs .....Patient Reported Outcome Measures
RCA .....Root Cause Analysis
RNOH .....Royal National Orthopaedic Hospital NHS Trust
SHMI .....Summary Hospital-level Mortality Indicator
SNCT .....Safer Nursing Care Tool
TDA .....NHS Trust Development Authority
UCL .....University College London
UTI .....Urinary Tract Infections
VTE .....Venous Thromboembolism
WHO .....World Health Organization

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Imperial College Healthcare
NHS Trust

Health & Social Care Scrutiny Sub-Committee REPORT SUMMARY	
Title of report: Final Draft Quality Account 2018/19	☒ Information
Date of Meeting: 12 June 2019	**Item and report no.** xx
Responsible Executive Director: Julian Redhead, medical director	**Author:** Clemmie Burbidge, compliance and assurance improvement lead

Summary:
Quality accounts are annual reports to the public from NHS healthcare providers about the quality of services they deliver. Their purpose is to encourage boards and leaders of healthcare organisations to demonstrate their commitment to continuous, evidence-based quality improvement, to assess quality across all of the healthcare services they offer and to explain their progress to the public.

Appendix 1 is Imperial College Healthcare NHS Trust's final draft quality account for 2018/19. It was approved by our Audit, Risk & Governance Committee on 22nd May 2019 and has undergone the required consultation process with internal and external stakeholders. It is being presented to the committee at the request of the council.

Recommendations:
The committee is asked to note the final draft quality account.

This report has been discussed at:
☒ Executive Quality Committee
☒ Board Quality Committee
☒ Audit, Risk & Governance Committee

Quality impact:
The improvement priorities and metrics outlined in the quality account span all five of the CQC domains (safe, caring, responsive, effective, well-led) and were developed in consultation with stakeholders both internal and external to the Trust.

Financial impact:
This paper has no financial impact.

Risk impact and Board Assurance Framework (BAF) reference:
There is an associated divisional risk on Datix (ID 1640 – new quality strategy development and implementation)

Workforce impact (including training and education implications):
N/A

Has an Equality Impact Assessment been carried out or have protected groups been considered?
☒ Not applicable

What impact will this have on the wider health economy, patients and the public?
The priorities outlined in our quality account will directly impact on the quality of care we provide.

The report content respects the rights, values and commitments within the NHS Constitution
☒ Yes ☐ No

Trust strategic objectives supported by this paper:
- To develop a sustainable portfolio of outstanding services
- To build learning, improvement and innovation into everything we do

1. Executive Summary

1.1. Quality accounts are annual reports to the public from NHS healthcare providers about the quality of services they deliver. Their primary purpose is to encourage boards and leaders of healthcare organisations to demonstrate their commitment to continuous, evidence-based quality improvement, to assess quality across all of the healthcare services they offer and to explain their progress to the public.

1.2. Quality accounts are required by the Health Act 2009, and in the terms set out in the National Health Service (Quality Accounts) Regulations 2010 as amended ('the quality accounts regulations').

1.3. As part of the regulations, NHS providers are required to consult with their clinical commissioning groups, local healthwatch organisations and overview and scrutiny committees. Statements provided by these organisations in response to the quality accounts are published in the final quality account.

1.4. The commissioners have a legal obligation to review and comment, while local Healthwatch organisations and OSCs are offered the opportunity to do so on a voluntary basis.

1.5. The attached document (appendix 1) is the Trust's final quality account for 2018/19 for review by the OSC.

2. Purpose

2.1. The purpose of this paper is to put forward the final draft quality account for noting. It is being presented to the committee at the request of the council.

3. Background

3.1. The Trust's annual quality account sets out the organisation's improvement priorities and metrics for the following year, and describes progress in delivering the priorities outlined in the previous document.

3.2. The quality account has been developed using the Department of Health Quality Account Toolkit and complies with the mandatory requirements in the following structure:

- Part 1: Statement from the Chief Executive and About Our Trust.
- Part 2a: Our quality improvement plan and priorities for 2019/20
- Part 2b: Statements of assurance from the Trust Board
- Part 3: Review of our quality progress 2018/19

3.3. The final document will include statements from our external stakeholders and the independent auditor's assurance report which are being collated currently.

4. Consultation process

4.1. As part of the process, the Trust is required to seek engagement from internal and external stakeholders. This includes offering our commissioners, Healthwatch and the local Overview & Scrutiny Committees the opportunity to comment on the draft report.

4.2. The first draft was circulated for consultation following approval at executive quality committee in April to our external stakeholders, our lay partners, and also internally, to our non-executive and executive directors.

4.3. Feedback on the draft has been constructive and helpful and where possible has been addressed in the final draft. A number of questions about the content, structure and the density of data included prompted a full review again of the guidance and regulations with changes made as a result including moving some of the data into the appendices following external audit's approval.

4.4. The final draft was approved at Audit, Risk and Governance Committee in May. It was circulated to our external stakeholders to allow them to formulate their final statements. Once received these will be incorporated into the document prior to publication.

4.5. The quality account is subjected to external auditing, with the external auditors' statement also included in the published document.

5. Conclusion and next steps

5.1. Appendix 1 is the final draft of the Trust's quality account for 2018/19. Next steps for the document are:

- Final draft to be professionally designed and graphics included – throughout May/early June 2019;
- Final sign off by CEO and Chair on behalf of the Board – by 14th June 2019;
- Publication of quality account – by 28th June 2019.

6. Recommendations

6.1. The committee is asked to note the final draft quality account.

Author **Clementine Burbidge, compliance and assurance improvement lead**
Date 28 May 2019

Appendix 1 – Final draft Quality Account 2018/19

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Imperial College Healthcare NHS
NHS Trust

Quality Account 2018/19

Contents

Glossary

We have tried to make this document as straightforward and reader-friendly as possible. A glossary of terms used throughout the document can be found on page 102.

Alternative formats

This document is also available in other languages, large print and audio formation on request. Please contact the communications directorate on 020 3313 3005 for further details.

Este documento encontra-se também disponivel noutros idiomas, em tipo de imprensa grande e em formatoáudio, a pedido.

Waxaa kale oo lagu heli karaa dokumentigaan luqado kale, daabacaad ballaaran, iyo cajal duuban haddii la soo waydiisto.

هذه الوثيقة متاحة أيضا بلغات أخرى والأحرف الطباعية الكبيرة وبطريقة سمعية عند الطلب.

Dokument ten jest na zyczenie udostepniany takze w innych wersjach jezykowych, w duzym druku lub w formacie audio.

এই ডকুমেন্ট অন্য ভাষায়, বড় প্রিন্ট আকারে এবং অডিও টেপ আকারেও অনুরোধে পাওয়া যায়।

Este documento también está disponible y puede solicitarse en otros idiomas, en letra grande y formato de audio.

Dipas kërkesës, ky dokument gjithashtu gjendet edhe në gjuhë të tjera, me shkrim të madh dhe në formë dëgjimore.

Part 1: Statement from the Chief Executive

[DN: to be included once annual report statement is complete to ensure they align]

About this report

Quality accounts were introduced in 2009 by the Department of Health to make healthcare organisations more accountable when it comes to quality of care. They are designed to report on how we have performed against the targets we set for ourselves last year, and to share our targets for next year.

There are inherent limitations in the preparation of quality accounts which may impact the reliability or accuracy of the data reported. These include:

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

We have sought to take all reasonable steps and exercised appropriate due diligence to ensure the accuracy of the data reported, but we recognise that it is nonetheless subject to the limitations noted above. We are working to improve data quality across the organisation, as described on page 29. Following these steps, to the board's knowledge, the quality account is a true and fair reflection of the Trust's performance.

The report complies with the requirements set out by the Department of Health for quality accounts in the following format:

- Part 1: Statement from the Chief Executive and About Our Trust
- Part 2a: Our quality improvement plan and priorities for 2019/20
- Part 2b: Statements of assurance from the Trust Board – these are mandatory statements relating to specific aspects of the quality of our services. This information is common to all quality accounts.
- Part 3: A review of our quality progress for 2018/19 – how we performed in relation to the priorities we set ourselves last year. This includes statements our external stakeholders have provided in response to the document.

The quality account is subjected to a limited assurance engagement carried out by the external auditor; this includes testing of two key indicators (VTE risk assessment and incidents causing severe and extreme harm). This year, it was recommended by NHS England that we also consider auditing SHMI (a mortality indicator) in line with foundation trusts. Following discussion with our external auditors, including a review of the potential benefits and the additional costs required, it has been agreed that we will not be auditing a third indicator this year. We will review whether we should move to comply with all elements of the foundation trust requirements going forward in 2019/20.

We have tried to make this document as straightforward and reader-friendly as possible, but in such a complex organisation some abbreviations are inevitable. A glossary of terms used throughout the document can be found on page 102. If you have any questions, would like to provide feedback on this report, or to be involved in producing it next year, please email imperial.quality.team@nhs.net.

Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare quality accounts for each financial year. The Department of Health has issued guidance on the form and content of annual quality accounts, which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended).

In preparing the quality account, directors are required to take steps to satisfy themselves that:

1. The quality account has been prepared in accordance with Department of Health guidance and National Health Service Regulations 2010 (as amended) and presents a balanced picture of our performance over the period covered.

2. The content of the quality account is consistent with internal and external sources of information including:
   - Trust board minutes and papers for the period April 2018 to May 2019;
   - Papers relating to Quality reported to the Trust board over the period April 2018 to May 2019;
   - Feedback from Clinical Commissioning Groups;
   - Feedback from local scrutineers, including Healthwatch and local authority overview and scrutiny committees;
   - The national inpatient survey 2018;
   - The national staff survey 2018;
   - The General Medical Council's National Training Survey 2018;
   - Mortality rates provided by external agencies (NHS Digital and Dr Foster).

3. There are proper internal controls over the collection and reporting of the measures of performance included in the quality account, and those controls are subject to review to confirm they are working effectively in practice.

4. The data underpinning the measures of performance reported in the quality account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.

The directors have reviewed the quality account at executive quality committee in May 2019 and confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality accounts. The quality account was reviewed at our Audit, Risk and Governance Committee held in May 2019, where the authority of signing the final quality accounts document was delegated to the chief executive officer and chair.

By order of the Trust board

[Signatures and date will be inserted once final document is signed off in June]

Chief Executive Officer Chair

About our Trust

This part of the report provides some background to our organisation and the people we care for. It describes our governance framework and structures, our values and behaviours, vision and objectives and some of the key strategies which are driving improvement in all areas across the organisation.

Imperial College Healthcare NHS Trust provides acute and specialist health care in north west London for around a million and a half people every year. Formed in 2007, we are one of the largest NHS trusts in the country, with over 12,000 staff.

We provide care from five hospitals on four sites as well as a range of community facilities across the region. Our five hospitals are Charing Cross Hospital, Hammersmith Hospital, Queen Charlotte's & Chelsea Hospital, St Mary's Hospital and Western Eye Hospital.

Our Trust in numbers

[DN: this data will be displayed as an infographic in the final designed version]

Our services

Patient contacts (including inpatients, outpatients and day cases)	1,225,000
Emergency attendees (including A&E and AEC)	312,000
Babies born	10,000
Operations (including day and inpatients)	40,000
Inpatients who would recommend us to their friends and family	97%

Our staff

Number of staff, including:	12,000
Doctors	2,700
Nurses and midwives	4,800
Allied health professionals	770
Scientists and technicians	1,200
Pharmacists	130
Medical students	900
Nurses in education, pre-registration	500

Our finances

Control total surplus	£28m
Turnover	£1,213bn
Efficiencies	£44m
Capital investments including buildings, infrastructure and IT	£55m

Better health, for life: our vision and strategy for 2019-2029

In 2015/16, we worked with our staff and partners to define our vision and values. Since then, we have sought to embed them in everything we do, for example by incorporating them in our quality improvement methodology and our appraisal framework. There is still more to do and, alongside more recent work on our strategy, we have now developed a behaviours framework that sets out how we want to see and be seen to live our values in practice.

Our vision
Better health, for life

Our values

- Kind - we are considerate and thoughtful so everyone feels valued, respected and included
- Expert - we draw on our diverse skills, knowledge and experience so we provide the best possible care
- Collaborative - we actively seek others' views and ideas so we achieve more together
- Aspirational - we are receptive and responsive to new thinking, so we never stop learning, discovering and improving

In 2017/18, we began to articulate three new and overarching strategic goals to create a stronger connection to the delivery of our vision. These were refined in 2018/19, following feedback and analysis of the long term challenges facing our organisation and the wider NHS.

Our strategic goals:

- To help create a high quality integrated care system with the population of north west London
- To develop a sustainable portfolio of outstanding services
- To build learning, improvement and innovation into everything we do

We will continue to engage with staff, patients and partners and have begun to link these three strategic goals to specific priorities and developments, starting with our quality improvement priorities for 2019/20. Through our organisational strategy, we will now set out what we plan to do over the next 3-5 years and ten years. This will include developing new clinical models and clinical roles, a focus on quality improvement and development of estates, digital and workforce.

In addition to our organisational strategy, we are working with our NHS partners in North West London to re-shape and improve services. Since 2012, this work has been done under the banner of 'shaping a healthier future'. With the publication of the NHS Long Term Plan in January 2019, followed by a Government announcement in March, the North West London health and care partnership agreed to draw the shaping a healthier future programme to a conclusion. As part of our response to the NHS Long Term Plan, we will bring our on-going efforts to improve health and care together in a new programme called the NHS North West London long term plan.

Our Governance framework and structures

Management structure

We put in place an organisational structure in July 2016 to reduce the number of management layers and devolve more authority to clinical staff. Services are organised into 24 clinical directorates, each with its own 'triumvirate' of lead doctor, nurse and manager. The directorates are organised into three clinical divisions, each led by a practising clinician, who is an executive director reporting to the chief executive. They are:

- Medicine and integrated care;
- Surgery, cardiovascular and cancer;

- Women's, children's and clinical support.

In addition, Imperial Private Healthcare is our private care division, offering a range of services across our sites. Private income is invested back into supporting services across the whole Trust.

The clinical divisions are supported by six corporate divisions:

- Office of the medical director (including quality, improvement, education and research);
- Nursing director's office (including patient experience, estates and quality compliance);
- Finance;
- People and organisational development;
- Information and communications technology;
- Communications (including public and patient involvement).

Governance framework

There are five board committees overseeing specific aspects of our work:

- Quality;
- Finance and investment;
- Audit, risk and governance;
- Remuneration and appointments;
- Re-development.

Below these board committees is an executive committee which meets every week. In addition, executive sub-groups meet monthly to allow time for detailed work to deliver improvements. For example the sub-group to the executive quality committee reviews the work of the divisional quality committees and brings divisions together to consider trust themes.

Our governance structure is shown in figure 1 below.

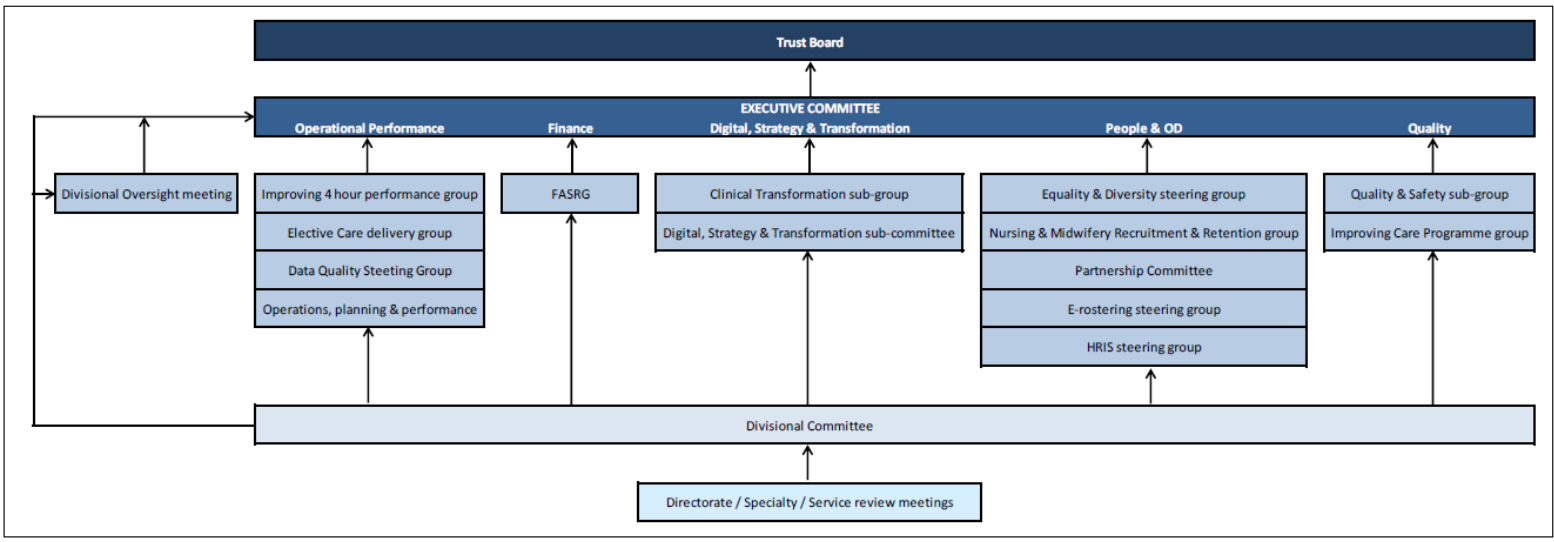


Figure 1 – Trust Governance Structure

This year we implemented divisional oversight meetings. These are where the three clinical divisions are formally held to account for four key areas: quality, people, performance and finance. At these meetings the divisions present a summary of their performance across all domains, celebrating achievements and raise any areas of risk or concern.

Our key strategies

Quality strategy

Our previous quality strategy came to an end in 2018. A number of key successes were achieved throughout its lifetime, many of which are outlined in this document. They include:

- Creating a standardised quality improvement methodology, supported by an improvement team.
- Creating a culture of safety programme. This includes work streams to improve incident reporting, serious incident investigations, and nine 'safety streams' which are addressing key areas of clinical risk.
- Strengthened processes for clinical audit, including a priority audit plan.
- Complaints improvement, which has seen an increase in timely responses and a reduction in the number of complaints escalated to the Parliamentary & Health Service Ombudsman.

We are currently developing our new quality strategy which will align with our organisational strategy. See page 12 for more information.

Patient and public involvement strategy

In 2016, we developed a trust-wide approach to increasing and improving patient and public involvement. We set out ambitious goals for achieving meaningful involvement in strategic developments, service improvements and health and wellbeing.

Implementation of this strategy is overseen by our strategic lay forum, a diverse group of lay partners and senior trust staff, as well as Imperial Health Charity and Imperial College, and is actively engaged in our work and plans. It played an important role in the co-design and development of our vision and strategy.

People & organisational development strategy

Published in 2016, this strategy is designed to develop skills and capabilities amongst our staff. It focuses on attracting, developing and retaining quality people through continuous improvement and closer engagement with our workforce. Detailed work is currently underway to refresh our people strategy so that it describes how we are intending to align this work with our organisational strategy to help us to achieve these goals.

Clinical Strategy

Our clinical strategy sets out how we develop, organise and connect our services and specialties. This year we completed our speciality review programme (SRP) as the foundation for a new five-year clinical strategy. Information on the SRP is included on pages 47-48. This important work has given us better understanding of the clinical pathways, quality outcomes, workforce implications and financial sustainability issues within each specialty. The new clinical strategy is currently being finalised and will align to our new organisational strategy.

Estates strategy and redevelopment programme

We have the largest backlog maintenance liability of all trusts (£1.3 billion), largely due to the age of our estate. We have had to close beds and departments to react to structural issues, and failures of obsolete equipment where repairs are challenging or spare parts unobtainable. This is a key risk for us, is challenging for our staff, affects patient experience, impairs service provision and, at times, creates a risk to patient safety.

The scale of these challenges are substantially beyond the resources of the Trust, but our estates strategy for 2016 to 2026 considers every realistic option to ensure that, insofar as possible, we continue to provide safe, secure, high-quality healthcare buildings capable of supporting current and future service needs.

Digital strategy

We are progressing well with our digital strategy, spanning the five years from 2015 to 2020. We are moving from paper records to digital data capture and processing, so that staff and patients can easily and securely access, update, analyse and share information to provide best patient care. This is driving more productive working internally and across the local health system by:

- providing a complete and continuously updated electronic patient record so that all relevant information is available when needed;
- creating the ability to share relevant information to support clinical decision making;
- enabling patients to access, interpret, update and share their record, and play a full part in managing their own health;
- optimising integrated care pathways to reduce unnecessary variation and improve patient outcomes;
- using information and analytics to support direct care, service improvement, research and population health.

Part 2a: Our quality improvement plan

This section of the report describes our approach to quality improvement, progress with developing our new quality strategy and how we monitor our performance throughout the year to ensure we are continuously improving our services. It also sets out the targets and work streams we have chosen to prioritise in 2019/20.

Our approach to quality improvement

We launched our quality improvement methodology and our approach to creating a culture of continuous improvement with our 2015-18 Quality Strategy. We use the Institute for Health Improvement's (IHI) model for improvement[1]. This ensures that all improvement work has a clear aim and that at the start of any work, we have identified clear measures to track improvement. Driver diagrams are used to articulate why certain work / projects / initiatives will logically lead to achieving the aim and are co-designed with our staff, patients and wider communities. In collaboration with them, we can then undertake rapid tests of change using multiple Plan-Do-Study-Act (PDSA) cycles which help to roll out sustainable improvement at scale and pace.

The programme is underpinned by seven key objectives for 2019/20:

Over 6000 staff have taken part in our education programmes, and are encouraged to use their skills to make local improvements within their teams. We now have over 170 improvement coaches in the organisation who have participated in our Coaching and Leading for Improvement Programme (CLIP).

Three and a half years into our quality improvement journey, many aspects of the programme are now embedded across the organisation and leading to outstanding results. For some examples, please see the sections on our safety streams (page 50-55) and our Flow Coaching Academy (page 41-43).

[1] http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx

Developing our Improving Quality Strategy

We are developing our new 'Improving Quality Strategy', which will cover 2019-2023. It will make the crucial link between all of our work on how we gather quality insights, govern and improve quality, and our organisational vision and strategy. It will set out our plans for quality over the next five years with the aim to be consistently providing outstanding and sustainable care during its lifetime. It will clearly define what we mean by high quality and how we measure it. It will give a clear narrative around how we will put our standardised improvement methodology into action in everything we do. The strategy will focus on getting the basics right as well as fulfilling our role of pushing the boundaries of innovation.

The strategy will be based on:

- an evidence scan to ensure it is designed to meet a range of national, system-wide and community needs and priorities;
- the learning and insights we have gathered through the co-design of our organisational strategy and vision;
- what we heard during a listening campaign with over 1,000 people which commenced in December 2017. We plan to repeat this exercise every year so that we can ensure that patients, staff and community groups are involved in setting our priorities and in the co-design of improvement initiatives.

Our quality priorities for 2019/20

Our goals

We measure quality using the five domains the Care Quality Commission (CQC) use. They're designed to ensure that we focus on the things that matter to people, and that we make improvements which are aligned to the CQC's regulatory requirements. They are:

- **Safe**: people are protected from abuse and avoidable harm
- **Effective**: people's care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence.
- **Caring**: staff involve and treat people with compassion, kindness, dignity and respect.
- **Responsive**: services are organised so that they meet people's needs.
- **Well-led**: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around people's individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

We have included one more domain, which was defined by the National Quality Board (NQB) and which is monitored by NHS Improvement and included in CQC inspection reports, to ensure that we deliver value for money for our patients, communities and taxpayers:

- **Use resources sustainably**: we use resources responsibly and efficiently, providing fair access to all, according to need, and promote an open and fair culture

Each quality domain has an aim and a suite of metrics so that we can measure improvement. The metrics for 2019/20 are set out over the following pages. A driver diagram is included for each domain which describes the drivers, change ideas and improvement which will support delivery of the metrics.

Last year, we identified thirteen priority improvement areas using the driver diagrams for each domain, feedback from our listening campaign and CQC inspections as well as our operational objectives. Recognising that we still have work to do to make and sustain improvements in a number of areas; we plan to continue the following into 2019/20:

- To reduce avoidable harm to patients
- To continue to define, develop, implement and evaluate an organisation approach to reducing unwarranted variation

- To improve access to services across the Trust through a focus on increasing capacity and improving emergency flow (this is a combination of two previous priorities)
- To improve access for patients waiting for elective surgery
- To improve compliance with the equality and diversity standards

Two of last year's priorities are being changed slightly for 2019/20. These are:

- To improve the behaviours across the Trust related to safety. This has changed from 'to improve the safety culture across the Trust' to better fit with the work we are doing around our organisational strategy – see page 6 for further information
- To improve staffing levels for permanent nurses and non-consultant doctors. We have included non-consultant doctors to bring us in line with national requirements.

These are described in more detail on pages 34-48, setting out progress made in year and outlining plans for further improvements into 2019/20.

We are also introducing an additional priority for the coming year:

Improvement priority	To review our approach to inspection, accreditation and reviews
Rationale for inclusion	Learning from the work undertaken in the lead up to the recent trust inspection by the CQC it is timely to review the approach and plans to support teams to improve against key lines of enquiry and expected standards.
What will we do?	We will review our current approach and roll out a new improving care assurance programme. This will be an annual inspection of all core services and will include staff interviews, patient and staff focus groups, observation of practice, documentation review and an inspection of the care environment. Through this process we will celebrate what is being done well, sharing and spreading these examples to other areas through the improving care programme group. We will mobilise improvement coaches to support variation or areas with improvement opportunity identified during this process.
Measureable target for 2019/20	The success of this priority would be an improvement in the Trust's CQC rating overall.

Monitoring quality

Our governance arrangements for quality are led by the medical director who has executive responsibility. These are included in figure 1 on page 8. Progress with our quality metrics and priorities are reported through this framework, to enable monitoring from ward to board.

Our metrics are reported in our integrated quality and performance scorecard (IQPR). Each month, our executive team and the trust board reviews these core indicators, which are organised into the Care Quality Commission's five quality domains, with an additional domain on use of resources. For each indicator, we look at how we are performing against national standards and/or our own targets. In 2018 we introduced exception reporting, which incorporates action plans for areas that need to return to trajectory, with gradual introduction of measurement for improvement methods.

On our website, we publish an easy-to-understand monthly performance summary as well as the full scorecard.

Our improvement priorities are varied in nature and scope and are therefore not fully covered by the IQPR. Each priority therefore has a confirmed executive lead with separate reporting arrangements through an executive committee. Every quarter we provide a summary of progress with all the improvement priorities to the executive quality committee so that we are

considering them together and to allow the executive team to take stock of progress and support improvements.

An annual summary of our progress in delivering our quality metrics and priorities is provided in our quality account (see section 3 – pages 33-76).

We also work closely with our commissioners to monitor performance in all areas of quality through the monthly Clinical Quality Group. We monitor progress with delivery of the quality strategy and work collaboratively to develop the annual quality account, acute quality schedule (see glossary on page 102) and priorities. This ensures that our quality agenda aligns with local and national priorities.

Quality Domain 1: Safe

Aim/CQC Definition: People are protected from abuse and avoidable harm

Area	Description	Target
Patient safety – incidents and reporting	To eliminate avoidable harm to patients in our care as shown through a reduction in the number of incidents causing extreme harm/death	Below national average
Patient safety – incidents and reporting	To eliminate avoidable harm to patients in our care as shown through a reduction in the number of incidents causing severe/major harm	Below national average
Patient safety – incidents and reporting	To eliminate avoidable harm to patients in our care as shown through a reduction in the number of incidents causing moderate harm	Below national average
Patient safety – incidents and reporting	We will maintain our incident reporting numbers and be within the top quartile of trusts	Top quartile
Patient safety – incidents and reporting	We will have zero never events	0
Patient safety – incidents and reporting	We will ensure all patient safety alerts issued through the national central alerting system are reviewed and acted on in the specified timeframes	0 outstanding
Patient safety – incidents and reporting	We will ensure 100% compliance with duty of candour requirements for every appropriate incident graded moderate and above	100%
Infection prevention and control	We will achieve a 10% reduction in healthcare-associated BSIs caused by E. coli	10% reduction (n=65)
Infection prevention and control	We will have no healthcare-associated BSIs caused by CPE	0
Infection prevention and control	We will ensure we have no avoidable MRSA BSIs and cases of C. difficile attributed to lapse in care	0
Infection prevention and control	We will meet flu vaccination targets for frontline healthcare workers as part of the national seasonal flu campaign	National target
VTE	We will assess at least 95% of all patients for the risk of VTE within 24 hours of their admission	95%
Sepsis	We will ensure at least 90% of our patients	90%

Area	Description	Target
	receive antibiotics within one hour of a new sepsis diagnosis	
Maternity standards	We will maintain postpartum infections (puerperal sepsis) to within 1.5 per cent or less of all maternities	1.5 per cent or less
Safe staffing	We will maintain the percentage of shifts meeting planned safe staffing levels at 90% for registered nurses	90%
Safe staffing	We will maintain the percentage of shifts meeting planned safe staffing levels at 85% for care staff	85%
Estates and facilities	We will improve the number of reactive maintenance tasks completed within the allocated timeframe	70%
Estates and facilities	We will ensure our cleanliness audit scores meet or exceed the required standards	95% (very high risk areas) 90% (high risk areas)
Workforce and People	We will achieve compliance of 90% with core skills training	90%
Workforce and People	We will ensure that 90% of eligible staff are compliant with level 3 safeguarding children training	90%
Workforce and people	We will have a general vacancy rate of 10% or less	10%

Goal	Primary Driver	Secondary Driver
Safe: People are protected from abuse and avoidable harm.	1. We follow best practice standards (clinical, professional, safeguarding, Information governance and operational) to provide the safest possible patient care	The appropriate standards/ policies/ contracts are in place
		The standards/ policies/ contracts are being implemented or part of a quality improvement initiative
		We have oversight of whether the standards/ policies/ contracts are having the intended effect and we are sharing learning
	2. We have oversight of risks and issues affecting the safety of patients & staff and proactively learns from mistakes & best practice	Systems and processes for alerting and recording safety related risks and issues are in place and being used
		There is strong quality governance arrangements from board to ward
		We are managing and learning from safety risks and issues that occur internally and externally to the organisation
	3. There is a culture where safety is our number one priority	There is a safe space to speak up when things go wrong and listen and respond to all
		Share patient and staff stories related to safety when things go wrong and when they go right
		Collective leadership is promoted in which everyone takes responsibility for the safety of patients
		Staff are aware and trained in safety culture concepts, practices and responsibilities
		We are exploring how to embed a “just” culture
	4. There are always enough staff on duty with the right skills, knowledge and experience and equipment	There are safe staffing levels across all professions
		Staff are appropriately trained and competent
		We have equipment and supplies in place to provide safe care
		Staff health and wellbeing is supported

Quality domain 2: Effective

Aim/CQC Definition: People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Area	Description	Target
Mortality indicators	We will improve our mortality rates as measured by HSMR (hospital standardised mortality ratio) to remain in the top five lowest-risk acute trusts	Top five lowest-risk acute trusts
Mortality indicators	We will improve our mortality rates as measured by SHMI (summary hospital-level mortality indicator) to remain in the top five lowest-risk acute trusts	Top five lowest-risk acute trusts
Mortality reviews	We will ensure structured judgement reviews (SJRs) are undertaken for all relevant deaths in line with national requirements and Trust policy and that any identified themes are used to maximise learning and prevent future occurrences.	SJRs undertaken in 100% of relevant cases 100% of SJRs completed within 30 days of date of commencement
Readmissions	We will reduce the unplanned readmission rates for patients aged 0-15 and be below the national average	Better than national average
Readmissions	We will reduce the unplanned readmission rates for patients aged 16 and over and be below the national average	Better than national average
Clinical trials	We will ensure that 90% of clinical trials recruit their first patient within 70 days	90%
Clinical audit	We will participate in all appropriate national clinical audits and evidence learning and improvement where our outcomes are not within the normal range	100%

Goal	Primary driver	Secondary driver
Effective: People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence**.**	1. Supporting self-care and self-management of conditions and promote a healthy lifestyle	Self-care: Partner with patients to recognise, treat and manage their own health
		Self-management: Encourage and enable patients to protect their own health, choose appropriate treatments and manage long-term conditions
		Promote healthy lifestyles and every interaction with patients
	2. Produce and translate the latest advances in research and technology for better patient outcomes	Collaborate with research partners
		Promote pioneering research into diagnostic methods and treatments
		Ensure timely and appropriate participation of patients in clinical trials
		Introduce new care bundles
		Support improvements to patient care through innovation
	3. Systematically review outcomes and clinical practice to identify improvement opportunities and implement evidence based practices	Undertake audits to understand where there is scope for improvement
		Review services to develop forward-looking clinical strategies and workforce
		Regular internal inspections of wards to promote safer patient care and spread good practice
		Regular internal inspections of core services
		Regular review of health outcomes to identify areas for improvement
		Review and standardise practices, ensuring they are in line with national standards, guidelines and policy
	4. Reduce unwarranted variation to provide consistently good services	Ensure clinical teams own and use their own data to drive improvements
		Use rigorous improvement methods to design, test and implement changes
		Improve the quality of patient records through the increased use of structured data
	5. Making sure care is coordinated to meet patient need	Support transitions of care between different services and settings of care within the organisation
		Support transitions of care between different organisations

Quality domain 3: Caring

Aim/CQC Definition: The service involves and treats people with compassion, kindness, dignity and respect.

Area	Quality account description	Target
Friends and family test	To maintain the percentage of inpatients who would recommend our trust to friends and family (FFT) to 94% or above	94%
Friends and family test	We will achieve and maintain a FFT response rate of 15% in A&E	15%
Friends and family test	To maintain the percentage of A&E patients who would recommend our trust to friends and family to 94% or above	94%
Friends and family test	To maintain the percentage of maternity patients who would recommend our trust to friends and family to 94% or above	94%
Friends and family test	To increase the percentage of outpatients who would recommend our trust to friends and family to 94% or above	94%
Friends and family test	To maintain the percentage of patients using our patient transport service who would recommend our trust to friends and family	90%
Mixed sex accommodation	We will have zero mixed-sex accommodation (EMSA) breaches	0

Goal	Primary Driver	Secondary Driver
Caring: The service involves and treats people with compassion, kindness, dignity and respect	1. Patients are looked after in a caring environment	Ensure our sites are easy to access
		Identify opportunities and plans for refurbishing and redeveloping our sites
		Ensure our patient facing services have patient experience at their heart
		Ensure patients are treated in a clean and infection free environment
		Improve patient nutrition
	2. Patients have access to the most up-to-date and accurate information to make decisions about their own care	Promote openness and honesty at all times
		Support patients to have access to medical records
		Provide patient information that is clear, consistent and accessible to all
	3. Staff recognise and treat every patient as an individual	Improve feedback and learning from events, complaints and compliments
		Embed the Trust values into all interactions between staff, patients and the public
		Recruit and develop team leaders based on their values
		Provide accessible and prompt emotional and social support for staff

Quality domain 4: Responsive

Aim/CQC Definition: Services meet people's needs

Area	Description	Target
Referral to treatment – elective care	We will reduce the percentage of patients waiting over 18 weeks to receive consultant-led treatment in line with trajectories	92%
Referral to treatment – elective care	We will reduce the percentage of patients waiting over 52 weeks to zero in line with trajectories and implement our agreed clinical validation process	0
Cancer	We will maintain the percentage of cancer patients who are treated within 62 days from urgent GP referral at 85% or more	85%
Theatre management	We will increase theatre touchtime utilisation to 95% in line with trajectories	95%
Cancelled operations	We will reduce cancelled operations as a percentage of total elective activity	Below national average
Cancelled operations	We will ensure patients whose elective operations are cancelled are rebooked to within 28 days of their cancelled operation	Below national average
Critical care admissions	We will ensure 100% of critical care patients are admitted within 4 hours	100%
Accident and Emergency	We will admit, transfer or discharge patients attending A&E within 4 hours of their arrival in line with trajectories	95%
Accident and Emergency	We will reduce the number of A&E patients spending >12 hours from decision to admit to admission to zero	0
Length of stay	We will reduce the percentage of patients with length of stay over 21 days	25% reduction
Length of stay	We will discharge at least 33% of our patients on relevant pathways before noon	33%
Diagnostics	We will maintain performance of less than 1% of patients waiting over 6 weeks for a diagnostic test	1%
Outpatients	We will reduce the proportion of patients who do not attend outpatient appointments to 10%	10%
Outpatients	We will reduce the proportion of outpatient clinics cancelled by the trust with less than 6 weeks' notice to 7% or lower	7%
Complaints	We will maintain the numbers of formal complaints at less than 90 per month	Less than 90 per month
Complaints	We will ensure that we respond to complaints within an average of 40 days	40 days
Complaints	We will ensure that at least 70% of complainants are satisfied with the overall handling of their complaint	70%
Patient transport	We will improve pick up times for patients using our non-emergency patient transport service	Collection within 60 minutes: 97%
Data quality	Data Quality Maturity Index	TBC

Goal	Primary Driver	Secondary Driver
Responsive: Services meet people's needs	1. Care and treatments are designed to meet individual patient needs	Have accurate and clear information covering patients' past and present condition/ Improve the availability, quality and sharing of medical records in line with guidelines
		Patients are able to access and control their information
		Patients (with long term conditions) have and are support to design their own care plans
		Patients, families and carers are at the centre of decision-making about their care
		Develop proactive relationships with healthcare professionals in primary, community and mental health settings.
	2. Promote equality and equity in access to our services	Make adjustments to care to take account of age, disability, gender, gender identity, race, religion or belief and sexuality
		Improve transport services to and from hospital
		Support physical and mental health in a more integrated way
		Understand care needs for specific patients groups
	3. Patients have timely access to our services	Patients have access to timely planned care (from pre-referral advice and outpatients, to diagnostics to patient admissions)
		Patients have access to timely acute, emergency and urgent care
	4. Listen to and act on feedback from patients and the public	Improve mechanisms for capturing patient feedback
		Improve feedback and learning from events, complaints and compliments.
		Empower teams to act on patient feedback data
		Support co-production of improvement work
		Ensure we consult, listen to and involve patients and the public in decisions about our services

Quality domain 5: Well led

Aim/CQC Definition: The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Area	Description	Target
Workforce and people	We will have a voluntary staff turnover rate of 12% or less	12%
Workforce and people	We will maintain our sickness absence rate at below 3%	3%
Workforce and people	We will achieve a performance development review rate of 95%	95%
Workforce and people	We will achieve a non-training grade doctor appraisal rate of 95%	95%
Workforce and people	We will have a consultant job planning completion rate of 95% or more	95%
NHS Improvement (NHSI) segmentation	We will maintain or improve NHSI provider segmentation	3

Goal	Primary Driver	Secondary Driver
Well-led: The leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture	1. Build improvement capacity and capability at all levels	Design and deliver a comprehensive quality improvement education programme accessible to staff at all levels
		Develop multiple cohorts of improvement coaches and leaders
		Support staff to have the capacity to undertake and lead improvement work
		Ensure effective and high quality management capability
	2. Recruit, develop and retain a highly motivated and expert workforce	Effective recruitment, attraction and onboarding strategies are in place
		Prioritise professional development opportunities and networks
		Focus on talent management
		Ensure effective staffing levels and working patterns are in place
		Ensure high levels of staff mental and physical wellbeing
		Improve equality and diversity through embedding the new work programme
	3. Become a learning organisation	Listen to and act on patient feedback
		Listen to and act on staff feedback
		Maximise learning capacity by developing skills in staff
		Share and celebrate stories across and beyond the organisation
	4. Develop strategic and operational plans to meet current and future needs of our population	Develop strategies with our partners in North West London to improve the health of our communities
		Ensure our states are fit for purpose
		Emergency preparedness plans

Quality domain 6: Use resources sustainably

- **Aim/CQC Definition:**: we use resources responsibly and efficiently, providing fair access to all, according to need, and promote an open and fair culture

Area	Description	Target
Finance KPIs	Monthly finance score (1-4)	N/A
Finance KPIs	In month position	N/A
Finance KPIs	YTD position £m	N/A
Finance KPIs	Annual forecast variance to plan	N/A
Finance KPIs	Agency staffing	N/A
Finance KPIs	CIP (Cost improvement programme)	N/A

There will be further development of the use of resources domain during 2019/20.

Part 2b: Statements of assurance from the Trust board

In this section of the quality account, we are required to present mandatory statements about the quality of services that we provide, relating to financial year 2018/19. This information is common to all quality accounts and can be used to compare our performance with that of other organisations. The statements are designed to provide assurance that the board has reviewed and engaged in cross-cutting initiatives which link strongly to quality improvement.

A review of our services

In 2018/19, Imperial College Healthcare NHS Trust provided and/or sub-contracted 99 NHS services.

We have reviewed all the data available to us on the quality of care in all of these NHS services through our performance management framework and assurance processes.

The income generated by the NHS services reviewed in 2018/19 represents 100 per cent of the total income generated from the provision of NHS services by the Trust for 2018/19.

The income generated by patient care services associated with the services above in 2018/19 represents 84 per cent of the total income generated from the provision of services by the Trust for 2018/19.

Participation in clinical audits and national confidential enquiries

Clinical audit drives improvement through a cycle of service review against recognised standards, implementing change as required. We use audit to benchmark our care against local and national guidelines so we can put resource into any areas requiring improvement; part of our commitment to ensure best treatment and care for our patients.

National confidential enquiries investigate an area of healthcare and recommend ways to improve it.

During 2018/19, 55 national clinical audits and two national confidential enquiries covered NHS services that Imperial College Healthcare NHS Trust provides. During that period Imperial College Healthcare NHS Trust participated in 89 per cent of national clinical audits and 100 per cent of national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries that Imperial College Healthcare NHS Trust was eligible to participate in are included in the table in appendix A with the number of cases submitted presented as a percentage where available.

We did not participate in the five BAUS audits in 2018/19. This decision is currently being reviewed by the Trust executive team.

We have now joined the inflammatory bowel registry and have been participating since April 2019.

The reports of twenty six national clinical audits and confidential enquires were reviewed by the provider in 2018/19. The majority of these have provided a satisfactory level of assurance; however the exceptions are listed in appendix B with the actions required to improve the quality of healthcare provided. All other reports are under review by our divisions with assurance reporting planned in line with our governance framework.

The reports of 313 local clinical audits were reviewed by the provider in 2018/19. Some examples of the actions we have taken or intend to take can be found in appendix C.

Participation in clinical research

We continue to develop ambitious and world-leading programmes of clinical research, partnering closely with Imperial College London as Imperial College Academic Health Science Centre (AHSC). In collaboration also with industry, the charity sector and government, this partnership drives the biomedical and clinical research strategy in the Trust. It ensures we remain at the forefront of scientific discovery, and can then apply that new knowledge to the clinical needs of our patients and wider population.

Through the AHSC we also work closely with the Royal Brompton & Harefield NHS Foundation Trust and the Royal Marsden NHS Foundation Trust, coordinating and aligning our priorities across North West London.

Much of our innovative clinical and biomedical research is made possible because of significant infrastructure funding, awarded through open competition by the National Institute of Health Research (NIHR). This includes our NIHR Biomedical Research Centre (BRC), Clinical Research Facility (CRF), Patient Safety Translational Research Centre (PSTRC), Experimental Cancer Medicine Centre (ECMC) and MedTech & In Vitro Diagnostics Cooperative (M&IC). Funding from our own Imperial Health Charity ensures this work is directed towards the benefit of our NHS patients, as well as providing career development opportunities for our medical staff and for those working in professions allied to medicine.

Since April 2017, the BRC has funded more than 250 individual experimental medicine research projects. In total, 605 new clinical studies were initiated in 2018/19, including those with external funding from the commercial, government and charitable sectors.

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2018/19 that were recruited to participate in research approved by a research ethics committee was 18,988. 15,300 patients have been recruited into 377 NIHR Portfolio studies in 2018/19. This included 2,820 patients within 75 studies sponsored by commercial clinical research and development organisations.

In 2018/19, we also launched a strategy to develop our capacity for research led by non-medical staff communities, including research nurses, allied health professionals and clinical research practitioners. It aims to support and build research awareness, research involvement, research activity and research leadership across the Trust.

Through joint working with our academic partner, we have continued to make significant scientific advances in 2018/19, translating discovery into patient benefit. Highlights include:

- A first-in-human, commercially-sponsored gene therapy trial showed remarkable success in treating patients with haemophilia A. The success of the study has led commentators to hail this as a potential cure for haemophilia A;
- ORBITA – the first, placebo-controlled double-blind randomised controlled trial of percutaneous coronary intervention (PCI) – demonstrated the potential placebo effect of heart stents. The trial exposed the flawed position of PCI in current clinical recommendations;

- A unique CAR-iNKT cell treatment strategy, developed by scientists in the Imperial BRC Cancer Theme, has proved more effective than conventional treatments. It has clear clinical implications and a patent has been filed;
- In 2014, Imperial established a Faecal Microbiota Transplantation (FMT) unit with support from the BRC and Imperial Health Charity. A number of patients with antibiotic-resistant *C. difficile* infections (CDI) saw improved health and normal wellbeing after a single dose of FMT. Recently, the first-ever UK FMT Guidelines were published (which Imperial FMT clinicians contributed to), providing evidence-based advice of best clinical FMT practice. FMT has now been accepted as an appropriate treatment option for recurrent/refractory CDI by the National Institute for Health and Care Excellence (NICE);
- The NIHR Imperial BRC, in collaboration with the University of Edinburgh, have developed new software capable of detecting small vessel disease (SVD), a leading cause of stroke and vascular dementia. Based on Artificial Intelligence (AI) techniques, the new method allows for precise and automated measurement of the disease.
- Our research has provided new insights into the transmission of Group B streptococcus, a very common bacteria which is normally harmless. In newborn babies, the bacteria can cause serious infection, with transmission occurring during birth. In late-onset cases, the source of infection is often unclear. In our study, genomic analysis of 11 late-onset cases provided evidence to suggest a greater role for transmission between patients. As a result, a range of interventions have now been introduced to reduce the risk to patients;
- Imperial BRC researchers have developed an Artificial Intelligence (AI) system that could be used to personalise the treatment of patients with sepsis in real time. The computational model learned the best individual treatment strategy from medical records of almost 100,000 sepsis patients and provided recommendations that proved more reliable than decisions made by doctors. The system will now be trialled in UK hospitals. This cutting-edge work is a direct result of the Imperial ethos that brings together engineers and clinicians to solve real health problems and improve healthcare;
- In February 2019, as part of a collaboration with other UK and international universities and hospitals, one of our patients became only the second person ever reported to have been cleared of HIV after receiving a stem-cell transplant that replaced their white blood cells with HIV-resistant versions. The patient was able to stop taking antiretroviral drugs, with no sign of the virus returning 18 months later.
- A new research centre – the first of its kind in Europe – will accelerate research to reduce and prevent the risk of premature birth. The March of Dimes Prematurity Research Centre, will be funded by the US charity March of Dimes and supported by a grant from Ferring Pharmaceuticals, who specialise in reproductive medicine and women's health. March of Dimes support research, lead programs and provide education to improve the health of mums and babies.

More detail on each of these examples, as well as well other translational research work can be found on the NIHR Imperial Biomedical Research Centre website [insert hyperlink: https://imperialbrc.nihr.ac.uk/research/].

Our CQUIN performance – CQUIN framework

A proportion of our income in 2018/19 was conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (CQUIN) framework. The value of the schemes was 2.8 per cent of the contract value for NHS acute healthcare services as agreed with NHS England and 2.5 per cent of the contract value for agreed CCG schemes. This equated to £7.2M (NHS England schemes) and £10.05M (CCG schemes) of our planned income. A summary of the 2018/19 CQUIN goals and achievements can be found in appendix D.

Care Quality Commission registration status

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. It makes sure health and social care services provide people with safe, effective, caring, well-led and responsive care that meet fundamental standards.

The Trust is required to register with the CQC at all of our sites and our current registration status is 'registered without conditions'.

The CQC did not take enforcement action against Imperial College Healthcare NHS Trust during 2018/19.

We have not participated in any special reviews or investigations by the CQC during 2018/19.

All trusts are captured in CQC patient surveys, of which two were published during 2018/19: adult inpatients and maternity. Our performance in the maternity survey, carried out during 2018, was the same as or better than the results of the previous survey. For the Adult Inpatient Survey, carried out during 2017, the Trust's performance was generally better than the results of the previous survey.

The CQC inspected four of our core services in February 2019:

- Critical care at St Mary's and Charing Cross and Hammersmith hospitals
- Services for children and young people at St Mary's and Hammersmith hospitals
- Maternity at St Mary's and Queen Charlotte & Chelsea hospitals
- Neonatal services (the neonatal ICU) at Queen Charlotte & Chelsea Hospital.

Our inspection of the well-led domain took place from 2 - 4 April 2019. We expect to receive the inspection reports for the core services and well-led inspections in draft form in July 2019, and published by the CQC in their final form in August 2019.

Our data quality

High quality information leads to improved decision making which in turn results in better patient care, wellbeing and safety. There are potentially serious consequences if information is not correct, secure and up to date.

We continued to focus on data quality improvement in 2018/19 through our data quality framework which we introduced in 2017/18.

Key data quality indicators are reported weekly and are included in our performance scorecards to ensure data quality governance is aligned with our Performance Management Framework. A monthly executive-led Data Quality Steering Group is in place to provide leadership and oversight of the development and delivery of all aspects of our Data Quality Framework.

A key component of the data quality framework is a quality assurance and audit process to inform training, learning and development. We carry out routine audits of referral to treatment (RTT), A&E performance, Diagnostics and Cancer waiting time information to identify recurrent errors with data entry. Currently three out of four waiting time audits are reporting under the 5 per cent threshold recommended by NHS Improvement.

Our Director of Operational Performance is leading a refresh of our approach to data quality which will be completed by June 2019. The priorities are:

- Expanding the routine audit programme to include length of stay, the inpatient waiting list and the outpatient new and follow up waiting lists;
- Developing a quality assurance process to routinely analyse income and activity data sets; and

- Improving the accuracy of the Secondary Users Service (SUS) submission, particularly in relation to the reporting of bed occupancy.

We will produce a monthly data quality report from April 2019 to inform senior leaders of the current status of data quality within the Trust.

NHS number and general medical practice code validity

The Trust submitted records during 2017/18 to the Secondary Users Service for inclusion in the Hospital Episode Statistics (see glossary on page 102 for definitions) which are included in the latest published data. The percentage of records in the published data to month 10 2018/19 (most recent available) which included the patient's valid NHS number was:

- 97.5 per cent for admitted patient care;
- 99.2 per cent for outpatient care;
- 91.7 per cent for accident and emergency care.

The percentage of records in the published data which included the patient's valid general medical practice code was:

- 100 per cent for admitted patient care;
- 100 per cent for outpatient care;
- 99.7 per cent for accident and emergency care.

Information governance toolkit scoring

The Data Security and Protection Toolkit is an online self-assessment tool that all organisations must use if they have access to NHS patient data and systems. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly. This replaced the previous Information Governance toolkit from April 2018.

We met all the mandatory standards of the toolkit and therefore produced a 'satisfactory' return. This was published to the Department of Health and verified as 'low risk' and 'reasonable assurance' following independent audit.

Clinical coding quality

Clinical coding is the translation of medical terminology as written by the clinician to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format which is nationally and internationally recognised. The use of codes ensures the information derived from them is standardised and comparable.

The Trust was not subject to the Payment by Results clinical coding audit by NHS Improvement during 2018/19. There are no Payment by Results audits currently planned.

North West London Clinical Commissioning Groups reviewed our non-elective clinical coding and day case Haematology data quality in 2018/19 and the cases with an error were found to be 4.4% and 61.7% respectively. The latter was due to classification of activity as day cases and reclassification as outpatient attendances is under discussion with our commissioners.

Learning from deaths

We comply with all elements of the national learning from deaths process with a policy that sets out standards and measures reported up to Trust Board. Through this process, 93 per cent of deaths which occurred at the Trust between April 2018 and March 2019 have been reviewed so far. Of these, 14 per cent have gone forward for structured judgment review (SJR). This is a validated methodology and involves trained clinicians reviewing medical records in a critical

manner to comment on phases of care and determine whether the death may have been due to problems with the care the patient received. We have identified avoidable factors in eleven deaths this year.

The SJR process includes presentation to the monthly Mortality Review Group where we identify learning opportunities and themes and share these across the Trust. Where the review identifies avoidable factors in a death, we also complete a Serious Incident investigation.

Our target is to undertake SJRs for all selected cases within 30 days of death. For next year, we will move to reporting from date of death to date of SJR request as this will allow us to monitor performance more transparently.

In late 2018, we identified some improvements to the process which will support us in the lead up to the implementation of the nationally mandated role of a medical examiner (ME). We have established a Learning from Deaths steering group to oversee this work.

We are required to provide the following statements in this document based on our findings as part of the learning from deaths process.

Deaths which occurred in 2018/19
During 2018-19, 1,702 of our patients died. This comprised the following number of deaths which occurred in each quarter: 413 in the first quarter; 408 in the second quarter; 440 in the third quarter; 441 in the fourth quarter.

223 case record reviews (structured judgement reviews) and 15 serious incident investigations have been carried out in relation to these 1,702 deaths.

In 12 cases, a death was subjected to both a case record review and a serious incident investigation. The number of deaths in each quarter for which a case record and a serious incident investigation was carried out was: 7 in the first quarter; 2 in the second quarter; 1 in the third quarter; 2 in the fourth quarter.

Eleven (0.65%) of the 1,702 patient deaths which occurred in 2018/19 are judged to be more likely than not due to problems in the care provided to the patient. In relation to each quarter, this consisted of: 4/413 (0.97%) for the first quarter; 2/408 (0.49%) for the second quarter; 0/440 (0%) for the third quarter; 5/441 (1.13%) for the fourth quarter.

These numbers have been estimated using our structured judgment review process described above.

Themes for deaths deemed to have avoidable factors link to five of our safety streams (see pages 50-55 for more information); ‘falls and mobility’, ‘responding to the deteriorating patient’, ‘safer medication’, ‘safer surgery’, and ‘fetal monitoring’. Additional themes include poor communication and treatment delays. Cases are shared with the safety stream leads to ensure the improvement work covers the findings of the SJRs. Actions taken by the safety streams linked the SJRs, and the impact of these, are included on pages 50-55.

Individual action plans are also developed in response to each case. Examples of these actions include:

- Review of the Venous thromboembolism protocols in Renal;
- Repatriation guidance in trauma patients to be considered;
- Multi-disciplinary learning undertaken for management of hyperkalaemia;
- Emergency Department exit checklist to be incorporated into Cerner;
- Local teaching on treatment of pulmonary embolism.

We expect that the impact of these actions will be improvements in the overall quality and safety of care provided to our patients. On a trustwide level, we continue to have some of the lowest mortality rates in the country and have seen a reduction in both avoidable deaths and patient safety incidents causing extreme harm/death compared to last year.

Deaths which occurred in 2017/18
248 case record reviews and 38 serious incident investigations that related to the 1895 deaths that took place during 2017/18 were completed. Of these, 18 of the deaths reviewed or investigated during that year were judged to be more likely than not due to problems in the care provided to the patient. This represents 0.95% of the deaths that occurred during that financial year.

In total, for financial years 2017/18 and 2018/19 combined we have reported 29 deaths for which we have identified avoidable factors through our learning from deaths process.

National Outcomes framework indicators 2018/19

The NHS Outcomes Framework 2018/19 sets out high level national outcomes which the NHS should be aiming to improve. For full information about our performance, please see pages 96-100.

Part 3: A review of our quality progress 2018/19

This part of the report shares the quality improvement priorities and metrics that we set ourselves for 2018/19 and reports our progress against each of these. It also outlines our performance against the NHS Outcomes Framework 2018/19, the Quality Schedule agreed with our commissioners and national targets and regulatory requirements.

As described on pages 12-13, for 2018/19 we identified 13 areas where we wanted to prioritise our improvement activity. Progress against these is outlined below. They are not described under a quality domain as many of them span multiple.

Improvement priority 1	**To reduce avoidable harm to patients**
Executive lead	Medical Director
Why this was included for 2018/19	Although our incident reporting rates and harm profile are good we take avoidable harm seriously and strive to continuously minimise it.
What we achieved	This year, we have seen **a reduction in the number of incidents causing the most harm to patients**, whilst maintaining high numbers of incidents reported. We had reported 11 severe and extreme harm incidents, compared to 27 last year. We have also reported **fewer avoidable deaths** – 11 this year, compared to 18 last year and continue to have **some of the lowest mortality rates** in the country. We have improved outcomes for patients in several key areas, including a **reduction in mortality for patients diagnosed with sepsis** from 18 per cent to 14 per cent, and a 22 per cent **reduction in falls with harm**. However, this year we also reported **seven never events**, compared to one last year. We have developed actions in response to make sure we are reducing the likelihood of similar incidents occurring again.
What we did	**Progress with the 'safety streams'** Work continued in our nine safety streams which address the key risks identified from our most frequently reported Serious Incidents (SIs) – progress with each of these is outlined in more detail in the safe domain (see pages 50-55). Each stream is chaired by an experienced clinical lead with dedicated support from an improvement team lead. **Implementation of our Sepsis policy and alert** Sepsis is an inflammatory response triggered by infection, with the risk of in-hospital mortality. Early recognition and intervention can reverse the inflammatory response and improve the outcome for patients. In 2018 we launched a sepsis policy, to support the early recognition, management and treatment of sepsis. This was accompanied by a live alert in our electronic patient record designed to improve the identification of adult patients at high risk of sepsis and a treatment care plan for when sepsis is identified. This

	work was implemented through our Sepsis 'Big Room' (see pages 41-43 for more information) and has resulted in a reduction in mortality for patients with sepsis. We started reporting on our performance with our target to ensure at least 50% of our patients receive antibiotics within one hour of a new sepsis diagnosis in November 2018 and have achieved it every month since then. The work is continuing, with recruitment of new sepsis nurses underway and the development of a training programme for staff which will roll out in 2019. **Our response to the never events** Never events are defined as serious, largely preventable incidents that should not occur if the available preventative measures have been implemented. The seven never events we reported this year are: • wrong route medication in May 2018 (emergency medicine at Charing Cross Hospital) • retained swab in July 2018 (maternity at Queen Charlotte's and Chelsea Hospital) • retained foreign object in September 2018 (cardiac surgery at Hammersmith Hospital) • wrong site surgery in October 2018 (urology at Charing Cross Hospital) • wrong site block in November 2018 (plastic surgery at Charing Cross Hospital) • wrong site block in January 2019 (CT radiology at St Mary's Hospital). • retained swab in January 2019 (maternity at Queen Charlotte's and Chelsea Hospital) Six of the seven were related to invasive procedures. All of them have been investigated and have action plans in place. We have had agreement from our commissioners that the never event which occurred in May will be re-classified to a Serious Incident as following investigation, it was found that the swab concerned had been intentionally retained. We also implemented a trustwide action plan. This included the medical director visiting theatres, talking to staff on the frontline about how to make improvements and encouraging staff to support each other to work safely; the roll out of a tailored coaching and simulation training programme for all areas where we undertake invasive procedures, starting with the specialties where we've had never events; actions to improve, monitor and provide assurance around compliance with key safety checks, including the five steps to safer surgery, and a review of all Trust policies and processes related to invasive procedures. At our request, Dr Fowler, the national director of patient safety visited us to discuss our plans. He was supportive of the actions and approach we are taking.
Further work we need to do	This will continue to be an improvement priority, with work continuing in the nine safety streams, the implementation of recommendations to improve both our learning from deaths and serious incident processes, and the continued roll out of sepsis monitoring across all areas of the Trust.

Measurable targets	• Reduction in the most commonly occurring SIs which have caused or have potential to cause harm • Increase in the percentage of patients receiving antibiotics within one hour of a sepsis diagnosis in line with our trajectory, with the aim to achieve 90 per cent in line with new national requirements. • Reduction in the number of incidents resulting in harm • Reduction in never events

Improvement priority 2	**To improve the safety culture across the Trust**
Executive lead	Medical director
Why this was included in 2018/19	Culture is "the ideas, customs and social behaviour of a particular people or society" which defines how people behave and interact with others. Safety culture is about the attitudes, values and behaviours that staff share about safety, often described as the "the way we do things around here to keep patients and staff safe". The safety culture programme was launched in 2016, and is in place to ensure that safety is a universal priority for all staff groups.
What we achieved	An important measure of an organisation's safety culture is its willingness to report incidents affecting patient safety to learn from them and deliver improved care. A high reporting rate reflects a positive reporting culture. Since we started our incident reporting improvement programme we have seen an **increase in the numbers of incidents reported** by 746, from 16,166 in 2016/17 compared to 16,912 in 2018/19, while maintaining low levels of harm. Our incident reporting rate per 1,000 bed days has however reduced and is below the top quartile when compared nationally, this is due to a number of issues with our published bed day data for quarter three which is used to calculate our reporting rate for the last six months of 2018/19. The quarter four bed occupancy data is expected to reduce, bringing our reporting rate up. In our staff survey we saw a further **improvement in the percentage of staff feeling able to raise concerns** (77 per cent compared to 75 per cent in 2017), with performance being maintained for staff being encouraged to report patient safety concerns (85 per cent) and for staff feeling that the Trust encourages staff to report incidents (78 per cent). We have also improved how we are enacting the duty of candour and being open with our patients when things go wrong, with **patients receiving both a verbal and written explanation and apology for all appropriate incidents in over 90 per cent of cases**, which is an improvement on last year, though below our 100 per cent target. We are reviewing how we measure this target. We are very proud that our safety culture work has been **shortlisted for a HSJ award** in the category of 'Changing Culture'.
What we did	We investigate all patient safety incidents (see glossary on page 102 for definition and harm levels) which are reported on our incident reporting system, Datix. Those graded at moderate harm and above are reviewed at a weekly panel chaired by the medical director. Incidents that are deemed to be Serious (SIs) or never events then undergo an investigation which involves root cause analysis (a systematic investigation that looks beyond the people concerned to try and understand the underlying causes and environmental context in which the incident happened).

	Serious Incident improvement programme This was launched in 2017 to improve the way we investigate, manage and learn from Serious Incidents (SIs). Key improvements as a result include: • Over 140 staff members trained as investigators and a new role of lead investigator agreed with divisions. • A suite of new products to support staff to complete quality investigations, including new templates for the 72 hour report and the final SI report. By improving the initial investigations into the incidents, this has supported a decrease in the total number of SIs we reported (145 this year, compared to 184 last year) and a decrease in the number of de-escalation requests we made to our commissioners (4 this year, compared to 9 last year).The use of these documents has been evaluated throughout the Trust during 2018 and further changes will be made in the coming months. **Incident reporting improvement programme** In 2017 we launched this programme to plan, develop and oversee improvements to our reporting and management processes. Progress made this year includes the launch of 'Learning from excellence' (LfE) – positive incident reporting. Traditional incident reporting focuses on identifying and learning when things go wrong; LfE aims to capture learning from when things go well, with the added benefit of improving staff engagement and motivation. The programme went live in five pilot areas in August with over 114 reports submitted and was rolled out across the Trust in the Autumn. We are now focusing on how we are spreading and showcasing the good practice highlighted through these reports. We targeted interventions aimed at increasing and sustaining our incident reporting rates including communications, focused awareness and education with staffing groups that have been identified as low reporters and local engagement work within individual directorates. Through collaboration with software developers, healthcare staff and clinical academics and in partnership with the Patient Safety Translational Research Centre (PSTRC), we have developed an app-based incident reporting system called CareReport. The aim is to assess whether CareReport increases the number of incident reports and improves staff experience of the reporting process. We are planning to trial this in the Accident & Emergency Department at St Mary's Hospital in early 2019/20. The achievements of the first phase of the Incident Reporting Improvement Programme were published in a peer-reviewed journal 'Health Affairs' in November 2018. **Safety culture communications** In response to staff feedback, we developed a safety communications plan. This includes a number of safety communications templates, designed with staff, which have been in use since April 2018. There is evidence that these are being used in practice by frontline staff.
Further work we need to do	Culture is not something that changes quickly so it is important that we continue our focus on this programme. However for 2019/20 we will refocus this on improving the behaviours related to safety. We will focus on the behaviours we expect staff to display. These include being open and transparent when things go wrong, being encouraged to report, reflect and learn and being supported in a just and caring way.

	Metrics related to SI submission and action completion show that more work is required around improving the quality of our investigations. We completed a 'stock take' of progress, which involved interviews with staff involved in investigations, and identified next steps for further improvement. This includes establishing a new central investigation team with expert investigators. We are also reviewing how we can best support staff psychologically following a SI. We will continue to develop and co-design communications with staff, including creating an Imperial safety campaign and video.
Measurable targets	• An increase in our incident reporting rate, maintaining our position within the top quartile when compared with other trusts • Improvements in the percentages of staff responding positively to the relevant staff survey questions • Improvements to the quality of SI investigations as measured by a reduction in the number of reports returned from the commissioners with queries before they can be closed, an increase in the number of reports submitted on time and a reduction in the number of de-escalation requests made • An increase in the number of 'Learning from Excellence' reports made by staff

Improvement priority 3	**To improve permanent nurse staffing levels**
Executive lead	Director of P&OD
Why this was included in 2018/19	Feedback from the listening campaign conducted in December 2017 reported the importance of having the right number of staff to enable care to be provided, with a specific focus on nursing. Vacancy rates at the Trust in 2016/17 were above target with variance across departments.
What we achieved	We have **not achieved our target of 13 per cent**, reporting an average vacancy rate for nursing and midwifery staff of 15.56 per cent across the year. Despite this, we have **ensured staffing meets planned safe levels** this year. Where shifts were not filled, staffing arrangements were optimised and any risk to safe care minimised by the senior nurses taking the following actions: • Using the workforce flexibly across floors and clinical areas; • The nurse or midwife in charge of the area working clinically and taking a case load; • Specialist staff working clinically during the shift to support their ward based colleagues. We have achieved a number of other key performance indicators, including **an increase in conversion rate for students** who train with us and take up employment, an **increase in the internal/external hire ratio**. Internal targets to recruit international nursing and midwifery staff, and nursing associates and graduate nurse apprenticeships have also been met.
What we did	In March 2018 we launched a strategy to improve our nursing retention and recruitment. Our action plan for 2018/19 consisted of 6 workstreams, highlights of which include:

	• Refer a friend scheme launched in October covering hard to fill roles. • Re-launch of the internal transfer scheme in September 2018. • Careers clinics were piloted successfully and ran until December 2018. • International recruitment is underway, with a pipeline of over 300 nurses who are all expected to have joined by the end of quarter two 2019/20. • Recruitment and retention premiums are being offered across a number of hard to recruit areas and have resulted in an increase in applications. • 8 nurse associate apprenticeships are now in place. • Additional Practice Educators have been recruited to support the student nurses and the nurse workforce. We have also run recruitment and retention campaigns for other areas and staff groups with high vacancy rates, including radiographers, middle grade critical care doctors and started one for middle grade doctors in the emergency department in March 2019.
Further work we need to do	Further work will continue with our recruitment and retention plan into 2019/20. We will maintain this as a priority for 2019/20 given the challenge we face. We will also widen this to include non-consultant doctors.
Measurable targets	Achievement of our vacancy rate targets for all staff groups.

Improvement priority 4	**To ensure our staff are up to date with the mandatory skills to do their jobs**
Executive lead	Director of P&OD
Why this was included in 2018/19	Core skills and core clinical training rates have previously been below target despite many interventions. Core skills are mandated training programmes which all our staff must complete in accordance with the requirements of their roles.
What we achieved	The percentage of staff who have completed all the core skills modules has increased significantly this year and has been **above our 90 per cent target** since November 2018.
What we did	Our core skills training programme ensures the safety and well-being of all our staff and patients; this includes modules which have a direct impact on patient safety. Actions taken to achieve this include: • review of all modules, leading to a reduction in the total amount by removing duplicates. • review of all staff profiles to make sure that everyone was doing the right core skills training based on their role. • a communications campaign and focused targeting of staff who were non-compliant.
Further work we need to do	A new learning management system which will further support staff to undertake the training and provide more accurate data has been procured and is mid-implementation. Work is on-going to cleanse data, upload historic records and convert e-learning content, and a soft go live is planned for late April. This will return to business as usual monitoring through the integrated quality performance report with reporting to the executive people and organisational

	development committee.
Measurable targets	Maintenance of core skills compliance at over 90 per cent

Improvement priority 5	**To ensure our equipment has planned maintenance in line with targets**
Executive lead	Director of nursing
Why this was included in 2018/19	We recognise that the safe and appropriate use of medical devices is critical to the delivery of high quality patient care. Equipment maintenance, oversight and management have been problematic in the past including assuring it is completed within manufacturing recommendations.
What we achieved	Our targets for planned maintenance are monitored monthly through the IQPR and are being **consistently met for medium risk and low risk equipment** (performance in March 2019 was 82 per cent for both against targets of 75 per cent and 50 per cent respectively). There has been a **significant improvement for high risk equipment**, with 96 per cent of equipment being reviewed in line with the requirements by March 2019, compared to 72 per cent in April 2018.
What we did	All our medical equipment has a planned maintenance programme at a frequency determined by the manufacturer's instructions or on a risk based strategy by Clinical Technical Services. An e-learning package to inform staff of essential safety aspects prior to using a medical device went live in December.
Further work we need to do	This is now business as usual so it is proposed that this is stepped down as a priority for 2019/20 and monitored through routine governance processes.
Measurable target	Maintenance of compliance with our targets for equipment maintenance

Improvement priority 6	**To improve the management of medicines**
Executive lead	Director of nursing / Divisional Director for WCCS
Why this was included in 2018/19	Medicines are the most common intervention in healthcare and can be associated with risk and harm. Management of medicines has been raised at each of our CQC inspections since 2014. In November 2017 the CQC reported that medicines were not consistently given, recorded and stored well. The CQC report of 2018 identified similar concerns. A new approach was implemented to support improvement.
What we achieved	We audit 33 standards around storage and security of medicines, controlled drugs and medicines fridges weekly. Results show **98 per cent compliance with the medicines standards**, with **sustained improvements in the management of medicines fridges**. We reported a **reduction in Serious Incidents** related to medications (2 this year compared to 4 last year).
What we did	In response to the audit results, we have taken action to make it easier for staff to do the right thing including: • A standardised Controlled Drug (CD) key fob • An algorithm regarding the disposal of CDs on wards • A new fridge monitoring form and fridge temperature action lists • An algorithm regarding fridge checking actions

	• A list of roles and responsibilities of pharmacy, nursing, midwifery and operating department assistant staff These were co-designed with clinical staff from a range of professional groups, colleagues from the PSTRC and a design company and launched at a trustwide 'medicines matter event'. We have also revised our policies and procedures for destruction of medicines at ward level and 'returns to pharmacy' and changed our medicines management training from face-to-face to an online module - compliance is currently on target at 90.56 per cent. We identified a risk around medicines shortages, with concerns that this will worsen with the impact of Brexit. The Pharmacy team have a database of all 'medicines in shortage' and work with the clinical teams to identify alternatives.
Further work we need to do	This will move to business as usual monitoring through routine governance processes, with the medicines safety stream continuing as part of improvement priority 1. Phase 2 of the medicines safety stream has been scoped and agreed and will focus on improving the management of high risk medicines to reduce harm to patients, specifically insulin and anticoagulation. This will be monitored through the priority to reduce avoidable harm.
Measurable targets	A reduction in incidents with harm associated to high risk medications

Improvement priority 7	**To ensure hand hygiene compliance is measured accurately with focused improvement to support staff where risk exists.**
Executive lead	Medical director
Why this was included in 2018/19	Our hands are the principle route by which cross-infection happens, and hand hygiene is the single most important factor in the control of infection. Monthly point prevalence hand hygiene audits had been completed by front line nurses for their own areas for the last 10 years up to 2018. Results consistently showed excellent performance (over 90 per cent) however independent audits did not always give the same results. This and feedback from inspections had raised concerns about consistency of compliance. When published research is considered compliance would be expected to be lower than that seen in our point prevalence results.
What we achieved	Audits were conducted in May 2018, November 2018 and February 2019. **Compliance with hand hygiene improved on the wards selected for focused improvement support** (29 per cent in the May audits, to 69 per cent in the February audits). Overall, the results did not improve on the wards which did not receive intensive support. We have seen a **decrease in the number of infection control Serious Incidents**, with 9 reported this year compared to 16 last year.
What we did	Our new approach to audit started in May 2018 with all inpatient areas. This new model involved a partnership between the Infection Prevention and Control team (IPC) and Divisional staff in collecting hand hygiene audit data for compliance with the WHO's five Moments For Hand Hygiene (the key moments when healthcare workers should wash/gel their hands).

	Overall compliance in the May audits was 56 per cent (Published evidence suggests that hand hygiene in clinical areas is typically around 45 per cent). The results prompted a Trust-wide hand hygiene improvement programme, and the identification of a small number of 'focus wards', which received intensive support in developing local improvement plans. The inpatient areas along with some other high risk areas were re-audited in November 2018 and February 2019. The focus wards were the most improved, with compliance increasing from 29 per cent in the May audits to 69 per cent in the February audits. Overall compliance did not improve, falling to 55 per cent in February. The hand hygiene improvements across the Trust are being supported by an upgrade of the hand hygiene dispensers, and a new hand hygiene communications campaign, which was piloted on the focus wards during February and March 2019.
Further work we need to do	The February audit results show that when supported to do so, ward areas can make a real improvement in their hand hygiene compliant. We have therefore identified more wards for focused improvement support. We will also ensure that all areas have an agreed improvement plan in place with regular reporting of progress through the divisional governance processes. We will evaluate our new communications campaign and gel dispensers and roll this out trustwide if successful. A hand hygiene celebration event will be held in the Trust in May 2019 to coincide with World hand Hygiene Day and an improvement sprint is also planned to explore with our patients and the public how we can better involve them in hand hygiene improvement work. Hand hygiene improvement is a safety stream and so we propose to manage this under that priority rather than it sitting separately.
Measurable targets	• Continued improvements as shown through our hand hygiene audits (target is 70 per cent) • Reduction in Serious Incidents related to infection prevention and control

Improvement priority 8	**To continue to define, develop, implement and evaluate an organisational approach to reducing unwarranted variation**
Executive lead	Medical Director
Why was this included in 2018/19	Variation in care can be unacceptable as it may be harmful or inefficient. This is referred to as "unwarranted variation"; occurring by chance and being characterized by patients not consistently receiving high quality care. The reduction of unwarranted variation across patient pathways is a key part of how we will improve sustainability and experience for our patients. One of our approaches to reduce variation is the use of 'flow coaching' within a clinical pathway. This involves coaching pairs taking part in training and using what they learn to coach weekly 'big rooms' – a face-to-face session bringing together a range of staff and patients involved in the pathway to discuss, plan and review improvements.
What we achieved	Our Flow Coaching Academy (FCA) has resulted in improvements for patients in several pathways, including:

	➢ *Sepsis* – Sustained **reduction in mortality** for all patients coded with a diagnosis of sepsis from 18 per cent to 14 per cent from June 2017 onwards; Increased percentage of patients receiving antibiotics within an hour of screening. ➢ *Diabetes* – **Decreased length of stay** for diabetic foot patients from 24 days to 18 days in 2018 ➢ *Paediatric Asthma and Wheeze* – **Increased percentage of written management plans** received by paediatric asthma and wheeze patients from 25 per cent average to 60 per cent from September 2018 onwards ➢ *Lower Urinary Tract Symptoms* - **Increased proportion of new LUTS patients either discharged or listed for surgery** from 24 per cent to 91 per cent; reduced DNAs (patients who did not attend their appointment) from 19 per cent to 2 per cent ➢ *Recovery* - **Reduced number of patients staying overnight** in Recovery per month from average of 70 to under 30 from August 2018 onwards; and **reduced average total time in Recovery** per patient from 8 hours to 3 hours from September onwards ➢ *Antenatal* - **Reduced length of stay** in maternity triage/day assessment units from average of 154 minutes to 110 minutes from November 2018 onwards ➢ *Vascular* - **Reduced length of stay** average by 2 days for all elective patients; Increased number of total discharges per week in Zachary Cope ward from a mean of 11 to 18 patients; Secured £100,000 funding to pilot a supportive discharge model ➢ *Acute Respiratory* - Trend indicating **the percentage of NIV patients dying in hospital has decreased** from 24 per cent to 17 per cent from May 2018 onwards ➢ *Young People* - Established **a new renal transition clinic** at Hammersmith to provide focus care for paediatric patients transitioning to adult services.
What we did	**Flow Coaching Academy (FCA) Imperial** Building on the success of the three pilot pathways with Sheffield Teaching Hospital, in 2018 we launched our own flow coaching academy. FCA Imperial has so far trained 24 flow coaches within the Trust, and established five staff as faculty who are able to deliver the programme training autonomously. It has generated ~£90k income for the Trust by offering places to external organisations, and influenced the establishment of other 'big rooms' including Digital; Strategy; Faster moves (part of the 'keeping care flowing collaborative' – see page 43-44 for more information); Paediatric Flow Collaborative; and Frailty. **GIRFT** Getting It Right First Time is a national programme designed to improve clinical care within the NHS by reducing unwarranted variations in quality, outcomes and costs. GIRFT reviews are being conducted nationally across 30 clinical specialties, led by frontline clinicians who are expert in the areas they are reviewing. We are fully engaged with GIRFT, with 15 specialties participating so far. We have used GIRFT data to inform our internal speciality review programme (see pages 47-48 for more information). In areas where both have been completed, we have implemented combined action plans, such as Urology co-location onto one site, delivery of innovative mass knee and hip clinics in trauma and orthopaedics and establishing high-volume theatre lists for cataract surgery. GIRFT data is

	also being used to support changes in the FCA pathways.
Further work we need to do	Each of the current pathways' big rooms will continue and become part of 'business as usual' to identify, test and implement changes to improve care. The Improvement Team will continue to provide support and direction as part of the overall programme management. This will include ensuring agreed reporting processes for each pathway with clear measurement of impact against their specific aims. The 9 internal pathways which form part of cohort 3 will began their teaching sessions in April 2019. As well as continuing to develop the FCA programme we will further develop our trustwide approach to unwarranted variation, including how we use clinical audit data, quality insights and other indicators to identify variation and how we build capability to respond appropriately using improvement methodology.
Measurable targets	Each of the pathways have defined measurable targets for improvement. Progress will be reviewed through our governance structures throughout the year.

Improvement priority 9	**Emergency flow through the hospital**
Executive lead	Divisional Director, MIC
Why this was included in 2018/19	In early 2017 we launched a programme to improve operational performance across the whole urgent care patient pathway at the Trust and to enable us to meet the trajectory for performance against the four hour A&E wait standard. Although significant work was completed, we did not meet the four hour A&E target in 2016/17 or 2017/18.
What we achieved	A&E performance is measured by the percentage of patients that are seen, treated and discharged from an urgent or emergency care setting within four hours. Our overall performance is derived from attends across all our emergency areas. These include: • The main Emergency Departments (Type 1) • Western Eye Hospital (Type 2) • The Urgent Care Centres at our three main sites (Type 3). The measure is important as it shows how well 'flow' through the whole of our care pathways is working and is a reflection of collaboration and co-ordination across services and teams. Although we have not met our target, in March 2019 **our A&E four-hour access performance was significantly better (5.2 per cent) compared to March 2018**, despite having 4.3 per cent more attendances. Overall, we achieved an average of 88.11 per cent across 2018/19, compared to 87.11 per cent last year. We also saw a **reduction in delayed beds**, an **increase in patients discharged before noon**, an **increase in the use of our discharge units** (from 10 per cent in 2017/17 to 14 per cent in 2018/19). Average discharge time has been brought forward by 46 minutes. We delivered **pathway efficiencies equivalent to creating an additional 35 inpatient beds**. We do still have issues with capacity and increased lengths of stay.
What we did	We have made improvements through our 'keeping care flowing collaborative' - a network of staff, partners from the community and our lay partners, working across the trust who have come together to deliver the

	improvements seen. For example: • Ambulance handover action plan which sets out agreed protocols, escalation processes and action cards to ensure that reducing ambulance handover delays is embedded into everyday practice. Currently, patients wait an average of around 230 minutes between when their ambulance arrives to when they are first assessed, which we are working to reduce. Additional actions have been added in response to new national guidance. • 'Keeping care flowing' intranet site now live, with all relevant policies and operating procedures and the latest materials available in one place for staff to access, to support improved flow through our hospitals. • New 'Majors area' opened at Charing Cross A&E. • Introduction of an electronic live bed state so we can better track our capacity. • Implementation of the 'red to green' approach – which helps teams identify delays by flagging days when a patient does not receive enough 'value-adding' care - and the SAFER care bundle, which blends five elements of best practice for discharge, leading to improvements in discharging patients when they are clinically ready. • Expansion of Ambulatory Emergency Care services; with a 30 per cent increase in the amount of patients seen, helping reduce growth in emergency admissions. • Expansion of our frailty services – including OPAL (older persons assessment liaison service), frailty at the front door, the "red bag" project which helps improve communication between care homes and hospitals – avoiding admissions and reducing length of stay. • Active participation in the development of a North West London-wide Delayed Transfers of Care escalation procedure. • Frequent attenders programme – working alongside voluntary sector colleagues and mental health trusts to manage high users of our emergency departments. The service has had significant success in reducing the A&E attendances of the initial 13 patients selected to participate, supporting them to access the services they need for long-term support.
Further work we need to do	We will focus on delivering the keeping care flowing collaborative 2019/20 work programme. The aim of the programme is: to meet the 4hr wait standard, our urgent and emergency care system supports staff to deliver safe, compassionate and high quality care to our patients in the right setting and at the right time.
Measurable targets	Improvements in our performance with the four hour target. In May, we are testing a proposed new A&E standard, as one of 14 pilot sites so we will also measure progress against this.

Improvement priority 10	**To improve access to services across the Trust through a focus on increasing capacity**

Executive lead	Chief executive officer
Why was this included in 2018/19	Emergency and Referral to Treatment (RTT) performance continued to be challenged during 2017/18 with deterioration over the winter period. To achieve these important access targets, additional capacity was needed as well as efficiency improvements in 2018/19.
What we achieved	**Although we have seen improvements in emergency and RTT performance, these continue to be challenged**, with both being below target and off trajectory in March 2019 (see improvement priorities 9 and 11 for detail). We are **meeting our target for cancelled operations** (0.89 per cent against a target of 1 per cent).
What we did	In 2018 we identified a 100 bed shortfall. Since then we have invested in 50 additional beds whilst delivering another 35 through efficiencies in A&E and patient flow.
Further work we need to do	This work will continue into 2019/20; however it will be merged into improvement priority 9.
Measurable targets	Reduction in the number of cancelled operations (below 1 per cent) Improvements in occupancy levels and the number of days where black escalation is in place

Improvement priority 11	**To improve access for patients waiting for elective surgery**
Executive lead	Divisional director of surgery, cardiovascular and cancer
Why was this included in 2018/19	Over a sustained period of time, the Trust had encountered a number of data quality & operational performance challenges to delivering a balanced position on elective care.
What we achieved	**We did not meet the standard of 92 per cent of patients treated within 18 weeks of referral** in 2018/19, although we have improved since last year reporting an average of 84.12 per cent in 2018/19 compared to 83.34 per cent in 2017/18. Improvement trajectories were agreed with our commissioners and NHS Improvement and a number of workstreams are in place to drive improvement. We are pleased to have **significantly reduced the number of patients waiting over 52 weeks for surgery**, with 573 reported in 2018/19 compared to 1,854 in 2017/18, and **none in March 2019**. There were **no cases of confirmed clinical harm** for patients waiting over 52 weeks in 2018/19; four have been confirmed since the process began in August 2016.
What we did	We have had a wide ranging programme of work for improving the management and delivery of Referral to treatment (RTT) standards since July 2016. The programme remains patient focused with a clinical harm process monitoring the impact waiting for treatment is having on our patients to ensure that they are not coming to harm. The current programme is focused on 3 key priorities: 1) People (through developing training programmes and learning management system development) 2) Systems (data validation, correction and visualization tools being implemented to support efficient and proactive tracking of pathways) 3) Processes (to ensure a performance management and accountability framework is developed and embedded in the organisation to ensure

	appropriate actions are taken at all levels to support meeting the RTT standards and improve waiting times for patients).
Further work we need to do	We will continue to implement our improvement programme as above to improve performance against the standard. We will review our clinical harm review process and the specialties included, and develop a clinical harm review policy for the Trust.
Measurable targets	Achievement of our trajectories for RTT performance Reduction in the number of patients waiting 52 week waits

Improvement priority 12	**To improve compliance with equality and diversity standards**
Executive lead	Director of P&OD
Why was this included in 2018/19	We want to provide a better working environment, free from discrimination, for our staff. The results of our staff survey highlighted that we have more work to do to improve equality and diversity across the Trust, with performance lower than we would want.
What we achieved	**Our performance with the workforce race equality standard (WRES) has improved since the previous year**. Some of the improvements include: • The likelihood of black and ethnic minority (BAME) staff being involved in a formal disciplinary procedure has reduced from 2.125 times more likely than white staff to 1.439 times more likely. • The percentage of staff experiencing harassment, bullying or abuse from staff has dropped from 32 per cent to 28 per cent. • The percentage of staff believing that we provide equal opportunities for career progression or promotion has increased for both groups, BAME from 74 per cent to 83 per cent, White from 87 per cent to 88 per cent • Staff having personally experienced discrimination at work from other staff members has dropped by 2 per cent for both BME and White staff to 17 per cent and 5 per cent respectively.
What we did	Our 2017-18 annual equality and diversity (E&D) report and workforce race equality standard report (WRES) was submitted to executive committee and approved in September 2018. It showed that whilst the experience of our staff is similar to that in other organisations, there was still a significant difference between the experience of white staff and ethnic minority staff. In response we developed an E&D work programme with sets of actions covering the main protected characteristics groups (ethnicity, gender and disability). In 2018 we formed two staff networks: a women's network and a nursing and midwifery BAME network, which have helped shape our plans. We are planning to establish a trustwide network for ethnic minority staff in 2019.

Further work we need to do	**WRES:** Based on the results of our annual WRES report in 2019/20 our WRES work stream will: • Improve workforce BAME representation in Band 7 and above roles. • Mitigate against a disproportionate number of BAME staff entering formal workforce procedures. • Reduce the relative likelihood of BAME colleagues receiving a lower PDR rating compared with people from a white background. • Address harassment and bullying issues reflected in the NHS staff survey. We will also: • Introduce ethnically-mixed interview panels for the recruitment of band 7 + roles • Develop an 'unconscious bias' training programme • Establish a 'reverse mentoring' programme for executive directors. The national strategy - a *Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS* - gives individual targets for each NHS Trust, based on its most recent WRES report. These will be included in our work programme. **Gender equality:** The gender equality work stream will: • Improve female workforce representation at Band 8A+. • Reduce the difference in the amount of bonus paid to female staff in comparison with male staff. **Disability:** The Workforce Disability Equality Standard (WDES) work stream will: • Improve quality of disability data on our electronic staff record. • Identify Trust priorities for disability equality work
Measurable targets	Achievement of the key deliverables outlined in our E&D action plan.

Improvement priority 13	**Specialty review and clinical strategy development**
Executive lead	Medical director
Why was this included in 2018/19	The Trust specialty review programme (SRP) is our clinically led process which is being used to inform the bottom-up development of a refreshed Clinical Strategy.
What we achieved	We have used this process to identify opportunities for improvement and to help make our services more efficient. This has worked best where we could link it with the GIRFT reviews and the Flow Coaching Academy (FCA). For example, we have achieved a **2 day reduction in elective stay for vascular patients**. Opportunities identified in ten 'early adopter' specialities have helped **save £14.6 million** since the programme began. We have completed reviews of all 37 specialties with individual strategies in

	place in many. These are being used to inform the clinical strategy which will link these to the organisational strategy approved in March 2019.
What have we did	Each specialty participated in three workshops focused on improving financial, operational and clinical sustainability. As the programme was clinically led, we had high levels of engagement throughout the process, with positive feedback. In several specialties we have been able to start conversations with other providers across the sector to better plan how services should meet the needs of the patient population. We have also been able to collaborate with other providers to start discussions with national commissioners around how we can make services more sustainable.
Further work we need to do	The clinical strategy will be published in early 2019/20. The Director for Transformation is now the executive lead for the SRP and is taking forward the next stage where we translate the specialities' visions into tactical plans to implement during FY19/20 ('Realising the Vision'). These sessions are currently being scheduled for 11 of the specialties which have moved through the SRO process. As this is being taken forward as part of the development of the organisational strategy, this has been stepped down as an improvement priority.
Measurable targets	Strategic objectives and action plans in place for each specialty

In addition to our 13 priorities, last year's document set out a number of metrics to support improvement in the five quality domains, and the additional domain of 'use of resources'. Our performance with these is described below, along with other key workstreams being undertaken.

Safe

We want to ensure our patients are as safe as possible while under our care and that they are protected from avoidable harm. We are committed to continuously improving the safety of our services for patients and staff. We do this through delivering improvements in key areas of safety as well as by understanding and improving our safety culture.

Seven of our improvement priorities are closely aligned to this domain:

- To reduce avoidable harm to patients
- To improve the safety culture across the Trust
- To improve permanent nurse staffing levels
- To ensure our staff are up to date with the mandatory skills to do their job
- To ensure our equipment has planned maintenance in line with targets
- To improve the management of medicines
- To ensure hand hygiene compliance is measured accurately with focused improvement to support staff where risk exists

Progress with these has already been described on pages 33-48. To avoid repetition we have not included these here again.

Introducing 'Streams' results viewing

In January 2019 we began to roll out the use of 'Streams', which is an app-based results viewing platform to allow staff to view their patients' latest blood test and radiology results securely from a mobile phone. This will support quick decision making if test results show changes to someone's health condition, without staff having to leave their patient's bedside to log into a hospital computer. We plan to roll this out across the Trust in 2019/20.

Response to the Gosport Independent Panel report

The Gosport Independent Panel report, published in June 2018, concluded that the lives of over 450 patients were shortened while an inpatient at Gosport War Memorial Hospital and that concerns raised by staff and families were not appropriately taken into consideration. We reviewed the report and identified key learning points, and examples of systems and governance processes we have in place that would help prevent a similar situation happening here. In addition to our existing processes (which include incident reporting and investigation, mortality review, complaints, duty of candour and freedom to speak up), we took several actions for additional assurance, including a review of our opioid prescribing. The new Medical Examiner role will provide further assurance when we implement it in 2019 (see page 31 for further information).

Pressure Ulcers

A pressure ulcer is a type of injury that affects areas of the skin and underlying tissue. They are caused when the skin is placed under too much pressure. They can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle. We reported twenty four category 3 and un-stageable Trust acquired pressure ulcers in 2018/19, which is seven more than last year. We have not reported a Trust acquired category 4, the most serious of pressure ulcers, since March 2014. We have nominated skin champions in each of our clinical areas and we run quarterly study days for our staff in the prevention of pressure ulcers and wound care.

Safety Streams

The safety streams were established in 2016 to focus and target work to drive improvements in patient safety in nine well-recognised areas of clinical risk. Progress is summarised in the table below. We are undertaking a full evaluation of each of the safety streams which will inform further improvement plans for each.

Safety Stream	Rationale	Progress to date	Key areas for improvement
	Recognition of and response to abnormal results is a key patient safety priority. We previously reported a number of serious incidents (SIs) which related to delays in the management of abnormal results. We took immediate action in response to these SIs including escalation of unsuspected abnormal results to the clinician and to the appropriate multidisciplinary team; however we recognised that the issue of endorsement of results was a key risk area.	This year we built on the large amount of background work previously undertaken to understand the difficulties and variations in practice. This included an evidence scan and investigation into other Trusts processes and procedures which allowed us to build reporting systems designed to monitor the endorsement of results. These will launch in May 2019, supported by a standard operating procedure which includes agreement on abnormal ranges of results. When this is implemented into our electronic patient record this should lead to all normal results being automatically endorsed. We have designed communications campaign, including a podcast, to provide staff with guidance on the new process and to emphasise the importance of endorsement from a safety perspective.	Our priority is to use our reporting systems to help us identify variation, so we can learn from areas who have got it right and to focus improvement work related to the endorsement of results in those areas where there are still delays. As the endorsement processes have only just been finalised, we cannot yet monitor the impact of this work. Going forward, we will measure improvement through: • Increase in endorsement of results • Reduction in incidents causing harm
	For patients, a fall can result in pain, injury, loss of confidence, loss of independence and increased morbidity and mortality. The aim of this safety stream is to support patients to mobilise safely and to reduce the rate of inpatient falls with harm.	We have piloted 90 day cycles of improvement on key wards, addressing local risk factors, with the support of the improvement team. This has resulted in improvements, including a reduction in falls with harm on several of the pilot wards. Data from the latest national falls audit shows that we are below average both for the rate of falls in total and for the rate of	In 2019/20 we will focus on the following: • Embedding falls assessment and care plans in the electronic patient record and monitoring the completion. • Staff engagement in identifying falls as a trigger for incident reporting. • Improving risk assessments and

		falls resulting in moderate/severe harm. Overall, we have seen a 22 per cent decrease in falls with moderate and above harm since 2016 when the safety stream started, and a 73 per cent reduction in SIs.	environment checks. • Engaging with and encouraging patients to minimise actions which result in an increased likelihood of falls. We have reviewed the governance arrangements for falls prevention and a quarterly falls steering group, chaired by the Director of Nursing is being formed to oversee and join up all falls activity across the trust.
	This safety stream aims to reduce the number of infants delivered with poor outcomes as a result of misinterpretation of the fetal heart rate – also known as 'CTG'	The original work of this safety stream focused on introducing a central monitoring system called 'Fetalink'. This provides remote monitoring of key clinical metrics (including the fetal heart rate) allowing rapid escalation of issues. The system is now fully implemented and staff are trained to use it through local induction and within the labour ward environment. Further improvements include: • Weekly educational meetings (per site) with presentation and CTG interpretation including case outcomes and learning points. • Updated clinical guidelines and CTG learning package in line with current NICE (National Institute for Health and Care Excellence) guidelines.	The improvements made so far will continue to be embedded through changes to the electronic patient record, a review and refresh of guidance, and the rolling training programme. The impact will be monitored through on-going audit as well as a continued reduction in incidents causing harm.

		• Improved training for staff, with 94 per cent of medical staff at Queen Charlotte's & Chelsea Hospital and 93.2 per cent of medical staff at St Mary's Hospital having received training in CTG. For midwifery staff, 98 per cent of midwives cross site are trained and assessed in Fetal Monitoring. • Introduction of 'Fresh Eyes' - a 'buddy system' where a second midwife confirms the fetal heart rate pattern. • Weekly fresh eyes audits using consistent methodology. We have reduced the number of incidents where misinterpretation of CTG as a contributing factor, with none since August 2018 There has also been a reduction in complaints and claims relating to CTG interpretation, with no current complaints and any existing claims relating to previous Serious Incidents.	

	For information on the work we have done as part of this safety stream, see improvement priority 7 (page 40).		
	Ensuring patients are correctly identified every time care or treatment is given including where samples are taken and processed is central to the safe delivery of care.	In 2018 we launched a new policy which incorporates national guidance and learning from incident investigations, which is starting to embed. Through a review of incidents, we identified a risk around 'wrong blood in tubes' (WBIT); this is where blood taken from a patient is mislabelled as having come from a different patient. Targeted improvement work has resulted in a 33 per cent reduction in WBIT incidents this year. We reported two Serious Incidents under the category of 'patient identification error', which is the same as last year.	In early 2019/20 we will be undertaking an audit with compliance with the policy which will support identification of further areas for improvement. A trust wide campaign will be launched in quarter one 2019/20 to increase awareness of "right patient all of the time". Printer location is a key root cause of incidents and is being reviewed in areas where incidents are reported most often – we will focus on this as part of the campaign.
	This safety stream was established in 2018 in response to delays to treatment for mental health patients in the emergency department (ED) leading to extended waits for patients	We continue to have significant delays for mental health patients in the emergency departments. This year, we had 68 patients who waited in A&E over 12 hours before being admitted. The majority of these were patients waiting for a mental health bed to become available. We are working closely with Central North West London NHS Foundation Trust to improve the patient pathway and reduce delays. We established this safety stream in	We have established a multi-stakeholder steering group which is leading on delivering an action plan to address these root causes. The steering group will initially focus on the St Mary's Hospital ED but have cross-site representation and strong links with work at Charing Cross Hospital ED.

		November 2018 to drive improvements internally. Actions taken so far have been successful in improving documentation and transport delays. We have also identified other issues, including patients absconding, Registered mental health nurse (RMN) cover, staff training, limited home treatment team and authorise mental health professionals to review and refer patients, and lack of appropriate environment. To help ensure the safety of these patients, our mental health waiting suites in our A&E departments have been refurbished so we have separate, quiet spaces for patients with mental health issues waiting to be seen. We have also developed an educational video for staff.	On 1st May, we are hosting a Mental Health Pathways Education Day for our staff and stakeholders which includes presentations on safety, safeguarding and crisis management in the ED. The main outcome measure for this safety stream will be a reduction in 12 hour delays for mental health patients.
	Failure to detect, respond and escalate the care of an acutely unwell patient may result in further avoidable clinical deterioration, impairment or in extreme cases, death. This safety stream's primary focus is to enable clinical staff to identify those patients at risk and prevent clinical deterioration through accurate and robust observation, using data to identify patients at risk at	This year we focused on the implementation of NEWS2 which was completed in March 2019. This is the latest version of the National Early Warning Score which enables staff to calculate a standardised score enabling them to more effectively respond to acute illness. As a result of work undertaken by this stream, we have seen a 30% reduction in out of ICU cardiac arrests. Overall, we have seen an increase in reporting of incidents where there was a failure to respond to the deteriorating patient, with a 64 per cent reduction in incidents	We will regularly audit the use of NEWS2 to inform the next phase of improvement work. We are planning further small tests of change to encourage staff to discuss and escalate deteriorating patients, including escalation ladders, an acute dashboard in the electronic patient record and a patient escalation project.

	safety briefings and encourage effective escalation conversations between clinical staff.	resulting in moderate or above harm in 2018/19 compared to 2016/17 when this safety stream began.	
Safer medicines	For information on the work we have done as part of this safety stream, see improvement priority 6 (pages 39-40).		
Safer surgery	Following a series of surgical 'never events' in 2016/17, we set up this stream to create a culture of safety in our theatres and areas where we carry out invasive procedures to reduce avoidable harm and improve performance and outcomes.	Throughout 2018/19, we developed and piloted a simulation and coaching programme for interventional procedure areas to support teams to focus on improving how we carry out safety checks, teamwork and behaviours to support a safe and efficient working culture. This was planned for a slow roll out in 2019/20. Given the increasing number of invasive procedure never events (we reported six between April 2018 and January 2019), we agreed to speed up the roll out of the programme, starting with the five specialties where we have had never events. All of these had completed their first training sessions by 15 May. For further information on our response to the never events, see pages 33-34.	From June 2019, we are rolling out an 18 month programme called the 'HOTT' programme (Helping Our Teams Transform) to all other specialties where they do invasive procedures. It involves simulation training, in situ coaching, 'conversation cafés', and human factors training. Each specialty has assigned leads responsible for providing leadership and training for the programme within their specialty. Progress with the programme will be monitored through training data, feedback from staff in response to the training and ultimately in a reduction in SIs and never events.

Safe quality highlights & challenges

Appendix D sets out our performance with the metrics under the Safe domain in 2018/19. Where applicable, it presents national targets and averages and information relating to our performance against these indicators in 2017/18.

Highlights and challenges in performance are shown below. To avoid repetition, we have not included information about metrics which have previously been described under our 'quality improvement priorities' section.

Although we met our VTE assessment target in the first three quarters of this year, we have been below target since December 2018: Venous thromboembolism (VTE) is a blood clot within a blood vessel that blocks a vein, obstructing or stopping the flow of blood. The risk of hospital acquired VTE can be reduced by assessing patients on admission.

From April 2018, we met the 95 per cent target consistently until December 2018, with average compliance across the year of 95.42 per cent. We are working with the areas that are below target to support staff to complete the assessment, including additional training for staff and introducing VTE 'champions'. We are also addressing technical issues with the electronic system that prompts staff to undertake the assessment.

In addition, we are reviewing our compliance with national guidance and are developing reports which will allow us to better monitor the percentage of patients who received appropriate prophylaxis and the outcomes of root cause analysis into VTE cases.

We are reviewing this metric in response to updated NICE guidance. We expect to return to meeting the target in May 2019.

We did not meet our infection prevention and control targets: Despite seeing a reduction in the number of cases of *Clostridium difficile* compared to last year (51 compared to 63), and maintaining the same number of MRSA blood stream infections (3), overall we have seen an increase in avoidable infections (cases of MRSA BSI occurring 48 hours after admission and cases of *Clostridium difficile* related to lapses in care) in 2018/19, reporting 14 compared to 10 last year.

Last year, we were one of only 59 trusts who achieved a 10 per cent or greater reduction in *Escherichia Coli* bloodstream infections. Unfortunately this year we did not achieve our target of a further 10 per cent reduction, reporting 83 cases, which is more than last year. On reviewing the cases, many of them were a direct result of necessary interventions, or related to advanced malignant conditions, and were not preventable. Where they were preventable, they were often associated with urinary catheters so we are focusing on hydration, continence and promotion of early removal of catheters. We are also working with our commissioners to identify and mitigate community drivers of hospital-onset Gram-negative BSI.

We reported seven carbapenemase-producing Enterobacteriaceae bloodstream infection cases (CPE BSI), one more than last year. The seven cases this year all occurred in patients with advanced malignant disease or conditions; review of these cases has confirmed that no specific preventive action could have been taken. We have a CPE action plan to help prevent the spread of CPE which includes regular screening of high risk patients. Throughout the year we have improved our screening rates, which are currently over 90 per cent.

On-going work to improve infection prevention and control includes:

- our hand hygiene safety stream (see page 40-41)
- anti-microbial stewardship (ensuring the appropriate use of antibiotics) – we have seen a steady reduction in antibiotic use over the last 4 years, while increasing the percentage

of antibiotics prescribed appropriately and for the correct duration, according to our latest six-monthly audit of anti-microbial prescribing.

- improving our cleaning processes. Since September 2018 we have been reporting our cleanliness audit scores in our scorecard. Although we have not met our target this year, reporting an average of 86.8 per cent in very high risk patient areas against a target of 98 per cent and 91.6 per cent in high risk patient areas against a target of 95 per cent, we expect to see improvements into 2019/20 as we continue to work to improve cleaning standards across the Trust.

We did not meet our target for flu vaccinations: In 2017/18, we were the most improved trust for vaccination take-up rates, with 60.5 per cent of our frontline healthcare workers vaccinated against flu. In 2018/19, our vaccination rate was about the same as last year's at 60.2 per cent and did not meet the national target of 70 per cent. We ran a communications campaign to encourage staff to have the vaccine, and we had a number of different ways in which staff could get vaccinated - through peer vaccinators, roaming vaccinators and at occupational health walk in centres. Overall, take up of the vaccination across London has been low this year, due to a milder climate and limited national news.

We met our maternity standards for puerperal sepsis and the ratio births to midwifery staff: We monitor two key maternity standards in our integrated quality and performance report. These are:

- 1:30 midwife to birth ratio. We continue to be funded to this ratio and have many mechanisms in place to ensure safe midwifery staffing across our service. In 2018/19 our average ratio improved to 1:27.
- Postpartum infections (puerperal sepsis): our target is an infection rate of less than 1.5 per cent of all maternities, which we achieved, reporting an infection rate of 0.64 per cent.

We also monitor another twelve maternity metrics. These form part of the quality schedule, which contains quality metrics agreed with our commissioners which we are required to deliver as part of our contract. In quarters 1-4 this year, we achieved the following targets:

- 95 per cent of women receiving one-to-one midwife care in established labour. 100 per cent of women with a named midwife or named team.
- 14 per cent of women giving birth in a midwifery led unit. Less than five per cent of women smoking at the time of delivery
- Less than three per cent of women experiencing third or fourth degree tears.
- 87.5 hours per week consultant presence on the labour ward at St Mary's Hospital and 98 hours per week on the labour ward at Queen Charlotte's & Chelsea Hospital, both of which meet the London standards for a minimum of 12 hours every day.

Home births

The number of women giving birth at home was below the threshold of 1 per cent in quarters one to three, however we met the target in quarter four. We continue to work to increase home birth choices where clinically appropriate and have recently increased the number of midwives who lead on our homebirth service.

Breastfeeding initiation rate

At the end of 2017/18 we identified a recording error which was producing inaccurate results for this metric. Since then, data has been reported accurately. Our current breastfeeding initiation rate is 86 per cent, just below the target of 90 per cent. Attendance at breastfeeding classes is high and midwives and maternity support workers continue to advise and support women. We expect to see improved performance in early 2019/20.

Percentage of women having an elective caesarean
We were just above the target for this standard in quarter one and quarter three. NICE guidance states that a woman who requests a caesarean section should be fully counselled regarding the risks, but following this counselling if she still wants a caesarean it can be granted. We are ensuring that appropriate counselling occurs for all women.

Percentage of women having a non-elective caesarean
We met the target for this standard in the first three quarters of 2018/19, but were just above the 16 per cent target in quarter four. All cases of non-elective caesarean sections are reviewed by a consultant obstetrician.

Postpartum haemorrhage
A focused action plan is in place to improve performance; however we were above the 2.8 per cent threshold agreed with our commissioners for all three quarters this year, although we are below the North West London threshold of 3.6 per cent. Most postpartum haemorrhages occur during a caesarean section. We are looking at introducing a drug called carbetocin, which is used to help control bleeding after birth.

Maternity booking assessments in 12 weeks and six days
We met the 95 per cent in the first three quarters of 2018/19, but were below target at 94 per cent in quarter four. This was due to issues with capacity which have since been resolved.

We met our target to ensure that 90 per cent of eligible staff are compliant with level 3 safeguarding children training: we are committed to the protection and safeguarding of all patients, including children and young people. As part of this, we provide staff with different levels of safeguarding training, depending on their role. In 2018/19 we included compliance with level 3 children's safeguarding training in our scorecard. We have seen an improvement in compliance with safeguarding training for all levels meeting the 90 per cent target for all, including level 3 children's safeguarding, by February 2019.

We have met most of the targets we set ourselves for estates and facilities improvement: we have one of the poorest estates in the country, with a £1.3bn backlog maintenance liability. Through our estates strategy (see page 9) we are working to improve and to make sure we minimise potential disruption and inconvenience for our patients and staff. To monitor this we included five targets in our scorecard for 2018/19, four of which we have met:

- Over 90 per cent of our main passenger and bed lifts have been kept in service
- Over 70 per cent of our planned maintenance tasks have been completed within the allotted timeframe
- 99.9 per cent of relevant staff have completed the required estates training
- Performance against our planned maintenance targets for medical devices has significantly improved (see page 39 for more information).

With only an average of 37.38 per cent of reactive maintenance tasks completed within the timeframe we allocated, we did not meet our 70 per cent target. Uncompleted tasks are prioritised at a bi-weekly meeting. At the beginning of the year we had a large back-log of unfinished tasks, which is starting to reduce. We expect to see continued improvements in 2019/20.

We have achieved our target to have 10 per cent of staff trained as fire wardens and departmental safety coordinators in 75 per cent of clinical wards, clinical departments and corporate departments: These targets are included to drive improvements in health and safety. We are pleased to have met both in 2018/19. This is the result of improved training packages and a targeted approach to ensure coverage across all areas.

We have not met our target to have no reportable serious accidents, occupational diseases and specified dangerous occurrences in the workplace: in 2018/19, we reported 55 of these accidents, known as RIDDOR, which is a similar number to last year (51). The majority of these are 'slips, trips and falls' and 'dangerous occurrences' (mainly sharps injuries). Plans are in place to support a reduction in these types of incidents including the launch of a new online workplace inspection module to help staff identify areas of risk.

Effective

We want to ensure the outcomes for our patients are as good as they can be using best available evidence to continuously improve care and treatment.

Clinical guidelines programme
Our aim is to ensure that we have no out of date clinical guideline documents (recommendations on how healthcare professionals should care for people with specific conditions) at any time. We have made real progress this year and by February 2019 we had no overdue guidelines published on our intranet.

We identified some issues with the transfer of clinical guidelines to our new trust intranet when it launched in December 2018. We are completing an action plan to resolve these issues, with task and finish groups for each division to ensure that a full list of up-to-date guidelines and standard operating procedures are easily accessible to staff. We expect these changes to start having an impact in quarter one 2019/20.

Quality surveillance programme
The role of the Quality Surveillance Team (QST) is to improve the quality and outcomes of clinical services through a programme of self-assessment and targeted peer review for all NHS England (NHSE) specialised commissioned services and all cancer services irrespective of how they are commissioned.

Our clinical teams completed the annual self-assessment process at the end of June for all 83 services which were required to report, with actions implemented where areas of risk or non-compliance were identified. In February 2019 we received our final results. 58 of our specialties were classified as 'routine surveillance', with 25 classified as 'enhanced surveillance', requiring action from us, our commissioners or both. We improved our performance overall, with fewer services requiring commissioner action (nine in 2018 compared to 25 in 2017).

Specialist services quality dashboards (SSQDs)
The quarterly SSQDs are designed to provide assurance on the quality of care by collecting information about outcomes from healthcare providers. SSQDs are used by NHSE, alongside the Quality Surveillance Programme (QSP) I self-assessments to make judgements with regard to the quality of specialised services delivered by the Trust.

We have previously struggled to submit all the required data for the SSQDs; however we improved significantly this year, submitting 68.8 per cent in quarter two, compared to 34.9 per cent in quarter one. We will continue to work to ensure we are submitting all the required data.

Alerts are generated in response to the data we submit for the SSQDs – positive alerts where performance is above national average and negative alerts where it is below. In quarter two, we had 47 positive alerts and 25 negative alerts, all of which have actions in place to improve.

Seven Day Services
The seven day services programme is designed to ensure patients that are admitted as an emergency receive high quality consistent care, whatever day they enter hospital. We have made progress in delivering the four core national standards; we are currently meeting three of

them (seven-day access to diagnostic services; 24 hour, 7 day as week access to consultant directed interventions; and twice daily consultant review for patients with high dependency needs).

We do not meet the standard that 'all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital'. When we first audited against this standard in September 2016, we delivered consultant led reviews within 14 hours to 64 per cent of patients during the week and 61 per cent of patients at weekends. By April 2018, this had increased to 81 per cent during the week and 82 per cent at weekends. We made a risk based decision not to increase investment for extra consultant rotas at weekends as we are confident that the medical model we offer provides appropriate specialist expertise if patients need it.

In order to reduce the burden of manual notes audits on trusts, NHS England has changed reporting of these standards to a 'Board Assurance' model for 2019. We will submit our first formal notification of assurance by the end of June 2019.

West London Genomic Medicine Centre

In December 2019 the national 100,000 genome project led by NHS England reached its target of sequencing 100,000 genomes for patients with rare disease and cancer. This makes the UK a world leader in genomics and also marks a major milestone in NHS England's mission to provide a truly personalised medicine service.

As one of the first Genomic Medicine Centres (GMCs), in partnership with the Royal Brompton & Harefield NHS Foundation Trust, The Royal Marsden NHS Foundation Trust and Chelsea and Westminster Hospital NHS Foundation Trust, we have been gathering samples and medical information from patients with cancer or inherited rare diseases for the last four years.

We have already used gene sequencing to produce life changing results - some patients with rare diseases have been provided with diagnosis for the first time after years of uncertainty and living with their symptoms. We are now able to develop personalised treatment plans so that patients get the right treatments at the right time. This work will transform how the NHS will diagnose, treat and care for patients. Some of our achievements include:

- Identifying the genes responsible for Huntington's disease and how they work to enable family members to be screened more easily and be given appropriate treatments.
- Identifying Lynch syndrome to help put patients on a bowel screening programme to reduce their cancer risk. This has also opened up new treatment options such as giving patients aspirin, which has been shown to cut cancer risk by 50 per cent.

To build on the legacy of the project, we have merged with Great Ormond Street Hospital to become a regional genomic laboratory hub for the north, east and west of London (London North GLH).

North West London Pathology

We host North West London Pathology across the sector. This is a new model for delivering pathology testing, merging the services from three North West London trusts into one modern, efficient operation that manages 25 million tests per year. The partnership between us, Chelsea and Westminster NHS Foundation Trust and The Hillingdon Hospitals NHS Foundation Trust has created an innovative and sustainable service that delivers outstanding quality to users and patients alike. In 2018, North West Pathology reported an increased number of patient safety incidents following the implementation of an electronic system for results processing due to IT issues. These have since been resolved and the number of incidents related to this has reduced.

Effective quality highlights & challenges

Appendix E sets out our performance with the metrics under the effective domain in 2018/19. Where applicable, it presents national targets and averages and information relating to our performance against these indicators in 2017/18.

Highlights and challenges in performance are shown below. To avoid repetition, we have not included information about metrics which have previously been described under our 'quality improvement priorities' section.

Our mortality rates remain consistently low: As part of our drive to deliver good outcomes for our patients we closely monitor our mortality rates, using two indicators, HSMR (Hospital Standardised Mortality Ratio) and SHMI (Summary Hospital-level Mortality Indicator), which enable us to compare ourselves with our peers. Both of these have remained low, with our Trust having the lowest HSMR across the last year of data, and the fourth lowest SHMI. We also monitor the percentage of deaths with palliative care coded as this may affect the data. Our palliative care coding rates are high, and we are confident that they are accurate with a clinical coding review process in place.

The Trust participated in 27 out of 32 of the relevant national clinical audits which were published in 2018/19, and action plans have been implemented where required: Audits and service evaluations are important assurance and governance tools, producing data which can be used for improvement. Our Clinical Audit and Effectiveness Group (CAEG) oversees our participation in these audits and the action plans for improvement as a result.

Our aim is for all national clinical audit reports to be formally reviewed by the clinical lead within 90 days. We have improved over the last year, with 26 out of 27 reviews completed by the end of March 2019, 19 of which were done within the timeframe. Of these, two audits have been assessed as significant risk/little assurance and have action plans in place; these are described in appendix A, alongside other audits which identified areas for improvement.

Patient Reported Outcome Measures (PROMs): PROMs measure quality from the patient perspective and seek to calculate the health gain experienced following surgery for hip replacement and knee replacement. Patients who have these procedures are asked to complete the same short questionnaire both before and after surgery. The Trust is responsible for ensuring completion of the first questionnaire (part A) pre-surgery. The number of pre-surgery forms sent to NHS Digital is compared to the number of surgical procedures performed at the Trust and it is this which provides the Trust's participation rate.

An external agency is responsible for sending patients the second questionnaire (part B) post-surgery. Analysis of any differences between the first and second questionnaires is used to calculate the overall health gain. If insufficient Part B questionnaires are returned to Capita, and in turn to NHS Digital who publish the results, they will not publish an organisation's health gain score.

Final PROMs data for 2017/18 shows improved participation rates and good health gain across both procedures. Provisional data for April-September 2018 shows that our participation rates remain high, however health gain is unable to be calculated as there weren't enough post-surgery questionnaires returned by our external agency. We now have a dedicated nurse in post to oversee the process and have re-tendered the external agency which should lead to improvements when the data is next published.

We met our target to ensure that 90 per cent of clinical trials recruit their first patient within 70 days from quarter two this year: This metric provides assurance that we are giving patients the opportunity to participate in research in a timely way. Performance declined nationally following changes to the process and data introduced by the Department of Health in 2016/17, but the

national trend is now upward again. Since Q2 2018/19, we have been above our 90 per cent target.

We have maintained our low unplanned readmission rate for both paediatric patients and adult patients with both rates remaining below national average throughout the year: We are pleased that despite long-standing pressures around demand, capacity and patient flow (see responsive section on pages 65-68) that we are continuing to ensure that we treat and discharge patients appropriately so that they do not require readmission.

Caring

We want to ensure that our staff involve and treat people with compassion, kindness, dignity and respect as we know this has a positive effect on recovery and clinical outcomes. To improve their experience in our hospitals, we ensure that we listen to our patients, their families and carers, and respond to their feedback.

Improving how we use patient experience data – winner of a BMJ award
Traditionally, we have focused on using the quantitative data from the 'Friends and Family Test' (FFT) to drive improvements in patient experience. However, there is a lot of information in the free text comments from patients about their experience that we have found it harder to act on in a systematic way. Our improvement and patient experience teams have been collaborating on a project with the Patient Safety Translational Research Centre (PSTRC) funded by the Health Foundation using a technique called Natural Language Processing so that a computer can learn how to extract themes from thousands of free text comments. This will give us an additional source of qualitative patient feedback so that we are better able to respond and make improvements. This work won the BMJ Award for Digital Innovation in 2019.

Improving care for patients with learning disabilities
This year, we have continued to build upon our on-going work for patients with learning disabilities, including:

- Updating our learning disability 'purple pathways' developed in 2017 following learning from incidents to highlight the risk of aspiration pneumonia and constipation to staff.
- Holding a joint event with community learning disability teams and care home providers to share experiences and develop closer networks.
- Working with our safeguarding team and inclusion and vulnerability officer to deliver more training to staff on Mental Capacity and Deprivation of Liberty Safeguards (DoLS), in addition to our on-going training on caring for people with learning disabilities and autism.
- Continuing to promote the use of hospital passports and working with our community colleagues to increase their use.

Improving care for young people
One of our objectives is to improve care for young people moving from paediatric to adult services. Our initial focus has been on outpatient services, with improvements including the development of bespoke patient experience surveys and age appropriate information leaflets, and piloting transitional care tools to promote a consistent approach in clinics.

Wayfinding
In response to patients reporting issues with finding their way around our sites and services we implemented a wayfinding project in 2017 to make navigation easier. This has included improvements to signage and physical and digital wayfinding systems. This is a long-term project and will continue into the coming year.

Bereavement support

We reviewed how we provide support for people whose family members have died while they were a patient with us. Currently we have several services that provide support to the bereaved –our Patient Affairs Team, the chaplaincy service, complaints, our Patient advice and liaison service (PALs) and specialty-based services e.g. bereavement midwives. This can lead to people experiencing disjointed and inefficient support at an already difficult time. In 2019/20 we will form a comprehensive Patient Affairs and Bereavement Service which will provide holistic care, responding efficiently and compassionately when a patient dies. This service will deliver the current function of our Patient Affairs Team, as well as the functions required for the new Medical Examiner service (see page 31 for more information).

Caring quality highlights & challenges

Appendix F sets out our performance with the metrics under the Caring domain in 2018/19. Where applicable, it presents national targets and averages and information relating to our performance against these indicators in 2017/18. Highlights and challenges in performance are shown below.

We have exceeded our target for the percentage of our inpatients who would recommend us to friends and family: The Friends and Family Test (FFT) is a key indicator of patient satisfaction which asks patients whether they would be happy to recommend our Trust to friends and family if they needed similar treatment. Our average inpatient FFT rate was 97.42 per cent, similar to last year's performance.

We collect feedback through a range of different methods including text messaging; paper surveys; Trust website and our real time patient experience trackers. This system also means we can accurately track key protected characteristics (gender, age, ethnic group, religion and disability) and work to implement improvements based on any concerns that impact on one group more than another. In April 2018 we introduced an easy read version of the survey and added in a non-binary choice in our gender category.

We also saw a slight improvement in the national inpatient survey, although our overall score remained the same. Out of 62 questions, we scored about the same as average in 60, better than average in one and worse than average in one. This is an improvement on the previous year when we scored worse than average in five questions and better than average in none. Overall this is a positive survey result and one of the best we've seen in a number of years, reflecting our continued focus on improving patients' experience of care.

For patients reporting a positive experience, interaction with staff continues to be the most significant factor. We are continuing to build upon this relationship by actively encouraging staff to understand and act upon patient feedback.

In addition to the improvement workstreams outlined above, we have:

- Introduced patient support volunteers at St Mary's and Hammersmith Hospitals (kindly sponsored by Imperial Charity) following a successful pilot in 2018. These volunteers provide a 'listening ear' for patients and have proven to be very popular with our patients and staff. We are continuing to develop other volunteer roles including; meal time support volunteers; youth volunteers (aged 16-25 years); meet and greet roles and outpatient volunteers.
- Launched a project called 'Eat & drink, Move; Sleep'. Our patients continue to tell us that noise at night and the quality of our food is a problem. In response, we:
    - Reinstated weekly food audits, including food tasting and patient feedback, the outcomes of which are being used to improve food service locally.
    - Updated our guidelines around protected mealtimes, now called 'Time To Eat', to ensure that we are giving patients more opportunity to eat their meals without

unnecessary interruptions and that staff can use this time to better support patients who are unable to eat independently.

- Created a Food and Drink Strategy which launched in March 2019 and is going to support further improvements next year including the development of a Fasting Policy, and the implementation of MUST (Malnutrition Universal Screening Tool) in our electronic patient record from 1st May 2019.
- Began quality improvement projects began on three pilot wards to reduce general environment noise and staff talking at night. Improvements on the pilot ward at Charing Cross Hospital have resulted in a reduction in the number of negative comments about noise at night. The pilots on the other wards have been impacted by works to increase our bed capacity and relocate some of the clinical areas. The work finished in February so we renewed our focus on this in March and expect to see improved results in 2019/20.
- Are actively encourage patients to be more active, building on the 'end PJ paralysis' work promoted nationally earlier this year.

When patients report a negative experience, the cause is usually due to ineffective systems and processes. We continue to take steps to improve and ensure that waiting and delays are kept to a minimum and, where they are unavoidable, patients are kept informed and the environment and staff are as welcoming and supportive as possible.

We met our target for the percentage of our A&E patients who would recommend us and were significantly above national average: Despite not achieving the waiting time standard for A&E we are pleased that over 94 per cent of our patients would still recommend our A&E services.

We are working hard to improve the response rate to the FFT question in our A&E departments. Although our response rate is above national average, it remains below our target of 20 per cent, with St Mary's A&E particularly challenged. We have introduced a range of different collection methods, including a kiosk, handheld device and texting options. We began a 90 day improvement programme in March 2019 which is developing interventions to support sustained improvement.

We have improved the percentage of outpatients who would recommend our Trust since last year: Our outpatient FFT score has improved slightly this year from 91.06 per cent to 92.98 per cent. As we continue to make changes through our outpatient improvement programme, we are confident that we will carry on seeing improvements to outpatient experience.

We have improved the percentage of patients using patient transport who would recommend our Trust since last year: Patient transport has been a key issue for those who are not able to travel to appointments independently. We have a team dedicated to facilitating patient transport. As a result, we are consistently sustaining a likely to recommend score of over our 90 per cent target which is a big improvement compared to last year. Our new non-emergency patient transport contract, which was re-tendered with the CCG and with the help of patients and service users, will begin in June 2019 and will deliver further quality improvements for our patients.

We have not improved the percentage of patients who would recommend our maternity services: Our maternity FFT rate has dropped slightly this year to 93.6 per cent which is just below our target of 94 per cent. Some of the changes we've made to improve patient experience in this area include: volunteer support with managing queues and informing women about waiting times, 'quality rounds' delivered by a leads nurse who talks to all the women on the ward to discuss any issues they've identified; and new equipment, including chairs, fans, and ear plugs and ear masks. Imperial Health Charity have kindly funded redecoration of the parents room and the creation of a milk kitchen and private area to use breast pumps; this work will finish by the middle of 2019.

We have seen an improvement on our national cancer patient experience survey results: our results have slightly improved (8.7/10 for overall care this year compared to 8.5/10 last year). The number of questions which scored in the lowest range decreased from 23 to 17. We also scored above or within the expected range for 35 questions, compared to 29 previously. These improvements reflect our on-going work around the role of the Clinical Nurse Specialist, who provide expert advice related to cancer and focus on improving patient care and developing services, consolidating our navigator service (a single point of contact for cancer patients, aiming to create a more streamlined service and positive experience for the patient) and strengthening links with primary care.

We have reported a significant number of mixed sex accommodation (MSA) breaches:
The national standard for mixed sex breaches is none for level one patients (patients requiring ward-based care). In 2018/19, we reported 554 MSA breaches. All of these were because of patients whose condition had improved and were waiting to be discharged from critical care to a ward. We are reducing the number of delayed discharges from critical care as part of our on-going work to increase capacity and improve flow across our sites, which in turn will support reductions in MSA breaches.

Responsive

Having responsive services that are organised to meet people's needs is a key factor in improving experience and preventing delays to treatment, which can cause harm to our patients.

Four of our improvement priorities are closely aligned to this domain:

- To continue to define, develop, implement and evaluate an organisation approach to reducing unwarranted variation
- Emergency flow through the hospital
- To improve access for patients waiting for elective surgery
- To improve access to services across the Trust through a focus on increasing capacity
- Specialty review and clinical strategy development

Progress with these has already been described on pages 34-48. To avoid repetition we have not included these here again.

PLACE
All patients should be cared for with compassion and dignity in a clean, safe environment. PLACE (Patient Led Assessments of the Care Environment) was introduced in 2013 as an annual patient led initiative that monitors and scores the environment based on six criteria. The assessments provide a clear message, from patients, about how the environment or services might be enhanced. PLACE focuses entirely on the care environment and does not cover clinical care provision or how well staff are doing their job. Results are reported publicly to help drive improvements.

This year's results showed an improved position, meeting the targets we set ourselves in five of the six areas reviewed:

- Cleanliness – scores above national average.
- Food and hydration – scores above average, and has improved since last year.
- Privacy, Dignity & Wellbeing – although our results remain below average, they have improved since last year.
- Condition, appearance and maintenance – scores above national average
- Dementia – scores have deteriorated slightly, and are now slightly below national average (78.7 per cent compared to 78.89 per cent).

- Disability – scores remain below average, but have improved since last year

The improvements made were the result of a detailed action plan led by the PLACE steering group, as well as progress with our wayfinding, clinical and estate strategies. Several areas have benefitted from major refurbishment programs including works to ensure areas meet the recommendations for dementia and disability.

We have completed a detailed analysis of the 2018 assessment findings to assess any recurring themes and develop actions to improve scores further next year. The focus is on improving the three key areas where we did not meet the national average – disability, privacy/dignity/wellbeing and dementia.

Responsive quality highlights & challenges

Appendix G sets out our performance with the metrics under the Responsive domain in 2018/19. Where applicable, it presents national targets and averages, and information about our performance in 2017/18.

Highlights and challenges in performance are shown below. To avoid repetition, we have not included information about metrics which have previously been described under our 'quality improvement priorities' section.

We have not met the national standard for critical care admission:
The national standard is that 100 per cent of admissions of critically unwell patients should be admitted within 4 hours. Delays to admission can be harmful to critically ill patients who need to be urgently managed within a specialised environment with expert medical and nursing care.

We admitted an average of 92.74 per cent of critical care patients within 4 hours across 2018/19. Improvements we are making include identifying potential patients for step down earlier and improving 'turn around' times for each bed.

We met five out of the nine cancer standards in all three quarters of the year: Table A shows our performance with the national cancer standards. We met all except the 62 day screening and 62 day upgrade standard in quarter four (up to end of February 2019). An action plan has been agreed, supported by the CCG and screening commissioners from NHS England. Performance is expected to recover in the new financial year.

Table A: Performance with cancer standards

Standard	Target	Q1	Q2	Q3	Q4 (Jan-Feb)
Two week wait	93%	93.6%	91.8%	94.1%	93.50%
Breast symptom two week wait	93%	94%	94.6%	95%	93.60%
31 day first treatment	96%	96.6%	96.8%	98.2%	98.00%
31 day subsequent chemo	98%	100%	100%	100%	100.00%
31 day subsequent radiotherapy	94%	97.9%	99.2%	99.6%	100.00%
31 day subsequent surgery	94%	95.4%	97.2%	97.3%	99.20%
62 day standard	85%	82.3%	78.9%	86.3%	100.00%
62 day screening standard	90%	82.9%	77.3%	76.6%	84.30%
62 day upgrade standard	85%	93.2%	93.3%	93.7%	65.00%

The improvements we have seen to our cancer waiting times overall have been the result of actions taken across each of the targets, including:

- Improvements to specific pathways e.g. the prostate RAPID diagnostic pathway in joint working with Royal Marsden Partners, the lung nodule surveillance pathway, and the establishment of a TKI clinic (Tyrosine-kinase inhibitor - an anti-cancer drug used as an alternative to chemotherapy).
- Development of straight to test access for GPs for a number of services e.g. lower GI endoscopy and two week wait UGI referrals. We are also currently developing this for suspected colorectal cancer referrals.
- Development of a report to highlight cancer patients affected by hospital cancellations.

Through the joint working led by the North West London Secondary Care Cancer Board we are committed to delivering the North West London Cancer Waiting Times recovery plan and are delivering the agreed actions to improve waiting times locally and across North West London.

We are below target for theatre management (touchtime utilisation), with overall performance of 79.43 per cent: One of the key areas to help increase our productivity is more efficient and effective scheduling of theatre lists – both the volume of patients booked and ensuring we are booking the right, properly prepared patients onto the right theatre lists and in the right order. Our surgical productivity programme has focused on coordinating the information flows between the different teams involved in surgical procedures, from pre-operative assessment to schedulers and the surgical teams and we're starting to see improvements in our oversight of elective theatre activity, and how we're using theatre sessions as a result.

We are pleased to have slightly reduced our percentage of operations cancelled for non-clinical reasons (at 0.89 per cent we are below our target and below national average), despite operational pressures, however we have not reduced the percentage of patients whose cancelled operations were not rebooked within 28 days (18.46 per cent in 2018/19 compared to 12.77 per cent in 2017/18). We have a number of workstreams in place to improve our understanding of and monitoring of cancellations and to reduce the root causes wherever possible.

We have seen improvements in performance with our outpatient targets: Around a million people come to the Trust's hospitals as outpatients every year, with a 5 per cent increase in attendances since 2017/18, and we have been running a major programme to improve the quality of their experience. As a result of this work, we are seeing improvements in performance in some key areas, with our average waiting time for the first appointment reducing by one week, a reduction in the average percentage of patients who do not attend their appointments from 11.68 per cent in 2017/18 to 10.69 per cent in 2018/19, and a reduction in the percentage of clinics we cancel with less than 6 weeks' notice from 8.01 per cent in 2017/18 to 7.93 per cent in 2018/19. We have also maintained the percentage of outpatient appointments made within five working days of receipt of referral at over 10 per cent. Some of the highlights of this work include:

<u>Using technology to improve our services</u>
The way we communicate with our patients has improved to keep pace with mobile lifestyles. Examples include:

- Enabling and empowering patients to manage their own care using an outpatient portal, the Care Information Exchange (CIE), which also provides us with the opportunity to redesign outpatient pathways to better meet the needs of our patients and to enable supported self-monitoring, reducing the need for physical outpatient attendances. Over 25,000 patients have now signed up to this service.
- Text and automated voice reminders to remind patients of their appointments.
- Providing a video interpreting service, reducing the reliance on face-to-face interpreters and improving access to interpreting, at a lower cost.

- Implementing a 'hybrid mail' service, which enables patients to choose whether to receive appointment letters by post or email. 30 per cent of appointment letters are now sent by email.

Implementing the 'Paper Switch Off Project'
Since October 2018, in line with the requirements of the NHS e-Referral 'Paper Switch Off' project, all GP referrals to consultant led outpatient services are now received through our electronic referral service. This enables patients to schedule their own appointments online at a date, time and hospital that suit them. We also offer advice and guidance services to GPs for some of our services, giving them timely access to specialist opinion, without the need to refer the patient.

Thinking differently about outpatients - models of care
We are collaborating with all providers and CCGs across North West London in delivering an Outpatient Transformation Programme, redesigning and optimising clinical pathways, whilst reducing hospital outpatient attendances where clinically appropriate. The first phase of this programme is focusing on five services: Cardiology, Dermatology, Gastroenterology, Gynaecology and Musculoskeletal, with further services to follow.

We have exceeded our target to respond to complaints within an average of 40 days: Our process for complaints handling is fully embedded and effective, with a strong commitment to resolving concerns as promptly and effectively as possible and with better access to complaints investigators. We have also had a further reduction in the number of complainants taking their complaint onto the Parliamentary & Health Service Ombudsman (PHSO). Overall, the volume of formal complaints has remained similar since last year, with values and behaviours of staff, care, clinical treatment and appointments continuing to be the main themes.

Throughout this year we have been redesigning the complaints questionnaire, which is sent to complainants six weeks after we have completed our response to their complaint. This will help us to continually improve our complaints handling by identifying the strengths and weaknesses in our processes. It will also allow us to measure our success in achieving our new metric in the IQPR of 'Overall satisfaction with complaints handling' for which we have set ourselves a target of 70 per cent.

In addition to the improvement made Trustwide, Imperial Private Health have revised their complaints process and are the first private patient unit to register with the Independent Healthcare Sector Complaints Adjudication Service (ISCAS) who will assess the way they manage complaints.

We have maintained similar pick up and drop off times for patients using our non-emergency patient transport service to last year: We expect that our new non-emergency patient transport contract, which will begin in June 2019, will help drive further improvements for our patients over the coming months.

We have not improved performance against our data quality indicators: For 2018/19 we introduced two data quality indicators to our integrated quality and performance scorecard to help ensure we accurately record the number of patients we treat so we can plan appropriately. At the end of the year we were off trajectory for both indicators. We have agreed recovery plans with areas that aren't meeting the targets.

Work we are doing to improve data quality is described on page 29.

Well-led

Evidence shows that staff who are engaged and happy in their jobs, respected and given opportunities to learn, provide better care for their patients. We have implemented a number of improvements to increase staff engagement throughout the organisation.

Two of our improvement priorities are closely aligned to this domain:

- To improve permanent nurse staffing levels
- To improve compliance with the equality and diversity standards

Progress with these has already been described on pages 34-48. To avoid repetition we have not included these here again.

Staff engagement programme

We monitor staff engagement through the national staff survey and through our annual internal survey 'Our Voice' which was run in May and June 2018. 3,146 of our people responded, which represents 34 per cent of the total workforce.

The survey included questions about whether staff would recommend the Trust to friends and family as a place for treatment or a place to work. The percentage of staff who would recommend us as a place for treatment remained the same as last year, however we were disappointed that the percentage of staff who would recommend us as a place to work decreased slightly (70 per cent would recommend, compared to 72 per cent in 2017). This was mirrored in the national staff survey, the results of which were very similar between 2017 and 2018.

Like last year, teams created specific action plans to improve engagement in their areas in response to the survey results. To facilitate this, we supported managers to run 'In our Shoes' team based listening exercises where staff could talk freely about their experiences of working here. Over 1,000 staff participated. We also developed a workshop and toolkit to support mangers, called 'Engage'. Around 100 managers took part.

As an organisation, we analysed our results and identified four key areas for action:

- Senior leadership behaviours
- Health and wellbeing
- Poor performance and behaviours
- Recognition

We refreshed a number of the plans we already had in place to drive improvements in these areas, including our health and wellbeing strategy, leadership development programmes, 'make a difference' staff award scheme, appraisal training for managers and our bullying and harassment/dignity and respect action plan. We implemented a board member site visit programme, to formalise walk rounds by our executive and non-executive directors and improve leadership visibility. We also reviewed our disciplinary process (see page 70 for more details) to help tackle staff concerns about how we address poor behaviour. Further details on these can be found throughout this section.

We also looked at what we could do further to address leadership behaviours and the cultural issues raised by the survey results. Using a framework developed by NHS Improvement to guide local action on developing NHS staff, more than 2,000 staff took part in activities designed to explore themes around our vision, values and behaviours. Their views and insights have fed into work to develop our organisational strategy (see page 7). One of the first practical outputs is an updated 'behavioural framework', co-designed with staff, setting out clear examples of the behaviours that demonstrate when we are living our values, and those that show when we

aren't. This will support conversations with colleagues about when behaviours are helpful and when they are challenging. The roll out and embedding of our values and behavioural framework is a key priority in 2019.

In addition, we have made changes to our award-winning suite of bespoke leadership development programmes to support managers through each stage of their careers. Many of the issues raised in staff surveys link back fundamentally to the quality of day-to-day line management and leadership. We have focused on providing more high quality development for our new and existing managers. We now offer six internal programmes, including:

- "First Steps" preparation for management
- "Foundations" introduction into management
- "Springboard" nurse/midwife leadership
- "Frontier" Medical Consultant Leadership
- "Headstart" management into leadership
- "Aspire" the Leadership Way
- "Horizons" Leading across systems

We also train and develop our managers and leaders with coaching skills, including in quality improvement through our Coaching and Leading for Improvement programme (CLIP), and have commissioned a programme with Imperial College Business School for our most senior leaders working in partnership with our AHSC partners Royal Marsden NHS Trust and Royal Brompton NHS Trust to run a Clinical leadership programme.

Next year, we are planning to make changes to the way we run our engagement surveys. Instead of running an internal survey for all staff and a national survey with a sample (10 per cent) of our workforce, we plan to run one full census national survey for all staff, with separate quarterly 'pulse' surveys in between focusing on particular areas of concern. This will allow us to better measure progress and track improvement.

Freedom to speak up strategy

Freedom to Speak Up (FTSU) promotes and encourages the raising of concerns from NHS workers, sub-contractors and volunteers to ensure patient safety is maintained at all times and to make the health service a better place to work. We are committed to embedding an open and transparent culture; one in which staff members and volunteers feel empowered to raise concerns, with confidence that these concerns will be acted upon and without fear of detriment for speaking up. This includes creating the appropriate structure and process that supports speaking up and ensuring that all staff members demonstrate the values and behaviours required to deliver this in practice.

In 2018, we recruited five volunteers within the Trust as FTSU guardians, one for each site, from a broad range of backgrounds. They are supported by a Non-executive director and the employee relations team. We carried out a self-assessment in September and identified some areas for improvement. In response we developed a draft FTSU strategy which will launch in 2019.

We also have a Raising Concerns policy which details the different ways in which staff can speak up, including through their immediate management team (most concerns are resolved this way), our Employee Relations Advisory Service, and our FTSU guardians. Staff who do raise concerns are given feedback promptly once an investigation has been completed, including any actions taken as a result.

Improvements to our disciplinary process

In August 2018 a report was published following an independent investigation into a disciplinary case that took place at the Trust in 2015. This report made recommendations for us to help improve our disciplinary process and better support managers who are undertaking the process, but also employees who are being managed through the process.

We put in place interim measures immediately following publication of the report, including a staff liaison officer to provide pastoral support. In 2019/20 we will implement a central investigation team who will be responsible for conducting all disciplinary investigations related to allegations of misconduct. This will mean a thorough investigation by an independent person who has the right level of training and experience.

Our aim is to reduce the number of cases requiring investigation by supporting staff to manage situations informally and handle low level conflict more effectively.

Patient and Public Involvement
We continue to make good progress with increasing and improving patient and public involvement in every aspect of our work. This year we collaborated with 53 lay partners across different projects, including the 'keeping care flowing collaborative' (see pages 43-44), improvements to palliative care, and facilities tenders.

We have also introduced a new annual award to our 'Make a Difference' scheme for staff scheme – a commemorative award in memory of Michael Morton, chair of our strategic lay forum who sadly passed away in November 2018. The award will recognise teams and individuals who have improved the outcomes and/or experience of patients through co-production.

Ward accreditation programme
Our internal annual ward accreditation programme (WAP) continues to support ward managers to understand how they are delivering care, identifying what works well and where further improvements are needed. Areas are assessed and given a rating, from gold (achieving highest standards with evidence in data) to white (not achieving minimum standards and no evidence of active improvement work).

In 2018 out of 109 areas reviewed, 35 had improved since last year. 39 per cent of clinical areas were rated as gold, 34 per cent were rated as silver, 19 per cent were rated as bronze and seven per cent were rated as white.

Key areas for improvement include environmental issues and medication storage and disposal. The outputs of the WAP have informed trustwide projects to improve these issues. Leadership is often identified as a problem in 'white' wards. In order to support our nursing staff further in preparation for leadership roles, we launched a leadership development programme 'Springboard' for band 5-6 nurses in 2017; 150 people have participated so far.

Medical Education Improvements
We aim to provide the best learning environment for our doctors. The General Medical Council's national training survey (GMC NTS) is one of the ways we monitor the quality of teaching we provide. In 2016, our results improvement significantly; since then we have largely maintained our performance overall. However in 2018 our results deteriorated, with an increase in red flags (negative outliers) and a decrease in green flags (positive outliers).

Following publication of these results in July, we met with trainees and unit training leads to understand the reasons for the results and share improvement approaches. Each specialty has developed a local action plan, with five specialties requiring action plans to be submitted to Health Education England for monitoring.

On an organisational level, we implemented a number of improvements including:

- A new education governance review process, including the addition of assurance meetings with the medical director for the five specialties where there are particular concerns, with supportive improvement plans in place.
- Improved focus on educational issues at divisional committees.

- Improvements to induction for junior medical staff to ensure they are 'day one ready' – this includes completion of core skills training, and training on how to use our electronic patient record.
- Improvements to our existing faculty development programme, focusing on resilience and coaching and mentoring skills.
- A process for monitoring gaps on medical staff rotas. We have 792 doctors in training working at the Trust, with 63 gaps on the rota. Twenty-seven of these gaps have been filled by locally employed doctors. We have 36 unfilled posts, 25 of which are being recruited to. The remaining eleven are going through the approval to recruit process. In addition to recruiting, we take action each month to make sure that the rotas are filled, including proactive engagement with Health Education England so we can accurately plan, targeted campaigns for hard to recruit specialties and the use of locums where necessary. From July 2019, we will report annually on rota gaps to our Trust Board as required by the Department of Health.

In September 2018, we formed a Task and Finish Group to resolve on-going concerns about junior doctor wellbeing and engagement, and the facilities available to them. The group has:

- Ensured all sites have communal rest facilities that are up to standard;
- Improved access to hot and cold healthy food at all sites;
- Developed new posts to support improved engagement and representation, including Senior Trainee Representatives for each specialty;
- Improved the junior doctor forum, including a junior doctor chair and regular presentations from the CEO and Medical Director.

As a result of improvements made, the General Medical Council advised us in March 2019 that they have removed Intensive Care Medicine at Charing Cross Hospital from Enhanced Monitoring.

Well-led quality highlights & challenges

Appendix H sets out our performance in 2018/19 with the metrics under the Well-led domain. Where applicable, it presents national targets and averages, and information about our performance in 2017/18.

Highlights and challenges in performance are shown below. To avoid repetition, we have not included information about metrics which have previously been described under our 'quality improvement priorities' section.

We have met our voluntary turnover rate and staff retention targets: A key aspect of reducing the voluntary turnover rate (the number of staff who choose to leave and work elsewhere) is to ensure staff have the opportunity for career progression, feel their job is worthwhile and fulfilling, and they are supported to develop. We are pleased to have met our 12 per cent target again this year and to have exceeded our 80 per cent staff retention rate target. Some of the ways we continue to work to ensure this include:

- Our Nurse Recruitment & Retention Strategy (see pages 37-38 for more information);
- Improvements to our leadership development programme and training schemes for staff;
- Our workforce equality and diversity work programme (see pages 46-47 for more information);
- Our talent management process which has been completed for all senior leaders in the organisation. This will ensure that all leaders have development plans in place, including those identified as potential successors of senior roles;
- "Great place to work week", which we ran for a second year in 2018, Trust magazine and our new intranet, which is easier for staff to use and includes a 'Working Here' section,

featuring courses and seminars, pay and benefits, training and development and reward and recognition.

We have also introduced a working group to oversee preparations for Brexit and supported staff by providing guidance about the EU Settlement Scheme.

Our sickness absence rate remains low, but is slightly above our target: Over the past year we have seen a small but steady increase in the levels of recorded absence. Working in healthcare can be stressful and emotional at times. We are continuing our focus on supporting the health and wellbeing of our staff along with supportive management interventions for those who are absent due to sickness. We have a range of activities and services available including occupational health, staff counselling, stress management, yoga and meditation classes, and smoking cessation clinics. We also continue to run our annual Healthy Living Week event; over 1,300 attended in 2018.

We have increased the percentage of doctors who have had an appraisal, although we have not met our target: It is a national requirement that non-training grade doctors have an annual medical appraisal as part of the General Medical Council's Revalidation process, during which doctors have a formal structured opportunity to reflect on their work and to consider how their effectiveness might be improved, with the focus on enhancing quality and improvements in patient care. The percentage of doctors who have completed their appraisal has been steadily increasing throughout the year and at 93.76 per cent it is now at its highest since we started measuring it.

We exceeded our target for completion of consultant job plans: Job planning involves regular reviews of consultants' time, including educational and research work as well as clinical practice, to ensure it is used efficiently and effectively. We review our consultants' job plans each year, with the aim of ensuring at least 95 per cent of our consultants have a completed, approved job plan in place. 99.5 per cent had a job plan in place at the end of the job planning round in July 2018. We are building on this success for the next job planning round, continuing to run drop-in support sessions and providing regular reports for clinical managers on progress.

We have improved the percentage of staff who have had a performance development review (PDR): Our appraisal scheme 'Performance Development and Review (PDR)' for staff, excluding doctors, is aimed at driving a new performance culture across the Trust. Although we are below target we have improved compared to last year. In total 8,100 staff members (89.6 per cent of our staff) had a PDR completed.

The National Staff Survey results for 2018 show that out of our staff members who completed the survey, 90.6 per cent had been appraised within the last year which is above the national average. Respondents also stated that the quality of appraisals was above the national average. We continue to run a one day essential training course for all managers undertaking PDRs and a day training to support managers in preparing for specific PDR conversations, maintaining a real focus on making sure that staff have meaningful and positive PDR meetings.

Next year, we will also ensure our consultants have PDRs, in addition to their annual appraisals. This will mean that they engage in the same values based conversations as all other staff.

We are in segment 3 of 4 in the NHS Improvement (NHSI) provider segmentation

Under the Single Oversight Framework, which is designed to help NHS providers attain, and maintain, CQC ratings of 'good' or 'outstanding', NHSI segment providers based on the level of support they need across the five themes of quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability.

We are currently in segment 3 out of 4, which is 'Providers receiving mandated support for significant concerns'. This is because we are rated as 'requires improvement' by the CQC and

because NHSI have sought formal undertakings from us related to our financial position, A&E performance and Referral to Treatment (RTT) performance. There are action plans in place in response which are being delivered, with regular reporting to the Board.

Use resources sustainably

For 2018/19, we have included one more standard, 'Use resources sustainably', which was defined by the National Quality Board (NQB) and which is monitored by NHS Improvement and included in CQC inspection reports. We have included this to ensure that we are delivering value for money for our patients, communities and taxpayers.

Clinical Services

In the context of continued year on year commissioned growth, we have worked hard to improve pathways and performance against national access standards, whilst remaining one of the safest hospitals in the country. This is despite the challenges presented by having one of the poorest estates, and an estimated beds deficit of more than 100.

This year we have improved efficiency in key areas, which have also seen real benefits for patients, including a reduction in non-patient elective cancelations, an increase in theatre efficiency and investment in 50 additional beds, whilst delivering another 35 through efficiencies in A&E and patient flow.

We still have work to do to reduce the number of pre-procedure bed days and our DNA rates, although both are improving. This will continue to be a focus into 2019/20.

We have delivered significant growth in imaging services, despite substantial challenges with the estate and aged asset base. We are leading the collaboration of imaging services through the North West London Imaging Network. This network has agreed a shared vision and aims, and are procuring a joint image share and reporting solution, as well as developing joint plans for asset growth and workforce training.

We are pioneering new services to deliver efficiency and improved patient outcomes, including:

- Thrombectomy service for Major Stroke, leading to significant reductions in length of stay and improved patient outcomes.
- Brain focused ultrasound (FUS) – cutting edge non-invasive care for patients, replacing the current treatment of Deep Brain Stimulation (DBS). This is expected to be significantly cheaper, with fewer potential complications.

Imperial Private Healthcare continues to grow, delivering a 3.8 per cent increase in income compared to last year.

People

We are a central London Teaching hospital, facing the people challenges of a highly mobile workforce, adjacent local career opportunities and high cost of living. This year we've delivered an increase in consultant job plans, consistently high appraisal levels, low sickness absence and recruitment and retention programme for nursing and midwifery staff.

We have also been improving how we use management information to optimise how workforce productivity and how we use technology to improve operational productivity and patient safety. We continue to work to improve our estate

Estates & Facilities

We continue to work to improve our estate, which is a major driver of our deficit. There are many reasons for this, including that we are a multi-site organisation, and the under-utilisation and inefficient configuration of the floor space of our aged estate. We have an 8 year £130m backlog investment programme to address critical infrastructure and fire safety.

The table below sets out our performance with the Use of Resources metrics in the IQPR during 2018/19.

Goal/Target	Performance in 17/18	Outcome in 18/19
Monthly finance score	3	2
In month position £m	N/A	1.48
YTD position £m	N/A	-0.10
Annual forecast variance to plan £m	£1.1m favourable (£2.6m favourable excluding STF)	-0.10
Agency staffing	£28.4m	£25.2m (4.37%)
CIP (cumulative financial YTD)	£43.1m	£44.1m (73.90%)

Use of resources quality highlights & challenges

We have met our financial plan: We met our financial plan for 2018/19, delivering a deficit of £22m. Meeting our financial plan – as well as our expected improvement in A&E performance – has given us access to additional central funding of just over £48m, meaning we posted a surplus of £28 million. Our savings also enabled us to reduce our underlying financial deficit by £2m, less than planned but still an important contribution to our longer term sustainability.

We have reduced annual agency spend by 40 per cent (£20.89m) since 15/16: this has been facilitated through robust control, recruitment and expanded bank provision. In 2018, fewer agency cap breaches have also been seen.

We have a good recent track record of delivering CIP above national targets: A cost improvement programme (CIP) is the identification of schemes to increase efficiency or reduce expenditure. The most successful CIPs are often those based on long-term plans to transform clinical and non-clinical services that not only result in a permanent cost saving, but also improve patient care, satisfaction and safety. We delivered £43m in 17/18 and £44m in 18/19. Our medical director and director of nursing review all proposed CIPs for their impact on quality of care using a quality impact assessment process.

For more detailed information about our financial situation, please see the annual report which will be published on our website in August 2019.

The NHS Outcomes framework indicators 2018/19

The NHS Outcomes Framework 2018/19 sets out high level national outcomes which the NHS should be aiming to improve. The framework provides indicators which have been chosen to measure these outcomes. An overview of the indicators and our performance is outlined in the table below. Some of this data is repeated because we chose to include these indicators as our quality strategy targets for 2018/19. It is important to note that whilst these indicators must be included in the quality accounts, the most recent national data available for the reporting period is not always data for the most recent financial year. Where this is the case, the time period used is noted underneath. This data is included in line with reporting arrangements issued by NHS England. Further information about what we are doing to improve our performance can be found in the individual target pages.

N.B. As of 1st October 2017 NHS England discontinued mandatory varicose veins surgery and groin hernia surgery PROMs collection.

Indicator	Trust performance 2018/19	National Average (Median Reporting Rates)	Where Applicable - Best performer	Where Applicable - Worst Performer	Trust Statement	2017/18	2016/17	2015/16
SHMI value and banding	73.21 (Q3 17/18 – Q2 18/19) Fourth lowest SHMI ratio of all non-specialist providers in England	100 (Q3 17/18 – Q2 18/19)	69.2 (Q3 17/18 – Q2 18/19)	126.8 (Q3 17/18 – Q2 18/19)	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • It is drawn from nationally reported data • We have reported a lower than expected SHMI rate for the last three years. • We have the fourth lowest SHMI ratio of all non-specialist providers in England. We intend to take the following actions to improve this rate, and so the quality of our services, by: • Continuing to work to eliminate avoidable harm and improve outcomes. • Reviewing every death which occurs in our Trust and implementing learning as a result. See pages 30-31 for more information on our implementation of the Learning from Deaths framework.	74.13 Second lowest SHMI ratio of all non-specialist providers in England	75.54 Second lowest SHMI ratio of all non-specialist providers in England	73.8 Third lowest SHMI ratio of all non-specialist providers in England
Percentage of admitted deaths with palliative care coded	57.5% (Q3 17/18 – Q2 18/19)	33.4%	Not applicable	Not applicable	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • It is drawn from nationally reported data. • It shows we have the second highest rate of palliative care coding as measured by this indicator of all acute non-specialist providers. • We are confident that we have a robust process in place to ensure that we are coding patients correctly. We intend to take the following actions to improve this percentage, and so the quality of our services, by:	56.7%	54.9%	53.5%

					• Continuing to work to improve the accuracy of our clinical coding.			
PROMs for hip replacement surgery	* (Low sample size)	EQ-5D: 0.458 EQ VAS: 13.877 Oxford knee score: 22.210 (April 2017 – March 2018 published Feb 2018)	Not available	Not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • Adjusted health gain was unable to be calculated as there were insufficient forms returned. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • implementing our action plan. See page 61 for further information.	EQ-5D: 0.464 EQ VAS: 15.379 Oxford Hip Score: 21.950	* (Low sample size)	EQ-5D: 0.475 EQ VAS: 14.259 Oxford Hip Score: 24.229
PROMs for knee replacement surgery	* (Low sample size)	EQ-5D: 0.337 EQ VAS: 8.153 Oxford knee score: 17.102 (April 2017 – March 2018 published Feb 2018)	Not available	Not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • Adjusted health gain was unable to be calculated as there were insufficient forms returned. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • implementing our action plan. See page 61 for further information.	EQ-5D: 0.298 EQ VAS: 8.283 Oxford Knee Score: 13.870 (April 2017 – March 2018 published Feb 2018)	* (Low sample size)	EQ-5D: 0.292 EQ VAS: * low sample size Oxford Knee Score: 13.420
28 day readmission rate for patients aged 0-15	4.88% (Dr Foster data – Oct 17 – Sep 18)	9.39% (Dr Foster data – Oct 17 – Sep 18)	Not available	Not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • It is drawn from the nationally reported data obtained from Dr Foster • We have maintained our low unplanned readmission rate for both paediatric patients and adult patients with both rates remaining below national average throughout the year. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • Continuing to ensure we treat and discharge patients appropriately so that they do not require unplanned readmission. • Working to tackle long-standing pressures around demand, capacity and patient flow.	4.92% (Oct 16 – Sept 2017)	5.15% (Oct 2015-Sep 2016)	4.81% (Jan-Dec 2015)

28 day readmission rate for patients aged 16 or over	6.75% Dr Foster data – Oct 17 – Sep 18)	8.49% Dr Foster data – Oct 17 – Sep 18)	Not available	Not available	See above.	6.92% (Dr Foster data – Oct 16 – Sept 2017)	6.64 % (Oct 2015-Sep 2016)	7.39% (Jan-Dec 2015)
Percentage of staff who would recommend the provider to friends or family needing care	71.7% [national staff survey – published February 2019]	71.3% [national staff survey – published February 2019]	87.3% [national staff survey – published February 2019]	39.8% [national staff survey – published February 2019]	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • It is drawn from the nationally reported data from the National Staff Survey which was published in February 2019. • The results are slightly above average for acute trusts. We intend to take the following actions to improve this percentage, and so the quality of our services, by: •See pages 69-70 for information on our improvement plans.	73% [national staff survey – published March 2018]	70%	68%
Percentage of admitted patients risk-assessed for VTE	96% (Q1 18/19) 96.37% (Q2 18/19) 95.23% (Q3 18/19) 93.97% (Q4 19/19)	95.63% (Q1 18/19) 95.49% (Q2 18/19) 95.65% (Q3 18/19)	100% (Q1 18/19) 100% (Q2 18/19) 100% (Q3 18/19)	75.84% (Q1 18/19) 68.67% (Q2 18/19) 54.86% (Q3 17/18)	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • It is drawn from the nationally reported data published quarterly by NHS England. • We have monitored VTE risk assessments on a monthly basis throughout the year. From April 2018, we met the target consistently until December 2018. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • See page 56 for information on our improvement plans.	93.87% (2017/18 full year data) Q1: 92.71% Q2: 91.63% Q3: 95.53% Q4: 95.64%	95.33%	95.87%
Rate of C-Diff per 100,000 bed days	15.1 (total number of cases: 51)	12.3 (2017/18 data)	0.0 (2017/18 data)	91 (2017/18 data)	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • It is drawn from nationally reported data • We monitor performance regularly through our Trust Infection Control Committee and weekly taskforce meeting. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • To reduce the risk of infections occurring in the hospital we will continue to work on reducing the use of anti-infectives (antibiotics) and improving hand hygiene. See page 56 for further information.	17.64 (63)	18.03 (63)	20.9 (73)

Responsiveness to inpatients personal needs: National Inpatient survey score	8.2 [overall score] 6.88 [responsiveness score] [no new data has been published since the national inpatient survey published June 2018]	Not available	Not available	Not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the nationally reported data from the National Inpatient Survey which was published in June 2018. We intend to take the following actions to improve this percentage, and so the quality of our services, by: •See pages 63-64 for information on our improvement plans.	8.2 [overall score] 6.88 [responsiveness score]	8.2 [overall score] 6.72 [responsiveness score]	7.9 [overall score] 6.74 [responsiveness score]
Rate of reported patient safety incidents per 1,000 bed days	50.4 (NRLS data: Apr – Sep 18) Internal data Apr 18 – Mar 19: 47.25	42.44 (NRLS data: Apr – Sep 18)	107.4 (NRLS data: Apr – Sep 18)	13.1 (NRLS data: Apr – Sep 18)	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • The NRLS data is nationally reported and verified. • The data shows all incidents reported by us for the period April – September 2018: our incident reporting rate for this period was 50.4 against a median peer reporting rate of 40.83 • Our individual incident reporting data is made available by the NRLS every six months • Based on our full year internal data, our reporting rate is below the top quartile at 47.25, although we have significantly increased the numbers of incidents reported since 2016/17 and maintained a similar number compared to 2017/18. This is due to a number of issues with our published bed day data for quarter three which is used to calculate our reporting rate for the last six months of 2018/19. The quarter four bed occupancy data is expected to reduce, bringing our reporting rate up. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • Improving how we report, manage and learn from incidents as part of our on-going safety culture work. See page 35-37 for further information.	Apr-Sep 17: 47.96 Oct 17 – March 18: 51.26 (rate per 1,000 bed days)	Apr – Sep 16: 42.3 Oct 16 – Mar 17; 46.82 (rate per 1,000 bed days)	Apr – Sep 15: 41.38 Oct 15 – Mar 16: 43.18 (rate per 1,000 bed days)
Percentage of patient safety incidents reported that resulted	0.0% severe/major harm (2 incidents) 0.06% extreme harm/death (5 incidents)	0.24% severe/major harm 0.10% (extreme harm/death)	0.0% severe/major harm 0.0% extreme harm/death	1.2% severe/major harm 0.5% extreme harm/death	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • It is drawn from the nationally reported data from the NRLS • Between April and September 2018 (most recent national data available), we reported 0.0% severe/major harm incidents (2 incidents) compared to a national average of 0.24%, and 0.06% extreme/death incidents (5 incidents) compared to a national average of 0.10%. • Based on our full year internal data, we have reduced the total number of	Apr – Sep 17: 0.1% severe/major harm (6 incidents) 0.1% extreme harm/death	Apr – Sep 16: 0.1% severe/major harm (7 incidents) 0.0% extreme harm/death	Apr -Sep 15: 0.1% - severe/major harm (8 incidents) 0.1% - extreme harm/deat

in severe/major harm or extreme harm/death	(NRLS data: Apr – Sep 18) Internal data Apr 18 – Mar 19: 0.04% severe/major harm (6 incidents) 0.03% severe/major harm (5 incidents)	(NRLS data: Apr – Sep 18)	(NRLS data: Oct 17 – Mar 18)	(NRLS data: Oct 17 – Mar 18)	incidents causing extreme harm/death or severe/major harm in 2018/19 reporting 11 compared to 27 in 2018/19. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • see pages 33-35 for an update on our improvement plans.	(6 incidents) Oct 17 – Mar 18: 0.1% severe/major harm (9 incidents) 0.1% extreme harm/death (6 incidents)	(2 incidents) Oct 16 – Mar 17: 0.1% severe/major harm (6 incidents) 0.1% extreme harm/death (10 incidents)	h (5 incidents) Oct 15 – March 16: 0.1% severe/major harm (10 incidents) 0.1% extreme harm/death (8 incidents)
Inpatient Friends & Family Test	97.42% (Apr 18 – Mar 19)	96% (Apr 18 – Mar 19)	100% (Feb 19)	76% (Feb 19)	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the nationally reported data • we have actively monitored our performance throughout the year. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • see pages 63-64 for an update on our improvement plans.	97% (2017/18)	97% (2016/17)	96% (2015/16)
A&E Friends & Family Test	94.26 % (Apr 18 - Mar 19)	86.6% (Apr 18 - Mar 19)	100% (Feb 19)	57% (Feb19)	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the nationally reported data • we have actively monitored our performance throughout the year. We have taken the following actions to improve this percentage, and so the quality of our services, by: • see pages 64 for an update on our improvement plans.	94% (2017/18)	95% (2016/17)	92% (2015/16)

Statements from stakeholders

(to be inserted once received)

Independent Auditor's Assurance Report

(to be inserted once received)

Appendix A: Participation in National Clinical Audit

National Clinical Audit and Clinical Outcome Review Programmes	Host Organization	Eligible	Participated	% submitted
Adult Cardiac Surgery	National Institute for Cardiovascular Outcomes Research	√	√	Ongoing collection
Adult Community Acquired Pneumonia	British Thoracic Society	√	√	Ongoing collection
BAUS Urology Audit - Cystectomy	British Association of Urological Surgeons	√	x	Did not participate
BAUS Urology Audit – Female Stress Incontinence (SUI)	British Association of Urological Surgeons	√	x	Did not participate
BAUS Urology Audit - Nephrectomy	British Association of Urological Surgeons	√	x	Did not participate
BAUS Urology Audit – Percutaneous Nephrolithotomy (PCNL)	British Association of Urological Surgeons	√	x	Did not participate
BAUS Urology Audit – Radical Prostatectomy	British Association of Urological Surgeons	√	x	Did not participate
Cardiac Rhythm Management (CRM)	National Institute for Cardiovascular Outcomes Research	√	√	N/A
Case Mix Programme	Intensive Care National Audit and Research Centre	√	√	Ongoing collection
Child Health Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	√	√	100%
Elective Surgery (National PROMs Programme)	NHS Digital	√	√	100%
Falls and Fragility Fractures Audit Programme (FFFAP) – Fracture Liaison Service Database	Royal College of Physicians London	√	√	Ongoing collection
Feverish Children (care in emergency departments)	Royal College of Emergency Medicine	√	√	N/A
Inflammatory Bowel Disease Programme / IBD Registry	Inflammatory Bowel Disease Registry	√	x	Did not participate
Learning Disability Mortality Review Programme (LeDeR)	University of Bristol's Norah Fry Centre for Disability Studies	√	√	N/A
Major Trauma Audit	The Trauma Audit and Research Network	√	√	96.9%
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Public Health England	√	√	Ongoing collection
Maternal, Newborn and Infant Clinical Outcome Review	MBRACE-UK, National Perinatal Epidemiology	√	√	N/A

Programme	Unit, University of Oxford			
Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	√	√	N/A
Mental Health Clinical Outcome Review Programme	National Confidential Inquiry into Suicide and Homicide be People with Mental Illness	x	N/A	N/A
Myocardial Ischaemia National Audit Project (MIN/AP)	National Institute for Cardiovascular Outcomes Research	√	√	Ongoing collection
National Asthma and COPD Audit Programme	TBC	√	√	N/A
National Audit of Anxiety and Depression	Royal College of Psychiatrists	x	N/A	N/A
National Audit of Breast Cancer in Older People	Royal College of Surgeons	√	√	N/A
National Audit of Cardiac Rehabilitation	University of York	√	√	589 patients
National Audit of Care at the End of Life (N/ACEL)	NHS Benchmarking Network	√	√	Ongoing collection
National Audit of Dementia	Royal College of Psychiatrists	√	√	100%
National Audit of Intermediate Care	NHS Benchmarking Network	x	N/A	N/A
National Audit of Percutaneous Coronary Interventions (PCI)	National Institute for Cardiovascular Outcomes Research	√	√	Ongoing collection
National Audit of Pulmonary Hypertension	NHS Digital	√	√	Ongoing collection
National Audit of Seizures and Epilepsies in Children and Young People	Royal College of Paediatrics and Child Health	√	√	N/A
National Bariatric Surgery (NBSR)	British Obesity and Metabolic Surgery Society	√	√	N/A
National Bowel Cancer Audit (NBOCA)	NHS Digital	√	√	95%
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre	√	√	100%
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	British Society for Rheumatology	√	√	100%
National Clinical Audit of Psychosis	Royal College of Psychiatrists	x	N/A	N/A
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs	King's College London/London North West Healthcare NHS	√	√	N/A

following Major Injury (NCASRI)	Trust			
National Comparative Audit of Blood Transfusion programme	NHS Blood and Transplant	√	√	100%
National Congenital Heart Disease (CHD)	National Institute for Cardiovascular Outcomes Research	x	N/A	N/A
National Diabetes Audits - Adults	NHS Digital	√	√	Ongoing collection
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	√	√	91.6% CXH 100% SMH
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research	√	√	Ongoing collection
National Joint Registry (NJR)	Healthcare Quality Improvement Partnership	√	√	Ongoing collection
National Lung Cancer Audit (NLCA)	Royal College of Physicians	√	√	Ongoing collection
National Maternity and Perinatal Audit (NMPA)	Royal College of Obstetricians and Gynaecologists	√	√	100%
National Mortality Case Record Review Programme	Royal College of Physicians	√	√	100%
National Neonatal Audit Programme (NN/AP)	Royal College of Paediatrics and Child Health	√	√	Ongoing collection
National Oesophago-gastric Cancer (N/AOGC)	NHS Digital	√	√	100%
National Ophthalmology Audit	Royal College of Ophthalmologists	√	√	98.1%
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health	√	√	Ongoing collection
National Prostate Cancer Audit	Royal College of Surgeons of England	√	√	N/A
National Vascular Registry	Royal College of Surgeons of England	√	√	100%
Neurosurgical National Audit Programme	Society of British Neurological Surgeons	√	√	Ongoing collection
Non-Invasive Ventilation - Adults	British Thoracic Society	√	√	Ongoing collection
Paediatric Intensive Care (PICANet)	University of Leeds	√	√	100%

Prescribing Observatory for Mental Health (POMH-UK)	Royal College of Psychiatrists's Centre for Quality Improvement	x	N/A	N/A
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Public Health England	√	√	Ongoing collection
Sentinel Stroke National Audit Programme (SSN/AP)	Royal College of Physicians	√	√	98.6%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Serious Hazards of Transfusion	√	√	N/A
Seven Day Hospital Services	NHS England	√	√	N/A
Surgical Site Infection Surveillance Service	Public Health England	√	√	N/A
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	x	N/A	N/A
Vital Signs in Adults (Care in emergency departments)	Royal College of Emergency Medicine	√	√	N/A
VTE risk in lower limb immobilization (care in emergency departments)	Royal College of Emergency Medicine	√	√	N/A

Appendix B: Actions in response to national clinical audits

As described on page 26, we fully reviewed the reports of thirty two national clinical audits and confidential enquires in 2018/19. The majority of these have provided a satisfactory level of assurance, however the exceptions are listed below with the actions required to improve the quality of healthcare provided.

National Diabetes Insulin Pump Audit (NDIPA)

This audit collects data on the number and characteristics of people with diabetes using an insulin pump, the reason for going on an insulin pump and the outcomes achieved since starting the pump. It has been a challenge to identify the total number of people with Type I diabetes at the Trust, but work is underway to better capture this data from the electronic patient record. An insulin pump MDT and training for patients has been established and Trust clinicians participate in the pan-London network.

National Audit of Dementia (NAD)

The Trust performs better than the national average for delirium screening on admission, clinical assessment of delirium and the symptoms of delirium being summarised in patient the record. The Trust aims to further improve, through the use of 4AT rapid clinical test for dementia for all patients aged over 65 (or those with known dementia) within 24 hours of admission and introduce education for all staff on the early features; the implementation of both will be monitored through local audit processes prior to the next national audit.

Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme

The Trust has reasonable assurance that transfusion training is in place. How to fully implement electronic blood management systems and the transfusion-associated circulatory overload (TACO) checklist into the electronic patient record is currently being scoped by the transfusion leads in collaboration with the Trust informatics team.

Critical Care Case Mix Programme

Across all units, standardised mortality rates were good. Highlights on the St Mary's site included low rates of unit acquired infection on the Charing Cross site non-clinical transfers and on the Hammersmith site low rates of unit acquired infection & blood stream infection, delayed discharge, out-of-hours discharge and readmission.

On the St Mary's and Charing Cross sites, areas for improvement mainly reflect capacity issues (delayed discharge and length of stay) which are being addressed through improvement work directed at improving flow on both sites. On the Hammersmith site, areas for improvement related to the number of high risk admissions and cardiac arrest pre-admission, which may reflect the specialisms and case mix on the Hammersmith site.

These will continue to be monitored through quarterly data submission to the Intensive Care National Audit and Research Centre.

National Emergency Laparotomy Audit (NELA)
The National Emergency Laparotomy Audit aims to look at measures for the quality of care received by patients undergoing emergency laparotomy. The Trust assessed itself against the ten key findings; with substantial assurance against five key findings, reasonable assurance in two (consultant surgeon in theatre where risk of death ≥ 5 per cent and admitted to critical care post-operatively where risk of death is > 10 per cent). Specific issues for the Trust where there is limited assurance relate to prospective data collection, reporting of CT scans & documentation of mortality risk pre-operatively and specialist review of elderly patients; improvement action plans have been agreed and will be monitored through local audit processes prior to the next national audit.

MBRRACE–UK Perinatal Confidential Enquiry
The MBRACE–UK study showed that our perinatal mortality rate for 2016 births was 10 per cent higher than the average. The department reviewed each case and none were deemed to be avoidable. The Trust has implemented the 'stillbirth bundle' which is a national toolkit aimed at reducing still birth in the UK. Our patient demographic was felt to more complex although the study says that the figures are 'risk adjusted'.

National Paediatric Diabetes Audit
This audit assesses compliance with important areas of diabetes services in childhood. The Trust performed better than the national average in terms of overall health check completion rate, treatment regimen, offering structured education and diabetes related hospital admission. In terms of outcomes of care the Trust is in the top 5 per cent local and the top 15 per cent nationally.

Elective Surgery National PROMs Programme
Adjusted for average health gain for the Oxford hip score is above the national average, whilst the knee score has been identified as below the national average. This has been reviewed by the service, with a move towards an improved knee clinic model where patients with high preoperative scores are offered options that do not involve surgery where there is low expected gain from operative treatment. This will be monitored through further quarterly audits.

Appendix B: Local Clinical Audit

Trustwide Priority Audits
Over the year the Trust has identified a number of areas for targeted audit work across the organisation. These have been selected as areas where improvement is needed, areas of risk or in order to support a strategic aim. Audits conducted in these areas have been coordinated centrally and reported to the trust audit group and to Executive Quality Committee for oversight and monitoring of actions and to provide assurance. Many of these audits are ongoing or form part of a wider improvement project and they will be taken forward with specific actions or a

requirement for further or wider audit and quality improvement involvement. These audits include:

- Patient falls
- Medicines safety and medicines management
- Safer surgery and the WHO safer surgery checklist
- The deteriorating patient: (NEWS and MEWS scoring)
- Hand hygiene
- Positive patient identification
- Never events

Some of the findings from these audits include:

- Improved compliance year-on-year with the WHO safer surgery checklists.
- An increase in hand hygiene compliance in wards receiving focused improvement support.
- A reduction in the number of falls with harm in wards receiving focused improvement support.
- A mean hospital wide reduction of patient identification errors to 25 per month in 2017 and 2018 compared to 30 per month in 2015 and 2016, and a 50 per cent year-on-year reduction in 'wrong blood in tube incidents'.

Local Clinical Audits

Over 2018/19 there were 313 local audits registered in the Trust. The findings and action plans from these audits are presented at directorate or divisional level with local oversight of the action plans.

A selection of these audits where specific learning or improvement has been identified can be found in table x below.

Table X: Local clinical audit examples

Audit Description	Findings	Actions identified
The trauma and orthopaedic team looked at the incidence of post-operative hyponatraemia in surgical patients undergoing elective knee or hip replacements. They investigated whether delays in discharge were incurred as a result	The study concluded that local practice is good and ensures patient safety, and that patients are not discharged with excessively sub-physiological serum sodium levels whilst also protecting patients from extended hospital admission. It was found that delayed discharges as a direct result of post-operative hyponatraemia were virtually zero.	Improvements identified. No action required.
The general surgery team audited compliance of emergency operational notes against RCS guidelines to ensure better information keeping, information sharing and better clinical practice and patient care.	This audit showed good compliance in most areas audited with the exception of blood loss and deep vein thrombosis (DVT) prophylaxis.	The team are currently developing a template on our electronic patient record with mandatory fields to ensure records contain accurate information.
The general surgical team carried out a re-audit,	The study found that there was good adherence to best	A VTE prophylaxis poster was developed and circulated to

evaluating adherence to NICE guidelines for the use of venous thromboembolism (VTE) prophylaxis	practice guidelines.	new medical members of staff to ensure continued compliance, and that clear decision making is continued when prescribing/withholding VTE prophylaxis
A re-audit was completed by the trauma and orthopaedic team for clinical coding for spine injections.	This audit demonstrated that there has been a 6-fold improvement in comorbidity documentation from 10 per cent in the previous audit to 63 per cent with resultant best practice tariff recovery.	Improvements identified. No action required.
The cardiology team audited providing fitness to drive advice following Acute Coronary Syndrome. It looked at the adequacy of advice provided on the electronic discharge summary including whether the patient was informed of whether they could drive after leaving hospital, whether there was medico-legal proof documented and whether this information was communicated to the patient's GP.	It was found that there was Low Risk/Satisfactory assurance for this documentation but the recommended 100 per cent was not achieved.	In response a local quality improvement project has been set up to increase compliance to 100 per cent, making junior doctors/advanced nurse practitioners aware of the documentation requirements.
The gynaecology & reproductive medicine team carried out a retrospective evaluation of pre-operative Computed Tomography (CT) findings with surgical and histological tumour dissemination patterns at cytoreduction for primary advanced and relapsed epithelial ovarian cancer.	The study showed that the pre-operative CT imaging, while being highly specific had a low sensitivity in detecting tumour involvement at key sites in ovarian cancer surgery	As a result of this study there is now a well-designed multicentre prospective trial currently underway to further evaluate different imaging modalities in the prediction and assessment of disease extent in patients with ovarian cancer.

Appendix C: CQUIN performance 2018/19

NHSE 2018-19 CQUIN schemes	Description of scheme	Full year plan value	Achieved % (Q1-Q3)
BI1 HCV Improving Treatment Pathways through ODNs	The Trust is an HCV ODN lead provider and as such this was a mandatory CQUIN. It recognises the Trust as a system leader in Hepatitis C and supports the governance and partnership-working across the North West London providers. The CQUIN requires prioritisation of patients with highest clinical need and supports the sustainability of treatment. The outcomes anticipated are: • Improvement in the engagement of patients • The planned roll-out, aligned to NICE guidance, of new clinical and cost effective treatments • Improved participation in clinical trials • Enhanced data collection to demonstrate the effectiveness and equity of this way of working and the availability of new treatments	£4.29M	Q1 – 100% Q2 – 100% Q3 – 100%
GE3 Hospital Medicines Optimisation	This CQUIN has been designed to support Trusts and commissioners to realise agreed targets and metrics to unify hospital pharmacy transformation programme (HPTP) plans and commissioning intentions to determine national best practice.. IT also includes year 2 of the antiretroviral drug switches scheme. The outcomes anticipated are: • Faster adoption of best value medicines with a particular focus on the uptake of best value generics, biologics and CMU frameworks as they become available • Significantly improved drugs data quality • The consistent application of lowest cost dispensing channels • Compliance with policy/ consensus guidelines to reduce variation and waste.	£1.07M	Q1 – 100% Q2 – 100% Q3 – 100%
IM4 Complex Device Optimisation	Clinical decision making around device selection varies between implanting units and may impact on clinical outcomes as well as inflating the overall cost. This scheme seeks to ensure that device selection for patients remains consistent with the commissioning policy, service specification, and relevant NICE guidance and that contractual requirement are in place for providers while new national procurement and supply chain arrangements are embedded. The outcomes anticipated are: • Enhancement and maintenance of local governance systems to ensure compliance with national policies and specifications; • Development of sub-regional network policies to encourage best practice when determining device choice including minimum standards for patient	£230,000	Q1 – 83% Q2 – 100% Q3 – 100%

	consent to ensure optimal device selection. • To improve timely access to all patients who need referral for consideration of complex device implantation. • To ensure that referral pathways and robust MDT decision making processes are developed for complex and clinically unusual cases, revisions and lead extractions.		
CA2 Nationally Standardised Does Banding Adult Intravenous SACT	This CQUIN is to incentivise the standardisation of doses of SACT in all chemotherapy units providing intravenous treatments across the country. The outcomes anticipated are: • Have the principles of dose banding accepted by their local oncology and haematology teams. • Have the drugs and doses approved by their local formulary committees. • Have SACT prescribed in accordance with the doses of drugs listed in the national dose-banding tables. • Agreement and adoption of standardised product definitions	£210,000	Q1 – 100% Q2 – 100% Q3 – 100%
WC5 Neonatal Community Outreach	To improve community support and to take other steps to expedite discharge, pre-empt re-admissions, and otherwise improve care such as to reduce demand for critical care beds and to enable reduction in occupancy levels. Options to be considered include: • Issuing all parents with accurate scales / feeding charts for “hospital at home” • Daily Skype / face time support • online educational and other materials to support • Weekly drop in clinics for parents • The option to develop wider packages of support e.g. psychology, dietetics etc. to be bolted on to the drop in sessions.	£290,000	Q1 – 100% Q2 – 100% Q3 – 100%
WC4 Paediatric Networked Care	This scheme aligns to the national PIC service review and aims to gather information which allows the demand across the whole paediatric critical care pathway to be considered. The output from this will be used to inform future plans for beds and models of care. The outcomes anticipated are: • work with local acute hospitals to collate data over a six month period August to December 2017 • provide a summary report by February 2018 • oversee the review of each of their referring acute hospitals in their usual catchment against the Paediatric Intensive Care (PICS) standards • provide a summary report.	£210,000	Q1 – 100% Q2 – 100% Q3 – 100%
STP Renal	This CQUIN is to encourage working across the primary and secondary care pathways to review and improve renal replacement therapy efficiencies and to implement the findings of the recent London Peer Review. The outcomes anticipated from are:	£780,000	Q1 – 95% Q2 – 95% Q3 – 85%

	• To support patients to be more pro-active in the management of their care through the use of self-management tools within hub and satellite units • To support the management of renal patients across the whole renal pathway by supporting primary care and providing rapid assessment and diagnosis so that patients with CKD can be managed effectively in the community. • To increase home dialysis uptake • Increase rate of haemodialysis with AV Fistulas in line with patient choice • To improve rates of pre-emptive transplantation as a therapy of choice for those suitable with chronic kidney failure		
Heamoglobinopathies Network	The prevalence of haemoglobinopathies across England varies widely, with the majority of patients concentrated around urban areas, as does the expertise to manage these conditions. The diseases mainly affect black and minority ethnic populations which often have poorer health outcomes. Despite this, there is not yet a comprehensive, approved network linking lead / specialist haemoglobinopathy centres with non-specialist centres to provide a clear pathway for appropriate referral and care. This CQUIN incentivises removal of the remaining barriers to achieving an appropriate network of care by enabling lead / specialist centres to provide MDT led annual review of all patients and the associated communications, clinical support, staff training and data entry to demonstrate the clinical outcome benefits of such a model.	£210.000	Q1 – 100% Q2 – 100% Q3 – 100%
CCG 2018-19 CQUIN Schemes	**Description of scheme**	**Full year plan value**	**Achieved % (Q1-Q3)**
Improving staff health and wellbeing	This CQUIN scheme aims to encourage the improvement of health and wellbeing of NHS staff with a focus on reducing workplace stress, providing healthier food options for NHS staff, visitors and patients and to improve the uptake of flu vaccinations for frontline clinical staff. In 2017/18, we were the most improved trust for vaccination take-up rates, with 60.5 per cent of our frontline healthcare workers vaccinated against flu. In 2018/19, our vaccination rate was similar to last year's. By the end of 2018 we had removed price promotions and advertising of all sugary drinks and food high in fat, salt and sugar, as well as removing them from checkouts. For more information on the work we are doing to promote staff health and wellbeing see page 73.	£1.01M	Q1 – 100% Q2 – 100% Q3 – 100%

Improving services for people with mental health needs who present to A&E	This CQUIN scheme aims to reduce the number of attendances to A&E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable. The frequent attender service runs at CXH. The team consists of an A&E doctor, a specialty trainee psychiatry doctor, an A&E consultant, and a liaison psychiatry consultant. A social prescriber joined the team in December 2017. The team has developed a person-centred approach to holistically address the complex needs of those who are disproportionately accessing A&E. The service has reported marked success in reducing the A&E attendances of their initial 13 patients selected to participate, supporting them to access the services they need for long-term support. A write-up of the service was included on the BMA website in January 2019.	£1.01M	Q1 – 100% Q2 – 100% Q3 – 100%
Reducing the impact of serious infections (antimicrobial resistance and sepsis)	This CQUIN scheme aims to reduce the impact of serious infections by focussing on the timely identification of sepsis in A&E and acute inpatient settings, the treatment of sepsis in A&E and acute inpatient settings, the assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours, and the reduction in antibiotic consumption per 1,000 admissions. For information on the progress we have made, please see pages 33-34.	£1.01M	Q1 – 100% Q2 – 100% Q3 – 100%
Advice and guidance	This CQUIN scheme aims to standardise and streamline the advice and guidance we provide for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care. 21 departments within our Trust currently offer an advice and guidance service. The current process is that the doctor on call will respond to as many queries as they are able to on their shift. We are performing regular audits as we start working towards a 48 hour response target.	£1.01M	Q1 – 100% Q2 – 100% Q3 – 100%
Preventing risky behaviours	This CQUIN scheme aims to incentivise non-specialist interventions for which there is sound evidence of effectiveness in reducing ill health and thereby the burden on health services, when delivered at scale. The interventions are brief, and include components such as: short screening questions, brief or very brief advice on the benefits of drinking less or stopping smoking, and where appropriate referral to specialist services. Specialists from local service providers at Change,	£1.01M	Q1 – 100% Q2 – 100% Q3 – 100%

	Grow Live and Kick-it have presented short talks on a range of topics relevant to smoking and alcohol addiction and risky behaviour including: • Supporting people with alcohol dependency • Introduction to Smoking Cessation course in accordance with the NCSCT guidance We have trained 10 staff to deliver a 'very basic assessment' (VBA) for patients who have been flagged as being a smoker or consumes alcohol and will be scheduling regular VBA clinics for inpatients.		

Appendix D: Safe Metrics

Area	Description	National Target / National Average	Performance in 17/18	Target for 18/19	Outcome in 18/19	Target achieved?
Patient safety – incidents and reporting	To eliminate avoidable harm to patients in our care as shown through a reduction in the number of incidents causing severe/major harm	0.25% (Oct 17 – Mar 18)	0.08% (14 incidents)	Below national average	0.04% (6 incidents)	Yes
Patient safety – incidents and reporting	To eliminate avoidable harm to patients in our care as shown through a reduction in the number of incidents causing extreme harm/death	0.10% (Oct 17 – Mar 18)	0.08% (13 incidents)	Below national average	0.03% (5 incidents)	Yes
Patient safety – incidents and reporting	We will maintain our incident reporting numbers and be within the top quartile of trusts	42.44 (Apr – Sep 18)	48.97 (Apr 17 – Mar 18)	Over 48.98 (Apr – Sep 18)	50.4 (Apr 18 – Sep 18 – NRLS published data) 47.25 (Apr 18 – March 19 internal data)	No
Patient safety – incidents and reporting	We will have zero never events	0 never events	1 never event	0 never events	7 never events	No
Patient safety – incidents and reporting	We will ensure that we comply with duty of candour and being open requirements for every incident graded moderate and above	N/A	SIs: 98% Level 1: 89% Moderate: 79% (Apr 17-Feb18)	100%	SIs: 90.9% Level 1: 93.7% Moderate: 97.5% (Mar 18 – Feb 19)	No
Infection prevention and control	We will ensure we have no avoidable MRSA BSIs and cases of *C. difficile* attributed to lapse in care	N/A	10 (3 MRSA BSI, 7 *C.difficile* lapses in care)	0 avoidable infections	14 (3 MRSA BSI, 11 *C. difficile* lapses in care)	No
Infection prevention and control	We will achieve a 10% reduction in healthcare-associated BSIs caused by E. coli	N/A	74	10% reduction (65)	83	No
Infection prevention and control	We will have no healthcare-associated BSIs caused by CPE	N/A	6	0	7	No
Infection prevention and	We will ensure our cleanliness audit scores	N/A	Not reported	98% (very high risk	86.8% (very high risk	No

Area	Description	National Target / National Average	Performance in 17/18	Target for 18/19	Outcome in 18/19	Target achieved?
control	meet or exceed the required standards			patient areas) 95% (high risk patient areas)	patient areas) 91.6% (high risk patient areas)	
Infection prevention and control	We will meet flu vaccination targets for frontline healthcare workers as part of the national seasonal flu campaign	N/A	60.5%	70%	60.2%	No
VTE	We will assess at least 95% of all patients for the risk of VTE within 24 hours of their admission, and maintain zero cases of avoidable harm	over 95%	Q1: 92.71% Q2: 91.63% Q3: 95.53% Q4: 95.64% 93.87% (full year data) 0 avoidable deaths	over 95%	Q1: 96% Q2: 96.37% Q3: 95.23% Q4: 93.97% 95.42% (Apr 18 – Mar 19)	No
Sepsis	We will ensure at least 50% of our patients receive antibiotics before the sepsis alert or within one hour of a new sepsis diagnosis	N/A	Not reported	50%	70.64%	Yes
Maternity standards	We will maintain the ratio of births to midwifery staff at 1 to 30	1:30	1:30	1:30	1:27	Yes
Maternity standards	We will maintain postpartum infections (puerperal sepsis) to within 1.5 per cent or less of all maternities	1.5%	0.42%	1.5%	0.64%	Yes
Workforce and people	We will have a general vacancy rate of 10 per cent or less	N/A	12.12%	10% or less	13.5%	No
Workforce and people	We will have a vacancy rate for all nursing and midwifery staff of 12 per cent or less	N/A	14.7%	12% or less	15.56%	No
Safe staffing	We will maintain the percentage of shifts meeting planned safe staffing levels at 90% for registered nurses	90%	97.02%	90%	96.67%	Yes
Safe staffing	We will maintain the percentage of shifts meeting planned safe staffing levels at 85% for care staff	85%	97.70%	85%	95.66%	Yes
Estates and facilities	We will improve medical devices maintenance compliance according to risk categorisation	N/A	76% high risk; 70% medium risk; 64% low risk	98% high risk; 75% medium risk; 50% low risk	96% high risk; 82% medium risk; 82% low risk	Partly
Estates and facilities	We will ensure lifts are kept in service to minimise disruption and inconvenience	N/A	Not reported	90% availability (main passenger and bed lifts)	97.11%	Yes
Estates and facilities	We will improve the number of reactive maintenance tasks completed within the allocated timeframe	N/A	Not reported	70%	37.38%	No
Estates and	We will ensure that planned	N/A	Not reported	70%	78.68%	Yes

Area	Description	National Target / National Average	Performance in 17/18	Target for 18/19	Outcome in 18/19	Target achieved?
facilities	maintenance tasks are completed within the allocated timeframe					
Estates and facilities	We will ensure compliance with statutory and mandatory estates requirements	N/A	Not reported	85%	99.9%	Yes
Staff training	We will achieve compliance of 85% with core skills training	N/A	87.44%	85%	92.1%	Yes
Staff training	We will achieve compliance of 85% with clinical skills training	N/A	74.80%	85%	87.8%	Yes
Staff training	We will ensure that 90% of eligible staff are compliant with level 3 safeguarding children training	N/A	Not reported	90%	91.12%	Yes
Health and safety	We will ensure we have no reportable serious accidents, occupational diseases and specified dangerous occurrences	0	51	0	55	No
Health and safety	We will have a departmental safety coordinator in 75% of clinical wards, clinical departments and corporate departments	N/A	49%	75%	82%	Yes
Health and safety	We will ensure at least 10% of our staff are trained as fire wardens	N/A	9%	10%	13%	Yes

Appendix E: Effective metrics

Area	Description	National Target / National Average	Performance in 17/18	Target for 18/19	Outcome in 18/19	Target achieved?
Mortality indicators	We will improve our mortality rates as measured by HSMR (hospital standardised mortality ratio) to remain in the top five lowest-risk acute trusts	100	67.37 (Jan – Dec 17) 2nd lowest risk	Top five lowest-risk acute trusts	64.0 (Jan – Dec 18) Lowest risk acute trust	Yes
Mortality indicators	We will improve our mortality rates as measured by SHMI (summary hospital-level mortality indicator) to remain in the top five lowest-risk acute trusts	100	74.29 (Q2 16/17 – Q1 17/18) 2nd lowest risk	Top five lowest-risk acute trusts	73.21 (Q3 17/18 to Q2 2018/19) 4th lowest risk	Yes
Mortality indicators	We will ensure that palliative	N/A	100% (for all reviewed deaths)	100%	100% (for all reviewed deaths)	Yes

Area	Description	National Target / National Average	Performance in 17/18	Target for 18/19	Outcome in 18/19	Target achieved?
	care is accurately coded					
Mortality reviews	We will ensure structured judgement reviews are undertaken for all relevant deaths in line with national requirements and Trust policy and that any identified themes are used to maximise learning and prevent future occurrences.	N/A	91%	100% of relevant cases	90%	No
Readmissions	We will reduce the unplanned readmission rates for patients aged 0-15 and be below the national average	9.39% (Oct 17 – Sep 18)	4.92% (Oct 16 – Sep 17)	Better than national average for 2018/19	4.88% (Oct 17 – Sep 18)	Yes
Readmissions	We will reduce the unplanned readmission rates for patients aged 16 and over and be below the national average	8.49% (Oct 17 – Sep 18)	6.92% (Oct 16 – Sep 17)	Better than national average for 2018/19	6.75% (Oct 17 – Sep 18)	Yes
Clinical trials	We will ensure that 90% of clinical trials recruit their first patient within 70 days		55.7% (Q1 – Q4 17/18)	90%	85.1% (Q1 18/19) 95.7% (Q2 18/19) 93.9% (Q3 18/19) 91.6% (Q1-Q3 18/19)	Yes
Clinical audit	We will participate in all appropriate national clinical audits and evidence learning and improvement where our outcomes are not within the normal range	N/A	Not reported	100%	84% (participation in relevant national clinical audits 2 high risk/significant risk audits Review process completed within 90 days for 19/27 audits	No
Patient reported outcomes	We will increase PROMs participation rates to 80%	Not available	Hip replacement: 87.6% Knee replacement: 90.5% (April 2017 – March 2018)	80%	Hip replacement: 67% Knee replacement: 80% (April 2018 – September 2018)	Partially
Patient reported outcomes	We will improve PROMs reported health gain to be better than national average	Not available	Hip replacement – better than national average for 3/3 indexes Knee replacement –	Better than national average	Health gain not able to be calculated (April 2018 –	No

Area	Description	National Target / National Average	Performance in 17/18	Target for 18/19	Outcome in 18/19	Target achieved?
			better than national average for 1/3 indexes, similar to national average for 1/3 indexes and below national average for 1/3 indexes		September 2018)	

Appendix F: Caring Metrics

Area	Description	National Target / National Average	Performance in 17/18	Target for 18/19	Outcome in 18/19	Target achieved ?
Friends and family test	To maintain the percentage of inpatients who would recommend our trust to friends and family to 94 per cent	96%	97.20%	94%	97.42%	Yes
Friends and family test	To maintain the percentage of A&E patients who would recommend our trust to friends and family to 94 per cent	86.8%	94.39%	94%	94.26%	Yes
Friends and family test	We will achieve and maintain a FFT response rate of 20 per cent in A&E	12.36%	14.19%	20%	13.63%	No
Friends and family test	To maintain the percentage of maternity patients who would recommend our trust to friends and family to 94% or above	N/A	93.83%	94%	93.81%	No
Friends and family test	To increase the percentage of outpatients who would recommend our trust to friends and family to 94 per cent	93.9%	91.06%	94%	92.98%	No
Friends and family test	To maintain the percentage of patients using our patient transport service who would recommend our trust to friends and family	92.18%	82%	90%	91.20%	Yes
Mixed sex accommodation	We will have zero mixed-sex accommodation (EMSA) breaches	0	295	0	554	No
National cancer survey	We will improve our national cancer survey scores year-on-year	8.8/10	8.5/10 (annual result from 2016 survey)	Above 8.5	8.7 (annual result from 2017 survey)	Yes
National inpatient survey	We will improve our score in the national inpatient survey relating to responsiveness to patients' needs	Not available	6.72 (annual result from 2016 survey)	Above 6.72	6.88 (annual result from 2017 survey) Overall rating of care: 8.2/10	No

Appendix G: Responsive Metrics

Area	Description	National target / national average	Performance in 17/18	Target for 18/19	Outcome in 18/19	Target achieved?

Referral to treatment – elective care	We will reduce the percentage of patients waiting over 18 weeks to receive consultant-led treatment in line with trajectories	92%	83.34%	92%	84.12%	No
Referral to treatment – elective care	We will reduce the percentage of patients waiting over 52 weeks to zero in line with trajectories and implement our agreed clinical validation process	0	1,854	0	573 (0 in March 2019)	No
Cancer	We will maintain the percentage of cancer patients who are treated within 62 days from urgent GP referral at 85% or more	85%	86.07%	85%	83.51%	No
Theatre management	We will increase theatre touchtime utilisation to 95% in line with trajectories	95%	N/A	95%	79.43%	No
Cancelled operations	We will reduce cancelled operations as a percentage of total elective activity	1%	1%	0.9%	0.89%	Yes
Cancelled operations	We will ensure patients whose elective operations are cancelled are rebooked to within 28 days of their cancelled operation	8%	12.77%	Less than 8% not rebooked within 28 days	18.46% not rebooked within 28 days	No
Critical care admissions	We will ensure 100% of critical care patients are admitted within 4 hours	100%	Not reported	100%	92.74%	No
Accident and Emergency	We will admit, transfer or discharge patients attending A&E within 4 hours of their arrival in line with trajectories	95%	87.11%	95%	88.13%	No
Accident and Emergency	We will reduce the number of A&E patients spending >12 hours from decision to admit to admission to zero	0	60	0	68	No
Bed management	We will reduce the percentage of patients with length of stay over 7 days and 21 days as a percentage of occupied beds in line with national planning assumptions		7+ days: 37.45% 21+ days: 10.74%	A reduction of 50% from baseline (for 21 days)	7+ days: 57.33% 21+ days: 25.23%	No
Bed management	We will maintain the average number of delayed beds in the month as a percentage of occupied beds in line with national planning assumptions	3.05%	Not reported	3.5% of beds	2.70%	Yes

Bed management	We will discharge at least 33% of our patients on relevant pathways before noon	N/A	10.22%	33%	14.32%	No
Diagnostics	We will maintain performance of less than 1% of patients waiting over 6 weeks for a diagnostic test	1%	3.66%	1%	0.80%	Yes
Outpatient management	We will maintain the average waiting times for first outpatient appointment at 8 weeks or below	8 weeks	8 weeks	8 weeks or below	7 weeks	Yes
Outpatient management	We will reduce the proportion of patients who do not attend outpatient appointments to 10%	10%	11.68%	10%	10.69%	No
Outpatient management	We will reduce the proportion of outpatient clinics cancelled by the trust with less than 6 weeks' notice to 7.5% or lower	N/A	8.01%	7.50%	7.93%	No
Outpatient management	We will ensure 95% of outpatient appointments are made within 5 working days of receipt of referral	95%	84.12%	95%	94.87%	Yes
Complaints management	We will maintain numbers of PALS concerns at less than 250 per month	N/A	226	Less than 250 per month	241	Yes
Complaints management	We will maintain the numbers of formal complaints at less than 90 per month	N/A	81	Less than 90 per month	85	Yes
Complaints management	We will ensure that we respond to complaints within an average of 40 days	N/A	Not reported	40 days	30	Yes
Patient transport	We will improve pick up times for patients using our non-emergency patient transport service	N/A	Collection within 60 minutes: 92.11% Collection within 150 minutes: 99.11%	Collection within 60 minutes: 97% Collection within 150 minutes: 100%	Collection within 60 minutes: 93.51% Collection within 150 minutes: 99.29%	No
Patient transport	We will improve drop off times for patients using our non-emergency patient transport service	N/A	0-5 miles: 92.28% 5-10 miles: 77.15%	No longer than 60 minutes 0-5 miles: 95% 5-10 miles: 85%	0-5 miles: 92.25% 5-10 miles: 76.47%	No

Data quality	We will improve data quality by reducing diagnostic and surgical orders waiting to be processed on our system in line with trajectories	N/A	1,498 (Dec-March only)	286	1,271	No
Data quality	We will improve data quality by reducing outpatient appointments not checked-in or out on our system in line with trajectories	N/A	Not checked in: 1,716 Not checked out: 1,208	Not checked in: 769 Not checked out: 707	Not checked in: 2,361 Not checked out: 2,524	No

Appendix H: Well-led metrics

Area	Description	National target / national average	Performance in 2017/18	Target in 2018/19	Outcome in 2018/19	Target achieved?
Workforce and people	We will have a voluntary staff turnover rate of 12% or less	N/A	9.82%	12%	11.51%	Yes
Workforce and people	We will have a general staff retention rate of 80% or more	N/A	Not reported	80%	85.46%	Yes
Workforce and people	We will maintain our sickness absence rate at below 3%	N/A	2.90%	3%	3.07%	No
Workforce and people	We will achieve a performance development review rate of 95%	N/A	88.54%	95%	89.57%	No
Workforce and people	We will achieve a non-training grade doctor appraisal rate of 95%	N/A	84.53%	95%	93.76%	No
Workforce and people	We will have a consultant job planning completion rate of 95% or more	N/A	Not reported	95%	99.5%	Yes
NHSI segmentation	We will maintain or improve NHSI provider segmentation	N/A	Not reported	N/A	3	N/A

Glossary

Avoidable infections – within the Trust we define 'avoidable infections' as: a case of MRSA BSI occurring 48 hours after admission; and a case of *Clostridium difficile* that is both PCR and toxin (EIA) positive occurring 72 hours after hospital admission when there is non-compliance with the antibiotic policy or the patient crossed pathways with a known case of the same ribotype (a method used to compare the genetic relatedness of different *C. difficile* strains).

Big Room - A big room is a regular standardised meeting which provides time and space for a range of staff and patients to come together to discuss improvements to the quality of patient care.

Carbapenem-resistant Enterobacteriaceae (CRE) - gram-negative bacteria that are resistant to the carbapenem class of antibiotics. They are resistant because they produce an enzyme called a carbapenemase that disables the drug molecule

Care Quality Commission (CQC) – the independent regulator of health and social care in England. It makes sure health and social care services provide people with safe, effective, caring, well-led and responsive care, and encourages care services to improve.

Cerner - supplier of health information technology (HIT) solutions, services, devices and hardware

Clinical Coding – the translation of medical terminology as written by the clinician to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format which is nationally and internationally recognised. The use of codes ensures the information derived from them is standardised and comparable.

Clinical Guidelines – these are recommendations of how healthcare professionals should care for people with specific conditions. They can cover any aspect of a condition and may include recommendations about providing information and advice, prevention, diagnosis, treatment and longer-term management. They aim to help health professionals and patients make the best decisions about treatment or care for a particular condition or situation.

Clinical Nurse Specialist (CNS) – provide expert advice related to specific conditions or treatment pathways. They focus on improving patient care and developing services.

Clostridium difficile – an anaerobic bacterium that can live in the gut of healthy people where it does not cause any problems, as it is kept in check by the normal bacterial population of the intestine. However, some antibiotics used to treat other illnesses can interfere with the balance of bacteria in the gut which may allow *C. difficile* to multiply and produce toxins that damage the gut. Symptoms of *C. difficile* infection range from mild to severe diarrhoea and more unusually, severe inflammation of the bowel.

Core Skills Training – nationally defined and mandated training programmes which all Trust staff must complete in accordance with the requirements of their roles.

Cost Improvement Programme (CIP) – programmes designed to reduce costs while improving patient care, patient satisfaction and safety.

CQUIN - Commissioning for Quality and Innovation (CQUIN) is a payment framework that allows commissioners to agree payments based on agreed quality improvement and innovation work.

Datix – patient safety and risk management software for healthcare incident reporting and adverse events. This is the system the Trust uses to report incidents, manage risk registers and to record mortality reviews.

Departmental Safety Coordinator (DSC) – appointed by departmental managers to assist them in meeting their health, safety and wellbeing responsibilities.

DNA (‘did not attend’) – when a patient misses a hospital appointment.

Driver Diagrams – a visual model used in quality improvement (QI) methodology that identifies all the things that must in place to achieve an aim by breaking it down into small steps that can be directly influenced with change ideas and can be measured.

Dr Foster – provider of healthcare variation analysis and clinical benchmarking.

Duty of Candour – Secondary care providers registered with CQC in England are subject to a statutory duty of candour, introduced in November 2014. It is a statutory requirement to ensure that patients and their families are told about patient safety incidents that affect them, receive appropriate apologies, are kept informed of investigations and are supported throughout.

Emergency readmissions – unplanned readmissions that occur within 28 days after discharge from hospital. They may not be linked to the original reason for admission.

Flow – the progressive movement of people, equipment and information through a sequence of processes. In healthcare, the term generally denotes the flow of patients between staff, departments and organisations along a pathway of care.

Flow coaching - providing training to build team coaching skills and improvement science at care pathway level

Friends and Family Test (FFT) – The NHS FFT was launched in 2013 to help service providers and commissioners understand whether their patients are happy with the service provided. It is a quick and anonymous way for patients to give their views after receiving care or treatment.

General Medical Council (GMC) – The GMC regulates doctors in the United Kingdom. They set standards, hold a register, quality assure education and investigate complaints.

Getting it Right First Time (GIRFT) – is a national programme designed to improve medical care within the NHS by reducing unwarranted variations.

Hospital Episode Statistics (HES) - HES is a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England.
This data is collected during a patient's time at hospital and is submitted to allow hospitals to be paid for the care they deliver.

Hospital Standardised Mortality Ratio (HSMR) – an overall quality indicator that compares a hospital's mortality rate with the average national experience, accounting for the types of patients cared for.

Information Governance – ensures necessary safeguards for, and appropriate use of, patient and personal information.

Integrated Care – NHS England has recently changed the name of accountable care systems to integrated care systems. Integrated care happens when NHS organisations work together to meet the needs of their local population.

Local Faculty Group – a group in each department which meets regularly to take responsibility for the learning environment, and undergraduate and postgraduate training in that service.

Medical Appraisal - all doctors must undertake and record an annual medical appraisal in order to demonstrate that they comply with Good Medical Practice as required by the GMC.

Medical Devices – any instrument, apparatus, material, software or healthcare product, excluding drugs, used for a patient or client for:

- diagnosis, prevention, monitoring, treatment or alleviation of disease;
- diagnosis, monitoring, treatment or alleviation, or compensation for, an injury or handicap;
- investigation, replacement or modification of the anatomy or a physiological process;
- control of conception

Methicillin-resistant *Staphylococcus aureus* (MRSA) – a type of bacteria that's resistant to a number of widely used antibiotics. This means MRSA infections can be more difficult to treat than other bacterial infections. Staphylococcus aureu is a common type of bacteria. It's often carried on the skin and inside the nostrils and throat. If the bacteria get into a break in the skin, they can cause life-threatening infections, such as blood poisoning or endocarditis.

Model for improvement - a method for structuring an improvement project, guiding the development of an idea and testing it out using a simple framework.

National Reporting and Learning System (NRLS) – the NRLS enables patient safety incident reports to be submitted to a national database on a voluntary basis and is designed to promote learning. Participation enables us to compare our incident reporting rates with our peers.

Never events – serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

NEWS2 – the latest version of the National Early Warning Score which following an assessment enables staff to calculate a standardised score enabling them to more effectively respond to acute illness.

Palliative Care – a multidisciplinary approach to specialised medical care for people with serious illnesses. It focuses on providing patients with relief from the symptoms, pain, physical stress, and mental stress of a serious illness, whatever the diagnosis. Palliative care is normally offered to terminally ill patients, regardless of their overall disease management style, if it seems likely to help manage symptoms such as pain and improve quality of life.

Patient advice & liaison service (PALS) – PALS offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.

Patient led assessments of the care environment (PLACE) – A national system for annually assessing the quality of the patient environment in hospitals, hospices and day treatment centres providing NHS funded care. The assessments see local people go into hospitals as part of teams to assess how the environment supports privacy and dignity, food, cleanliness and general building maintenance.

Patient reported outcome measures (PROMs) – tools we use to measure the quality of the service we provide for specific surgical procedures. Patients complete two questionnaires at different time points, to see if the procedure has made a difference to their health.

Patient safety incident – any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care. Patient safety incidents are categorised by harm level, defined as follows by the NRLS:

- Near miss –incident that had the potential to cause harm but was prevented, resulting in no harm.
- No harm – incident that ran to completion but no harm occurred.
- Low harm: incident that required extra observation or minor treatment and caused minimal harm.

- Moderate harm: incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm.
- Severe harm: incident that appears to have resulted in permanent harm.
- Extreme harm/death: incident that directly resulted in the death of one or more persons.

Patient safety translational research centre (PSTRC) - The NIHR Imperial Patient Safety Translational Research Centre (PSTRC) is part of National Institute for Health Research (NIHR). It is a partnership between Imperial College Healthcare NHS Trust and Imperial College London, with researchers from a specialised set of research groups working together to improve patient safety and the quality of healthcare services.

Performance Development Review (PDR) – our annual performance review process for all staff, excluding doctors, which is aimed at driving a new performance culture across the Trust.

Quality Improvement (QI) – is a formal approach to the analysis of performance and systematic efforts to improve it. It is a method for developing, testing and implementing changes so that improvements can be made quickly.

Quality Schedule - Each year, we agree a number of quality metrics with our commissioners which we are required to deliver as part of our contract. These include nationally mandated metrics, as well as locally agreed ones. These are set out in the Quality Schedule. Our commissioners (local and NHS England) monitor our performance with these indicators throughout the year through the Clinical Quality Group.

Referral to Treatment (RTT) – consultant-led Referral To Treatment (RTT) waiting times, which monitor the length of time from referral through to elective treatment.

Revalidation – the process by which all licensed doctors and nurses are required to demonstrate on a regular basis that they are up to date and fit to practise in their chosen field.

RIDDOR – this stands for the Reporting of Injuries, Diseases and Dangerous Occurences Regulations 2013. Under RIDDOR, employers, self-employed people and anyone who's in control of a business' premises are legally required to report specified workplace incidents. There are seven different categories of RIDDOR, and these are: deaths, specified injuries, over seven day injuries, injuries to people not at work, some wok-related diseases, dangerous occurrences and gas incidents.

Root Cause Analysis (RCA) – a systematic investigation that looks beyond the people concerned to try and understand the underlying causes and environmental context in which the incident happened. Serious incidents and never events undergo RCA as part of the investigation.

Safeguarding – protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It is fundamental to high-quality health and social care.

Secondary Users Service (SUS) – the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.

Serious Incident (SI) – events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

Summary hospital-level mortality indicator (**SHMI)** – a national way of measuring mortality. It includes deaths related to all admitted patients that occur in all settings – including those in hospitals and those that happen 30 days after discharge.

Standard Operating Procedure (SOP) – a set of written step-by-step instructions compiled by an organisation that describe how to perform a routine activity.

Stakeholder – a person, group, organisation, member or system who affects or can be affected by an organisation's actions.

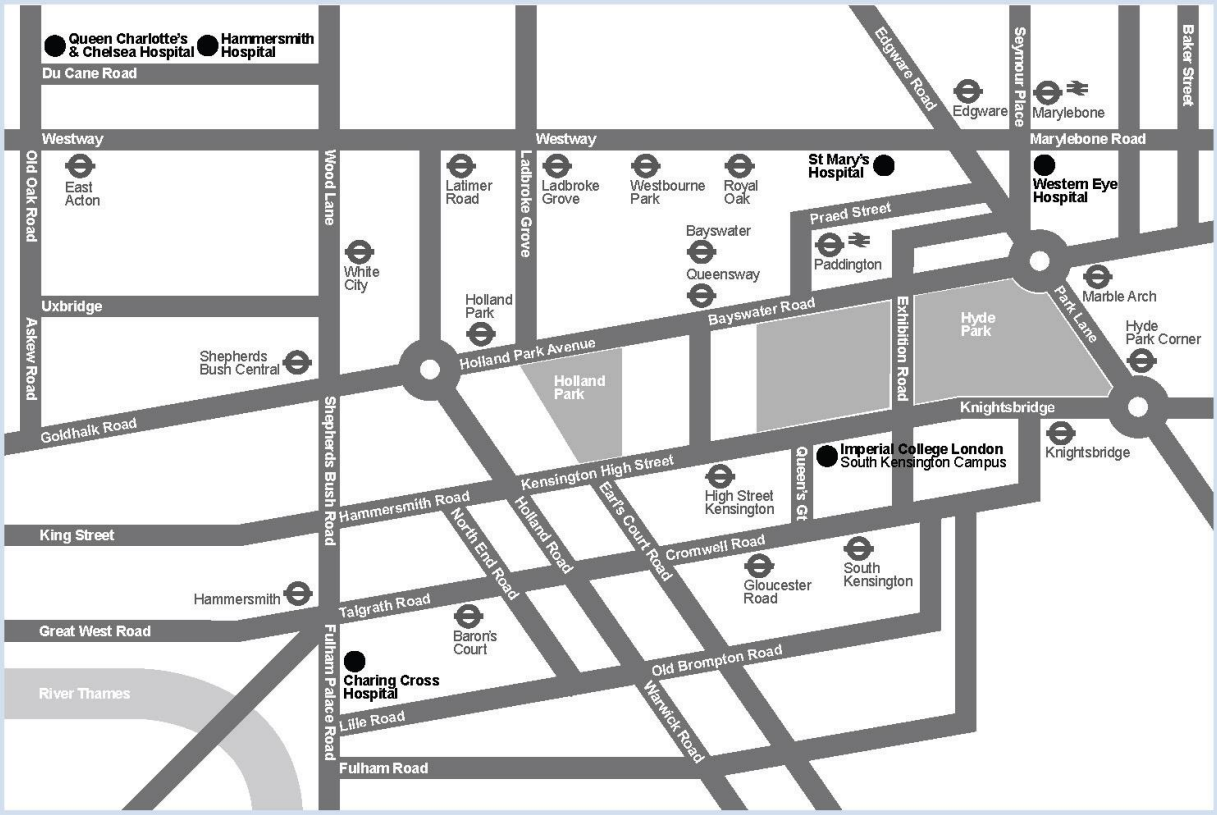
Statistical process control (SPC) – a method of quality control which employs statistical methods to monitor and control a process.

Structured judgement review (SJR) - based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.

Venous thromboembolism (VTE) – a blood clot within a blood vessel that blocks a vein or an artery, obstructing or stopping the flow of blood.

Ward accreditation programme (WAP) – Reviews of patient areas during which patient care is observed, documentation reviewed, the environment assessed and discussion with patients, carers and staff members takes place.

Contact us and map of sites



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Hammersmith Hospital
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Honesty Equality Accountability Respect Teamwork

Putting **patients** at the **HEART** of everything we do

NHS
London North West University Healthcare
NHS Trust

Quality account 2018 to 2019

Inside

Introduction

Quality accounts are annual reports to the public from providers of NHS healthcare regarding the quality of services that they provide and deliver.

The primary purpose of this report is to enable the Board and leaders of our Trust to assess quality in its broadest form across all of the healthcare services we offer. It allows us to demonstrate a shared commitment to continuous, evidence-based quality improvements and for the Trust to openly share its commitment and progress with the communities we serve.

The Quality Report incorporates a review of the activities and achievements in improving the quality of our care during 2018/19, and states and explains our quality priorities for 2019/20.

There are three additional considerations for inclusion within the quality account this year:

a. Providers of acute services are asked to include a statement regarding progress in implementing the priority clinical standards for seven-day hospital services. This progress should be assessed as guided by the Seven Day Hospital Services Board Assurance Framework published by NHS Improvement.[1]
b. In its response to the Gosport Independent Panel Report, the Government committed to legislation requiring all NHS trusts and NHS foundation trusts in England to report annually on staff who speak up (including whistle blowers). Ahead of such legislation, NHS trusts and NHS foundation trusts are asked to provide details of ways in which staff can speak up.
c. For the first time the new NHS England Learning Disabilities Standard submission is included within quality account.

The retrospective elements of this report pertain to the activities undertaken by the Trust during the financial year of 2018/19 and incorporate all of the mandatory reporting requirements set out by NHS Improvement, referenced with in the following documents:

What does it mean for patients, members of the public and stakeholders?

By putting information about the quality of services in an organisation into the public domain, NHS healthcare organisations are offering their approach to quality for scrutiny, debate and reflection.

The quality account should assure patients, members of the public and its stakeholders that as an NHS healthcare organisation that we are scrutinising each and every one of our services, providing particular focus on those areas that require the most attention.

[1] https://improvement.nhs.uk/resources/seven-day-services/

How will the quality account be published?

In line with legal requirements, all NHS Healthcare providers are required to publish their quality account electronically on the NHS UK website by 30th June 2019.

London North West University Healthcare NHS Trust also makes its quality account available on its website.

Part 1: Introducing our quality account

This section includes:

- a statement on quality from the Chief Executive, Dame Jaqueline Docherty DBE
- our Statement of Directors' responsibilities
- priorities for improvement and Statements of Assurance from our Board
- an overview of some of our success stories and highlights from 2018/19.

Thank you for taking the time to read our quality account. Within this document, which is drafted for the purpose of our patients, partners and other key stakeholders, we aim to demonstrate our achievements during 2018/19, and to outline our commitment to continuous care quality improvement throughout 2019/20.

As a team of healthcare professionals dedicated to providing high quality, patient-focussed care, we pride ourselves on living our values and putting patients at the heart of everything we do.

In showcasing our achievements and learning from 2018/19, this document will outline our key priorities for the coming year whilst also referencing our ongoing focus on fundamental aspects of care provision that are important to our patients.

Developed with input and feedback from stakeholders, including patients and staff, to inform and drive our continuous improvement journey, we aspire to use our quality account as a foundation upon which to build for the future.

With visible leadership, inspiring our team to excel, building the confidence of our patients with a commitment improving engagement and involvement we aim to promote the profile of London North West University Healthcare to one which is renowned for living its values and delivering the highest possible care quality standards.

Welcome from the Chief Executive

I am pleased to present our Quality Account for 2018/19. Here, we not only scrutinise our performance against our quality indicators and priorities throughout the last year, but look forward to our future. We have worked with patients and staff to develop our new quality priorities for the year ahead, which you can read on page 11.

There is much to look back on with pride over the last twelve months.

We have invested in state of the art facilities for our West London Vascular and Interventional Radiology Centre, which allows for speedier, less invasive, and seamless treatment for patients.

Our stroke service remains one of the few double-A rated services across the country, with both our hyperacute stroke service and our stroke unit receiving the highest rating of A from the Sentinel Stroke National Audit Programme.

Mortality across all of our sites is lower than expected. On the Summary Hospital-level Mortality Indicator (SHMI), our mortality is the 10th lowest nationally. This demonstrates a clear focus on safety that is so critical to providing high quality care.

At the core of our approach to quality is a forward-looking drive for improvement, and this is driven by the commitment and energy of our staff. We have continued to develop a culture of learning, kindness, and dignity with our HEART values of Honesty, Equality, Accountability, Respect, and Teamwork.

In 2018/19, 43 of our staff became HEART Heroes, recognising exceptional performance over and above their day to day work, and I hope that this valuable source of recognition and inspiration will grow further this year.

In addition, our growing group of HEART Ambassadors continue to work across the organisation in representing our values, undertaking local work with departments and teams, and developing our culture. We look to build on our successes over the coming year.

One important way in which we identify improvements we need to make is through working with our regulatory colleagues, and in June 2018, the Care Quality Commission (CQC) visited a number of our sites and services.

The CQC did recognise many aspects of excellent care, rating critical care services at Northwick Park Hospital, our community hospitals, and our community dental services as Good. They also described our staff as caring and committed.

Overall, however, they continued to rate our organisation as Requires Improvement, as well as issuing us with some warning notices. Their report identified a number of areas where we can make improvements, and we immediately developed a wide-reaching action

plan which provides us with the framework to make lasting changes and improvements to the quality of care we provide.

More details about the findings from the CQC report can be found on page 81.

I am pleased to say that the CQC returned for a short visit in January 2019, and noted a series of improvements. In particular, the CQC recognised that “significant steps” had been taken to improve care at Ealing Hospital, and the detailed improvement plan we had developed in this area.

They also commented on the changes we made to the physical environment in our maternity and critical care units and noted the difference that these changes have made for our patients.

We have recently been advised that the warning notices will be lifted given the results of this most recent visit, and we look forward to being able to move forward with our broader improvement plans.

In November, we held a Quality Summit with our partners in health and social care and representatives from our staff. The summit has helped us to define the broad themes that will support us to move forward with our quality improvement agenda.

Both we and our partner organisations have made specific pledges to set us on this path.

These themes and pledges form the basis of our new Quality Improvement Plan, which we are developing with patients and staff and which brings together all the various strands of improvement across our Trust into one descriptive document.

One vital element of this improvement work is our Transformation Programme. This approach to quality aims to bring about a change in our culture to one of continuous quality improvement and puts the lived experiences of our staff and patients at the heart of these changes.

The programme works closely with individual clinical teams, using their expertise to make long term plans for development and change.

One area where this has already proved enormously successful is in refreshing the enhanced recovery model in surgery: by improving their processes, the team has safely reduced the amount of time patients need to stay in hospital by an average of 6 days. This offers patients a better and safer experience, as well as ensuring that helping our teams more rapidly treat those patients who are still awaiting our care.

The programme benefits from executive leadership by our Medical Director, and I have become an Improvement Champion. Yet its true goal is to empower and involve staff on the ground, equipping them with the knowledge, tools and support that they need to make evidenced and sustainable change at a local level wherever they are.

I am delighted to report that over 1954 staff have already received some form of formal improvement training in the last six months – a remarkable achievement and one that I am confident will serve us well in the future.

Operational performance and quality go hand in hand, and indeed, in their report, the CQC noted the importance of good patient pathways and flow to high quality care. I am truly delighted to say that our teams' sustained focus on performance in the last year has resulted in a dramatic improvement.

Recent data showed that our Emergency Department performance is the third most improved in the country since January 2017, and this is a significant achievement given the real increase in attendances to our A&Es over that time period.

Meeting our referral to treatment targets has been challenging over the last year, and we recognise this is another area of focus aided by the work being undertaken with our improvement programmes.

Finally, in the year in which the NHS celebrated its 70th birthday, it is very clear to me that our service cannot stand still.

Innovation and the ambition for ever better patient care is at the core of what we do, and I am confident that our work over recent months will stand us in great stead as we move forward in our journey to outstanding care.

I can confirm, in accordance with my statutory duty, that to the best of my knowledge, the information provided in this Quality Account is accurate.

I can confirm, in accordance with my statutory duty, that to the best of my knowledge, the information provided in this quality account is accurate.

(SIGNATURE)

Jacqueline Docherty DBE
Chief Executive

Statement of directors' responsibilities

The Directors are required under the health Act 2009 to prepare a quality account for each financial year. The Department of health has issued guidance on the form and content of annual quality account (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amended Regulations 2011).

In preparation the Quality Account, directors are required to take steps to satisfy themselves that:

- The quality account presents a balanced picture of the Trust's performance over the period covered
- The performance information reported in the quality account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality account, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the quality account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review
- The quality account has been prepared in accordance with Department of Health guidance.
- The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality account.

By Order of the Board

Date:

Peter Worthington
Chairman

Date:

Jacqueline Docherty DBE
Chief Executive

Priorities for improvement and statements of assurance from our Board

London North West University Healthcare NHS Trust is committed to providing safe, high quality care to all patients and service users. Our focus is on sustainable continuous quality improvement and transformation driven by the Quality Priorities, as identified with the Quality Improvement Plan.

The Quality Improvement Plan will be the vehicle to drive the Quality Priorities, and will be monitored, updated and amended throughout the year. Regular progress reports will be submitted to the Trust Board, the Trust Quality and Safety Committee and Board of Directors as part of the routine cycle of business.

The following sources have been used to identify and agree on the Quality Priorities for 2019/20

- Stakeholder and regulator reports and recommendations
- CQC inspection report and CQC Insight reports
- Clinical Commissioning Groups and STP feedback and observations following their quality visits
- Commissioning for Quality and Innovation (CQUIN) priorities
- National inpatient, outpatient and maternity service surveys
- Feedback from our Trust Board and Council of Governors
- Emergent themes and trends arising from complaints, serious incidents and inquests
- Feedback from senior leadership assurance visits
- Nursing, and Midwifery quality assurance tools including: National clinical key performance indicators, Excellence assessments and Perfect Ward assessments
- Quality and Safety Priorities dashboard and reports
- Internal and External Reviews including NHSI
- National Policy
- Feedback from Healthwatch through joint partnership working
- Feedback from stakeholders, partners, regulators, patients and staff in the development of the quality priorities

As part of our continuous quality improvement programme and integral Transformation Programme, the Trust is in the process of further improving its governance, risk and performance framework. This is to ensure that risks to the safety and quality of patient care in addition to financial recovery are identified, well led and managed. This should result in improved patient outcomes, involvement and experience, clinical sustainability, transformation of services and financial viability not only for the Trust but North West London STP.

The achievement of each quality priority will be measured through a range of key performance indicators or metrics. Progress will be underpinned by the Trust assurance processes, with formal monitoring and measurement reported through a range of

committees and groups that in turn report through the Quality and Safety Committee to the Board of Directors.

Approach to quality improvement

The Trusts approach to quality improvement and transformation is based on proven tools for accelerating improvement that have been widely adopted across the NHS.

The following principles guide how care quality is improved at the Trust. Based on the experience and learning from other Trusts, our continuous quality improvement journey begins by asking these important questions:

- What problem are we attempting to solve – what are we trying to achieve?
- What change can we make to bring about transformation and improvement?
- How will we know that making a change delivers an improvement?

These questions ensure that there are clear aims, measures, specific interventions and how changes will be tested, in the clinical settings and services across the Trust. By implementing changes, succeeding, failing and learning as the Trust moves forwards, we will identify and enact change that will provide sustainable improvement and learning.

Quality priorities 2019-20

During 2018/19, the Trust received the Care Quality Commission's report of August 2018 which rated the Trust as Requires Improvement, as well as Section 29A Improvement Notices. In response, the Trust has reviewed its quality priorities and pledges to improve and strengthen its approach to continuous quality improvement and transformation with its staff, patients, regulators, commissioners and stakeholders.

The Trust has invested in transformation expertise to advance quality, safety and develop our staff to lead, learn and continuously improve services now and as we move forward.

The quality account for 2019/20 is informed by a detailed review of its achievements areas for improvement.

The Trust has built on both its successes and areas for improvement and developed a Quality Improvement Plan that takes the Trust forward on our continuous quality improvement journey to become an outstanding Trust by 2021.

The Trust's strives to provide outstanding care that is sustainable, high value, high quality and delivered with our health and social care partners across the north-west London STP.

The driving force to our Quality Improvement Plan roadmap is partnership and integration with our STP partners, bringing about closer integration across the NWL health system to deliver, safer, financially sustainable care and services to the population and communities we serve.

The Trust recognises that it is fundamental to include the voices and views of the public in its plans. However, it recognises that there is more to do to improve and make it easier for the public to engage.

As a result, it is currently undertaking a review of its current approach against NHSI Patient Experience Improvement Framework. This is to ensure that it has a robust Patient Experience and Involvement Plan, which prioritises patient engagement, co-design of service improvements in addition to learning from feedback on patient experience. The aims are to ensure that the public has opportunities to inform, influence, shape, be involved in and influence the Trust's plans and services.

In setting out the key quality priorities for 2019/20, the Trust explains the fundamental reasons why it is important and the actions it is taking to ensure it becomes a learning organisation that excels.

We will do this by creating a culture of honesty and transparency to enhance understanding and accountability, so that staff can understand and articulate their duty, and by promoting a positive culture of shared learning aligned to Trust-wide quality improvement and transformation strategies.

Agreed quality priorities:

- Priority 1: Safe for our patients and safe for our staff
- Priority 2: Leading from the HEART values) and enabling our staff to be the best they can be
- Priority 3: Delivering change for excellent patient experience

Outlined below is a detailed breakdown of areas of focus within each priority, highlighting why these aspects of quality are important and what our primary aims will be

.Priority 1: Safe for our patients and safe for our staff

- Improved outcomes for deteriorating Adult patients – Sepsis, Acute Kidney Injury, Early recognition using NEWS 2
- Improved outcomes, through Saving babies lives;

Our ambition is to reduce harm for those using our services by delivering 'better fundamental care' and reducing the likelihood of potential harm, or complications that may occur.

1a: Deteriorating patient: adults

Patients receiving care within our hospital or community settings have the right to expect safe care, in addition to early detection and an appropriate clinical response to any deterioration in their condition.

Patients admitted to hospital expect that should their condition deteriorate they are in the best place for prompt and effective treatment. There are occasions where patients who

are, or who become, acutely unwell in hospital, may deteriorate for a number of reasons. Early recognition of a patient's deterioration through the use of observations and a national early warning score will enable appropriate planning, review and escalation of care where required.

The National Early Warning Score (NEWS 2) introduced in April 2019 as an updated version of the previous NEWS assessment tool enables us to ensure early identification of a patient's deterioration through the use of observations and to respond effectively according national guidelines and best practice standards. This optimises patient care.

Our focus during 2019/20

- Evidence a reduction in cardiac arrest calls on a quarterly basis
- Evidence appropriate utilisation of calls to the Medical Emergency Team (MET), in accordance with NEWS 2 Standards
- Review cardiac arrest calls outside critical care and identify themes and areas for improvement, feeding into deteriorating patient group and divisional governance forums on a quarterly basis
- Evidence ongoing compliance with NEWS 2 Related training via the appropriate eLearning module, including in quarterly divisional governance reports, with exceptions being monitored within the 'Deteriorating Patient Group (DPG) on a monthly basis
- Implement monthly audit profile to evidence compliance with national standards and the appropriate escalation of care
- Improve patient outcomes with early recognition of signs and symptoms of sepsis, in accordance with NICE guidelines
- Improve awareness of Acute Kidney Injury (AKI) through focused education and development for clinical staff

1b: Improving patient outcomes within maternity care with the delivery of the Saving Babies' Lives care bundle aimed to reduce perinatal mortality in 2019/20

Our focus during 2019/20

The Saving Babies' Lives Care Bundle has been produced to reduce perinatal mortality across England. It brings together five elements of care that are widely recognised as evidence-based and/or best practice.

The outcome indicators are set in line with the national guidance and included in the Quality Contract Schedule for Maternity with the commissioners

Reducing smoking in pregnancy

This element provides a practical approach to reducing smoking in pregnancy by following NICE guidance. Reducing smoking in pregnancy will be achieved by offering carbon

monoxide (CO) testing for all women at the antenatal booking appointment, and as appropriate throughout pregnancy, to identify smokers (or those exposed to tobacco smoke) and offer them a referral for support from a trained stop smoking advisor.

Risk assessment, prevention and surveillance of pregnancies at risk of foetal growth restriction (FGR)

The previous version of this element has made a measurable difference to antenatal detection of small for gestational age (SGA) babies across England2. It is however possible that by seeking to capture all babies at risk, interventions may have increased in women who are only marginally at increased risk of FGR related stillbirth. This updated element seeks to address this possible increase by focusing more attention on pregnancies at highest risk of FGR, including assessing women at booking to determine if a prescription of aspirin is appropriate. The importance of proper training of staff who carry out symphysis fundal height (SFH) measurements, publication of detection rates and review of missed cases remain significant features of this element.

Raising awareness of reduced foetal movement (RFM)

This updated element encourages awareness among pregnant women of the importance of detecting and reporting RFM, and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM. Induction of labour prior to 39 weeks gestation is only recommended where there is evidence of foetal compromise or other concerns in addition to the history of RFM.

Effective foetal monitoring during labour

Trusts must be able to demonstrate that all qualified staff who care for women in labour are competent to interpret cardiotocographs (CTGs), always use the buddy system and escalate accordingly when concerns arise, or risks develop. This element now includes use of a standardised risk assessment tool at the onset of labour and the appointment of a Foetal Monitoring Lead with the responsibility of improving the standard of foetal monitoring.

Priority 2: Leading from the HEART and enabling our staff to be the best they can be

- Developing a sustainable workforce that is fit for purpose – creating a culture of continuous and sustainable improvement
- Build a patient focused safety culture enhancing the ‘patient voice and influence’ to improve their experience of care and outcomes

2a: Developing a sustainable workforce that is fit for purpose – creating a culture of continuous and sustainable improvement.

Evidence suggests a direct correlation between staff and patient experience. Staff who work within a culture of transparency and openness feel better supported and enabled to actively contribute positively to sustainable provision of high-quality care.

Our focus during 2019/20

- Train our staff in continuous improvement as part of our 'innovation and improvement' transformation work stream
- Ensure staff are appropriately developed and empowered to advocate for patients with complex needs by improving compliance in development relating to safeguarding, mental health. Learning disabilities and Mental Capacity Act
- Engage staff in all aspects of care quality improvement work, promoting access to education and development opportunities, to support professional development and career progression
- Enhance the positive culture of continuous quality improvement by improving access to support mechanisms which encourage staff to speak up when concerns arise, in accordance with professional standards and learning from the Gosport Inquiry.

2b: Build a patient focused safety culture enhancing the patient voice and influence to improve their experience of care and outcomes

Developing a workforce who are engaged and motivated to optimise learning and development opportunities whilst being actively encouraged to utilise mechanisms for appropriate reporting of risks, concerns incidents and variances to care quality is essential in the delivery of safe patient care.

Our focus during 2019/20

- Develop a culture of openness and honesty when things go wrong embedding best practice around the professional duty of candour.
- Reduce harm for those using our services including those with learning disabilities, to get to the learning faster from serious incidents, complaints, claims and incidents. This will be progressed through the Trust's triangulation and learning from complaints, incidents and claims project 2019/20; to perform in the top 25% of Trusts for levels of incident reporting and near misses

Priority 3: Delivering change for excellent patient experience

- Enhancing the patient journey to optimise safe and timely discharge
- Reducing inequalities in care provision for patients with complex needs

3a: Enhancing the patient journey to optimise safe and timely discharge

Evidence suggests that encouraging patients to maintain independence, within activities of daily living promotes recovery, restores self-confidence and can reduce the amount of time spent in Hospital. As an integral component of the multi-disciplinary team, Allied Health Professionals (AHPs) are the next biggest clinical workforce in the Trust after nursing and midwifery.

AHP expertise and contribution in the management of patient care is vital to both the patient's experience and recovery and is essential to safe and effective discharge planning. Evidence suggests that improved clinical focus on the patient journey serves to optimise patient wellbeing and recovery reducing length of stay, improving proactive discharge planning and patient experience.

Our focus during 2019/20

- Optimise patient independence with a robust approach to initial assessment and early referral to therapies and complex discharge teams, ensuring seamless care provision in accordance with best practice standards
- Improve compliance on response times achieved in 2018/19 for therapy input within 24 hours from time of referral (bedded units) in accordance with clinical risk and best practice standards
- Improve the approach to proactive discharge planning at the point of initial assessment utilising the appropriate assessment tools, evidencing that both patient and carers, are actively involved in the process
- Improve discharge planning with early referral to pharmacy for patients with polypharmacy needs, facilitating improved review and communication and limit delays with discharge medications

Reducing inequalities in patient experience for people with complex needs

Patient feedback within 2018/19 suggests there are a number of areas of care where patient experience and involvement could be improved for individuals who may be living with complex needs or disabilities.

As providers of healthcare we must give due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it.

Our focus during 2019/20

We are committed to reducing inequalities for patients in accessing our healthcare services, to ensure improved care outcomes.

This includes:

- Overcoming communication difficulties; Speech and language
- Hearing difficulties
- Visual impairment
- Learning disabilities – as outlined in the Learning disabilities standard[2]
- Disabilities
- Mental health related challenges
- Bariatric care provision
- Develop and implement a robust patient experience improvement plan in accordance with the NHSI national patient experience framework.
- Evidence co-design approach in all work streams related to service review, environmental redesign presented for review at Trust board level
- Utilise available specialist MDT supports to review provision for each of the above patient groups, demonstrating improvements in care through positive patient feedback
- Ensure staff development includes improvements in communication for all patients, dependent upon need.
- Involve our staff and patients in determining appropriate signage and way finding, including those with complex needs to ensure patient independence is optimised
- Clinical areas to ensure available equipment is fit for purpose and staff appropriately trained to support patients with complex needs
- Aim to deliver improvements in care in accordance with NICE Guidelines for improving patient experience for people using adult services.[3]

In accordance with best practice standards, having highlighted the above as key quality priorities, it is acknowledged that there is a significant amount of additional work ongoing to enhance and sustain fundamental aspects of care in accordance with national standards. While much of this improvement work is well underway, there is continued focus on embedding and sustaining these practice improvements into everyday practice.

An overview of key areas for enhanced focus can be found below, with additional detail being outlined in the Trust wide quality improvement plan.

Stakeholder engagement schedule

To support greater engagement and transparency in the development of the quality account an enhanced process of staff engagement was developed as outlined within fig 2.

A variety of differing approaches were taken in order to optimise the ability of clinical teams to input to the priorities ensuring ownership at the local level. We also engaged with Healthwatch for Brent, Ealing and Harrow. The aim of this is to ensure the 2019/20 quality account is utilised in a way in which is meaningful, benefiting both staff and patient

[2] https://improvement.nhs.uk/resources/learning-disability-improvement-standards-nhs-trusts/
[3] https://www.nice.org.uk/guidance/cg138/chapter/1-Guidance

experience by informing quality initiatives, transformation work streams, driving improvement in the coming year, in accordance with the overall aims of the quality improvement plan.

Schedule	
Task and finish group established	January 2019
Identification of key leads responsible for submissions	January 2019
Structured schedule of sessions developed support for key leads	February 2019
Leads review of 2018/19 priorities	February 2019
Initial meeting with external auditors – requirements & process	February 2019
Stakeholder engagement sessions – 3 acute sites	March and April 19
Engagement sessions within clinical areas – Board rounds	March and April 19
Divisional engagement – review of 2018/19 to 2019/20	February to April
Communications – review and formatting of final draft	May to June 2019
Submission for exec review of final Draft for circulation	16 April 2019
Circulation for external Stakeholder review and input	30 April 2019
Presentation at board – to include stakeholder feedback	29 May 2019
Finalisation for publication	30 May 2019
Publication	31 May 2019

Part 2: Review of our achievements

The information within this section provides a structured summary of the review of priorities as outlined within the 2018/19 quality account. The detailed review which informs this document was carried out by an experienced multidisciplinary team having triangulated care quality metrics with a number of feedback mechanisms and benchmarking standards, supported by NHSI. Information contained in this section is as follows:

- Information on Sign up to Safety
- An overview of performance against 2018/19

A detailed update on the performance, achievements and further improvements against the 2018/19 quality improvements

Sign up to Safety Campaign

The 'Sign up to Safety' campaign is a national patient safety campaign with a mission to strengthen patient safety in the NHS and make it the safest healthcare system in the world through continuous learning and improvement. It is supported by NHS England, NHS Resolution, NHS Improvement, the Care Quality Commission, and the Department of Health.

The Trust signed up to the campaign and made the following safety core pledges in 2016/17 which we continued in 2018-2019 and will continue in 2019/20:

Put patient safety first

Commit to reduce avoidable harm in the NHS by half and to make public the goals and plans developed locally.

Continually learn

Review incident reporting and investigation processes to make sure that the Trust learns from them and using these lessons to make the organisation more resilient to risks. Listen, learn and act on the feedback from patients and staff and by constantly measuring and monitoring how safe services are. This has been reviewed during 2018/19 and will be improved further during 2019/20 and is integral to our Transformation programme on example being our involvement in the 'Productive Ward' NHSI programme.

Honest

Being open and transparent. Support staff to be open and honest with patients and their relatives when things go wrong.

Collaborative

Take a leading role and actively collaborating with other organisations in sharing work, ideas and learning so that improvements are made across all of the local services that patients use.

Support

Helping staff to bring joy and pride to their work. Give staff the time and support to improve and to celebrate success.

The Trust aligned the 'Sign up to Safety' campaign with the quality account improvement plan and the Care Quality Commission (CQC) five key domains of quality and safety: safe, effective, caring, responsive and well-led.

The Trust continues to monitor the "Sign up to Safety' campaign pledges through a quality and safety programme. Progress and action plans in relation to the sign up to safety campaign pledges are monitored by the trust sub-board committee though a quality and safety dashboard.

We have launched the Safety Attitude Questionnaire (SAQ) Survey for all the staff to give their views on teamwork, safety climate, stress recognition, job satisfaction, and perception of management and work conditions. Arising trends and themes will be analysed in order for each division to respond and improve the safety culture within the organisation. The SAQ survey was conducted in collaboration with Imperial College Health Partners (ICHP) and Patient Safety Translational Research Centre (PSTRC).

Funding from Imperial Health Care Partners (ICHP) was received to pilot NEWS 2 app through mobile technology in the community and development of a web based daily safety brief. The NEWS 2 project which aims to facilitate quicker recognition of and response to deteriorating patients in the community has been piloted in Short Term Assessment, Rehabilitation and Re-ablement Service (STARRS) with the view of cascading this to all community services in the Trust.

The Daily Safety Web Based Project is being developed with the aim of streamlining data collection process, improved data quality and accuracy to improve clinical ownership and reduce administration time.




Review of performance against quality priorities 2018/19

The following section provides an overview of the Trust's quality priority performance during 2018/19.

The three quality priorities selected for 2018/19 were:

1. Safer care
2. Better outcomes
3. Better patient experience

We implemented a Quality and Safety dashboard that monitored the quality account priorities including a range of local improvement priorities.

The Trust also introduced a mobile application to support a weekly quality inspection of Matrons and the Excellence Accreditation Tool. This will be enhanced further through the planned development and implementation of an exemplar multi-disciplinary accreditation tool, this will be aligned aligned to the NHSI new 'Productive Ward Programme' that is part of our Transformation Programme in 2019/20

The following section describes our 2018/19 priorities in detail and the progress made.

Key

✓	**Goal achieved**
●	**Improvement made compared to previous year**
×	Goal not achieved

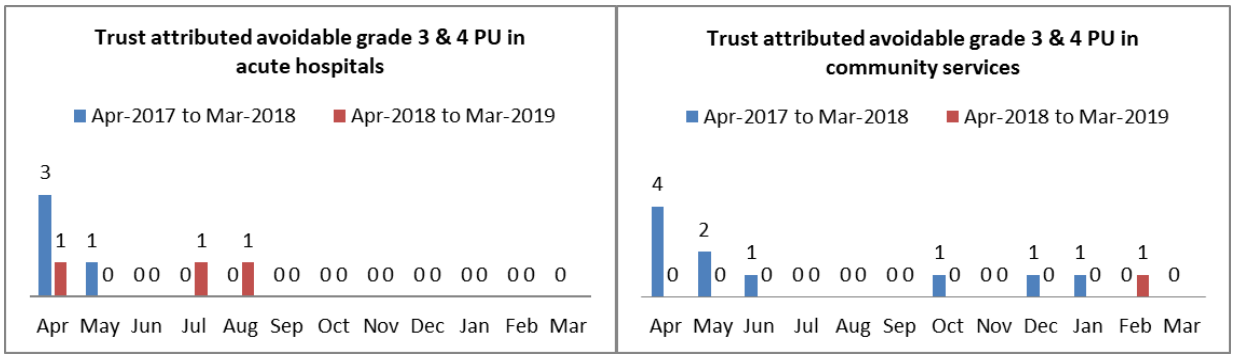
Priority 1: safer care (safe, caring, responsive and well led)

Hospital acquired pressure ulcers: partially achieved

Pressure ulcers (PU) can develop when a large amount of pressure is applied to an area of skin over a short period of time. They can also occur when less pressure is applied over a longer period of time. The extra pressure disrupts the flow of blood through the skin. Without a blood supply, the affected skin becomes starved of oxygen and nutrients, and begins to break down, leading to an ulcer forming. Pressure ulcers tend to affect people with health conditions that make it difficult to move; especially those connected to lying in a bed or sitting for prolonged periods of time

A large proportion of pressure ulcers are preventable and every effort needs to be made to ensure that they do not occur.

What we aimed to achieve in 2018/19	Outcome
Zero incident Trust attributed avoidable grade 3 & 4 PU in acute hospitals	×
50% reduction in Trust attributed avoidable grade 3 & 4 PU in community services	✓
50% reduction in Trust attributed avoidable grade 2 PU in the acute hospitals	×
Increase staff compliance on PU prevention and management training	✓
Continued participation in the National Stop the Pressure campaign	✓
Review and implement the DH Safeguarding Adults and Pressure Ulcer Protocol	✓
Continued daily monitoring of PU incidents in the wards through the daily safety brief	✓



While there is evidence of some improvement during 2018/19 the aim in relation to grade 3 and 4 hospital acquired pressure ulcers was not met. This priority is therefore only partially achieved overall and has provided sufficient learning as to have a sustained focus in 2019/20.

The themes identified from 18/19 relate to communication, initial and ongoing assessment, evaluation and review. Transition and transfer between departments, health care providers, primary / secondary care are identified as areas of increased risk that have been prioritised as a quality priority for 2019/20

Actions taken are as follows:

- Trust requested a NHSI review of tissue viability service – report received, action plan in place for improvement in place.
- Implementation of NHSI new guidance/standard for monitoring, recording and reporting of pressure ulcers: revised definition and measurement.
- Compliance with Department of Health & Social Care requirements relating to Safeguarding Adults and pressure Ulcers interface.
- Implementation of tissue viability Trust wide education and development strategy
- Initiation of a serious incident review group with specific focus on Hospital Acquired pressure ulcers.
- Tissue viability advisory group has been initiated in order to facilitate development, review and evaluation of local, divisional and corporate action plans to facilitate required care quality improvements.

Nutrition and hydration: achieved

Adequate nutrition and hydration is imperative for both the physiological and psychological health of our patients. It is vital we address potential barriers and obstacles that may restrict or prevent our patients receiving optimum nutrition and hydration.

Up to 40% of adults have signs of malnutrition on admission to hospital and often their hospital stay makes this worse. Certain groups of patients, such as older people and those with certain physical health conditions, have particular dietary and eating requirements that need to be met to prevent malnutrition and dehydration and to aid recovery.

NICE has shown that better nutritional care reduces complications and length of stay. NICE cost calculations show that better nutritional care is achievable with financial savings for the NHS.

What we aimed to achieve in 2018/19	Outcome
Promote Patient Protected Mealtime and Beverages and monitor through regular audit	✓
Invite peer/external review (Health Watch) with regards to nutrition and hydration in the wards	✓
Standardise nutritional screening tool trust wide	✓
Improve staff compliance on conduct of patient nutritional screening assessment on admission i.e. weight and height	✓
Standardise food chart across the Trust bedded units and compliance monitored through walkabouts and Matrons audit	✓
Increase compliance on food and drink chart and monitored through the Matrons weekly quality walkabout	✓

Medicines optimisation: partially achieved (continued from 2017/18)

Medicines are the most common therapeutic intervention and it is imperative that the Trust has assurance of the impact medicines have on the quality of care, patient safety and patient experience. The Trust will undertake a range of initiatives to improve medicines optimisation over the coming year.

What we aimed to achieve in 2018/19	Outcome
Increase in the number of medication incidents and near misses reported during 2018/19 compared to 2017/18 by improving the reporting culture within the Trust in line with the HEART values	✓
Increase the range of methods used to feedback the lessons learned from reported medication incidents.	✓
Improve the level of patient satisfaction with the local medicine related patient experience measures during 2018/19 compared to 2017/18.	×
Promote the local medication safety dashboard to reflect current medication related priorities, improve compliance with these standards during 2018/19 and provide feedback to clinical staff	●
Reduction in antibiotic consumption per 1000 admissions median values measured quarterly compared to 2017/18	✓

This priority was only partially achieved, based on listening and learning from patient feedback on our discharge process and safety of medicines. As a result, we have reviewing and improved the way we provide information and communicate on the safety of medications to our patients.

With enhanced focus on medications safety standards there has been significant focus on improving practice. An electronic medication safety dashboard was introduced, in addition to a process of joint safety rounds between pharmacy and matron, to ensure sustained application of recommendations to practice.

Fortnightly circulation of a new medications safety update for staff highlighting good medicines management tips is proving very successful. The Trust also introduced a robust additional medicines management training programme initially delivered to over 280 nurses at our Ealing Hospital site, prior to progressing to other areas of the trust.

The Trust has implemented a medicines management dashboard to ensure compliance against national medications safety standards.

WHO checklist: achieved (continued from 2017/18)

The introduction of the WHO Safer Surgery Checklist was a great step forward in the delivery of safer care for patients undergoing operations. Experience with its use has suggested that the benefits of a checklist approach can be extended beyond surgery towards all invasive procedures performed in hospitals. The aim of this priority is to strengthen the commitment of clinical staff to address safety issues within clinical settings that conduct invasive procedures. This includes improving anaesthetic safety practices, ensuring correct site surgery, avoiding surgical site infections and improving communication within the team. Continuous safety improvement depends on continuous audit of outcome and compliance with safety standards, and on the collection and analysis of data on adverse patient events and near misses. Although we did well on self-audit of the WHO checklist in our operating theatres this year, to maximise safety we do intend to review our processes to make these audits even more effective in 2019/20.

What we aimed to achieve in 2018/19	Outcome
Monitor compliance on WHO Surgical Safety Checklist across hospitals sites	✓
Improve compliance on WHO Surgical Safety Checklist	✓
Development and monitoring of surgical safety checklist compliance in the maternity services	✓
Development and monitoring of surgical safety checklist compliance in:	
Endoscopy	✓
Ophthalmology	✓
Interventional radiology	✓
Inpatient wards	✓
Cardiology (cath lab)	✓
Emergency Department	✓

Priority 2: Better outcomes (effective safe and caring)

Deteriorating Patient: Adult: achieved (continued from 2017/18)

Patients who are admitted to hospital expect that should their condition deteriorate they are in the best place for prompt and effective treatment. However, there are occasions where patients who are, or who become, acutely unwell in hospital may deteriorate for a number of reasons. In rare circumstances where this deterioration is not sufficiently recognised or acted upon in a timely manner the patient may not receive timely escalation of care and may deteriorate further due to the appropriate response to the change in condition being delayed. Early recognition of a patient's deterioration through the use of observations will enable appropriate planning and escalation of care.

What we aimed to achieve in 2018/19	Outcome
Monitor number of Cardiac arrest calls and MET calls	✓
Review cardiac arrest calls outside critical care and identify themes and areas for improvement	✓
Reduction in number of cardiac arrest call (positive cardiac arrest call)	✓
Launched NEWS eLearning module and monitor staff compliance uptake	✓
Review and implement NEWS2 trust wide in line with national guidance	✓
Improve Sepsis bundle compliance	✓
Review Acute Kidney Injury (AKI) bundle and improve compliance	✓
Monitor number of patients admitted to ITU/ICU for hemofiltration as a result of AKI and identify themes and areas for improvement	✓
Improve staff compliance on completion of the standardised LNWH fluid chart	✓

This priority in 2018/19 was achieved and this will continue as a priority in 2019/20.

Continence care: partially achieved (continued from 2017/18)

An ageing population, greater prevalence of bladder and bowel problems and the wide range of care groups affected, mean that continence services require a higher priority.

Effective community-based continence services can save valuable NHS resources whilst restoring dignity to people and improving quality of life. Not all costs are financial and there is a large body of evidence about the effect of continence problems not just on the system but on people's lives. There can be considerable psychological impact and physical harm related to complications and treatments for continence problems which can lead to admission to hospital and care facilities for extended lengths of stay.

What we aimed to achieve in 2018/19	Outcome
Monitor number of monthly new referrals to the Bladder and Bowel Service and identify trends	✓
Improve response time of the service in comparison to previous year	×
Development of care pathway between primary community and secondary care	✓
Promote standardisation of continence care products across hospital sites and community	✓

This was partially achieved due to delayed response times. This has been due to limited availability of suitably trained staff. The trust is reviewing its recruitment and retention plan to put in place sustainable improvements in our staffing resource in 2019/20.

Allied health professionals: partially achieved (continued from 2017/18)

Allied Health Professionals (AHPs) are the next biggest clinical workforce in the Trust after nursing and midwifery. AHPs expertise and contribution in the management of patient care is vital in the speedy recovery of patients, reducing length of stay, inappropriate admissions and unnecessary care costs which are necessary to ensure affordable and sustainable NHS service in the future. AHP interventions can significantly reduce unnecessary hospital stay and diminish dependency on care services, resulting in significant savings and improvement in patient experience.

What we aimed to achieve in 2018/19	Outcome
Monitor therapist productivity (allocated and actual patient seen) and triangulate with staffing and workforce data	✓
95% compliance on response time for therapy input within 24 hours from time of referral (bedded units)	×
Improve waiting time for therapy input in community services	✓
Improve staff turnover rates and vacancy rates of therapist by March 2018	✓
Maintain Ealing MSK interface Surgical Conversion Rates at 80% and onward referral into secondary care at 20%	●
Address service historical service boundaries and reduce duplication and fragmentation	●
Continue monitoring of dietetics activity (new referrals and total contacts received from inpatient wards/units)	✓

The trust is reviewing therapy input, systems and processes; surgical conversion rates, boundaries, duplication and fragmentation with our commissioners across NWL to improve response times as part of our focus on safe discharge planning.

Priority 3: Improved experience (caring, responsive and well led)

Dementia: partially achieved (continued from 2017/18)

Dementia is a common condition that affects about 800,000 people in the UK. The risk of developing dementia increases as you get older and the condition usually occurs in people over the age of 65. Dementia is a syndrome (a group of related symptoms) associated with an ongoing decline of the brain and its functionality.

Dementia is a significant challenge for the NHS with an estimated 25% of acute beds occupied by people with dementia. Their length of stay is longer than patients without dementia and they are often subject to delays in discharge when leaving hospital. Patients with dementia are also more likely to come to harm than patients without dementia.

What we aimed to achieve in 2018/19	Outcome
Increase staff training compliance on dementia	✓
Continue to monitor usage of carer's passport/agreement in the bedded units through the daily safety brief	✓
Increase staff compliance Confusion Care Pathway (CCP) implementation in bedded units	✓
Conduct of Carers' experience survey to identify themes and areas for improvement	✓
Additional Reminiscence Interactive Therapy Activities (RITA) for elderly care patients in bedded units • Monitor number of activities conducted • Monitor number of participants	✓
Development and implementation of "Always Event" incorporating standards that really matters to patients and families at patient admission and discharge	●

The trust has taken the learning from the Always event pilot ward, to develop further as an integral component of dementia care, and the Trust new Dementia Strategy.

End of life care: achieved (continued from 2017/18)

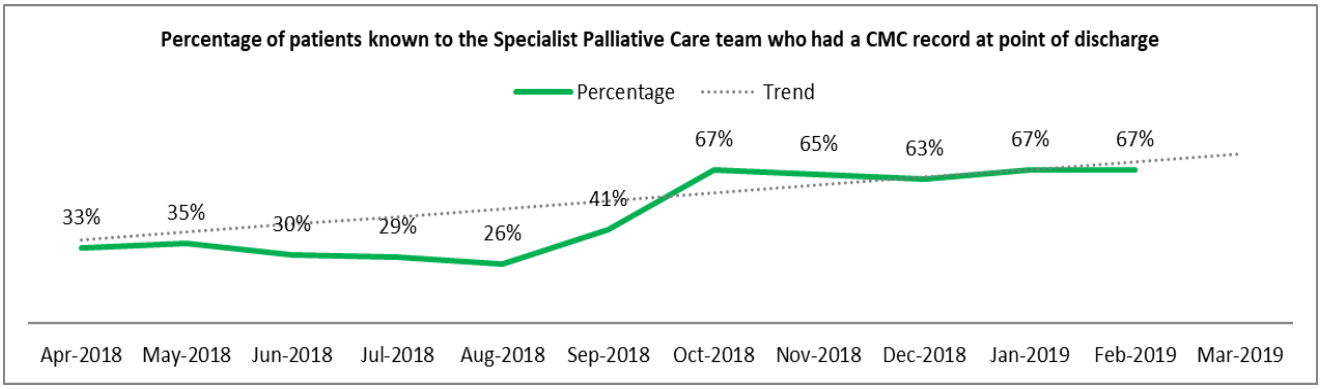
Around 500,000 people die each year in the UK. Of these deaths, 75% are not sudden, but expected (NICE 2015). How we care for the dying is an indicator of how we care for all sick and vulnerable people. It is a measure of society as a whole and it is a litmus test for Health and Social Care services' (DoH, 2008).

End of life care helps people with advanced, progressive and incurable illness to live as well as possible until the moment of death. It facilitates the identification of the supportive and palliative care needs of the patient and his or her family and carers, and delivers the care required throughout the last phase of life and (for those left behind) into bereavement.

The Trust has a duty to deliver high quality, equitable and compassionate end of life care to all patients.

What we aimed to achieve in 2018/19	Outcome
Increase percentage of patients who have died in acute setting for whom the Last Days of Life Care Agreement (LDLCA) was used to guide care	✓
Improved compliance with usage of Last Days of Life Care Agreement (LDLCA) in the acute hospitals	✓
Increase percentage of patients on pilot wards who have with completed RESPECT/TEP documentation	✓
Increase percentage of patients known to Specialist Palliative Care Team who had a CMC record at the point of discharge	✓
Learning form rolling Survey of Bereaved fed back to the End of Life Care (EoLC) group	✓
End of life complaints collated, thematically analysed and reported to the End of Life Group every two months	✓

Percentage of patients known to the Specialist Palliative Care team who had a personal plan of care.



There will be a focus on End of Life Care in 19/20 to continue to improve the care and service

End Pyjama Paralysis Campaign: partially achieved (continued from 2017/18)

We know that if patients stay in their pyjamas or gowns for longer than they need to, they have a higher risk of infection, lose mobility, fitness and strength, and stay in hospital longer. But if we can help patients get back to their normal routine as quickly as possible, including getting dressed, we can support a quicker recovery, help patients maintain their independence and help get them home sooner.

Ensuring patients get into their own clothes not only helps them to recover more quickly and changes how they are viewed by staff and the patient's family. It also has benefits for staff on the front line. It can help to build system capacity by improving patient flow, enabling more timely discharges, reducing the patient's length of stay, and enable more timely admissions for other patients.

Encouraging patients to get dressed into their own clothes and building their strength, as well as improving their mental outlook on the reason for their stay. It enhances the mental wellbeing of patients as they are encouraged to take greater responsibility for their own health and become active participants in their personal health journey. However, we do acknowledge that this is not always applicable to all inpatients in the acute hospital.

What we aimed to achieve in 2018/19	Outcome
Promote " End Pyjama Paralysis Campaign" in the bedded units trust wide	✓
Monitor the campaign through patients' feedback captured by Matrons weekly quality walkabout	●
Develop and implement monitoring of the number of patients dressed on their own clothes and had been mobilized in bedded units	×

The Trust has taken the learning from the campaign that included the need to focus on maintaining and promoting independence of all patients and is encouraging patients wherever practical to wear their own clothes. This will aid their independence, and support the focus on reducing length of stay and effective discharge planning.

As a campaign this priority underwent a high profile launch and the concept adopted within inpatient areas trust wide. Wherever possible, patients were actively encouraged to wear their own clothes promoting an improved approach to maintaining both independence and dignity.

There is evidence to suggest that this approach was embraced more by patients in some specialties than others and anecdotal information suggests that this possibly relates more to the cohort of patients within each service, than the service itself due to a number of variables relating to patient preference, laundering and availability of clothing.

Monitoring of compliance with PJ paralysis has proven more complex than initially anticipated. Following amendments within the quality metrics and monitoring profile there is limited available information with which to triangulate and validate improvements in care relating to outcomes. Learning from this experience suggests a more focused approach on promoting patient independence and optimising therapy inputs to enhance discharge planning and reduce length of stay, may meet our patients needs more appropriately. This has been incorporated into our approach for 2019/20.

Patient reported outcome measures (PROMs): achieved

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys.

The four procedures are:

- Hip replacements
- Knee replacements
- Groin hernia
- Varicose veins

PROMs have been collected by all providers of NHS-funded care since April 2009. PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected before and after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients.

What we aimed to achieve in 2018/19	Outcome
Monitor Trust data with regards to the PROMs four procedures and reported to the relevant-board committee	✓
Improve performance with regards to PROMs indicators on the four procedures	✓
Development of improvement plan as result of the PROMs data by the relevant service and monitored by the Division	✓

Saving babies lives care bundle: achieved

In November 2014, the Secretary of State for Health announced a new ambition to reduce the rate of stillbirths by 50 percent in England by 2030, with a 20% reduction by 2020. Despite falling to its lowest rate in 20 years, one in every 200 babies is stillborn in the UK. This is more than double the rate of nations with the lowest rates.

While the majority of women receive high quality care, there is around a 25% variation in the stillbirth rates across England. This presents us with opportunities to make improvements spanning both public health and maternity care services in order to make an overall improvement.

The Saving Babies' Lives Care Bundle addresses this variation by bringing together four key elements of care based on best available evidence and practice in order to help reduce stillbirth rates. It will support commissioners, providers and professionals in making care safer for women and babies.

What we aimed to achieve in 2018/19	Outcome
Review Saving Babies' Lives care Bundle with an aim of adopting in the Trust	✓
Monitor compliance with regards to Saving Babies' Lives a care bundle for reducing stillbirth compliance and performance	✓
Monitor Maternity service performance on Emergency caesarean section and benchmarked against national median/peers.	✓

Baby friendly initiative: achieved (continued from 2017/18)

Infant and young child feeding practices have a strong impact on the nutrition status of children under 2 years of age as well as on their risk for infectious diseases and mortality The World Health Organisation (WHO) recommends that breastfeeding be initiated within one hour after birth, that breastfeeding be practised exclusively for the first six months of life followed by the introduction of safe nutritious complementary foods and that breastfeeding be continued until the child is at least two years old (WHO 2002).

The WHO guidelines are backed up by a strong body of evidence indicating that optimal breastfeeding behaviours are strongly associated with lower incidence of gastrointestinal and respiratory tract infections as well as with child survival. There are several research studies demonstrating breastfeeding health benefits to the children and the mother.

Baby Friendly Initiatives (BFI) are designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways which will support optimum health and development. It's a unique programme designed to support breastfeeding and parent infant relations making the BFI accreditation status a nationally recognised mark of quality care. The overall goal for Northwick Park Hospital is to achieve a stand-alone accreditation BFI status in 2018/2019.

What we aimed to achieve in 2018/19	Outcome
Maintain NPH Baby Friendly Hospital accreditation by UNICEF	✓
Increase the breastfeeding initiation rates by 2% from previous year	✓
Achieve 80% training compliance for eligible staff	✓
Monitor and aim to reduce the incidence of re-admissions of new-born babies and mothers with breastfeeding related issues	✓
Promote user friendly public website with adequate information for new mothers and families	✓

Our focus on this priority will continue during 2019/20.

Part 3: Review of our quality performance

This section includes:

- Trust Performance for 2018/19 and 2019/20 against the NHS outcomes
- SUS Data Quality
- An overview of the patient safety incidents reporting rates and actions taken to improve incident reporting across the organisation
- An overview of Serious Incidents and Never Events
- Trust compliance with National Patient Safety Alerts
- Information on the Ward/Service Accreditation Assessment Tool - Excellence Assessment Tool (EAT)
- Duty of Candour
- Patient-led assessments of the care environment (PLACE)

The NHS outcomes framework: quality indicators (the NHS outcome framework)

Measuring and publishing information on health outcomes is important for encouraging improvements in quality. **The White Paper: Liberating the NHS** outlined the Government's intention to move the NHS away from focusing on process targets to measuring health outcomes.

The NHS Outcomes Framework reflects the vision set out in the White Paper and contains a number of indicators selected to provide a balanced coverage of NHS activity. The NHS Outcomes Framework is grouped around five domains that set out the high level national outcomes that the NHS should be aiming to improve.

Performance against the quality indicators that are relevant to London North West University Healthcare Trust are detailed below.

They relate to:

- The Summary Hospital-level Mortality Indicator (SHMI)
- Patient Reported Outcome Measures (PROMs) (Refer to Section 2)
- Readmission rate with 28 days of discharge
- The Trust's responsiveness Patient Experience
- Performance against Friends and Family Test for staff
- Performance against Clostridium difficile infection (C. diff)
- Performance against Methicillin Resistant Staphylococcus aureus (MRSA) bloodstream infection (BSI)

Standardised hospital mortality indicator (SHMI)

The most recent available standardised data for the Trust is supplied by NHS Digital for the period October 2017 to September 2018. The previous period for comparison is October 2016 to September 2017.

Prescribed information	Previous period	Current period	National average	Best performer	Worst performer
SHMI Value	0.808	0.829	1.003	0.691	1.268
SHMI Banding	Better than expected	Better than expected			
Percentage of patient deaths receiving palliative care	32.0%	34.2%	33.6%	59.5%	14.2%

The Trust is proud to have consistently low rates of mortality and is 'better than expected 'when assessed using both the Hospital Standardised Mortality Ratio (HSMR), and on the Standardised Hospital Mortality Indicators (SHMI). The Trust has the 10th lowest mortality nationally, assessed using the Summary Hospital-level Mortality Indicator (SHMI). Using HSMR we can break down mortality by site and mortality is comparably low across our sites. This is supported by our robust clinical priorities, quality of data and our learning.

The Trust considers that our low mortality is attributable to the attention paid to review of mortality and to detection and response to detection and response to the deteriorating patient. We monitor and review mortality rates weekly and during monthly meetings via the Highly Level Mortality Report and Divisional reporting within Divisional Dashboards that are submitted to the Clinical Effectiveness Committee. Learning is gathered from each patient death and the Board receives a report on the learning each quarter. Learning themes are discussed and shared within specialities and then presented to the Learning from Patient Deaths Group, for Trust-wide learning, which is well attended. Mortality Reviews are a standard agenda item on the Clinical Effectiveness Committee which meets bimonthly and each Division also has Learning from Patient Deaths as a standard agenda item on their clinical governance meetings. The Trust has also improved its recognition of the deteriorating patient, with the implementation of the new national patient monitoring system NEWS 2 and has built into quality priorities for 2019/20.

Readmission rate within 28 days of discharge

The most recent available standardised data for the Trust has been analysed using the Healthcare Intelligence Portal from Dr Foster Intelligence for the period September2017 to August 2018. The previous period for comparison is November 2016 to October 2017.

Prescribed information	Previous period	Current period	National average	Best performer	Worst performer
Patients aged 0-15	6.6%	**5.8%**	6.9%	1.0%	18.1%
Patients aged 16 or over	11.8%	**8.1%**	13.0%	2.6%	11.1%

The Trust is pleased to have improved upon last year's position, with less patients now being re-admitted to hospital. The Trust is now below the National average for both adults and children, which is a significant achievement for the Trust, but also for our local partners in the health system, who help us to care for patients in the community. As a Provider of Integrated Care the Trust is well placed to deliver as much service continuity as is possible between our hospital services and those that we provide into the community. In the past year we have worked closely to improve our discharge arrangements and look at how we can continue to integrate these with GPs and Social Care services. Each of our local boroughs has rapid response teams that can often support patients who find themselves in difficulty after their discharge from hospital. The Trusts Ambulatory Care Services continue to expand, so that we reduce the demand for beds in our hospitals, but also so that patients can return for urgent appointments that might help to avoid a re-admission to hospital.

Trust's responsiveness (patient experience of hospital care)

The most recent available data for the Trust has been supplied by NHS England for the 2017 Adult Inpatient survey completed in January 2018 and published in June 2018. The previous period for comparison is the 2016/17 survey.

Prescribed information	Previous period	Current period	National average	Best performer	Worst performer
Overall Patient Experience Score	72.3	**74.6**	78.4	88.9	71.8

Friends and Family Test for staff

The most recent available data for the Trust has been supplied by NHS England for the period April 2018 to June 2018. The previous period for comparison covers the three publications in 2017/18. Staff FFT data is not collected for Quarter 3 when the national staff survey is active.

Prescribed information	Previous period	Current period	National average	Best performer	Worst performer
Staff who would recommend the Trust as a provider of care to family and friends	Q4: Not available Q2: 71.6% Q1: 69.1%	**71.6%**	81.4%	53.6%	98.4%

The trust continues to engage in our HEART values and putting patients at the HEART of everything that we do. Divisions encourage all staff to give FFT survey forms to all patients to increase response rate. Continue working with the Matrons, ward managers to review and improve results. Divisional action plans to improve performance are monitored by the Patient Experience Committee.

VTE risk assessment

The most recent available data for the Trust has been supplied by NHS Improvement for the period October 2018 to December 2018. The previous period for comparison covers the previous two publications in 2018/19.

Prescribed information	Previous period	Current period	National average	Best performer	Worst performer
Adult inpatients who have been risk assessed for VTE on admission	Q2: 86.4% Q1: 81.5%	**92.1%**	95.6%	100.0%	54.9%

C. Difficile Infection Rate

The most recent available data for the Trust has been supplied by Public Health England for the period April 2017 to March 2018. The previous period for comparison was April 2016 to March 2017.

Prescribed information	Previous period	Current period	National average	Best performer	Worst performer
Clostridium difficile (C. diff) infection rate per 100,000 bed-days (patients aged 2 or over)	11.7	**11.0**	13.7	0.0	91.0

MRSAB infection rate

The most recent available data for the Trust has been supplied by Public Health England for the period April 2017 to March 2018. The previous period for comparison was April 2016 to March 2017.

Prescribed information	Previous period	Current period	National average	Best performer	Worst performer
Methicillin Resistant Staphylococcus aureus (MRSA) bloodstream infection (BSI) rate per 100,000 bed-days	3.2	**1.0**	0.8	0.0	5.7

Secondary users service: quality data

London North West Healthcare NHS Trust submitted records during 2018/19 to the Secondary Users 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 provisional data for the period April 2018 to December 2018 that included the patient's valid NHS Number was:

- 98.7% for admitted patient care;
- 98.4% for outpatient care; and
- 96.3% for accident and emergency care.

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

- 100.00% for admitted patient care;
- 100.00% for outpatient care; and
- 100.00% for accident and emergency care.

The Trust is working to improve its clinical coding audit capability with full results not yet available for 2018/19. The interim results suggest accuracy levels of 88% for Primary Diagnosis is 89.9% for Secondary Diagnosis and 81.7% for Primary Procedures.

The Trust improves data quality through:

- Regular review of and compliance with the Trust Data Quality Policy through cleansing, audit and feedback to clinical and non-clinical teams.
- Working closely with clinicians to ensure the accuracy of coded data through regular and ad hoc joint reviews and through an education programme.
- Reviewing the level of risk associated with data quality through the Data Quality Management Group and the Corporate Quality and Risk Committee.
- Continuing the data quality assurance programme ensuring key elements of information reporting including data assurance, presentation and validation are delivered within national guidance and standards.
- Validation of 18-week referral to treatment time (RTT) and cancer pathways through audit, validation and education of both clinical and non-clinical teams.

Information Governance has this year has seen the introduction of two new related legislative requirements that focus on the protection of data and the increased rights of the data subjects. These new laws (Data Protection Act (DPA) 2018 and General Data Protection Regulation (GDPR), EU Legislation), have required an overall review of IG practices and procedures.

Transparency in relation to people's data is at the forefront of this and we have provided guidance and a detailed privacy policy to help our users. We have also been asked to self-assess our IG practices against a new Data Security and Protection Toolkit (formerly the Information Governance Toolkit). The Trust has been internally audited to review our

progress in the last year and we will continue to develop and improve our systems and processes to ensure the security and availability of the data (personal information) the Trust holds.

Overview of patient safety incidents

The Trust aims to provide care that is safe, effective and high quality for all patients and service users. The Trust's risk management system is designed to support this aim and is based on an open, honest, transparent culture of learning from experience underpinned by a systematic approach to managing Patient Safety Incidents. This cultural approach fully adheres to national guidance from a staff and patient perspective, including the Management of Health and Safety at Work Regulations (1974) and the Sign up to Safety campaign.

Serious incidents in healthcare are relatively uncommon but when they do occur the NHS has a responsibility to ensure that there are systemic measures in place for safeguarding people, property, NHS resources, and reputation. This includes responsibility to learn from these Patient Safety Incidents in order to minimise the risk of them happening again. The Trust takes this responsibility very seriously. It continues to build its safety culture (i.e. a high level of incident reporting); and improve its reporting culture, which stresses the significance of effective incident management. Incident reporting is a fundamental tool of risk management, the aim of which is to collect information about adverse incidents, including near misses, ill health and hazards, which will help us to facilitate wider learning across the organisation.

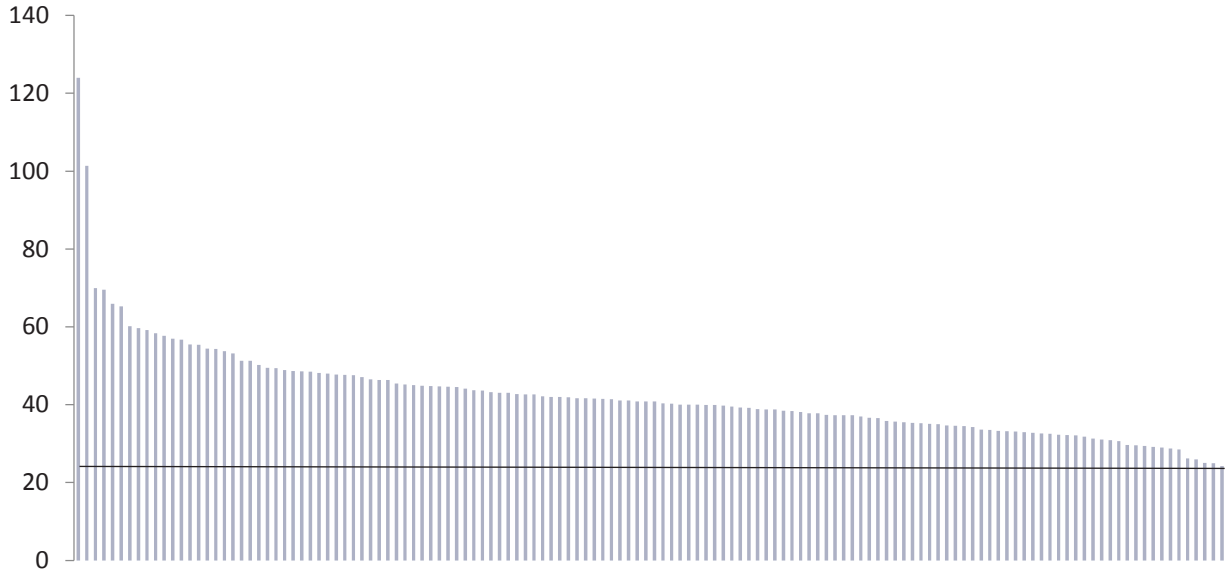
Figures 1 and 2 are taken from the latest National Reporting and Learning Service (NRLS) data report published in September 2018 for the period October 2017 - March 2018 and shows the Trust to be below average for reporting of patient safety incidents. The latest report covers incidents occurring between October 2017 and March 2018 and submitted to the NRLS on or before 31 May 2018. During this period 33.15 incidents per 1,000 bed days were reported.

The Corporate Clinical Governance Team ensures that detailed screening and quality checks of incident reports takes place before uploading to ensure accuracy of data, applicability to NRLS and that there are no breaches of confidentiality. The team prioritises the severe and catastrophic incidents and the detailed screening of these can result in delays in uploading incidents that are categorised as having lower harm or are near misses.

Uploaded data is analysed by NHSI and published every six months, in arrears, in the Organisation Patient Safety Incident reports. In addition, monthly statistics for provider organisations is published on the NHSI website. Please note this is not the number of patient safety incidents that have been reported in the Trust onto Datix, but the number of those screened and uploaded to the NRLS.

Training is provided at induction and at mandatory updates. In addition, training is now targeted at those departments and services with low reporting or falling trends in reporting.

Patient safety incidents per 1000 admissions for the period of 2018/19



As per best practice, the Trust uploads relevant clinical incidents reported from its incident reporting system (Datix) to the NRLS system once a month. Recent analysis shows the Trust has been an outlier compared to the cluster for taking longer to upload the data to NRLS. Work has been undertaken to improve the Trusts reporting times and the next NRLS report will be analysed to determine the effectiveness of these actions.

If an incident is reported that, based on the initial information, appears to have resulted in Serious Harm or Death, the Trust will upload this incident to the NRLS earlier than the date of the next batch upload. This supports shared learning and an open and honest management of incidents and risk. Those incidents which resulted in Serious Harm or Death will be the subject of a detailed Root Cause Analysis investigation. It is not unusual to establish during the gathering of information for the investigation, or at a later stage that the harm suffered or the patient's death was not as a result of an untoward incident, but was as a result of the patient's condition or disease. At this point the incident record on Datix will be updated to reflect this new information, however, this update will not be reflected in published NRLS reports unless the amendment is made before the reporting cut-off date and as a result there may be an over-reporting discrepancy between the number of incidents with Serious Harm or Death on the NRLS system compared to the more up to date information maintained by the Trust on Datix.

There were a total of 7288 (decrease from 7823 in the previous 6 month period) incidents that occurred between 1st October 2017 to 31st March 2018 that were uploaded to the NRLS between 1st October 2017 and 31st May 2018. Of these, 21 resulted in Severe Harm (down from 27 last year) and 12 contributed to the patient's death (up from 19 last year) as the result of an untoward incident. Serious incident investigation reports are uploaded to the Clinical Governance site on the Trust intranet to disseminate learning and recommendations to frontline staff.

The 5 most frequently reported incident types within our reporting cluster compared with the number reported by the Trust. The Trust profile in the Implementation of care and ongoing monitoring / review category does appear different from the cluster. The variance is attributed to a greater number of pressure ulcers that fall within this category and is due to the inclusion of community services in our “acute” organisation categorisation. Measures have been implemented to reduce the number of pressure ulcers developed and this has seen a general decrease in the number of pressure ulcers developed and with greater decrease in the most severe grades of pressure ulcers.

There has been an increase in the amount of training delivered to frontline staff to raise awareness of the need to report all incidents and near misses. This has seen a steady rise in the number of incidents reported onto the Datix system year on year.

The Trust has reported higher than the cluster for access, admission, etc. (Figure 6) In this category the highest reported issues have been the need to admit patients to beds that have breached the “Single sex accommodation” (SSA) requirements, delay in admitting patients due to operational pressures and patients who decide not to wait for treatment, once registered.

A number of actions were developed and undertaken resulting in increased incident reporting. There are ongoing efforts to improve staff awareness of incident reporting procedures, openness of reporting and to increase the number of incidents reported including:

- Reviewing areas of poor incident reporting as part of the Divisional Governance Deep Dive reports.
- Review of the incident and risk management training to further meet the demands of teams.
- Work with individual teams to review themes and trends of incidents reported and identification of lessons to learn e.g. patient’s falls and pressure ulcers.
- The reporting of real-time data and learning from incidents reported to groups and committees with the responsibility for oversight of patient safety.
- In partnership with the Communications team, the publication of the lessons learned information.
- Development and implementation of a module within the Datix system to meet the requirements of Learning from all patient Deaths and developing procedures to share and learn from this information not just within patient safety, but also, audit and effectiveness and clinical claims.

Duty of candour (DoC) compliance

Routinely, the Divisions are required to complete relevant DoC sections on Datix and ensure the DoC letter is uploaded to the system. Non-compliance of Trust internal policy is confirmed when the recorded verbal DoC is not implemented within 10 days of the incident being identified. Since April 2018 a total of 6 verbal DoC requirements were confirmed not to be aligned with the 10-day time limit. This is shown below in table 1. It is worth noting that

the severity of incidents can be downgraded or upgraded should new evidence become apparent in the future. This may be some months or years after the event.

Patient safety alert compliance

Patient safety alerts are used to inform the healthcare system of recognised safety risks and offer appropriate guidance for the prevention of incidents that may result in severe harm or death to patients. These alerts are issued through the Central Alerting System (CAS) which is a web-based cascade tool utilised for issuing alerts, public health messages and useful safety information to the NHS and other healthcare organisations.

Patient safety alerts can be issued for a number of reasons. Alerts can be issued for emerging or newly recognised patient safety issues where there is a potential for incidents to cause death or severe harm to a patient and where many healthcare providers will have limited knowledge or experience of the risk. Alerts can also be issued where there is a common problem occurring throughout the NHS and can be an important part of a wider programme of work.

Systems and equipment are commonly subject to patient safety alerts where there are recognised errors or faults and would therefore require action to be taken to reduce the risk to patient safety. Coordination of patient safety alerts is carried out by the Corporate Clinical Governance Team, who work with various Trust departments to facilitate compliance and monitor ongoing work or action plans used to address the issues raised.

Serious incidents and never events

A serious incident (SI) is described as “any event which has given rise to potential or actual harm or injury, to patient dissatisfaction or to damage/loss of property" (Ref:

NHS Executive). This definition includes patient/service user injury, fire, theft, vandalism, assault and employee accident and near misses. The Trust reviews reported incidents against the classification of a Serious Incident (SI) as defined within the Serious Incident Framework (NHS England, 2015). In broad terms "serious incidents are events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation’s ability to deliver ongoing healthcare". All SIs are fully investigated in line with the national guidance and are internally scrutinised by the Serious Incident Review Group before their submission externally.

The Trust is committed to working in an open and honest environment and this includes supporting staff to report incidents. All potential Serious Incidents are discussed at the Serious Incident Review Group, held weekly, chaired by the Deputy Chief Nurse or the Director of Corporate Affairs. The meeting is attended by Divisional Triumvirate and the Divisional Clinical Governance team. Lead investigators are also invited to present

completed SI reports which are discussed for quality assurance before the reports are sent to the Commissioners, NHSI or CCG as appropriate.

The Trust aims to establish the root causes of incidents to understand these and ensure lessons are learnt through monitoring of actions and ensuring suitable improvements are made to minimise any further recurrence.

Not all SI will result in harm to a patient; consideration is given to the level of potential harm or disruption to service. These can include near misses, as well as looking at cluster events where a pattern of lower harm events are occurring. Clusters may become apparent during the management of individual incidents or whilst incident reporting is being reviewed at Divisional and Trust level.

These are all events that the Trust believes to be worthy of investigation by an Independent Panel and/or falls into the category of an incident that must be reported to the local Commissioning agencies. Table 2 below shows the number of Never Events and SIs declared in April 2018 to Feb 2019 in comparison to April 2017 to March 2018.

The Trust has seen a reduction in most categories of Serious Incidents over the past year, with the highest reduction in Pressure Ulcers, Unexpected Deaths, Missed Diagnosis and Delayed Diagnosis and an increase in Patient Falls, Medication, Surgical/Treatment Errors, Unexpected Outcomes and Delayed Treatments.

Last year a key theme in investigations into Serious Incidents was around complications with Chest Drains and the investigations observed gaps in two existing policies within the Trust. As a result a task and finish group was established with operational & corporate nursing involvement to review the existing policies (update the policy and with recommendations on the removal of the drains - pig-tail chest drain) and carry out training need analysis and roll out training programme.

Never events

A Never Event (NE) is an event that should never happen and a pre-defined list is provided under the Never Event framework. The Never Events Framework was updated, where although the list of never events was not changed, the ‘need for harm’ has been removed from all incidents so that it is the event itself that triggers the ‘Never Event’ and not the outcome.

Since the beginning of the current financial year, the Trust has reported 5 Never Events which is the same number as reported in 2017/18. The level of harm in these incidents have been minor (with one resulting in readmission for 2 days and observations were stable throughout the admission) whilst others resulted in ‘low’ and ‘no harm’ to patients.

The Trust continues to review the Serious Incident reporting and management process to improve the timely management of these investigations. Although the Trust has not achieved its target of 100% of Serious Incident reports being submitted within 60 days, there has been an overall reduction in the number of Serious Incidents reported. Work continues to support the shared learning initiative of the monthly ‘learning from our mistakes’ information shared via screen savers and the monthly staff news mail. Further

work is planned to carry out an audit to analyse the compliance and assurance of completed actions derived from Serious Incident investigations.

Quality metrics

EAT Assessments

The EAT assessment questions have been aligned with the CQC key lines of enquiries (KLOEs) and incorporated into the five CQC domains, assessing if the ward is safe, caring, effective, responsive and well-led and given ratings if outstanding, good, requires improvement and inadequate.

The methodology used during the assessment process includes the following:

- Observation of care given and patients' documentation
- Discussion with patients and staff members
- Discussion with the Department Senior Sister/Charge nurse

It is a requirement that the auditor is not operational in the area they are assessing in order for the process to be seen as objective.

To ensure the process is both robust and reflects clearly the standard of care being delivered within a clinical setting, performance and outcome data is also used alongside these audits and is triangulated with the information obtained during the assessment process.

To improve further the process and ensure that the audits are appropriate to the specialty, questions have been reviewed and audits have been tailored to reflect the standards required for areas such as A&E, Maternity, Paediatrics, Neonatal Unit, Radiology, Endoscopy, Theatres, Surgical Intensive Recovery Unit, Intensive Therapy Unit, Theatre Admissions Unit and Recovery.

All clinical areas are reviewed quarterly to ensure that they meet the expected standards and continue with improvement plans as required. Once the assessment is completed an action plan is generated by the Ward manager, Matron and Head of Nursing for that area. Any elements of the 5 domains which scores red require early improvement plans put in place and are re- audited within 1 month. Completed action plans are monitored by the Divisional Heads of Nursing, who provide regular updates to the Chief Nurse and at relevant committee meetings.

To ensure transparency each ward / department displays its individual results on the Quality Board. These are for patients, relatives and visitors to view as part of our drive to be more transparent and accountable for the standards on that ward.

EAT assessment templates are ready to roll out within the Out Patient settings and Community to ensure a consistent approach with auditing Trust wide.

Matrons weekly walkabout

All Acute wards and Community areas have been conducting a weekly Matrons Quality Walkabout inspection, which is undertaken by their respective matrons. The methodology includes talking to staff and patients as well as observations and reviewing documentation.

The weekly walkabout provides a consistent tool for documenting evidence relating to standards of care in the clinical areas, with an opportunity to provide appropriate support at the time of the audit depending on the findings.

Matrons Quality Walkabout has now been rolled out to all the Outpatient Areas within the Trust.

There is a continual drive to review and improve both audit tools to ensure they are easy to use with relevant questions and are updated to capture areas which require improvements. This process is undertaken with involvement and engagement from the Matrons, Heads of Nursing and the Ward Managers to ensure ongoing feedback.

Safer staffing

LNWH has adopted a robust application of the National Quality Board guidance on safe staffing. Services and wards capture staffing levels, patient acuity and data on quality nurse sensitive indicators twice a day, this includes information on the CHPPD. The data is reported to the Trust Board along with national and peer organisation benchmarking analysis provided through the Model Hospital dashboard.

Ward managers' report on a daily and weekly basis to the DHON escalating areas where staffing levels are in exception, any variance and reasons for this. Daily safety brief/safety

huddle are conducted across bedded units and district nursing services where staffing resources are managed based on patient acuity and dependency and caseloads.

The CQC inspection was undertaken in March 2018 and identified concerns relating to vacancy rates, use of temporary staff and feedback in some of the areas reviewed was negative. The Interim Director of Nursing requested support from NHSI in regard to workforce and as part of the undertakings, NHSI stipulated that a safer staffing review be undertaken.

In November 2018 the Trust has obtained the Imperial Innovations Safer Nursing Care Tool (SNCT) recommended by NHSI and is now using this tool to calculate the six monthly establishment and staffing level reviews which is reported to the Trust Board.

Further training by NHSI on the safer nursing care tool and the application of acuity descriptors has been arranged for May 2019 and is ongoing.

Model Hospital Data (CHPPD) and quality markers are being used alongside SNCT. Support and training for on using and applying the data in the Model Hospital is in progress with senior nurses and ward managers/matrons.

The Trust has enhanced the training on e-Roster and improved the visibility of data from e-Roster in the form of an Insight report. During 2019 the quality and productivity of rosters will be monitored across operational divisions.

Patient-led assessments of the care environment (PLACE)

Patient led assessments of the care environment (PLACE) are self-assessments of a range of non-clinical services which contribute to the environment in which healthcare is delivered. They are carried out on an annual basis between February and June and NHS Digital oversees the process. The assessments are unannounced and the assessment team makes their decisions based entirely on the observations made at the actual time of the assessment. Patient Assessors make up at least 50% of the assessment team, thus providing us with an effective and independent patient voice.

PLACE is also an integral part of the Trust's Quality Account, which demonstrates the Trust's commitment to continuous, evidence-based quality improvement. In addition, each year the

Part 4: Statement of assurance

Statements of assurance from the Board include:

- review of services
- participation in clinical Audit
- participation in clinical research
- goals agreed with commissioners (CQUINS)
- what other says about the Trust – Care Quality Commission
- data Quality, information governance and Clinical Coding
- staff survey

Review of services

During 2018/19, LNWH provided.

- Emergency Department
- admitted patient care for planned and emergency treatment
- critical care
- non-admitted patient care
- maternity Services
- integrated community services

LNWH has reviewed all the data available to them on the quality of care in these relevant NHS services.

The income generated from services listed below in 2018/19 represents 98% review of the total income generated from the provision of relevant health services by the Trust for 2018/19.

These services covered the following specialties:

- emergency department
- anaesthetics (op only)
- anticoagulant service
- audiological medicine
- audiology
- breast surgery
- cardiology
- clinical genetics
- clinical haematology
- clinical oncology (previously radiotherapy)
- colorectal surgery
- community dental
- community paediatric
- community TB Service
- community continence nursing service
- community stoma service
- critical care medicine
- diabetic medicine
- district nursing service
- endocrinology
- endoscopy
- ear nose and throat
- gastroenterology
- general medicine
- general surgery
- genito-urinary medicine

- nutrition and dietetics
- obstetrics
- occupational therapy
- ophthalmology
- orthodontics
- paediatric audiological medicine
- paediatric cardiology
- paediatric clinical immunology and allergy
- paediatric diabetic medicine
- paediatric ear nose and throat
- paediatric endocrinology
- paediatric gastroenterology
- paediatric gastrointestinal surgery
- paediatric infectious diseases
- paediatric maxillofacial surgery
- paediatric medical oncology
- paediatric nephrology
- paediatric neuro-disability
- paediatric neurology
- paediatric ophthalmology
- GUM & integrated sexual & reproductive health services
- gynaecology
- health visiting
- school nursing
- infectious diseases
- integrated dermatology
- integrated respiratory
- intestinal failure unit
- maxillofacial surgery
- medical oncology
- midwife episode
- neonatology
- nephrology
- neurology
- paediatric respiratory medicine
- paediatric rheumatology
- paediatric surgery
- paediatric trauma and orthopaedics
- paediatric urology
- paediatrics
- pain management
- palliative medicine
- physiotherapy
- integrated rehabilitation & reablement
- podiatry
- psychotherapy
- restorative dentistry
- rheumatology
- speech and language therapy
- stroke and rehabilitation service
- tissue viability
- trauma and orthopaedics
- trustplus
- urology
- vascular surgery

Our overriding focus is to ensure that quality is at the heart of everything we do as we strive for continuous quality improvement, transformation, and personalised care for the care we give and the services we provide. In order to ensure that quality is given the highest priority we formally report on our progress against our quality priorities through our governance and committee structure to the Board of Directors, our regulators NHSI, CQC, our commissioners and from 19/20 the STP.

Participation in clinical audits

Clinical audit is an essential activity for all healthcare organisations, as it is used to evaluate clinical practice and identify areas for improvement.

As an organisation we encourage all services to review the care they deliver by undertaking local and national clinical audits.

During 2018/19 the Trust has conducted 143 local audits.

The Trust participated in all relevant national clinical audits, as these audits allow services to compare their practice with other similar Trusts and to benchmark their services.

Each year, the Healthcare Quality Improvement Partnership (HQIP) publishes a quality account list on behalf of NHS England detailing national clinical audits, clinical outcomes review programs and registries that NHS England would like each health service provider to report on. During 2018/19, a list of 73 national audits was published; of which 60 were applicable to services provided by the Trust.

During the period of April 2018, to March 2019, the Trust participated in all 60 national clinical audits and all 3 national confidential enquiries. Not all of the national audits were applicable to each site; therefore, participation has been broken down by site for the period:

- Central Middlesex Hospital participated in 100% (36/30) national clinical audits and 100% of national confidential enquiries which it was eligible to participate in
- Ealing Hospital participated in 100% (48/48) of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in
- Northwick Park and St. Mark’s Hospital participated in 100% (59/59) of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

Table 1: The national clinical audits that the Trust participated in are listed alongside the number of cases submitted and the percentage of cases required nationally

Name of national audit / clinical outcome review programme	Eligible to participate	CMH	EH	NPH / SMH
Adult cardiac surgery	N/A	N/A	N/A	N/A
Adult community acquired pneumonia 2018/19	Yes	N/A	Audit in progress	Audit in progress
BAUS Urology: cystectomy 2014-17	Yes	N/A	N/A	64/64 (100%)
BAUS Urology: nephrectomy 2015-17	Yes	N/A	N/A	66/66 (100%)
BAUS Urology: percutaneous nephrolithotomy 2015/17	Yes	N/A	N/A	187/187 (100%)
BAUS Urology audits: radical prostatectomy 2015/17	Yes	N/A	N/A	123/123 (100%)
Cardiac rhythm management 2017/18	Yes	82/82 (100%)	71/71 (100%)	280/280 (100%)
Case mix programme 2016/17	Yes	N/A	205/205 (100%)	124/124 (100%)
Child health clinical outcome review programme NCEPOD - long term ventilation 2018/19	Yes		No questionnaires requested from National team yet	
Elective surgery (national PROMs Programme) for hip and knee replacements 2017/18	Yes		534/721 (74%)	
Falls and fragility fractures audit programme 2018/19	Yes	In progress	In progress	In progress
Feverish Children (care in emergency departments) 2018/19	Yes	N/A	N/A	120/120 (100%)

Name of national audit / clinical outcome review programme	Eligible to participate	CMH	EH	NPH / SMH
Fresh frozen plasma neonates & children; national comparative audit of blood transfusion 2018/19	Yes	N/A	N/A	4/4 (100%)
Inflammatory bowel disease programme 2017/18	Yes		722 Trust-wide submissions are continuous	
Inflammatory bowel disease programme 2018/19	Yes		865 Trust-wide submissions are continuous	
Learning disability mortality review programme 2018/19	Yes		Trust-wide submissions are continuous	
Major trauma audit 2017	Yes	N/A	172/172 (100%)	239/239 (100%)
Mandatory surveillance of bloodstream infections and clostridium difficile infection	Yes		Trust-wide submissions are continuous	
Maternal, new-born and infant clinical outcome review programme 2017	Yes	N/A	N/A	Neonatal /stillbirth 37/37 (100%) Maternal deaths 0/0
Medical and surgical clinical outcome review programme -pulmonary embolism 2018/19	Yes	Organisational 1/1 (100%)	Clinical 4/4 (100%) Organisational 1/1 (100%)	Clinical 2/2 (100%) Organisational 1/1 (100%)
Mental health clinical outcome review	N/A	N/A	N/A	N/A
Major haemorrhage national comparative audit of blood transfusion programme 2018/19	Yes		10/10 (100%)	
Myocardial ischaemia national audit project 2017/18	Yes	12/16 (75%)	388/402 (97%)	761/868 (88%)
National asthma and COPD audit programme 2018/19	Yes	In progress	In progress	In progress

Name of national audit / clinical outcome review programme	Eligible to participate	CMH	EH	NPH / SMH
National audit anxiety and depression	N/A	N/A	N/A	N/A
National audit of breast cancer in older people 2011/15	Yes		400 Trust-wide submissions are continuous	
National audit of breast cancer in older people 2014/16	Yes		324 Trust-wide submissions are continuous	
National audit of cardiac rehabilitation 2018/19	N/A	N/A	N/A	N/A
National audit of care at the end of life 2017/18	Yes		80/80 (100%)	
National audit of dementia 2018/19	Yes	27/27(100%)	51/51(100%)	54/54(100%)
National audit of intermediate care 2018/19	Yes	Willesden Unit 45/50 (90%) Rehabilitation 54/60 (90%) Reablement 18/20 (90%)	Clayponds 49/49 (100%)	STARRS 1/1 (100%)
National audit of percutaneous coronary interventions 2018	Yes	N/A	185/185 (100%)	536/536 (100%)
National audit of pulmonary hypertension (specialist) 2018/19	N/A	N/A	N/A	N/A
National audit of seizures and epilepsies in children and young people 2018/19	Yes	N/A	Audit in progress	
National bariatric surgery 2018/19	N/A	N/A	N/A	N/A
Bowel cancer audit 2016/17	Yes		256/288 (89%)	

Name of national audit / clinical outcome review programme	Eligible to participate	CMH	EH	NPH / SMH
Bowel cancer audit 2017/18	Yes		281 Trust-wide submissions are continuous	
National cardiac arrest audit 2018/19	Yes	N/A	19/20 (95%)	93/93 (100%)
National clinical audit for rheumatoid & early inflammatory arthritis 2018-19	Yes	In progress	In progress	In progress
National clinical audit of psychosis 2018-19	N/A	N/A	N/A	N/A
National clinical audit of specialist rehabilitation for patients with complex needs following major injury 2018-19	Yes	N/A	In progress	In progress
Congenital heart disease	N/A	N/A	N/A	N/A
National diabetes audit: foot care	Yes	In progress	In progress	In progress
National diabetes audit: inpatient	Yes	In progress	In progress	In progress
National pregnancy in diabetes audit 2016-17	Yes	N/A	N/A	1/1 (100%)
National emergency laparotomy audit 2016-17	Yes	N/A	38/56 (68%)	147/247 (60%)
National heart failure audit 2017-18	Yes	34/37 (92%)	341/303 (113%)	674/853 (79%)
National joint registry 2017/18	Yes	721/747 (97%)	8/15 (53%)	22/46 (48%)
National lung cancer audit 2017	Yes		312 Trust-wide submissions are continuous	
National lung cancer audit 2018	Yes		241 Trust-wide submissions are continuous	

Name of national audit / clinical outcome review programme	Eligible to participate	CMH	EH	NPH / SMH
National maternity and perinatal audit	Yes	N/A	N/A	5522/5522 (100%)
National mortality case record review programme	Yes		Trust-wide submissions are continuous	
National neonatal audit programme 2018	Yes	N/A	N/A	460/460 (100%)
National oesophago-gastric cancer April 2015 to March 2017	Yes		209 Trust-wide submissions are continuous	
National oesophago-gastric cancer April 2017 to March 2019	Yes		111 Trust-wide submissions are continuous	
National ophthalmology audit 2016/17	Yes	962/962 (100%)	N/A	N/A
National paediatric diabetes audit 2016/17	Yes	N/A	124/124(100%)	262/262(100%)
National prostate cancer audit April 2015 to March 2016	Yes		260 Trust-wide submissions are continuous	
National prostate cancer audit April 2016 to March 2017	Yes		247 Trust-wide submissions are continuous	
National vascular registry 2017	Yes		440 cases Trust-wide submissions are continuous	
Neurosurgical national audit programme	N/A	N/A	N/A	N/A
Non-invasive ventilation - adults 2018/19	Yes	N/A	Not yet due	Not yet due
Paediatric intensive care	N/A	N/A	N/A	N/A
Prescribing observatory for mental health	N/A	N/A	N/A	N/A

Name of national audit / clinical outcome review programme	Eligible to participate	CMH	EH	NPH / SMH
Reducing the impact of serious infections (antimicrobial resistance and sepsis) 2018/19	Yes		Trust-wide Submissions are continuous	
Sentinel stroke national audit programme 2016/17	Yes	N/A	N/A	Submissions are continuous
Serious hazards of transfusion: UK national haemovigilance 2018	Yes		32/32 (100%)	
Seven day hospital services 2018/19	Yes	N/A		227/230 (99%)
Surgical site infection surveillance service 201/18	Yes		Hip 212/244 (87%) Knee 442/502 (88%)	
UK cystic fibrosis registry	N/A	N/A	N/A	N/A
Vital signs in adults (care in emergency departments) 2018/19	Yes	N/A	120/120 (100%)	120/120 (100%)
VTE risk in lower limb immobilisation (care in emergency departments) 2018/19	Yes	N/A	21/21 (100%)	52/52 (100%)

Reports received during 2018-2019

33 National Clinical Audit Reports were published and recommendations were put into action by the Trust during the period. Below is a summary of the main changes made to services as a result of these national recommendations.

Integrated Clinical Services Division

Service	Site	Title	Date published	Changes or improvements made to clinical care:
Blood transfusion	Trust-wide	National comparative audit of blood transfusion audit programme - patient blood management in adults undergoing scheduled surgery 16/17 (re-audit)	Oct 17	Training has been delivered to staff to enable them to identify patients who are anaemic at pre-operative assessment clinics and care pathways have been established. To support the training programme Trust-wide communication streams and screen savers have been used to educate staff about the need to assess these patients for anaemia.
Blood transfusion	Trust-wide	National comparative audit of blood transfusion programme 2017/18 (red cell platelet transfusion in adult haematology patients)	Mar 18	The Trust has developed an annual audit programme to continuously assess compliance with local blood transfusion guidelines. Clinical and nursing staff are provided with regular training on patient blood management. Staff are made aware of NICE guidance for transfusion thresholds through screensavers and the NHS BT Blood Components app.

Service	Site	Title	Date published	Changes or improvements made to clinical care:
Physiotherapy	NPH	National Parkinson's audit 2017/18	May 18	An annual development session has been delivered to staff on Parkinson's to ensure that all staff are updated. Additional staff have been allocated to the service to ensure the availability of appointments for patients and to maintain the service of the neurology outpatient physiotherapy service

Integrated Medicine Division

Service	Site	Title	Date published	Changes or improvements made to clinical care:
Cardiology	CMH	National cardiac arrest audit (NCAA) 2015/16	Jun 16	ILS training has been moved to Central Middlesex Hospital to increase training provision for staff and as a result of the recommendations, resuscitation officer regularly attends the site.
	EH	National cardiac arrest audit (NCAA) 2015/16	Jun 16	ILS training has been continually delivered to staff at the Ealing Hospital emergency department site.
	NP	National cardiac arrest audit (NCAA) 2015/16	Jun 16	Local audit has showed a compliance of over 90% of key information on completed DNAR forms.

Service	Site	Title	Date published	Changes or improvements made to clinical care:
	CMH	National cardiac arrest audit (NCAA) 2015/16	Jun 17	16 Resuscitation training courses have been delivered on the Central Middlesex site 2016/17. To improve data submission for this national audit, data is held locally and then submitted nationally. The national audit forms are consistently reviewed on collection and are supported by the continued provision of educational sessions on the quality of data collection. Incidents of cardiac arrest are routinely entered on Datix as a clinical incident and reviewed. Data showing wards with high incident rates are reported back to the deteriorating patient group for action.
	EH / NP	National cardiac arrest audit (NCAA) 2016/17	Jun 2017	PILS training courses continue to be delivered at Ealing Hospital on an on-going monthly basis. To improve data submission for this national audit, data is held locally and then submitted nationally. The national audit forms are consistently reviewed on collection and are supported by the continued provision of educational sessions on the quality of data collection. Incidents of cardiac arrest are routinely entered on Datix as a clinical incident and reviewed. Data showing wards with high incident rates are reported back to the Deteriorating Patient Group for action.

Service	Site	Title	Date published	Changes or improvements made to clinical care:
Elderly care	CMH / EH / NP	National audit of dementia 2016/17	Jul 2017	The national audit found that good nutritional food is provided for patients, all clinical staff have access to dementia training. Development of assessment and management of patients with delirium are in process.
	NP	Sentinel stroke national audit programme (SSNAP) 2016-17	Nov 2017	The national audit found that we are one of the leading stroke units in England; there were no recommendations to implement. The team will continue work to deliver high standards of care
Endocrinology	CMH / EH / NP	National diabetes audit adult (ANDA)	Jan 2016	Training has been delivered on the **10 point diabetes** on insulin and reducing medicine management errors. Proposals have been put forward to have glucose monitoring systems integrated to central computers.
Neurology	EH	National Parkinson's audit 2017/18	Mar-18	Parkinson's patients and their carers now have access to booklets discussing the medications used in Parkinson's and their side effects. These are given by the Parkinson's nurse specialist to increase patient and carer knowledge.

Service	Site	Title	Date published	Changes or improvements made to clinical care:
	NPH	National Parkinson's audit 2017/18	Mar-18	The service has a new information pack for Parkinson's patients and their carers that contains information from the Parkinson's UK support group; giving email, telephone and website support information. The pack includes information about the support available for carers and the roles of the different healthcare professions caring for with patients with Parkinson's.
	CMH	National Parkinson's audit 2017/18	Mar-18	To improve the assessment of Parkinson's patients, Parkinson's assessment forms have been developed by neurology. These are now available across the wider Trust.
Respiratory medicine (acute)	Trust-wide	National lung cancer audit - NCLA 2014 and 2015	Jan-17	To improve the service for patients, Northwick Park Hospital is currently involved in RM partner's project to determine whether new National optimal pathway in lung cancer is feasible. This covers early diagnosis to treatment. The pathway aims to achieve diagnosis by day 21 and treatment by day 49. The Trust is also working with Infoflex to integrate the detailed lung pathway tracker developed for the project.

Surgery Division

Service	Site	Title	Date published	Changes or improvements made to clinical care:
Colorectal surgery	EH /NP	National bowel cancer audit Programme (NBOCAP) 2014/15	Dec 2016	The service conducts yearly local audits to improve the quality of the data being submitted. Regular spot checks are undertaken to ensure that information is populated and accurate prior to national submission. A National Institute of Clinical Excellence (NICE) audit was conducted locally which indicated that the patients being treated by the Trust are those with stage 3 and 4 cancers (not early cancers).
	EH / NP	National bowel cancer audit programme (NBOCAP) 2015-16	Dec 2017	The Trust has continued to improve the quality of the data being submitted to this national audit. An audit co-ordinator role is now in place for both Ealing and St. Mark's Hospitals, providing monthly information to the cancer surgeons for review. Areas with missing information are raised at regular meetings and the audit co-ordinator is tasked with retrieving and populating this information, which should address data quality issues experienced in the past.

Service	Site	Title	Date published	Changes or improvements made to clinical care:
Gastroenterology	NP	National inflammatory bowel disease (IBD) programme (Biologics) 2015/16	Sep 2016	As a result of this national audit the majority of patients have had their medication changed to biosimilars, with a cost saving to the Trust of £375,000 over 6 months. A new Biological Multidisciplinary Clinic has been set up to deliver pre-treatment screening rates of 100% and offers a post-induction review follow-up appointment and one year annual reviews to patients. A new Registry Patient Management System (PMS) has been purchased, implemented and extensive training has been provided. The team is developing a tool to collate patient views in future.
Orthodontics	NHP	National orthognathic patient quality of life questionnaire 2015/16	May 2018	Of the forty six patients who undertook corrective jaw surgery, local survey shows 100% would recommend the service to others.
Theatres, recovery, and ITU	EH / NP	National case mix programme (CMP) audit 2016/17	Mar 2018	Quarterly CMP audits are carried out to reduce infection rates and non-clinical transfers to the intensive care unit has reduced to 0.1%.
	EH / NP	National case mix programme (CMP) audit 2016/17	Mar 2018	The Trust has instigated an intensive care unit specific infection control working group to reduce infection rates.

Women's and Children's Division

Service	Site	Title	Date published	Changes or improvements made to clinical care:
Neonatal	NPH	National neonatal audit programme (NNAP) (Neonatal intensive and special care) 2017/18	Oct 2018	The national audit found that 100% of applicable babies have temperature checks completed within one hour and 100% of applicable babies have retinopathy screening. The service has shared the national results with visitors to the ward by producing a poster of the results and actions being taken. Local audits are undertaken to improve practice, such as minimising the amount of time mothers & babies are separated.
Paediatrics	NP	Paediatric pneumonia 2016/17	Jan 2018	As a result of this national audit the Trust is reviewing the use of chest x-rays and IV antibiotics within paediatric care. A paediatric sepsis care bundle has been developed to reduce the number of blood investigations.

National confidential enquiries

There were three national confidential enquiries that the Trust was eligible to participate in during the period 1 April 2018 to 31 March 2019, as below:

Table 2: NCEPOD studies that the Trust participated in

National Confidential Enquires into perioperative Deaths (NCEPOD) Studies	Submissions	Central Middlesex	Ealing	Northwick Park / St Mark's
Bowel obstruction	List of cases for Pilot	5/5 (100%)	119/119 (100%)	372/372 (100%)
	List of cases	1/1 (100%)	13/13 (100%)	38/38 (100%)
	Case notes	None requested	2/2 (100%)	2/2 (100%)
	Surgical questionnaires	0/0 (0%)	0/4 (0%)	0/4 (0%)
	Organisational questionnaires	Awaiting from national team	Awaiting from national team	Awaiting from national team
Pulmonary embolism	List of cases	2/2 (100%)	24/24 (100%)	57/57 (100%)
	Case notes	No case note requested by national team	4/4 (100%)	2/2 (100%)
	Clinician questionnaire	Not Applicable	4/4 (100%)	2/2 (100%)
	Organisational questionnaires	1/1 (100%)	1/1 (100%)	1/1 (100%)

Table 3: Child Health Studies that the Trust participated in during 2018/19

National Confidential Enquiries Child Health	Submissions	Central Middlesex	Ealing	Northwick Park / St Mark's
Long Term Ventilation	List of cases	No cases	No cases	1 case submitted
	Clinician questionnaire	Awaiting from national team	Awaiting from national team	Awaiting from national team
	Organisational questionnaires	Awaiting from national team	Awaiting from national team	Awaiting from national team

Participation rates for national audits by financial year

The Trust treats all Quality Accounts and National Audits listed by NHS England as 'mandatory' and monitors their completion, across publication years. The Clinical Audit and Effectiveness Team continue to monitor these audits until they are 'fully completed'. To 'fully complete' a Quality Account/National Audit, a service must submit the national data, review the findings from national reports and produce an action plan to respond locally to the findings. Once all the actions within an action plan are completed, the audit is considered 'fully completed'. Action plans are correlated against information available in the CQC Insight Reports for Acute NHS Trusts, which highlight areas of practice where the Trust needs to focus improvement.

Below is the progress made for each published Quality Account List by year. Please note that it is not expected that all of these audits will be 'fully completed' within a financial year as national audits run across financial years and can take significant time to be published.

National Audits 2018/19

Division	Number applicable	Data collection	Awaiting national reports	Number ready to Implement	Action plan in place	Completed
Corporate Nursing	4	3	1	0		
Emergency & Ambulatory Care	10	4	5	1		1
Integrated Clinical Services	12	8		4	4	
Integrated Medicine	40	35	5	0		
Surgery	32	32		0		

Division	Number applicable	Data collection	Awaiting national reports	Number ready to Implement	Action plan in place	Completed
Women and Children's Division (Children)	8	7	1	0		
Women and Children's Division (Women)	3	3		0		
Grand Total	**109**	**92**	**12**	**5**	**80% (4/5)**	**20% (1/5)**

Table 2 shows that of the Quality Accounts listed for 2018/19 a total of 109 quality account / national clinical audits were registered, with some site needing to register separately.

Of these 92 are in the active 'data collection' phase, 12 are awaiting the publication of national reports and 5 are ready for implementation. Of these 4 have ongoing action plans and 1 has been completed.

In additional to the Quality Account/National Audits being completed (as above), Tables 3 to 6 below give the details of the remaining Quality Account / National Audits from previous financial years that continue to be monitored until completion.

National Audits 2017/18

Division	Number Applicable	Data Collection	Awaiting National Reports	Number ready to Implement	Awaiting Action Plan	Action Plan In Place	Completed
Emergency and Ambulatory Care	10		2	8	5	2	1
Integrated Clinical Services	15	3	0	12	1	6	5
Integrated Medicine	38	7	28	3			3
Surgery	37	20	7	10	4	6	0
Women and Children's Division (Children)	7	2	2	3		2	1
Women and Children's Division (Women)	2		2	0			
Grand Total	**109**	**32**	**41**	**36**	**28% (10/36)**	**44% (16/36)**	**28% (10/36)**

Outstanding National Audits 2016/17

Division	Number Applicable	Data Collection	Awaiting National Reports	Number ready to Implement	Awaiting Action Plan	Action Plan In Place	Completed
Emergency and Ambulatory Care	8			8		8	0
Integrated Clinical Services	4			4		3	1
Integrated Medicine	41		11	30	8	18	4
Surgery	40		10	30	7	9	14
Women and Children's Division (Children)	10		2	8		4	4
Women and Children's Division (Women)	5			5	1	1	3
Grand Total	**108**		**23**	**85**	**19% (16/85)**	**51% (43/85)**	**31% (26/85)**

Outstanding National Audits from Previous Financial Years: 2015-16

Division	Number Applicable	Data Collection	Awaiting National Reports	Number ready to Implement	Awaiting Action Plan	Action Plan In Place	Completed
Emergency & Ambulatory Care	2			2			2
Integrated Clinical Services	2			2		1	1
Integrated Medicine	28			28		2	26
Surgery	26		1	25	1	7	17
Women and Children's Division (Children)	4			4			4
Women and Children's Division (Women)	2			2		1	1
Grand Total	**64**		**1**	**63**	**1% (1/63)**	**18% (11/63)**	**81% (51/63)**

Outstanding National Audits from Previous Financial Years: 2014-15

Division	Total	Removed / N/A	Number Applicable	Action Plan In Place	Completed
Integrated Clinical Services	3		3	3	
Integrated Medicine (including E&A)	8		8		8
Surgery	2		2		2
Women and Children's Division (Children)	0				
Women and Children's Division (Women)	1		1		1
Grand Total	**14**		**14**	**3 (21%)**	**11 (79%)**

Local clinical audit activity across the Trust is based on evaluating aspects of care that are important for particular services / specialities. The Trust's expectation is that each service will review its record keeping every 18 months and conduct at least one other clinical audit each financial year, in addition to national clinical audits.

These local audits consist of those that may have been on the clinical audit programme in the previous financial year, which may have continued over a number of years, any areas of high risk or high volume, risk management issues that need further investigation or to confirm that change has taken place, audits to evaluate the implementation of local policies or NICE Guidelines and topics of clinical interest.

Summary of Completed Local Audits 2018-19

The following is a summary of local clinical audit activity across the Trust and then specific Divisional information.

Division	Registered	Data Collection	Report needs updating	Completed	
Corporate Services	8	2	1	5	63%
Women and Children's Division (Children)	44	10	6	28	64%
Emergency & Ambulatory Care	21	11	4	6	29%
Integrated Clinical Services	135	46	9	80	60%
Integrated Medicine	48	31	1	16	34%
Surgery	84	52	7	25	30%
Women and Children's Division (Women)	14	10	2	2	15%
Trust-wide Total	354	160	30	162	46%

Quality Account continuous improvement through research

The Trust has developed a process for developing improvement programmes which translates research problems and ideas into practice through development of pilot programmes. These pilots are evaluated against national best practice, clinical effectiveness, patient and staff satisfaction and cost effectiveness.

The benefit of these programmes is sustained and continuous improvement.

Evidence of Sustained and Continuous Improvement

National Clinical Audit Reports were published and recommendations were put into action by the Trust during the period. Below is a summary of the main changes made to services as a result of these national recommendations.

The Trust continues to exceed expectations with both patient recruitment targets and contribution to research in 2017/18.

The number of patients receiving NHS services provided by the Trust in 2017/18 that were recruited to participate in research approved by a research ethics committee and Health Research Authority was 5,309.

The Trust was involved in 103 research studies. Of these 71 (69%) were adopted onto the CRN portfolio and 32 (31%) not adopted. Twenty two (21%) of the total were commercially sponsored studies that brought in an income of £706,923. Fifty nine (57%) of the studies were given approval during the 2017/18.

Research and Development also supported 30 service Evaluations and 26 Quality Improvement projects which include outputs from CQUINS. Quality Improvement projects and Service Evaluations have further demonstrated the enthusiasm of staff to improve the care we provide to our patients through implementation of improvements from these projects.

We continue to work with our partners and grow our research portfolio in other specialties and new diseases areas across the Trust e.g Ophthalmology where the commercial activity has increased coupled with offering more choice to our patients for treatment.

Participation in clinical research and innovation

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2018/19 that were recruited during that period to participate in research approved by the ethics committee was

The Trust is actively involved in clinical research and has a dedicated research team that is responsible for increasing opportunities to expand the research portfolio. The recruitment of patients to participate in research is mainly through studies adopted from the National Institute for Health Research (NIHR) portfolio.

Looking forward to 2019/20

- Clinical audit will be re-launched in 2019/20 with a series of events, posters and communication to strengthen it further, including awareness and participation
- Support the divisions to enable staff groups to get an even better understanding of some of the outcomes and challenges faced as a result of audit
- Support the divisions to ensure all national clinical audits and NCEPOD findings are thoroughly evaluated and appropriate actions are documented and undertaken in a timely manner and lessons learnt

The Trust is committed to expanding research activities and has developed strong associations with other universities and NHS Trusts.

Quality Improvements agreed with commissioners

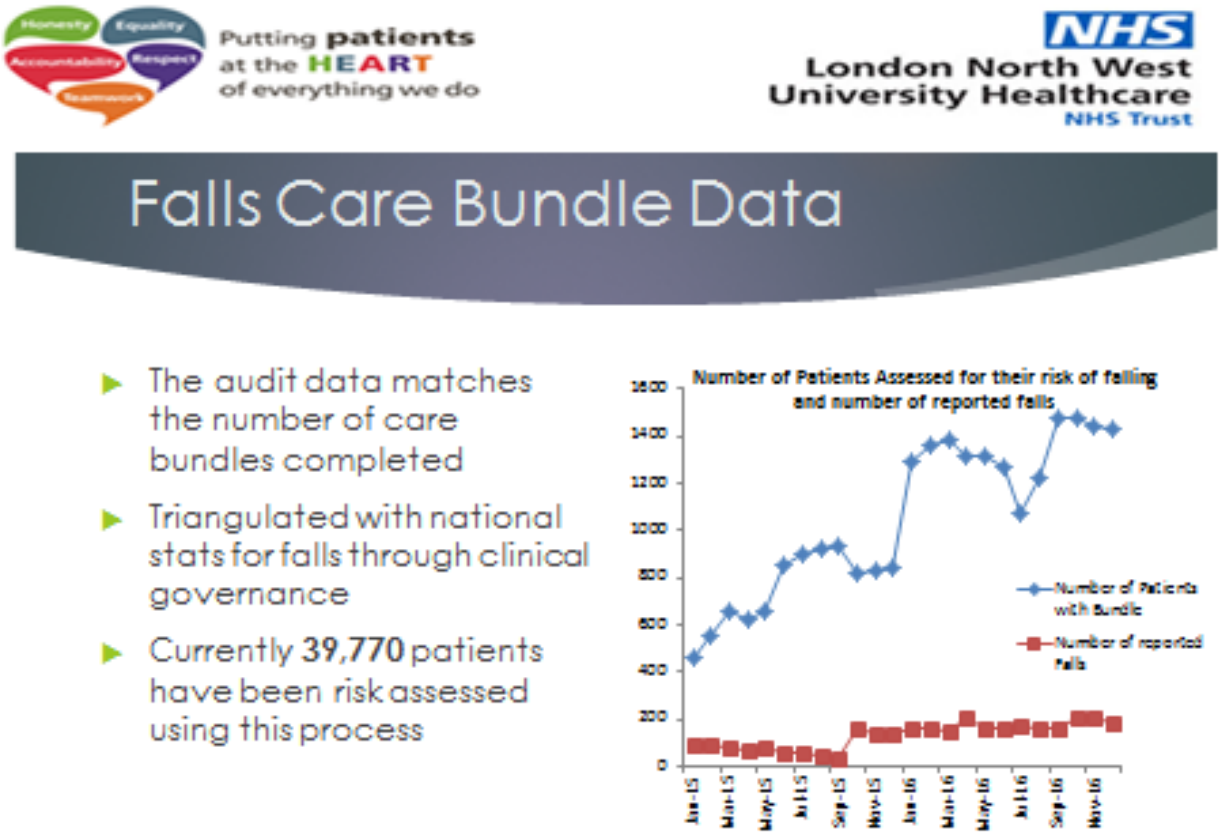
The trust agreed a range of CQUINS with its commissioners for 2018/19 which included falls care bundle, nasogastric bundle and sepsis bundle.

Care bundles

The care bundle programme has continued to sustain improvement as identified below.

Falls care bundle

Introduced in 2010, the care bundle uses national best practice to support clinicians to ensure that the right care is in place for patient at risk of falling. A total of 39,770 patients have received a risk assessment using the care bundle.

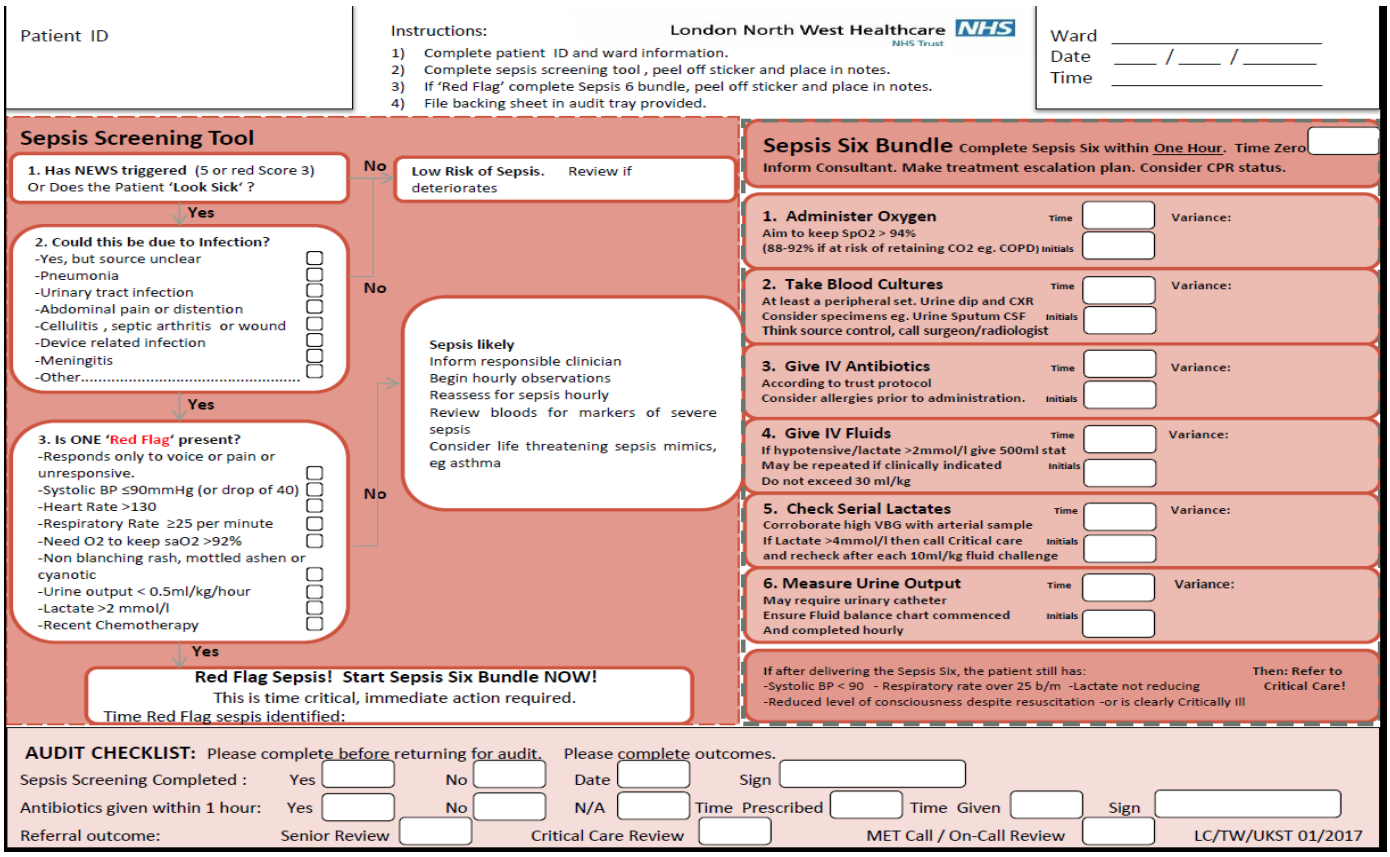


The Falls Bundle has identified that number of patients being risk assessed and showed a high prevalence of patients being risk assessed for falls. This has now been moved into patient documentation which is monitored by nursing staff on the ward. This has led to the bundle being used post fall to identify that all risk assessments were completed. This information is reviewed by the falls committee monthly.

Sepsis care bundle

The Trust has met the national standard for screening and initiating antibiotics within an hour of assessment for both the emergency departments and the inpatient departments.

This has informed the CQUIN programme for 2017 to 2019. The care bundle below uses national guidelines for screening and antibiotic initiation and the programme validates through review of patient notes. There have been **3,142** patients identified with severe sepsis through screening for sepsis

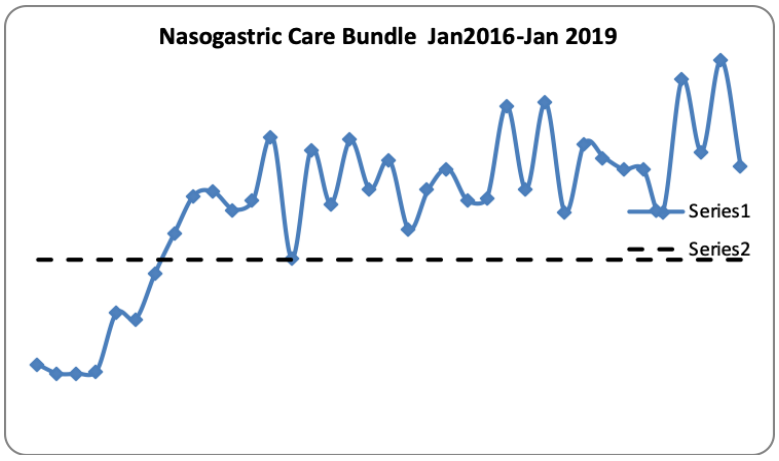


Nasogastric care bundle

The Trust has implemented a nasogastric care bundle following never events to ensure that staff are focused on completing all assessments pre and post insertion of a nasogastric tube. 3,024 patients have been assessed for any risk pre and post insertion of a nasogastric tube.

The graph below shows the use of the bundle on a monthly basis from January 2016 to January 2019.

Figure 1 Nasogastric care bundle January 2016 to January 2019



Managing the risk of patients deteriorating

The Trust has a deteriorating patient committee which monitors information with regard to national standards of care. This committee has had oversight on the management of sepsis, implementation of NEWS2 and monitoring of escalation through NEWS2 early warning score. This is done through monitoring of medical emergency call-outs and through Situation, Background, Assessment and Recommendation (SBAR).

SBAR is used to ensure clinical information is communicated appropriately and in a timely way to ensure patients are reviewed by the appropriate clinician. There have been **14,274** escalations of care using SBAR.

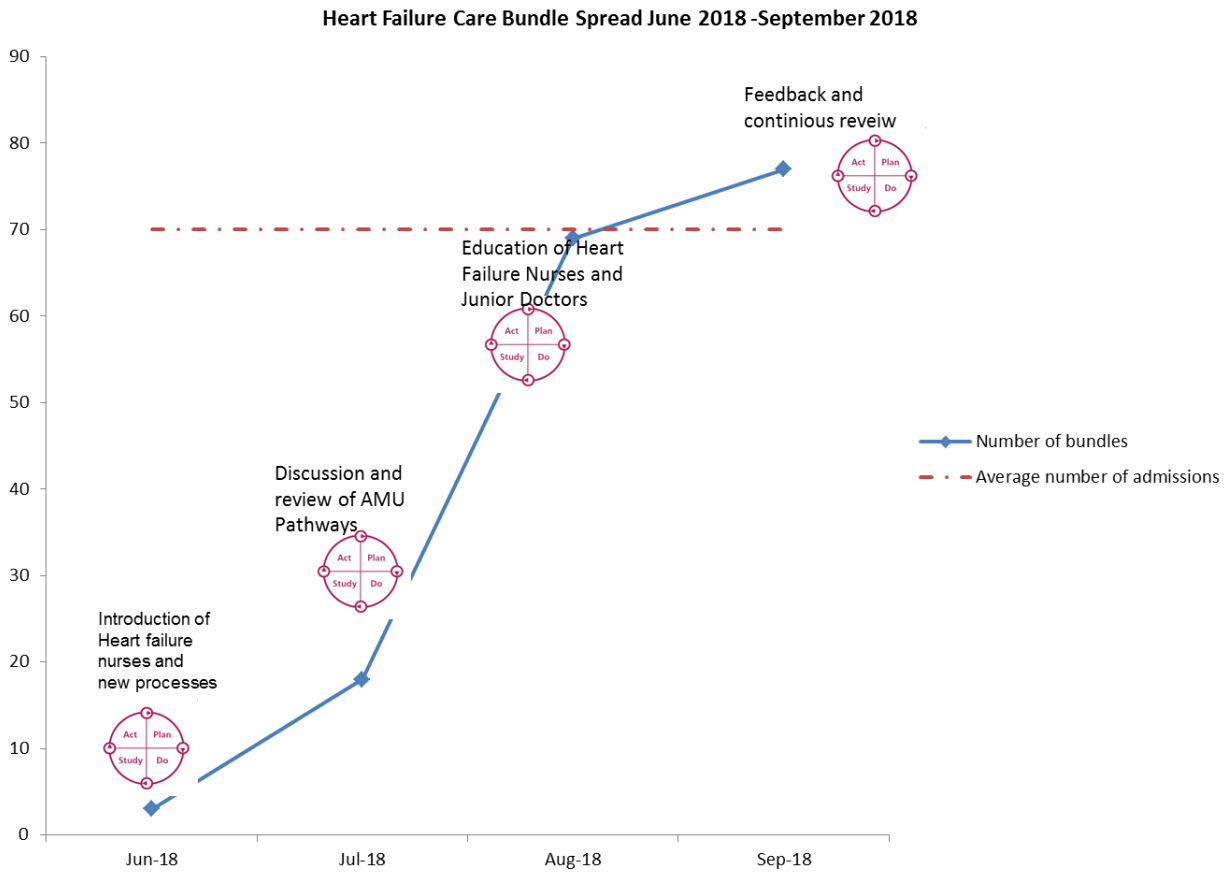
Continuous improvement heart failure programme

In 2014, the Trust began to develop and improve care for patients with heart failure. This was based on recommendations by the National Audit for Heart Failure with regard to improving specialist review for patient not admitted to a cardiology ward.

A care bundle approach was taken to drive improvement using best practice to identify the interventions needed to improve care. The programme was evaluated in 2017 and identified an improvement in specialty review from 35% to 82%. 67% of care bundles were completed in the Acute Assessment wards.

In 2017, we implemented the process with Ealing cardiology team which has shown comparable data, with 78% of patients receiving a care bundle in AMU.

This process has led to further innovation in avoiding admissions for patients who need diuretic therapy.



Co-design: Whole system improvement for patients with heart failure

In 2018, Ealing cardiology team identified an innovative programme of change to support patients with heart failure needing diuretic therapy and assessment by a specialist. These patients would normally be admitted to a medical ward for 7-15 days and would be re-admitted several times throughout the year.

Working in collaboration with Ealing Lead Clinician for cardiology and Clinical Nurse Specialists from the Imperial Community Service, the Trust has developed a patient pathway which enables patients to be seen within an ambulatory cardiology assessment area where they are treated and sent home with support from the community team.

Early outcomes have identified 78 out of 80 patients were successfully treated in this way, negating their need to be admitted to a ward. This programme of work has been seen as an example of collaborative working across networks for patient benefit and has been highlighted as a possible STP programme for north west London. Patient Experience is being monitored and reported

Patient feedback

It offers a lifeline for patients like Mr DL, who was admitted to Ealing Hospital six times for heart failure in a single year. He subsequently spent more than 100 days in hospital. He said:

"I've been seen twice at the new clinic and avoided any hospital stays since which is a relief. It makes a big different being able to go home."

CQUIN programme

Commissioning for Quality and Innovation (CQUIN) is mandatory as part of contractual agreements between commissioners and providers; there are three workstreams. The programmes are national or regional quality priorities which impact on patient outcomes. The CQUIN programme can also have local quality programmes agreed where there is a local driver to improve patient care. The Trust reports on CQUIN programme aligned to acute, community and specialist commissioned services

The CQUINs for 2018/19 were part of a two-year national programme for acute and community services, and a mixture of national and local programmes for specialist services

The programmes normally attract funding at 2.5% of the Trust's contract for each of the services commissioned.

In 2018/19, this was split to give funding for STP work programmes, leaving 1.5% funding for CQUIN Programmes

Acute CQUIN Programme

The Trust negotiated a 100% funding for CQUIN programmes for 2018/19 for acute and community services.

Acute CQUINs

CQUIN indicator	Quality Impact
Improvement of health and wellbeing of NHS staff	This is aimed at improving staff wellbeing and overall fitness for work through offering extended occupational health programmes. The Trust has identified new services to support staff to get fit, reduce stress and support mental health. The programme is assessed through the Staff Survey results which are taken annually.
Healthy food for NHS staff, visitors and patients	The programme has identified the need for health organisations to ensure healthy food options are available on their premises and offered by third party retail outlets The programme is assessed through assessment of retail providers healthy food offers against the trajectories set by the Department of Health.
Improving the uptake of flu vaccinations for frontline clinical staff within providers	This programme identifies the need for 75% of staff to be vaccinated against the risk of flu. This programme is assessed from the percentage of frontline staff vaccinated against flu.
Timely identification of patients with sepsis in emergency departments and acute inpatient settings	This programme identifies the need for 90% of patients to be screened for their risk of sepsis in emergency and inpatient areas. The programme for 2018/19 also involves the implementation of NEWS 2 (the National Early Warning score for adults) which stratifies patient observations to identify if a patient is deteriorating. The Trust has completed roll out of the NEWS2 scoring tool across the Trust and continues to meet the trajectory for screening and administration of antibiotics within the appropriate timeframe using the sepsis care bundle.
Antibiotic stewardship	This programme aims to reduce the number of antibiotics used within the Trust through the development of a stewardship programme run by pharmacy and microbiology team. The programme reviews the use of antibiotics for patients screened and identified as needing antibiotics with the aim of reviewing the need for ongoing treatment at 72 hours. Currently the Trust is meeting the trajectory to review 90% of those prescriptions reviewed.

CQUIN indicator	Quality Impact
Improving services for people with mental health needs who present to A&E	This programme identifies the need to improve the coding and diagnostic information used for mental health to support the targeting of patients to support patient care and reduce frequent attendances. The Trust has implemented frequent attender meetings on both acute sites to support the care of patients.
Offering advice and guidance (A&G)	The Trust has linked 100% of services to clinical directories to support the receiving of advice and guidance queries from GPs. A full programme of redesign is being followed through the STP outpatient programme across five services.
Preventing ill health from smoking	The Trust has reviewed patient notes to enable the review of smoking screening and assessment. The Trust has identified that they meet the trajectory for offering advice to patients most affected by smoking.
Preventing ill health from alcohol	This is an ambitious improvement programme to support better screening of patients with possible alcohol problems. The Trust has evidenced the screening of all patients and the receipt of advice for patients drinking above the standards set for good health, but there has been limited improvement in effecting patients to enter rehabilitation programmes.

Community CQUINs

CQUIN indicator	Quality Impact
Improvement of health and wellbeing of NHS staff	This is aimed at improving staff wellbeing and overall fitness for work through offering extended occupational health programmes. The Trust has identified new services to support staff to get fit, reduce stress and support mental health. The programme is assessed through the Staff Survey results which are taken annually.
Improving the uptake of flu vaccinations for frontline clinical staff within providers	This programme identifies the ned for 75% of staff to be vaccinated against the risk of flu. This programme is assessed from the percentage of frontline staff vaccinated against flu.

CQUIN indicator	Quality Impact
Self-management	This programme identifies how patients can be helped to support self-management for their ongoing conditions. The Trust has identified self- caring programmes for COPD and heart failure within this programme.
Improving wound healing	This programme identified the need to monitor and improve the healing of non-healing wounds through specialist intervention of Tissue Viability Nurse and specialist assessment. The programme links with the aim for the Trust to reduce the number of pressure ulcers of stage 3 and 4.
Preventing ill health from smoking	The Trust has reviewed patient notes to enable the review of smoking screening and assessment. The Trust has identified that they meet the trajectory for offering advice to patients most affected by smoking.
Preventing ill health from alcohol	This is an ambitious improvement programme to support better screening of patients with possible alcohol problems. The Trust has evidenced the screening of all patients and the receipt of advice for patients drinking above the standards set for good health, but there has been limited improvement in affecting patients to enter rehabilitation programmes.

Specialist CQUINs

CQUIN indicator	
Dose banding	Implementation of nationally standardised doses of SACT across England using the dose-banding principles and dosage tables published by NHS England (developed through the Medicines Optimisation Clinical Reference Group). The Trust has met trajectories for Q2 & Q3.

CQUIN indicator	
Medicines optimisation	This CQUIN scheme aims to support the procedural and cultural changes required fully to optimise use of medicines commissioned by specialised services. The following priority areas for implementation have been identified nationally by clinical leaders, commissioners, Trusts, the Carter Review and the National Audit Office, namely: • Faster adoption of best value medicines with a particular focus on the uptake of best value generics, biologics and CMU frameworks as they become available • Significantly improved drugs data quality to include dm+d code and all other mandatory fields in the drugs MDS and outcome registries such as SACT, as well as to meet the requirements of the pharmacy and Define agendas • The consistent application of lowest cost dispensing channels • Compliance with policy/ consensus guidelines to reduce variation and waste The Trust has met the trajectory for all three quarters so far.
Automated exchange transfusion for sickle cell	This programme identifies the transference of patients onto automated transfusion processes to ensure patients receive timely interventions for their condition. The trust has met the trajectory for this CQUIN for all three quarters.
Improving haemoglobinopathy pathways through ODN networks	This programme has been developed to redesign current services to support patient care through the development of network progression for adult and paediatric patients, combining acute and community services.
Neuro-rehabilitation (local CQUIN)	This scheme has been developed to ensure that patient outcomes are identified and reviewed as part of a rehabilitation pathway.
Home parenteral nutrition (local CQUIN)	This programme has been developed to reduce the waste of expensive parenteral nutritional products through assessment and monitoring of the patients' needs.
Genetic service (Service Developments & Innovations)	Implementation of genetic counsellor processes to triage referrals made to the service and target the right patient cohort. This is with the aim of ensuring that patients and families have a full understanding of any genetic disorders and treatments.

CQUIN 2019/20 acute and community

The national contract this year has identified that part of CQUIN provision will move into tariff uplift, and therefore CQUIN will be worth 1.5% of the negotiated contract.

The CQUIN scheme will be simplified, focusing on a small number of indicators aligned to key policy objectives drawn from the Long Term Plan.

A portion of the CQUIN monies will be dedicated to sustain and expand the work of Operational Delivery Networks (ODNs) in ensuring consistency of care quality across the country.

Access to seven day services

Seven-day working

The national programme for seven-day working was implemented in November 2015.

This programme of work was undertaken following the Academy of Royal College recommendations of the implementation of four standards which should be implemented as a priority to improve patient care

The standards are:

- Standard 2: time to consultant review, specifies that new admissions should be seen within 12 hours of admission to hospital
- Standard 5: access to diagnostics, specifies that diagnostic services should be available 7 days per week
- Standard 6: access to consultant directed interventions, specifies that expert interventions should be available 7 days per week
- Standard 8: ongoing review, specifies that patients should be seen by senior decision-makers on an ongoing basis

The Trust has now completed five national audits with regard to these four standards and is seen as one of the exemplar Trusts nationally. However, we recognise the limitations of this national audit process. The work programme and assurance process for 2019/20 has now changed, with providers to report Board Assurance with regard to the work being undertaken to meet the standard and reporting of the standards against the target trajectories. We intend to take the opportunity to make our internal assurance even more robust. Full implementation of the seven-day service Board Assessment Framework will take place in March to June 2019. This will follow the same process of completing the measurement template and subsequent board assurance of the self-assessment audit.

Figure 1: Seven-day audit results March 2017/18

Date	Population	Standard 2	Standard 5	Standard 6	Standard 8
March 2017	566,070	**92%**	**100%**	**100%**	**100%**
March 2018	674,205	**98%**	**97%**	**100%**	**100%**

Seven-day service audit board assurance

This will be reported using the seven-day self-assessment template and evidence of the outcomes along with actions or recommendations for improvement.

Board Assurance for this data is submitted through a direct report to the Board or board sub-committee following executive review.

Submission of seven-day self-assessment data June 2019

This will be based on local data such as consultant job plans and local clinical audits, as outlined in the full seven-day service National Assurance Framework guidance [4]

What others say about the Trust

LNWH is fully registered with the Care Quality Commission (CQC), and there are Warning Notices attached to the CQC registration as detailed below. The full report of the CQC formal inspection of LNWH undertaken in June 2018 was published and provided to the Trust in August 2018 during which the Warning Notices were issued. The Trust was rated as 'requires improvement'.

Following an unannounced inspection in January 2019, the Warning Notices have been lifted by the CQC. Whilst this is encouraging, the drive and focus on sustainability continues.

Warning Notices

29A Warning Notice: critical care

- You do not have beds appropriately located within critical care to perform emergency lifesaving care and treatment.
- You do not have sufficient hand washing facilities to mitigate the risk of cross-contamination.

29A Warning Notice: Ealing medicine

- You do not assess the risks to the health of service users on medical wards.
- You do not have staff following policies and procedures about managing medicines on medical wards.
- You do not have the sufficient numbers of suitably qualified, competent skilled and experienced persons deployed within the medical wards.

[4] https://improvement.nhs.uk/resources/seven-day-services/)

Section 31:

The trust was issued with a section 31.warning notice which was withdrawn on 27 July 2018, upon submission of satisfactory evidence by the Trust.

- The registered provider must stop treating children (individuals aged under 16) in the Ealing emergency department which is an emergency department for adults only except for clinically stabilising the child before transferring to an appropriate facility.
- The registered provider must develop a clear policy on the management of children who present to or are brought to the Ealing emergency department stating in clear terms the extent to which staff in the emergency department can be involved in the management and care of children.
- The registered provider must place visible signs in the Ealing
- Emergency department informing members of the public that the emergency department is not a paediatric emergency department.

29A Warning Notice: Emergency Department, Ealing

- In the accident and emergency (A&E) department at Ealing hospital you do not have the arrangements in terms of the environment and the equipment to treat children.
- You do not support the provision of safe care and treatment and do not demonstrate that there is proper and safe management of paediatric medicines.

29A Warning Notice: Maternity

- Your systems, policies and procedures in the response to emergency paediatric crash calls (a crash call or cardiac arrest call number is used by hospital staff to summon an emergency care team to patients suffering a cardia arrest) via 2222 are not disseminated appropriately to all staff within the hospital and are not operated effectively.
- You do not have robust systems in place to secure the maternity unit.

LNWH has not participated in any special reviews or investigation by the CQC during the reporting period.

The table below outlines the overall rating of the CQC domains in the report.

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

Quality Summit – (Quality Improvement Plan – 'driver of change')

Following receipt of the trust CQC report a Quality Summit was held in November 2018, and was attended by stakeholders to include local CCG, NHSI, CQC, local councils etc. Discussions were held to consolidate the CQC action plan and pledges agreed under five broad themes:

- Theme 1: leadership, culture, patient experience and staff engagement
- Theme 2: maternity
- Theme 3: Ealing Hospital
- Theme 4: continuous quality improvement and transformation
- Theme 5: patient flow

The Trust has made significant improvements in many areas in response to the LNWH CQC inspection full report publication. Progress against the CQC action plan is monitored within the Trust's governance and monitoring processes, as well as Board oversight through appropriate Trust Board committees which meet monthly or bimonthly to receive assurance.

The CQC action plan and Quality Summit outcomes' completion is progressing with our partners with ongoing review at the monthly Executive Team Meeting (ETM) dedicated to the CQC Improvement and Transformation Programme and the recent Trust and Commissioner Board to Board Meeting. The Executive Team monitor, address exceptions and assurance on progress including the CEO holding them to account for their respective portfolio areas.

In addition, the Trust had regular meetings with the Clinical Commissioning Groups (CCGs), NHSI and the Care Quality Commission to provide information and assurance on the progress and sustainability of the improvement plan, to ensure that all stakeholders are informed and engaged appropriately.

In January 2019, the CQC made a focussed unannounced inspection to test out implementation of the Warning Notices action plan and were satisfied with the progress made thus far. However, the Warning Notices will remain in place until the trust next CQC inspection and sustainable assurance received. The trust is in the process of finalising its overall quality improvement plan that will include the whole range of improvement and transformation priorities across the trust.

Friends and Family Test 2018/19

The Friends and Family Test allows the patient's voice to be to be heard promptly and at volume: 74,136 patients completed the survey this year with 94% saying they that they would recommend our services to their friends and families.

What is more important is to understand the reasons and the feelings under the ratings and the patient perspective on a range of areas of their experience. This valuable data has been analysed and is now reported monthly to the divisions to inform and improve learning and enact changes to the care and services we provide.

Overall, the Trust received a 95% rating for feeling safe, being treated with dignity and respect and with kindness and compassion.

Less positively, patients reported that they would like to feel more involved in decisions about their care and have more information. These are being actioned as part of our Patient Experience Improvement plan for 2019/20.

Patient involvement and engagement strategy

The Trust is committed to ensuring that patients are at the HEART of everything we do and to engaging them not only in decisions about their treatment and care but also to developing and improving Trust services. During 2019/20, the Trust is strengthening its approach to patient involvement, engagement and experience by taking the opportunity of working with the NHSI national lead, using their Patient Experience and Improvement Framework. This includes patients, relatives, carers and other stakeholders to co-design an improved Patient Involvement and Engagement Strategy and implementation plan.

NHS England Learning Disabilities Standard

An NHS Benchmarking lead Learning Disability survey took place during 2018. The audit looked at four Learning disability standards namely:

- respecting and protecting rights,
- inclusion and engagement,
- workforce and
- learning disability services.

The findings from this survey have been sent to NHS Improvement, who are yet to release the results. The Trust anticipates these will be available during summer 2019. The Trust has implemented a learning disabilities care bundle and other resources in partnership with people with learning disabilities, their families and advocates in keeping with the inclusion and engagement.

Freedom to Speak

The NHS Contract requires all NHS Trusts to have local Freedom to Speak Up Guardians in place. The trust has appointed two such Guardians and their role, as set by the National Guardians Office, includes:

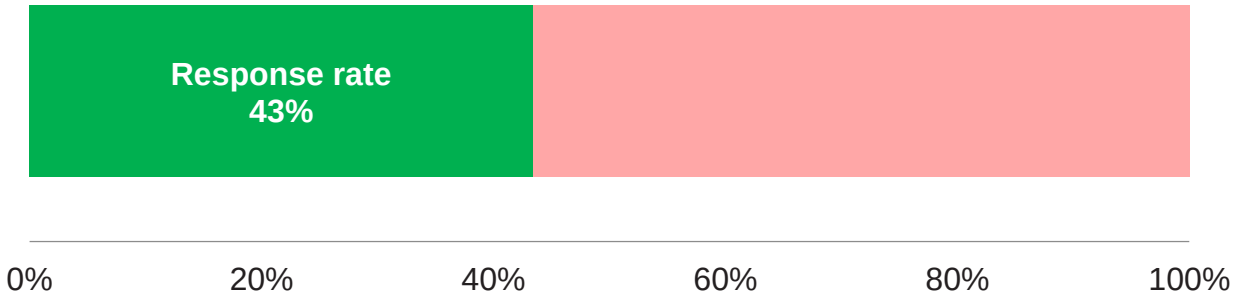
- Developing an open culture
- Ensuring processes are in place to empower and encourage staff to speak up safely
- Promote learning and development
- Improve the experience of workers
- Protect patient safety and the quality of care.

The Trust has also completed a Freedom to Speak Up (FTSU) self-assessment against the Gosport Independent Panel Report. This was initially reported to the Trust Board in September 2018 and has enabled the board to review its leadership and governance arrangements in relation to FTSU and identify areas for continuing development and improvement. The board receives quarterly reports from the FTSU Guardians.

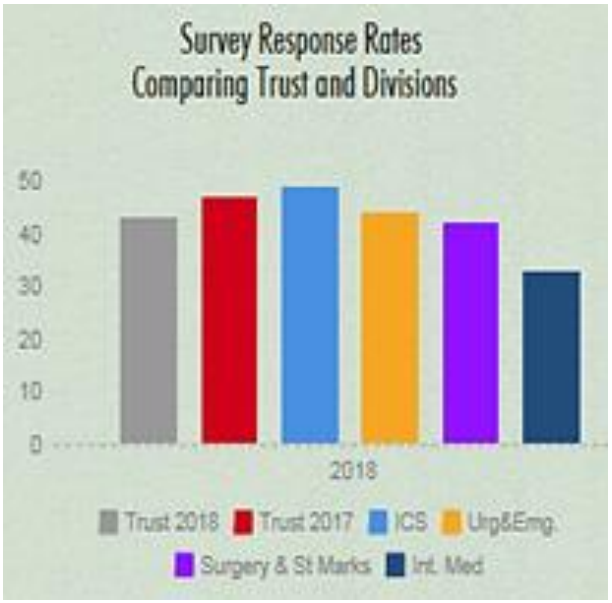
Staff Survey 2018: Summary of Results

The annual survey provides an opportunity for NHS organisations to build a picture of staff experience in the workplace. Obtaining feedback from our employees and taking account of their views is a priority for the Trust. This is important in transforming their working lives and continuing to implement improvements in the organisation.

Staff survey response rate



In 2018, a total of 3510 of our employees took part in the annual staff survey, giving the Trust an above average response rate of 43% when compared with other similar organisations.



This year's results indicate that we continue to improve in a number of areas particularly in creating a culture of development and learning. This equips our clinical staff to continue to deliver excellent care to our patients. We also saw improvements in appraisals and staff satisfaction with their level of pay. Our staff also told us that the Trust was continuing to recognise and value the important work that they do.

In terms of our performance when compared to the average of similarly sized Trusts, the organisation showed improved scores in seven questions, unchanged scores in 79 questions and worse scores in 11 questions.

Key themes from the survey

Staff training and development

Organisational investment in training and development continues to reflect strongly in the results. As in previous years, staff feedback indicated that the appraisal experience is valued by staff and informs objective setting and identification of their development needs. Our reputation for supporting training and development has been vital in recruiting staff to the organisation.

Staff Appraisal

Over the last three years, the Trust has seen year on year increases in positive scores from staff on questions relating to the quality of appraisal reviews they receive from managers.

Positive scores when compared with 2017 and other trusts

Questions where the Trust compares favourably when compared with previous year and other trusts include:

- Satisfaction with recognition for good work
- Satisfaction with the support from manager
- Satisfaction with the value organisation places on my work
- Satisfaction with level of pay
- Time passes quickly when working
- Training helping improve how staff do their work
- Training helped staff identify training needs and clarification of objectives for work
- Less staff putting themselves under pressure to come to work

The Trust also showed positive results over historical findings and average in questions relating to

- HEART values as part of appraisal process
- Identification of learning and development as part of appraisals
- Training helping improve job
- training helping agreeing clear objectives for work

Areas for improvement when compared with 2017 and other trusts

The survey has highlighted areas where the staff said the organisation needed to improve and where we did not perform favourably when compared with previous year and other trusts. Key areas for improvement include:

Errors and incidents

Although the number of staff saying they were witnessing potentially harmful errors, near misses and incidents (service users and staff) was unchanged when compared with 2017, the proportion that said they witnessed potential harm was higher when compared with similarly sized organisations (77% vs 82%). Reporting of errors and incidents was consistent with last year and the national average.

Violence, harassment and bullying

Results relating to staff saying they have experienced harassment, bullying or abuse (HBA) from colleagues, managers and patients showed an upward trend when compared with the average. In addition, 3% more staff reported HBA from colleagues when compared with last year.

Although there is no statistical difference in the number of staff who say they experienced violence in 2018 (when compared with the previous year), there was a slight increase in the statistical difference in the numbers who said they experienced physical violence when compared with the average. The numbers of staff who are reporting HBA remains unchanged with the average and in the previous year.

Staff health, wellbeing and safety at work

Questions relating to staff safety at work are combined with questions on health, wellbeing and safety at work (this includes questions relating to, discrimination, pressure to come to work, paid and unpaid hours and physical violence) against these questions, the Trust did not score favourably -1-7% when compared with the national average. This is a 2% fall when compared with 2017 and a 4% increase when compared with the national average.

The Trust continues to invest in staff health and wellbeing initiatives and has recently launched a new employee assistance programme. It is disappointing that the results indicate a 2% fall on these questions when compared with last year and 4% when compared with the national average.

Action for improvement

The results signposts the organisation to areas where staff feel the organisation does well and areas for further improvement. This information will be invaluable in the development of organisational and divisional action plans. This process will involve interaction with staff at all level through focus groups, discussion and meetings. This will enable strong engagement and inclusion which will ensure that the trust continues to work to transform the working lives of our workforce.

Annex

Amendments made following consultation

The Trust would like to thank all stakeholders for their comments on the 2018/19 Quality Account. We are pleased that the statements from our stakeholders demonstrate the collaborative commitment we share in improving the quality of services we provide and the outcomes for our patients and that stakeholders are in agreement that the quality and safety improvement priorities for 2019/20 are the right ones.

As a result of the formal stakeholder statements and additional comments and suggestions received to further improve the information in the Quality Account, the Trust has made the following amendments since the first draft sent to the stakeholders.

Statements on the content of the Quality Account from our stakeholders

PLACE HOLDER

Healthwatch Brent's response to the Quality Account 2018/19

AWAITING CONTENT

Healthwatch Ealing Statement on the Quality Account 2018/19

AWAITING UPDATED STATEMENT

Abbreviations

Abbreviation	Definition
A&E	Accident & Emergency
A&D	Acuity and Dependency
ACAD	Ambulatory Care and Diagnostic centre
AHP	Allied Health Professional
AECU	ambulatory emergency care unit
AMU	Acute Medical Unit
AQuA	Advancing Quality Alliance
BADBIR	British Association of Dermatologist's Biological
BRCA	National Breast Cancer Audit
BSCN	British Society for Clinical Neurophysiology
BTS	British Thoracic Society
CCG	Clinical Commissioning Groups
CEM	College of Emergency Medicine
CEO	Chief Executive Officer
CHD	Congenital heart disease
CHPPD	Care Hours per Patient Day
CIP	Cost Improvement Plans
CLAHRC	Collaboration for Leadership in Applied Health Research and Care
CMP	Case Mix Programme
CMR	Cardiovascular Magnetic Resonance
COPD	Chronic Obstructive Pulmonary Disease
CPAU	Chest Pain Assessment Unit
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRM	Cardiac Rhythm Management
CSCNS	Community Specialist Children Nursing Service
CT	Computed Tomography
CT2	Core Medical Trainee Year 2
DAHNO	Data for Head and Neck oncology
DNA	Did Not Attend
DoLS	Deprivation of Liberty Safeguards
DTOC	Delayed Transfer of Care
DVT	Deep Vein Thrombosis
EAT	Excellence Assessment Tool

Abbreviation	Definition
ECG	Electrocardiogram
ECHO	Echocardiogram
ED	Emergency Department
EDD	Estimated Discharge Date
EICO	Ealing Integrated Care Organisation
ERICE	Education, Research, Innovation and Clinical Excellence
FAIR	Find, Assess, Investigate and Refer
FFFAP	Falls and Fragility Fractures Audit Programme
FFT	Friends and Family Test
FY1	Foundation Year 1 (medical training)
FY2	Foundation Year 2
GAS	Goal Attainment Scores
GP	General Practitioner
HCAI	Healthcare-acquired infections
HES	Hospital Episode Statistics
HMB	Heavy Menstrual Bleeding
HPV	Human Papilloma Virus
HSCIC	Health & Social Care Information Centre
IBD	Inflammatory Bowel Disease
ICE	Intermediate Care Ealing
iHV	Institute of Health Visiting
IMT	Information Management Technology
IRP	Independent Reconfiguration Panel
KPI	Key Performance Indicator
LAS	London Ambulance Service
LDLCA	Last Day of Life Care Agreement
LNWH	London North West University Healthcare NHS Trust
LOLIPOP	London Life Sciences Prospective Population Study
LVEF	Left Ventricular Ejection Fraction
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries across the UK
MCAP	Managed Care Appropriateness Protocol
MDT	Multi-disciplinary Team
MHI	McKinsey Hospital Institute
MINAP	Myocardial Infarction National Audit Project
MOCHA	Models of Child Health Appraised

Abbreviation	Definition
MRSA	Methicillin Resistant Staphylococcus aureus
NAOGC	National Oesophago-Gastric Cancer Audit
NBOCAP	National Bowel Cancer Audit Project
NCAA	National Cardiac Arrest Audit
NCEPOD	National Confidential Enquiries into Perioperative Deaths
NCISH	National Confidential Inquiry into Suicide and Homicide
NDIA	National Diabetes Inpatient Audit
NELA	National Emergency Laparotomy Audit
NEWS	National Early Warning System
NHFD	National Hip Fracture Database
NHS	National Health Service
NHSI	National Health Service Improvement
NICE	National Institute for Clinical Excellence
NIHR	National Institute for Health Research
NIV	Non-Invasive Ventilation
NJR	National Joint Registry
NLCA	National Lung Cancer Audit
NOF	Neck of Femur
NPDA	National Paediatric Diabetes Audit
NPH	Northwick Park Hospital
NPSA	National Patient Safety Agency
NQB	National Quality Board
OD	Organisational Development
PALS	Patient Advice and Liaison Service
PBM	Patient Blood Management
PE	Pulmonary embolism
PEWS	Paediatric Early Warning System
PHSO	Parliamentary and Health Service Ombudsman
PHE	Public Health England
PICANet	Paediatric Intensive Care Audit Network
PICC	peripherally inserted central catheter
PLACE	Patient Led Assessment of Care Environment
PND	Post-natal Depression
POMH	Prescribing Observatory for Mental Health
PROMS	Patient Reported Outcome Measures
PTL	Patient Tracking List

Abbreviation	Definition
R&D	Research & Development
RTT	Referral To Treatment
SaHF	Shaping a Healthier Future
SBAR	situation, background, assessment, recommendation
SCBU	Special Care Baby Unit
SCPT	specialist community practice teacher
SHMI	Summary Hospital Mortality Indicator
SOAP	subjective, objective, assessment and plan
SpR	Specialty Registrar
SSNAP	Sentinel Stroke National Audit Programme
STARRS	Short Term Assessment, Rehabilitation and Reablement Services
TARN	Trauma Audit & Research Network
TB	Tuberculosis
UCC	Urgent Care Centre
UTI	Urinary tract infection
VTE	Venous Thromboembolism
WTE	Whole Time Equivalent

Auditor’s opinion

LETTERS NEEDS TO BE COPIED AND PASTED AS TEXT

NHS
Harrow
Clinical Commissioning Group

HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE – 12 JUNE 2019

Update on Alexandra Avenue GP Access Centre – June 2019

Section 1 – Summary and Recommendations

This report provides the committee with a summary of the latest activity at the Alexandra Avenue GP Access clinic In South Harrow.

Recommendation:
There is no decision required. The paper provides the Committee with an update on the activity at Alexandra Avenue GP Access Clinic.

Section 2 – Report

Introductory paragraph

In November 2018, the Walk in Centre (WiC) at the Alexandra Avenue Medical Centre was converted to the GP Access Centre. The primary change to the services was the removal of Walk In Services and the implementation of booked appointments. The appointments are available to patients registered with a Harrow GP. Patients registered with GPs outside of Harrow are directed to the GP Access Centre associated with the borough to which their registered GP is assigned**.**

Performance

Activity at Alexandra Avenue GP Access Centre

The table tomorrow provides a summary of the volumes of patients presenting at the GP Access Centre between December 2018 and April 2019.

Dec-18	Activity	%
Appointments Offered:	1502	
Appointments Filled:	1326	88%
Appointments Not Filled:	176	12%
Patient Did Not Arrive for Appointment	112	7%

Jan-19	Activity	%
Appointments Offered:	1490	
Appointments Filled:	1342	90%
Appointments Not Filled:	148	10%
Patient Did Not Arrive for Appointment	137	9%

Feb-19	Activity	%
Appointments Offered:	1381	
Appointments Filled:	1248	90%
Appointments Not Filled:	133	10%
Patient Did Not Arrive for Appointment	128	9%

Mar-19	Activity	%
Appointments Offered:	1504	
Appointments Filled:	1247	83%
Appointments Not Filled:	257	17%
Patient Did Not Arrive for Appointment	139	9%

Apr-19	Activity	%
Appointments Offered:	1480	
Appointments Filled:	1415	96%
Appointments Not Filled:	265	18%
Patient Did Not Arrive for Appointment	154	10%

The activity has increased steadily over the five months with a slight dip in March 2019. This was as a result of appointments being ring-fenced for a practice in Harrow which had requested assistance with appointment support.

The percentage of patients failing to attend is remaining static at around 10% - or one in 10 patients. The service provider is working on new models of care to help reduce this volume.

The monthly appointments offered variation is associated with the days within the month.

Weekday utilisation of the service accounts for around 70% of total activity whilst the remaining 30% occurs at weekends.

Weekday uptake of appointments is at almost 100% utilisation. Sunday appoint utilisation, particularly after 12md has been slow to build. It has been running at approximately 70%. The CCG is working with the Urgent Treatment

Centre, NHS 111 and the GP surgeries to increase the use of Sunday appointments.

Onward Referrals
NHS Harrow CCG has been working with the service provider at the Alexandra Avenue GP Access Centre to monitor the emergency activity at the service. The providers record the outcome for every patient, including onward referrals to A&E, 999 Ambulance calls, and referrals to the Urgent Treatment Centre

Alexandra Avenue GP Access Onward Referrals

Summary Dec 2018 - Jan 2019	Activity	%
Appointments Offered:	7357	
Appointments Filled:	6578	89%
Appointments Not Filled:	979	13%
Patient Did Not Arrive for Appointment	670	9%
999 Ambulance Requests	103	1.40%
Referrals to Acute Hospital A&E	39	0.53%

Less than 2% of patients were referred to the Acute Hospital. Of those 0.53% were referred to the A&E Department or Clinical Speciality such as Surgery of General Medicine. 1.4% of patients attending the CP Access centre required transfer to the acute hospital via 999 ambulance

Patient Feedback
NHS Harrow CCG has received around 150 responses to requests for feedback on the GP Access Centre. Overall the feedback from patients has been positive. Below is comment provided by a service user.

"The changes to the Alex has been very convenient for me as I am able to arrange a suitable time to book an appointment for my Mother who is 73, due to work and other commitments during the week. I have had difficulties in the past when trying to book a GP appointment at my Mother's practice within a short time frame, however, The Alexandra GP Access Centre enables be there to support my Mother and the booking system is easy to do via the 111 service. For this I am grateful".

A more detailed feedback summary will be provided to the committee.

The feedback process is ongoing with the provider seeking user feedback at every opportunity. This feedback is used as part of monthly service review meetings between the CCG and service provider so help reshape the service.

Risk Management Implications

The Alexandra Avenue service has a Risk Register which is supplied to NHS Harrow CCG. The register has risks and mitigation plans, focused on quality impact and business continuity

Equalities implications / Public Sector Equality Duty

The Alexandra Avenue GP Access Centre service has undergone a Quality Impact Assessment as well as an Equality Impact Assessment. Both assessments have been reviewed by the NHS Harrow CCG quality Committee.

Section 4 - Contact Details and Background Papers

Contact: Tom Elrick, Assistant Managing Director, NHS Harrow CCG.
Tel: 0208 966 1160

REPORT FOR: HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE

Date of Meeting:	12 June 2019
Subject:	Information report: Public Health Forward Plan
Responsible Officer:	Carole Furlong Director of Public Health
Scrutiny Lead Member area:	Health: Councillors Michael Borio and Vina Mithani
Exempt:	No
Wards affected:	All
Enclosures:	None

Section 1 – Summary and Recommendations

This report sets out the Public Health Department's plans for 2019-20, including an overview of the budgets and the priority areas of work for the team.

Recommendation: That the report be noted.
(For information)

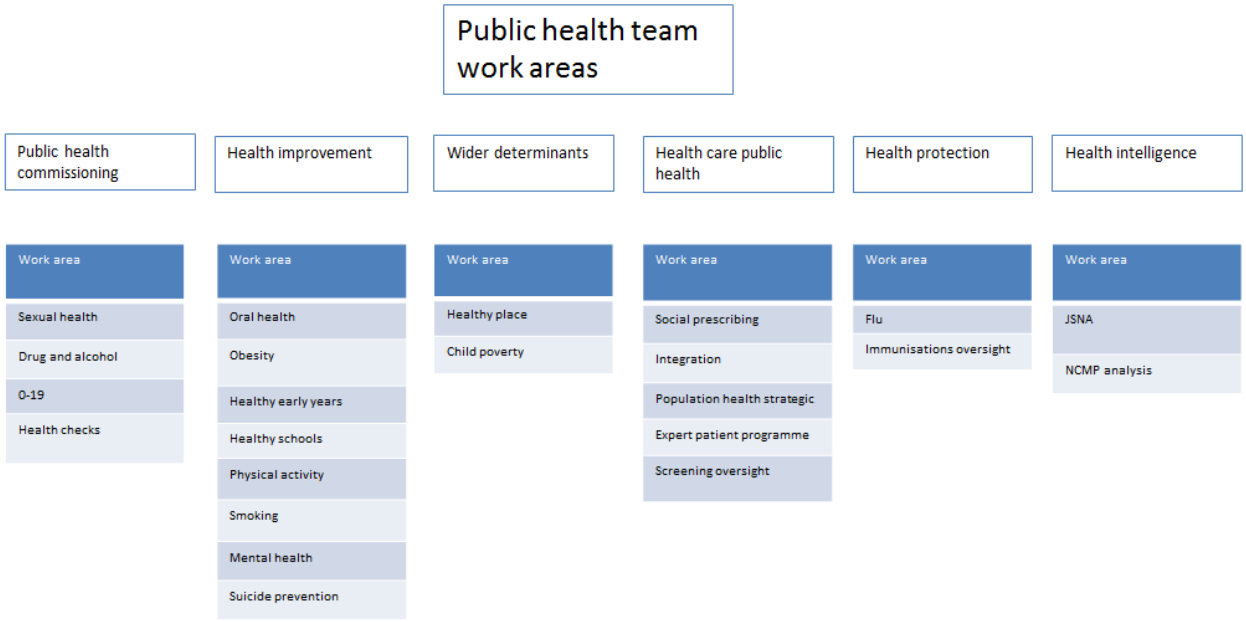
Section 2 – Report

Background

Prior to April 2019, public health in Harrow was a shared service with Barnet Council. From the 1st of April 2019, this team became two separate teams, with restructure of the team also occurring at this time. Now following one year of being a re-focused Harrow

team, the plans and priorities for the coming year are being brought to Health and Care Scrutiny.

Public health team areas of work are covered in the following:



Priorities within work areas

1. Development of overarching strategies

Joint Strategic Needs Assessment (JSNA):
This is being completed over the course of 2019-20. The JSNA is a statutory requirement shared between the CCG and Local Authority. It pulls together population and health data to assess the health needs of the population and inform priorities and strategies for the population of Harrow. The JSNA is structured using the life course approach of Start Well, Live Well, Work Well, and Age Well.

Joint Health and Wellbeing Strategy (JHWS):
This is being refreshed over 2019-20 to be launched as a new strategy for 2020-2023. The strategy will follow the same life course approach as the JSNA and will be informed by the needs and priorities highlighted in the JSNA. The JHWS will be developed through stakeholder consultation and signed off and owned by the Health and Wellbeing Board. The strategy will involve and engage stakeholders across the Council and CCG, with wide-reaching actions and responsibilities for health and wellbeing.

Annual Public Health Report (APHR):
The APHR is a statutory requirement to be produced annually. This year the focus will be on mental health and community resilience, revisiting and building on an APHR ("Building Bridges") completed four years ago which looked at social isolation and loneliness in Harrow.

2. Public health commissioning

Sexual health:
Harrow's sexual health services are commissioning jointly across Outer North West London (Harrow, Brent and Ealing), with a rolling lead commissioner. From September Harrow will be the lead commissioner.

The new integrated sexual health service at Caryl Thomas has now been officially launched – bringing together testing and treatment services.
Channel-shift to the London-wide e-service continues to increase and is being monitored carefully.

Substance misuse:
The adult drug and alcohol service contract is due for renewal by April 2020. This re-procurement will be the focus of this coming year.

0-19:
The new 0-19 service officially launched on 1st July 2018. Mobilisation and transition to the new service has been ongoing. The new service brings in changes to the health checks offered to babies, and these changes will be piloted over the coming year. KPIs will continue to be monitored closely.

NHS Health Checks:
The NHS Health Checks programme, delivered through GPs, met the target for the first time ever for Harrow Council at the end of March 2019. Over the coming year the focus will be to build on this, getting all GPs on board and working towards a higher conversion rate of Health Checks completed versus invited.

3. Health Improvement

Oral health:
Oral health is a priority for public health in Harrow, with the highest proportion of children with decayed missing or filled teeth by the age of 5 compared to the rest of London.

Over the coming year the oral health strategic group will be re-established to pull together and have oversight of various elements of work on oral health. These include:

- Managing Migration fund – recruiting an oral health promoter working with the Romanian community
- Continuing to supply oral health brushing packs
- Continue to evaluate impact of oral health training previously delivered to front line early years staff
- Healthy Pupil Capital Fund – this has been used to install water fountains in schools across Harrow

Obesity:
Obesity is a priority issue in Harrow. 18.8% of reception children in Harrow are overweight, rising to 34.4% in year 6 (National Childhood Measurement Programme data). This is comparable to overall rates in England. Obesity is a key risk factor for diabetes, and Harrow has the highest prevalence of diabetes in London.

The causes of obesity are complex, relating to many factors in the environment in which we live. Harrow has an obesity strategy, providing actions to prevent obesity and manage weight. However this strategy is out of date and will be updated during 2019-20, developing new actions for stakeholders working across various Council and wider departments that can influence prevention of obesity as well across the obesity pathway. One current gap is around weight management services, and this will be looked at as part of this strategy refresh.

Healthy Early Years and Healthy Schools:

Healthy Schools London is a pan-London GLA supported initiative to support schools to be healthier focussing on obesity, oral health, physical activity, and mental health as themes. Health Education Partnership are commissioned to provide support to schools. 54 of 62 schools are registered, with 32 bronze, 20 silver, and 11 gold awards. Over the coming year the aim is to increase the number of schools with awards – 10 new bronze, 8 silver, and 6 gold awards.

Healthy Early Years is a new pan-London GLA supported initiative which transposes the learning form the Health Schools programme into an early years setting. Introduced in Summer 2018, it is also being implemented in Harrow, again with support from Health Education Partnership. A number of early years settings are working towards bronze award, with Cedar's Children's Centre being the first to achieve it. This will be built on further over coming year aiming for more settings to achieve this award.

Physical activity:
Work on physical activity is led through the Active Harrow strategy group, a partnership that leads the monitoring and oversight of the physical activity action plan. The action plan is currently in the process of being updated, with new refreshed actions to bring wider stakeholders together to increase physical activity in more groups, particularly in established priority groups currently undertaking less physical activity. Actions will relate to transport, leisure, parks, and public health.

Smoking:
Harrow has not had a stop smoking service for the last two years. However there has been recent agreement to re-establish a small specialist stop smoking service; one stop smoking advisor (0.6 WTE) offering clinics in the community particularly focusing on high priority population groups such as people with mental health disorders, pregnant women, and those from more deprived areas. In addition Harrow has now signed up to the London-wide stop smoking helpline and promotional initiatives.

The priority for the coming year will be to recruit to this post and re-establish referral routes into this service.

Mental health:
Mental health support is not solely delivered through public health. Children's commissioning team commission Harrow Horizons, a tier 2 service for children and young people, and the CAMHS service is commissioned through the CCG. Through public health, Mental Health First Aid (MHFA) courses are commissioned for people working with both adults and children and young people. These have been very well received and help break down barriers and increase knowledge around mental health.

Over the coming year there will be more youth MHFA courses run, and work will be undertaken to ensure mental health is built in strategically across the JSNA and the health and wellbeing strategy.

Suicide prevention:
Public health is working collaboratively with the CCG to develop a joint Brent and Harrow suicide prevention plan. This will be signed off over 2019-20 by a wide stakeholder group, and two key areas for action will be agreed and plans developed through a working group.

4. Wider determinants of health

Over 2019-20 public health will continue to contribute to wider council initiatives that address the wider determinants of health (as shown in Table 1). It will be important that these programmes have identifiable public health outcomes so that they meet the grant conditions.

In addition to the public health grant spend described above, a priority for 2019-20 is to develop how public health is considered and approached across the council, across all services. This Health in All Policies (HiAP) approach systematically and explicitly takes into account the health implications of the decisions we make as a council; targets the key social determinants of health; looks for synergies between health and other core objectives and the work we do with partners; and tries to avoid causing harm with the aim of improving the health of the population and reducing inequity.

For example, transport strategies that relate to active travel and community safety have an impact on health and wellbeing, improving unemployment and economic development impacts on wellbeing, community cohesion impacts on wellbeing, regeneration and development can have a huge impact on wellbeing. It is important that opportunities to enhance health and wellbeing of the Harrow population are considered across strategies.

Work is underway already in linking in to transport in the Active Harrow workstream, and in discussion of approaches to health impact assessments in planning processes. Further strengthening and development across these areas is priority for 2019-20.

Harrow is also pilot for a “Superzone” around a school in Wealdstone – looking at factors in the wider environment that impact on health and wellbeing in a radius around the school. Consultation has taken place with parents and staff and issues around congestion, safety, and healthy eating were raised. Work is underway looking at enforcement around the congestion zone, investigating walking buses, promoting active travel, and healthier takeaway programme.

5. Health care public health

Integration and population health:
Public health is working with the CCG supporting the integration work with a focus on the working groups on dementia and on community mental health. Going forward, as the governance of the Integrated Care Partnership develops, public health will lead the population health management agenda.

Social Prescribing:
Public health are leading the development of a social prescribing offer for Harrow, working in partnership with the CCG. The proposal involves the social prescribing link workers from each Primary Care Network becoming part of a Harrow-wide social prescribing offer – with a digital solution and coordinator funded by public health. This work is a key priority for the coming year.

The Expert Patient Programme:
This programme provides peer-led support for individuals with long term conditions. It is being re-established this year, and will be a key service that can be referred to via a social prescribing service.

6. Health protection

A priority for this year going forward is to establish a Harrow Health Protection Board. This will provide robust assurance for outbreaks and cases of infectious diseases, provide oversight of immunisation programme uptake, and assurance of seasonal and pandemic flu plans.

7. Health intelligence

The priority for 2019-20 around health intelligence is development of the JSNA, as described above. This will be key for Harrow-wide intelligence and priority setting and will form the basis of a rolling programme of intelligence updates in the coming years. The purpose of the health intelligence function is to assess health needs within the population and identify health inequalities and their causes.

Ward Councillors' comments

None requested.

Financial Implications

Local authorities receive an annual ring-fenced public health grant from the Department of Health. The core condition of this grant is that it should be used only for the purposes of the public health functions of local authorities. The ring fenced grant is confirmed until March 2020 at which point the ring-fence may be lifted. The annual Public Health allocation has been reducing yearly. In 2018-19, the allocation was £10.808M and in 2019-20 is £10.523M.

Currently the grant is used to fund:

- Staffing: Core team (Director of Public Health (0.6 WTE); Consultant in Public Health (1WTE); PH Strategists (1.6 WTE); PH Commissioners (2 WTE); PH Analyst (0.8WTE); Commissioning Support officers (2 WTE)). Additional staffing to support the DPH functions that relate to prevention, planning for, and responding to, emergencies involving a risk to public health and funding for 0.2 WTE Child Death Overview Panel Support (provided by CCG) to support the Harrow Safeguarding Children's Board' responsibility.
- Commissioned services: including the mandated services for sexual health, NHS health checks, and 0-19 services (health visiting and school nursing including the National Child Measurement Programme), and a non-mandated but necessary service to treat those with substance misuse problems.
- Health improvement and prevention activity
- Activity to tackle the wider determinants of health across the council beyond the public health team. This includes contributing to the funding for children's centres, adult social care prevention activity, and strengthening employment support. In 2017-18, around £900k was spent on wider determinants. This allocation increased to £1.7M in 2018-19 and was further enhanced by savings made on the sexual health budget (net of the requirement to fund the grant reduction) so actual spend was £1.9M. The allocation to wider determinants has increased to £2.1M in 2019-20 requiring a contribution from the PH reserve)

Table 1 summarises the use of the public health budget for 2019/20 (rounded)

Table 1 Public Health Budget 2019-20

		Budget ('000s)
Staffing	*Core team*	*607.8*
	Additional	*24.8*
	Subtotal	**632.6**
Commissioned Services	*Sexual health*	*2,192*
	Substance misuse	*1,946*
	0-19 Public Health Nursing	*3,536*
	NHS Health Checks	*176*
	Subtotal	**7850**
Health improvement	*Stop Smoking Service*	*60*
	London Stop Smoking programme	*7*
	Physical Activity programmes:- adult	*20*
	Weight Management - adult	*20*
	Children's programmes	*50*
	School Superzone pilot	*10*
	Mental Health – Thrive London	*22*
	Mental health projects	*30*
	Subtotal	**219**
Wider determinants	*Early Intervention (excl mgt): 45% funded*	*921.6*
	Housing Related Support: 50% funded	*222.5*
	Welfare to Work: 50% funded	*52*
	Economic Development: 50% funded	*185.2*
	Leisure Contracts Development Officer: 100% funded	*47.9*
	Sports Development Officer: 100% funded	*54.6*
	London Youth Games: 100% funded	*10.8*
	Dementia Support - Annie's Place 100% funded	*30*
	The Bridge: 100% funded	*175*
	Age UK & HUG: 100% funded	*55*
	Rethink Recovery House: 100% funded	*210*
	Subtotal	**1,964.6**
	Contribution to overheads	**163**
TOTAL		**10,829.2**

Although this total in over the grant allocation, it is anticipated that in year savings may be made, and any excess spend will be covered by the public health reserve. An additional £250k for wider determinants has been requested and has been factored into the medium term financial strategy. This will also come from the public health reserve (and is not covered by the section below about the use of the reserve).

The public health ring fence is proposed to finish in April 2020 and that the public health services are funded from the retention of business rates thereafter. There is national lobbying for the ring fence to remain.

The Public Health Reserve

The public health grant is ring fenced and any underspend can be carried forward in a reserve fund. This funding is subject to the same grant conditions as the annual allocation. In 2017-8, the reserve increased while the public health team were being restructured and last year it increased further due to the underspend on the sexual health contract due to the new e-service being introduced.

Some contingency needs to be built into the public health budget to cover our role in health protection and emergency planning and any unexpected increases in costs of services. In order to continue with the planned programme of work, we propose to spend some of the reserve in providing maternity cover for a public health strategist for one year and to bring in additional support to develop the JSNA for the Health and Wellbeing Board.

In addition to the almost £2m funding of the above wider determinants of health, further funding has been used to fund or pump prime programmes that support the work of the council. These programmes have an expectation that they will deliver a cost saving in future years or that they fill a gap in programmes to support specific vulnerable groups. In 2018-19, over £37k was allocated to three of these projects and an additional £15k was allocated for continuation of the Capable Communities social prescribing project whose grant had finished. In 2019-20, over £270k has been allocated to these projects and a planned £175k for 2020-21.

Table 2 Planned use of Public Health Reserve 2019-21

Area of activity		**2019-20 (000s)**	**2020-21 (000s)**
Public Health Capacity	*PH Strategist Maternity Cover*	*32.3*	*17*
	JSNA PH Analyst – interim support	*40*	
Wider determinants	*ADHD and autism support*	*43*	
	ASC Hoarding project	*19*	
	STP-1 Employment for people recovering from alcohol misuse	*25.7*	*25.6*
	Dementia admiral nurse	*50*	*25*
	Dementia hub	*25*	
	Social prescribing	*100*	*50*
	Paramedic/ care homes pilot	*50*	
	H&SC integration	*75*	
	Assistive technology	*50*	*75*
	Total	**437.7**	**175.7**

Performance Issues

Through the focus of public health, we will be impacting on many of the Public Health Outcome Framework indicators. Public Health, by its nature, depends on partnerships to achieve improvement. Many of the public health indicators in the PHOF are not within the scope of the public health team to deliver on. We report on a number of corporate plan indicators that are related to commissioned services. We also monitor high level indicators of population health that contribute to the national and local ambition for increased healthy life expectancy and reduced differences in life expectancy and healthy life expectancy between communities.

Both life expectancy and healthy life expectancy in Harrow's men and women continues to be higher than the England average. However, the inequalities in life expectancy at birth have increased in from 5.7 to 7.0 years in men and from 3.3 to 5.0 years in women between 2010 and 2017.

Environmental Impact

Through actions that impact on active travel, such as some of the travel actions as part of the Active Harrow group and the Superzones work, there will be an impact on rates of active travel and therefore on air pollution.

Risk Management Implications

Risk included on Directorate risk register? No

Separate risk register in place? No

Equalities implications / Public Sector Equality Duty

Was an Equality Impact Assessment carried out?

No. A core principle underpinning the work of public health is inequalities and all of our work is informed by inequalities in health.

Council Priorities

Through the work of public health, all council priorities are being considered and are impacted.

1. Building a Better Harrow

- Create a thriving modern, inclusive and vibrant Harrow that people can be proud to call home
- Increase the supply of genuinely affordable and quality housing for Harrow residents
- Ensure every Harrow child has a school place
- Keep Harrow clean
- More people are actively engaged in sporting, artistic and cultural activities in ways that improve physical and mental health and community cohesion.

Active Harrow work impacts on the above, building on wider determinants activity impacts on employment, community development and engagement.

2. Supporting Those Most in Need

- Reduce levels of homelessness in the borough
- Empower residents to maintain their well-being and independence
- Children and young people are given the opportunities to have the best start in life and families can thrive
- Reduce the gap in life expectancy in the borough

All work of public health is looking to reduce the gap in life expectancy through addressing health inequalities.

The 0-19 service aims to give children the best start in life, and there are higher levels of service offered to the more vulnerable families.

3. Protecting Vital Public Services

- Harrow has a transport infrastructure that supports economic growth, improves accessibility and supports healthy lifestyles

- Healthcare services meet the needs of Harrow residents
- Everyone has access to high quality education
- A strong and resourceful community sector, able to come together to deal with local issues
- Harrow continues to be one of the safest boroughs in London.

Through working with transport we are aiming to support transport infrastructure. Health care public health work with the CCG aims to ensure health care services meet the needs of Harrow residents.

4. Delivering a Strong local Economy for All

- A strong, vibrant local economy where local businesses and thrive and grow
- Reduce levels of in-work poverty and improve people's job opportunities
- Harrow is a place where people and businesses invest

Wider determinants of health work particularly looking at employment services supports this objective.

5. Modernising Harrow Council

- Deliver excellent value for money services
- Reduce the borough's carbon footprint
- Use technology and innovation to modernise how the Council works
- Improving access to digital services.

Active travel work reduces the borough's carbon footprint.

Section 3 - Statutory Officer Clearance

Name: Donna Edwards	x	on behalf of the Chief Financial Officer
Date: 3 June 2019		

Name: Paul Hewitt	x	Corporate Director of People Services
Date: 3 June 2019		

Ward Councillors notified:	**NO, as it impacts on all Wards**

Section 4 - Contact Details and Background Papers

Contact: Sally Cartwright, Consultant in Public Health
Tel: 07927548184 Email: sally.cartwright@harrow.gov.uk

Background Papers: None.

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REPORT FOR: HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE

Date of Meeting:	12 June 2019
Subject:	Update from NW London Joint Health Overview and Scrutiny Committee
Responsible Officer:	Alex Dewsnap, Director of Strategy
Scrutiny Lead Member area:	Health: Policy Lead – Councillor Michael Borio Performance Lead – Councillor Vina Mithani
Exempt:	No
Wards affected:	All
Enclosures:	None

Section 1 – Summary and Recommendations

This report provides an update on discussions held at the meeting of the NW London Joint Health Overview and Scrutiny Committee (JHOSC) on 12 March 2019.

Recommendations:
The Sub Committee is asked to consider the update and provide any comments / issues that are to be raised in advance of the next JHOSC meeting on 21 June in Hounslow.

Section 2 – Report

Background
The North West London Joint Health Overview and Scrutiny Committee (JHOSC) comprises elected members drawn from the boroughs geographically covered by the NHS NW London Shaping a Healthier Future (SaHF) programme and was set up to consider the proposals and consultation process formally between the period of 2 July and 8 October 2012. The proposals set out the reconfiguration of the accident and emergency provision in North West London. This included changes to emergency maternity and paediatric care with clear implications for out-of-hospital care.

The JHOSC published its final report in October 2012, making recommendations on how the SaHF proposals could be developed and implemented, including the risks that needed to be explored. The JHOSC also recommended that the committee continue to meet beyond the original consultation period to provide ongoing strategic scrutiny of the development and implementation of Shaping a Healthier Future.

Harrow's ongoing participation in the JHOSC examining the implementation of the SaHF ensures that scrutiny of the issues is maintained at a regional level and that Harrow residents' perspectives are put forward to the NHS as it implements the SaHF programme. The Health and Social Care Scrutiny Sub Committee receives regular update reports on the JHOSC so that it can pick up any local issues in its own work programme as well as feed into the JHOSC's agenda planning and deliberations. Harrow's member representatives on the JHOSC for 2019/20 are Councillors Rekha Shah and Vina Mithani.

JHOSC meeting 12 March 2019
The last meeting of the JHOSC was held on 12 March 2019 at Harrow Council and attended by Councillor Rekha Shah. The agenda for this meeting included:

<u>Updates to committee</u> on:

i) NW London Patient Transport Services Quality Standards
ii) Health Based Places of Safety Suites Proposal Development
iii) Joint Committee of NW London Collaboration of Clinical Commissioning Groups
iv) Use of consultants by NW London CCG

<u>Coronary Heart Disease standards implementation in London</u> – Coronary Heart Disease (CHD) standards were consulted upon in 2015. The Royal Brompton Hospital (RBH) cannot currently meet the standard for paediatric co-location from the Chelsea site. In 2017, RBH proposed a partnership with another compliant provider (Guy's and St Thomas' Hospital) in order to meet all of the standards and continue to provide the service. Commissioners are working through the options for the CHD service reconfiguration including paediatric co-location.

Update on Strategic Outline Case Part 1 (SOC1) funding bid and Shaping a Healthier Future (SaHF) – Formal clarification on the status of the bid for SOC1 capital was still awaited at the time of the JHOSC meeting. Mark Easton, the Accountable Officer, explained that with an NHS capital budget of £1.2 billion, it was inevitable that some parts of the bid might be rejected. However, he reassured members that officers would continue to pursue the case for capital investment in London and acknowledged the need for the backlog of maintenance on sites to be addressed. There was also a need to ensure that sites were safe.

Long-term plan and creating an integrated care system in NW London – The report presented a strategic overview of the alignment between the NHS Long-Term Plan and the North West London Health and Care Partnership. As well as working on the alignment at regional level, it was crucial that work was carried out at borough level too – with a range of models which would vary from borough to borough. There is considerable work and engagement to be done over the next year and in terms of public engagement, there is opportunity for improvement by holding an outreach event in every borough and the establishment of a citizens' panel. Consideration is also being given to roadshows and consultation with local employers who could help shape the plans as well as NHS and local authority staff.

Continuing healthcare policy proposals - NHS North West London Clinical Commissioning Groups (CCGs) are proposing to make changes to the policy on funding community-based packages of care for people that were eligible for Continuing Health Care. This is essentially to manage the budget. Involvement of an individual's family in the determining packages is key.

Annual review of the JHOSC – Members agreed the suggested process for undertaking review of the JHOSC. Outcomes from the member workshop are given below.

Updates from the next JHOSC meeting (on 21 June at Hounslow) will be reported back to the following Health and Social Care Scrutiny Sub-Committee.

Other updates

Shaping a Healthier Future programme – close down and future steps
On 26 March, the Secretary of State for Health announced the closing down of of the Shaping a Healthier Future programme. In a letter dated 26 March, the NW London Collaboration of CCGs confirmed the decision and stated:

"All parts of the NHS are now in agreement to draw the SaHF programme to a conclusion and bring our on-going efforts to improve health and care together in a new programme as part of our NHS Long Term Plan response. We will not be taking forward the plans as set out in SaHF for changes to Ealing and Charing Cross hospitals, but this does not mean that services across NW London will not change…We want to work with local people, communities and organisations to develop this new plan for NW London, which ensures high quality care for all our residents. We think it should include continuing our expansion of primary and community services and the development of more

integrated care. We are also clear that services will need to be configured in such a way as to build a health system that is both clinically and financially sustainable. If we are to improve care and outcomes for local residents, we know that the status quo is not an option. This new plan for health and care in NW London will therefore still need to include changes, involving some difficult decisions and trade-offs, if we are to offer high quality, person-centered care sustainably. By realigning under the NHS Long Term Plan, updating our planning assumptions and enabling all of our staff, patients, partners and stakeholders to be involved in its development and delivery over time, we will have the best possible chance of success."

The NW London Collaboration of CCGs is establishing an engagement approach to help guide a first local response to the NHS Long Term Plan this coming autumn, as well as seeking to expand existing partnership working to enable further development and implementation of a new health and care strategy for NW London. This will involve talking to local people, and attending Health and Wellbeing Boards and Scrutiny Committees, with a view to developing a new plan for NW London.

Annual review of JHOSC - member workshop

A workshop for JHOSC members was held on 24 May, which Councillor Rekha Shah attended. The purpose of this workshop was the annual review of the JHOSC examining how the JHOSC had worked over the last year, and setting up a work programme for 2019/20.

At this workshop it was agreed that future agendas should focus on two topics only so as to allow proper and full discussion time, and that each borough should champion specific topics and lead/brief others accordingly. A protocol for change is being developed by officers. This will include revising the terms of reference to reflect the closure of the Shaping a Healthier Future programme.

Ward Councillors' comments

Not applicable as all wards affected.

Financial Implications

The costs of delivering the health scrutiny work programme will be met from within existing resources.

Performance Issues

There are no specific performance issues associated with this report.

Environmental Impact

There is no specific environmental impact associated with this report.

Risk Management Implications

There are none specific to this report.

Equalities Implications

There are a number of equalities implications that relate to the reconfiguration of health services in North West London as a whole. These implications form part of the ongoing considerations of the JHOSC.

Council Priorities

The work of the JHOSC relates most to the delivery of the following council priorities:

Supporting Those Most in Need

- Empower residents to maintain their well-being and independence
- Children and young people are given the opportunities to have the best start in life and families can thrive
- Reduce the gap in life expectancy in the borough.

Protecting Vital Public Services

- Healthcare services meet the needs of Harrow residents.

Section 3 - Statutory Officer Clearance

Statutory clearances not required.

Ward Councillors notified:	N/A

Section 4 - Contact Details and Background Papers

Contact:

Nahreen Matlib, Senior Policy Officer, nahreen.matlib@harrow.gov.uk

Background Papers:

Agendas papers for the JHOSC meetings can be found at:
http://www.harrow.gov.uk/www2/ieListMeetings.aspx?CId=1102&Year=0

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