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

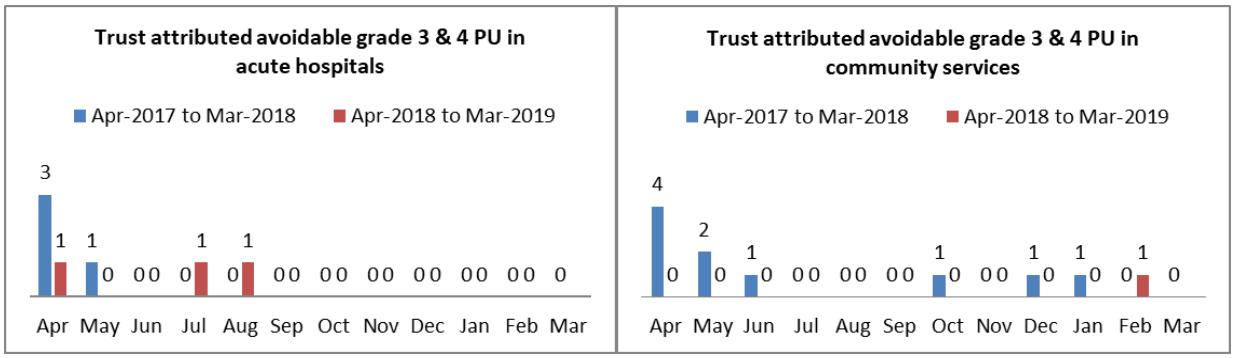
Priority 1: safer care (safe, caring, responsive and well led)

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)

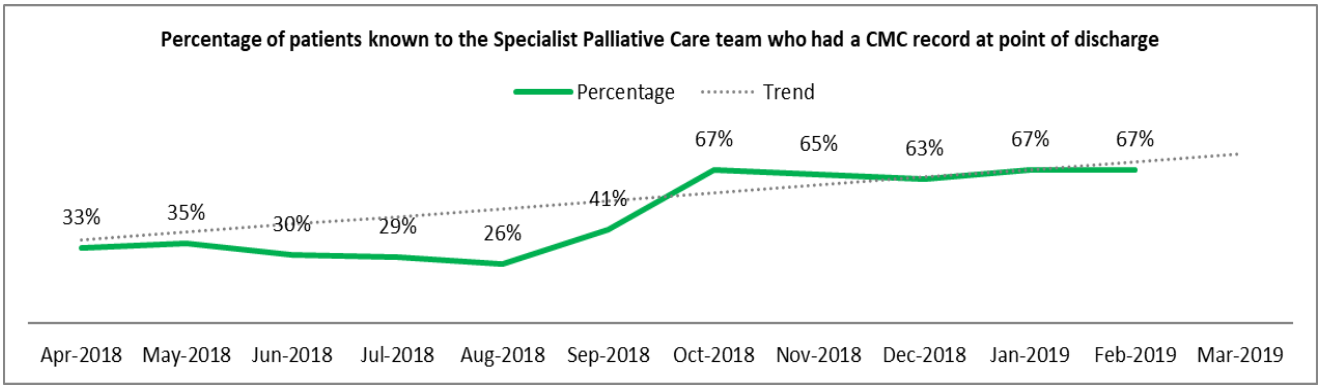
Around 500,000 people die each year in the UK. Of these deaths, 75% are not sudden, but expected (NICE 2015). How we care for the dying is an indicator of how we care for all sick and vulnerable people. It is a measure of society as a whole and it is a litmus test for Health and Social Care services' (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.

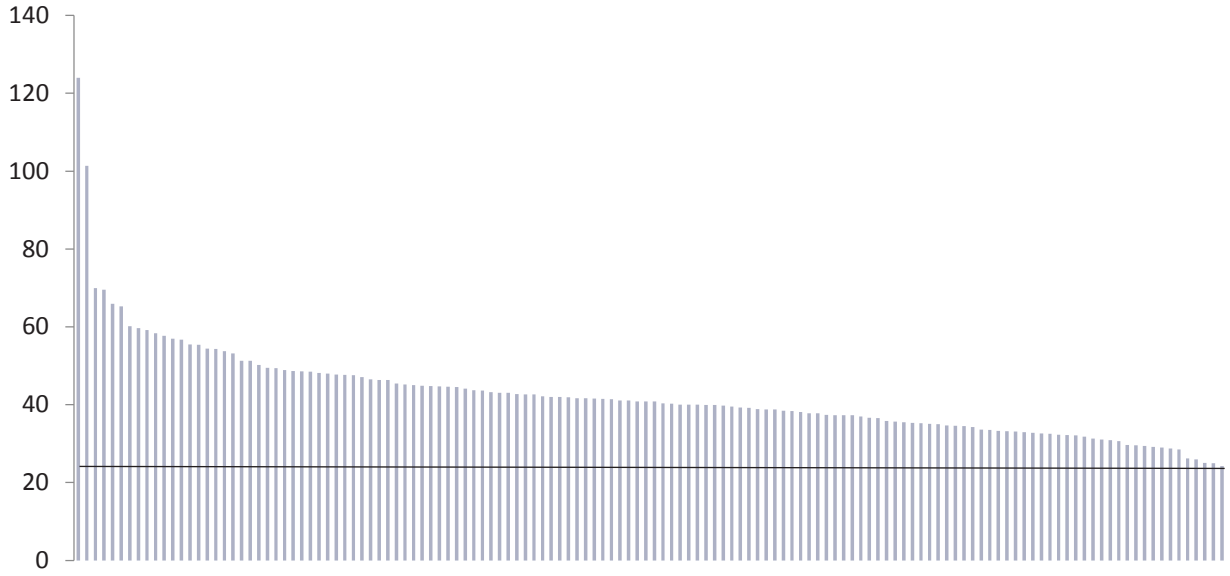
Figures 1 and 2 are taken from the latest National Reporting and Learning Service (NRLS) data report published in September 2018 for the period October 2017 - March 2018 and shows the Trust to be below average for reporting of patient safety incidents. The latest report covers incidents occurring between 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

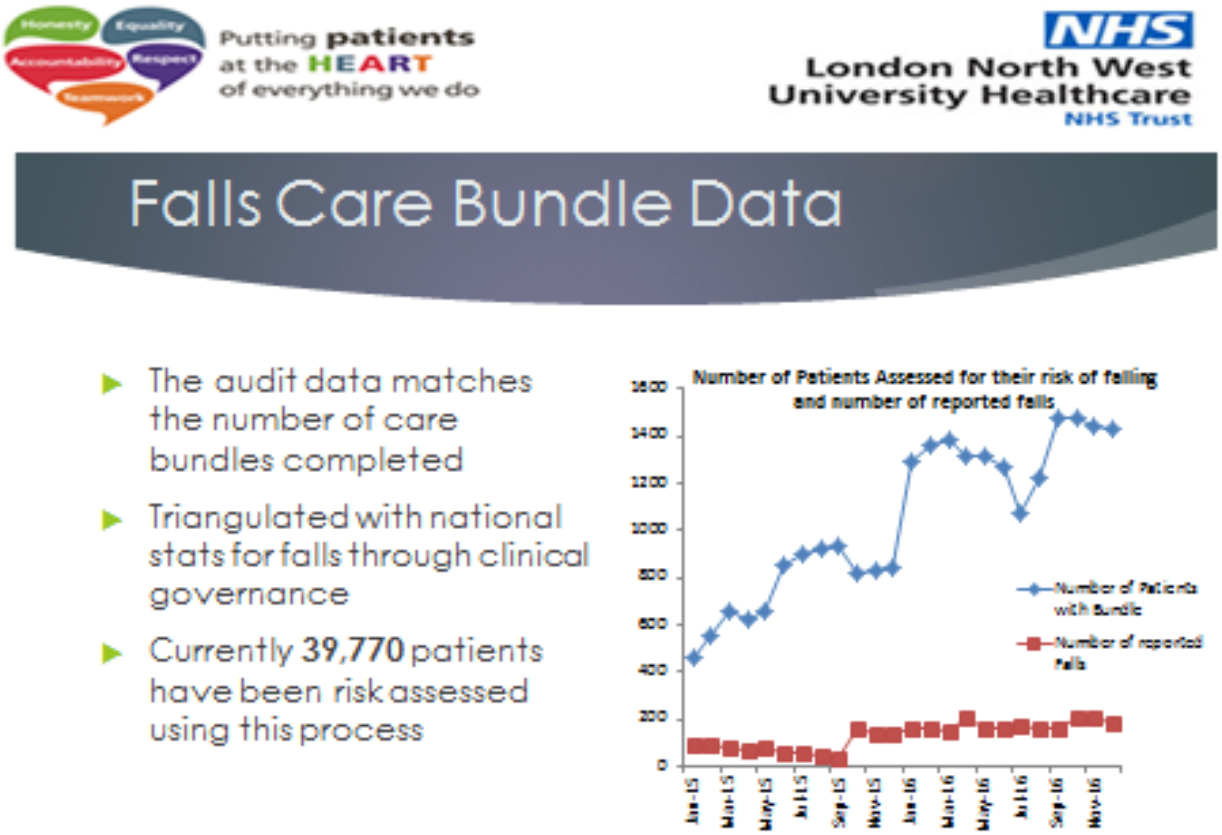
The trust agreed a range of CQUINS with its commissioners for 2018/19 which included falls care bundle, nasogastric bundle and sepsis bundle.

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.

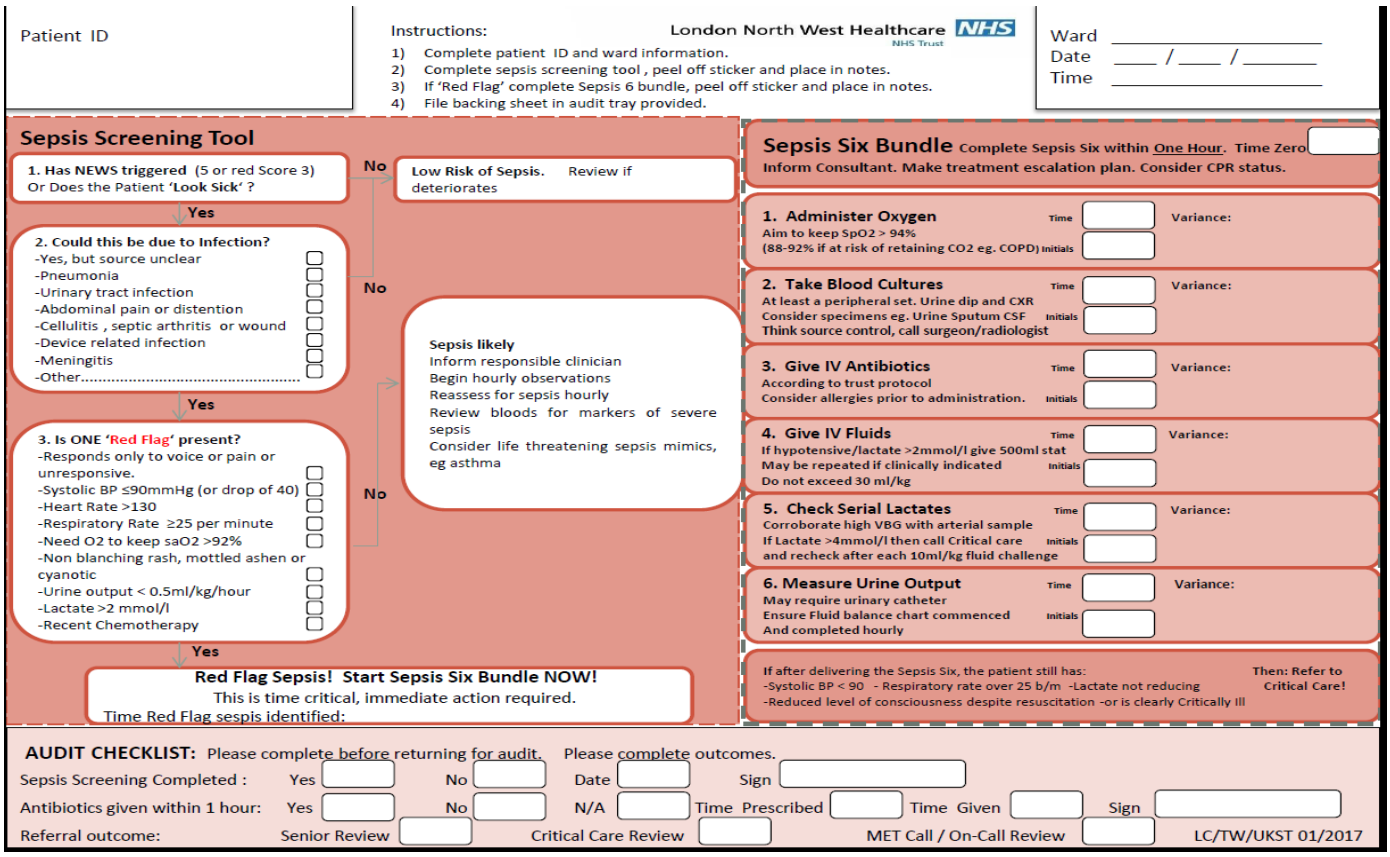


The Falls Bundle has identified that number of patients being risk assessed and showed a high prevalence of patients being risk assessed for falls. This has now been moved into patient documentation which is monitored by nursing staff on the ward. This has led to the bundle being used post fall to identify 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

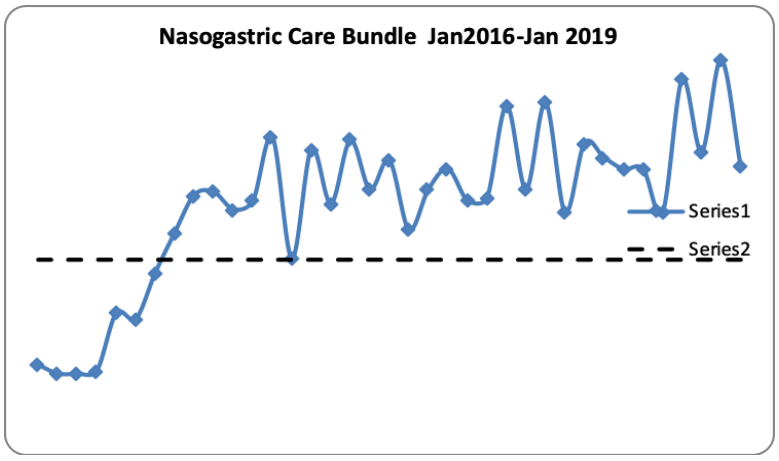


Nasogastric care bundle

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.

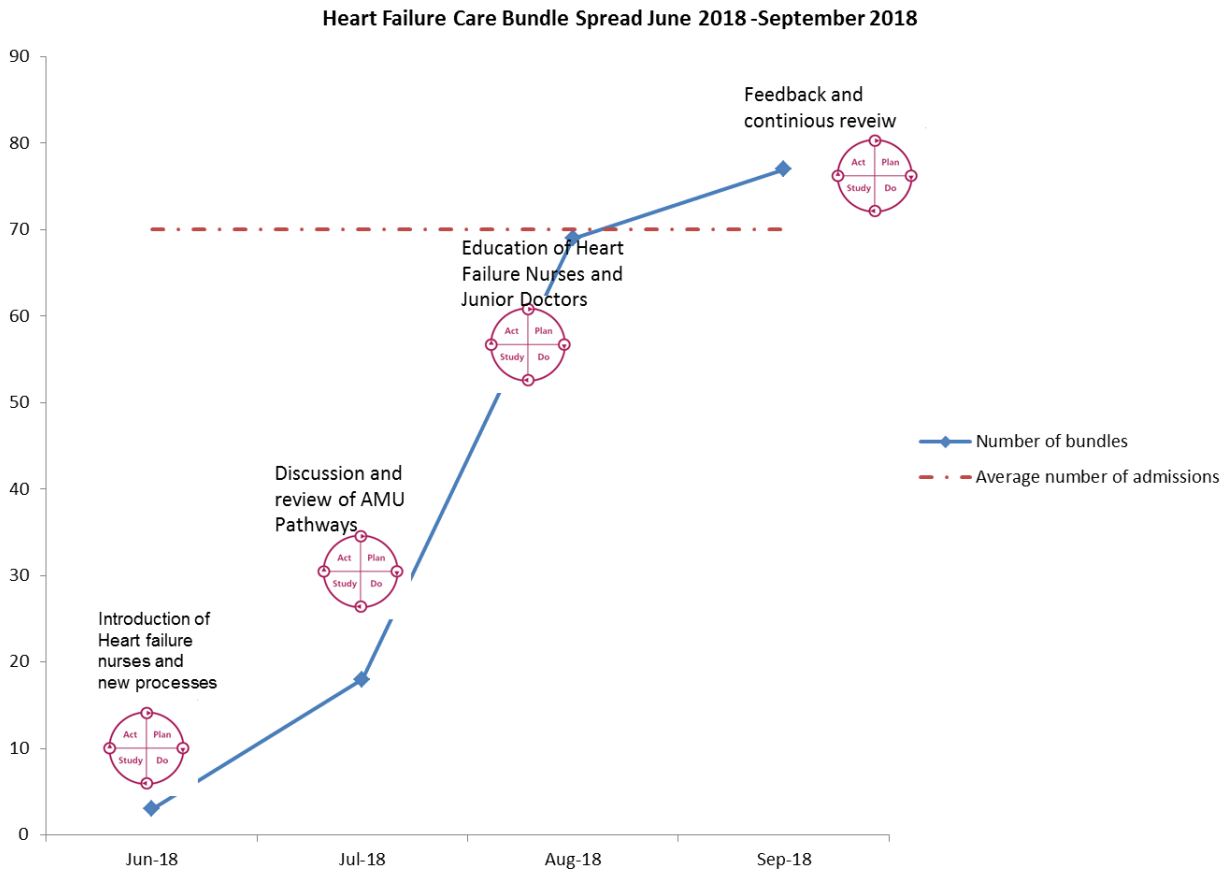
Continuous improvement heart failure programme

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:

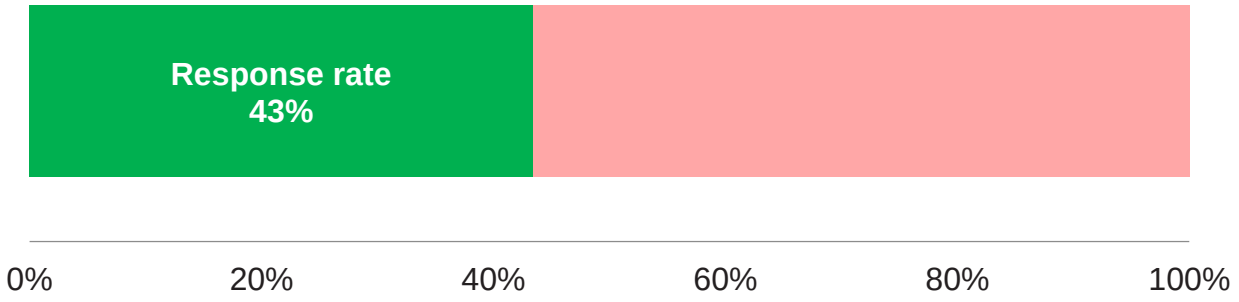
- Developing an open culture
- Ensuring processes are in place to empower and encourage staff to speak up safely
- Promote learning and development
- Improve the experience of workers
- Protect patient safety and the quality of care.

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.

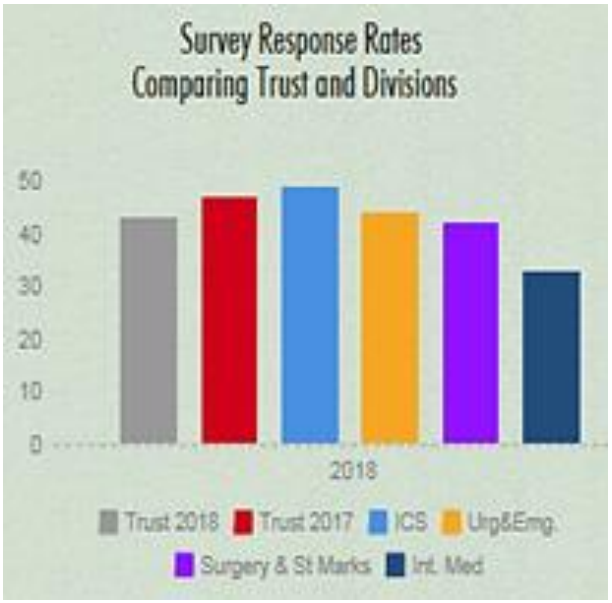
Staff Survey 2018: Summary of Results

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