ONE: INTRODUCTION

STATEMENT FROM THE CHAIR

Welcome to our Quality Account for 2018/19 – my second as Chair of our Trust.

It’s been an eventful year, but one I think we can look back on with no small amount of satisfaction. My overall reflection is that this has been a strong year, albeit one which started in a difficult place.

As I have reported regularly, both in this report last year and to the Board, there were and are significant challenges, particularly around our financial situation. There has also been continued change, particularly in the executive corridor, with Matthew Hopkins leaving us as Chief Executive, and Chris Bown joining in an interim capacity.

I am very pleased that we have taken a real grip on our finances this year. Setting and hitting our control total was a very positive step forward. Our regulators have expressed increased confidence in us, which is very good news.

However, I am clear that we must continue to work constructively and productively to reduce our deficit without compromising the quality and scope of patient care – which must and will continue to be our priority.

We cannot do what we do in isolation, so we continue to work hard on how we engage with others. These are internal – our patient partners, for example – who are an increasingly invaluable asset to our Trust (and I was pleased to create a place for a patient partner to join our Board). They are also our partners in the local and national health economy – NELFT, our clinical commissioning groups, GPs, the BHR Provider Alliance, NHS England and NHS Improvement to name a few, or internationally, the Virginia Mason Institute, which continues to shape our approach (The PRIDE Way) to driving improvements in our hospitals.

On the subject of The PRIDE Way, we are absolutely seeing the benefits of a renewed focus in recent months.

As I write this, a few weeks on from the close of the year, it was fantastic to recently attend our first ever PRIDE Way 3P event – a week-long workshop which created some visionary ideas about how we might redesign our Outpatients (in this case, our fracture clinic).

I was inspired by the energy and enthusiasm in the room, and the testimony of staff at all levels who were involved was a fantastic endorsement.

One of the big priorities we need to tackle in the coming months and years will be around the availability of capital resource to invest in our future.

This is something we face across the NHS but chairing both BHRUT and North East London Foundation Trust (NELFT), I see this all too acutely. We need to make the case loud and clear and I will be doing my best to do just that.

I must pay tribute to the continued work of the King George and Queen’s Hospitals Charity, which has funded many projects this year, making a real difference to our patients, visitors and staff. I’d like to thank everyone in the team and all who support our charity.

I would like to thank the Board, the leadership and the staff for their continued commitment and hard work and I look forward to the year ahead.

Joe Fielder
Chair
Barking, Havering and Redbridge University Hospitals NHS Trust
I am pleased to present our Quality Account for 2018/19. This shows how we performed against our priorities for the year, sets out our priorities for the year ahead and gives detail on all our key performance indicators and assurance statements. I’d like to thank all our staff, volunteers and partners for their hard work.

We had a focused inspection by the Care Quality Commission (CQC) prior to the commencement of the financial year, but we received the formal report in June 2018. This was a positive report in terms of the assessment of our care, which resulted in three services (Maternity, Surgery and Medical Care) being given improved ratings, with ‘good’ ratings overall. However, there were broader points raised which we need to progress.

We have taken steps on all the ‘must do’ actions identified by the CQC. More detail on this inspection and how we have worked on the areas identified for improvement is within this report.

We have again found it challenging to meet the constitutional standards on all fronts this year, but particularly the four-hour access target for emergency care.

We worked closely across the winter with a range of partners to try to find ways to improve performance, and have reintroduced Red2Green as a means of reducing patient stays and improving flow with some very positive results – we now need to successfully embed this practice across the organisation.

We also opened a new RAFTing area at Queen’s at the very end of the financial year, which we hope will improve ambulance transfers for patients and staff alike.

We have performed very well against all cancer standards, including the 62-day constitutional standard, hitting that in all quarters. Some particular specialties saw significant improvements which we need to sustain in the year ahead.

We did not hit the Referral To Treatment target of 92% of patients being treated within 18 weeks. Our original plan for the year was to work towards maintaining the delivery of this standard, but capacity challenges have made this difficult.

Good progress has been made in a number of areas, but over the next year, as part of our joint system recovery plan, we will be completely transforming how Outpatients works in our health economy, aiming to dramatically reduce numbers.

We did not hit the target for diagnostic performance of ensuring 99% of patients receive their diagnostic test within six weeks by some distance. This was due to significant issues around our endoscopy capacity – the fire in our Endoscopy Unit at Queen’s Hospital affected the endoscope decontamination facilities, requiring a mobile unit and outsourcing. As the year ended, we were pleased to reopen the decontamination unit with new kit installed, which should have a positive impact.

Secondly, for MRI we experienced mechanical failures and subsequent capacity issues which also required outsourcing, but towards the end of the financial year we brought in a mobile unit.

We reduced the number of cases of Clostridium difficile infection (CDI) again this year, registering just nine cases, but we did not hit the target of zero cases of MRSA, registering five.

We intend to undertake a project aimed at reducing blood culture contamination rates, which are a contributory factor to some cases of MRSAb and can result in a delay in the prompt treatment of patients.

This project will be undertaken with our Emergency Department, where the majority of blood cultures are taken, in order to promptly identify cases of sepsis.

On the topic of sepsis, we hit our targets for screening and made good progress overall. Achieving delivery of timely sepsis treatment in ED is a constant challenge due to exceptional demand in the departments. The appointment
of a new ED Consultant Lead for sepsis has strengthened the team and the multidisciplinary approach. We have also made significant improvements with implementing an electronic sepsis screening tool to help staff assess paediatric patients.

Measuring incident reporting is an important yardstick to assess the awareness and culture of safety within an organisation. Within our Trust, we have seen a dramatic improvement in recent years. We are now reporting far more. Where we fell short this year was on increasing the number of incidents with no patient harm, and reducing the numbers of serious incidents resulting in harm.

We had three Never Events this year. All have been investigated thoroughly (including with the Healthcare and Safety Investigation Branch – HSIB) with a full risk assessment and training provided to ensure we minimise the risk of them occurring again.

In 2018/19 we reviewed how we categorise and manage medication incidents to try to improve our processes. The medication incident harm levels are reviewed by a small multidisciplinary group. The data shows that we had one medication-related incident as potentially contributing to severe harm to a patient. Our target was for zero incidents.

This incident highlighted some broader issues to be addressed and this has been used to inform local actions and learning. Overall we continue to make good progress in reducing the medication errors classified as serious incidents and there were no medication-related Never Events.

We achieved our targets for staffing fill rates through successful recruitment of nursing staff, supported by our in-house temporary staffing supplier.

A highly-effective preceptorship programme, which achieved a Nursing Times award in 2018, provides mentoring and support for new staff and has resulted in improved retention of this staff group.

The Trust has provided a range of development opportunities for nursing staff including rotation and apprenticeship programmes.

We had a good year in improving complaints responses, reducing reactivations and measures of public satisfaction measured through Friends and Family Test results and the CQC inpatient survey, but we did not deliver a 2% improvement on the staff FFT recommendations.

This Quality Account has been prepared with our clinical teams, the people who are closest to the services being reported upon. Reporting on quality and performance necessarily involves judgement and interpretation. But to ensure that the account paints a fair picture it has been scrutinised by our stakeholders and by the board, including our non-executive directors.

To the best of my knowledge, and taking into account the processes that I know to be in place for internal and external scrutiny, I believe that this account gives an accurate account of quality at BHRUT, recognising the matters identified in the account including in respect of the ‘18-weeks referral to treatment incomplete pathway indicator’ and the ‘A&E maximum waiting time for four hours indicator’ as described in part 3 ‘Review of quality performance for 2018/19’.

I hope it will be read widely, by our staff, our patients and our partners.

Chris Bown
Interim Chief Executive
Barking, Havering and Redbridge University Hospitals NHS Trust
OUR YEAR IN PICTURES 2018/19

APRIL 2018: Our ‘Sound of PRIDE’ choir released a single to raise money for our charity – its own version of the single Proud by Heather Small. Speaking about being part of the choir, Alix Holmes, our Macmillan Cancer Information Officer, said that “forming the choir has really brought staff together.”

MAY 2018: A dedicated family room (above) was opened at Queen’s Hospital in memory of grandfather Dennis Sullivan. His family raised around £6,000 for the room, which is a place for families and loved ones to spent private time together during a terminal diagnosis.

JUNE 2018: Our Chief Nurse, Kathryn Halford, (left) received an OBE in the Queen’s Birthday Honours in recognition for her services to nursing.
**JULY 2018:** We marked the 70 years of the NHS with lots of celebrations across our hospitals including a big birthday breakfast, visits from some of our local MPS and a picnic at King George Hospital. We also hosted Channel 4 News, who filmed our Maternity department and held a live debate on the future of the NHS with our Chief Executive, Matthew Hopkins, and our Chief Nurse, Kathryn Halford, on the panel.

**AUGUST 2018:** We marked 12 months of delivering the NHS constitutional standard for cancer treatment times, ensuring that 85 per cent of patients were starting treatment within 62 days of referral from their GP.

**SEPTEMBER 2018:** We spoke to one of our consultant neurosurgeons, Nick Haliasos (right), about the £57,000 grant he secured to bring artificial intelligence (AI) to our Trust. The funding was for a tool which will help our Emergency department clinicians when they are triaging patients by helping to identify patients with serious conditions such as stroke or sepsis.
OCTOBER 2018: We were named Preceptorship of the Year at the Nursing Times Workforce Awards after developing a senior intern team to provide a successful mentoring and coaching programme for our new nurses – the first scheme of its kind in the country.

NOVEMBER 2018: Our fantastic Sustainability team picked up two awards at the Sustainable Health and Care Awards (above). The first was the Award for Sustainable Excellence – corporate approach and the second was the Carbon Reduction Award. Both awards recognised our Trust’s commitment to carbon reduction.

DECEMBER 2018: It was one of the busiest Christmases ever for new arrivals at Queen’s Hospital – with 25 babies born on Tuesday 25 December. First to make an entrance was Harriet Lindsay, (left) who arrived by c-section just 47 minutes after midnight.
FEBRUARY 2019: We had a record-breaking Nursing and Midwife Recruitment Day (right) thanks to the tremendous efforts of teams across our organisation who put on a fabulous show promoting our Trust as a place to work. We welcomed more than 150 potential new colleagues to Queen’s Hospital, offering 119 of them jobs on the day, with new recruits coming from far and wide to join us – we saw applicants from 12 universities from across the UK and three European ones too.

MARCH 2019: Our Emergency Department colleagues were delighted to get a whole new batch of point-of-care ultrasound machines up and running after investing around £170,000 in this terrific new kit to help us make better, faster decisions about caring for patients.

JANUARY 2019: Speech and language therapists from our Trust (left) travelled to Cambodia to teach healthcare workers there how to help patients with tracheostomies including how to manage swallowing difficulties.
TWO: OUR PLANS FOR THE FUTURE

Our Quality Account provides an opportunity for all our stakeholders to monitor and openly scrutinise the process by which we seek, year on year, to improve the quality of the services we provide. The Quality Account is an annual report which covers:
- an introduction to BHRUT and our commitment to quality
- looking forward and setting our priorities for the coming year
- our progress on the quality priorities we set for 2018/19.

We provide core hospital and specialist services from two large acute sites: Queen's Hospital in Romford and King George Hospital in Ilford.

We also provide services out in the communities of Barking and Dagenham, Havering, Redbridge and Brentwood and serve a population of around 750,000 across these areas.

TRUST OBJECTIVES

Our Operational Plan is driven by our long-term vision: “To provide outstanding healthcare to our community, delivered with PRIDE”.

Our 2019/20 annual goals link our vision to individual goals which aim to:
- enhance clarity and delivery
- align and empower individuals.

These are then cascaded into goals for specialties and individuals. In this way, the Trust aims to ensure the organisation is aligned from ward to board. This is known as Management by Policy, illustrated below as part of Virginia Mason world-
class management adopted through The PRIDE Way.

Delivery will be underpinned by The PRIDE Way management system and improving the culture in the Trust. Both are vital, given the scale of our challenges, and our opportunities.

The PRIDE Way is based on a proven, world-class management system used by Virginia Mason.

As shown right, Management by Policy is complemented by Daily Management (how we all both run and improve our organisation on a daily basis) and Cross-Functional Management (particularly relevant to our Integrated Care System).

Our executive and divisional leaders are committed to embedding The PRIDE Way in the Trust, including further training for 100 of our top leaders and using process improvement methodology to improve quality and reduce waste.

To deliver our vision, we have set ourselves nine goals for 2019/20, which are underpinned by five priorities, as shown in the table below:

**2019/20 Operating Plan Overview**

<table>
<thead>
<tr>
<th>Operating Plan area</th>
<th>Annual Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivering High Quality Care</td>
<td>CQC “Good” for caring, safe, effective and responsive</td>
</tr>
<tr>
<td></td>
<td>Medicines management</td>
</tr>
<tr>
<td>Running our Hospitals efficiently</td>
<td>Deliver agreed trajectories for emergency care, planned care, cancer and diagnostics</td>
</tr>
<tr>
<td></td>
<td>To improve length of stay</td>
</tr>
<tr>
<td>Becoming an employer of choice</td>
<td>Good place to work 53% to 56%</td>
</tr>
<tr>
<td></td>
<td>Vacancy rates 13% to 11%</td>
</tr>
<tr>
<td>Managing our finances</td>
<td>Reduce deficit £65m to £51m, incl. £28m of savings within the Trust</td>
</tr>
<tr>
<td>Working in Partnership</td>
<td>New care pathways across our Integrated Care System for patients + £10m from 50:50 partnership with CCG</td>
</tr>
<tr>
<td></td>
<td>Feasibility for an ICS Academy &amp; Innovation centre</td>
</tr>
</tbody>
</table>
QUALITY PRIORITIES FOR 2019/20

The Trust’s approach to quality is simple; we place excellence in patient care at the centre of all that we do. This means a relentless focus on patient safety, experience and clinical outcomes, driven through The PRIDE Way.

We will aim to build on our significant improvements in delivering safe, high-quality care. As a result, we will aim to improve our Care Quality Commission ratings and reach “good” for the caring, safe, effective and responsive domains at our next inspection.

We will also set out to deliver improvements in medicines management across the Trust.

In the 2019/20 Quality Account, our improvement priorities are set out under these three areas:
• patient safety
• clinical effectiveness
• patient experience.

Each of our priorities is led by an Executive Director to ensure that support is provided and progress is made.

The Chief Medical Officer and Chief Nurse hold responsibility for delivery of the direct clinical aspects, while direct operational priorities rest with the Chief Operating Officer.

Progress in these areas and risks to delivery will be reported monthly through the following groups/committees:
• Trust Board
• Trust Executive Committee
• Quality Assurance Committee
• Audit Committee
• Quality Governance Steering Group
• Clinical Quality Review meeting with our commissioners.

Please see below a table setting out the measures we are taking to track our quality priorities for 2019/20.

Quality Priorities for 2019/20

1. Quality Priority – Patient Safety

PS 1: Catheter Associated Urinary Tract Infections (CAUTI)

One of the most common infections in hospital is urinary tract infections, with many of these being linked to patients who have a catheter. The risk of acquiring an infection increases each day a patient has a catheter in situ.

Recognising the importance of this area and impact on patients, we plan to deliver an improvement programme during 2019/20 which will measure the use of urinary catheters in our hospital, manage timely removal via our electronic observation system and deliver a dedicated catheter care bundle which will support timely removal and management of the catheter according to the best practice evidence.

We will demonstrate our improvement in the 2019/20 Quality Account and will outline the progress against these actions alongside the impact this has had on our patients.
**PS 2: Reduction in missed medication**

Medication is a very important part of every patient’s treatment while in hospital. Occasionally we do not provide patients with their medication in a timely way due to a variety of factors which include communication on the ward, availability of the medication, patient difficulty with swallowing which requires obtaining liquid or other forms of the medicine, patient’s understanding of the need for the medication which results in refusal in taking the medication.

We have looked at the missed doses reported in 2018/19, and understand the issues which lead to omission of medicines. During 2019/20 we will deliver a range of improvements to help reduce the omission of medicines by at least 10%.

We will continue to use the national improvement tool, Medication Safety Thermometer, to help us improve the safety around medicines and compare ourselves with our peers. We will update our critical list of medicines that must not be omitted and raise the awareness of our staff. We will promote a campaign so that patients get their medicines on time.

We will report our progress in reducing omitted doses of medicines and outline the actions that have been taken. Reducing our omitted doses will benefit our patients and make a difference to our patients’ safety and experience and ensure our patients are helped to get the best out of their medicines. This action is strongly linked with our patient experience action which will improve the information our patients are provided with on medicines to help patients to understand their medicines better.

**PS 3: Reduce the incidence of hospital-acquired pressure ulcers**

During 2019/20 we will deliver a range of actions which will aim to reduce the incidence of hospital-acquired pressure ulcers.

Our particular attention will focus on category 3 and deep-tissue injuries (DTIs) as these were the categories where we identified an increase in the 2018/19 period.

Pressure ulcers can impact on the patient’s quality of life, can cause pain and discomfort and may lead to an increased length of stay in hospital. Our actions to improve in this area will include the key components of the SSKIN pathway which include timely assessment of a patient’s risk of pressure damage, initial and regular skin assessments, provision of suitable pressure reducing/relieving equipment to the level of the patient’s requirements, identifying a suitable reposition regimen where required, delivering incontinence management, and assessing and monitoring the patient’s nutritional requirements.

These key factors will ensure that existing pressure ulcers are identified and treated quickly, new damage is identified and reported, and care plans are put in place to prevent and treat pressure ulcers and these will be implemented and reviewed.

The Trust’s expectation will be to reduce acquired pressure damage category 2-4 by 3% in the 2019/20 period and we will report and review our progress periodically during this time via the Harm-Free Care Group.

Our current incidence of acquired pressure ulcers, based on 1,000 occupied bed days for the 2018/19 period was 0.38% and we will aim to reduce this to 0.37%.

**PS 4: We will ensure that all appropriate staff are trained in the application of the Mental Health Act**

In the UK, one in four people will experience a mental health problem at any one time and people simply don’t understand enough about the topic and so can do little to help.

We will ensure that relevant Trust staff have general mental health awareness training to ensure they are equipped with the relevant knowledge of mental health issues to enable them to provide appropriate support to our patients.

The course will provide an overview of mental health problems, outlining some of the symptoms and effects, and explain what staff can do to help patients feel supported and to encourage tolerance and understanding.
The Trust will work with North East London Foundation Trust (NELFT) to develop this course as an e-learning package by Q3 of 2019/20 and to identify relevant staff groups that this training would support.

During Q4 of 2019/20, the roll-out of the training package will begin, with support from the Trust’s Education department, to monitor compliance by division.

It is anticipated that the Trust would be able to achieve commitment of training of relevant staff with Mental Health Awareness Training by Q4 in year 1, and to achieve 85% of relevant staff training compliance by the end of year 2 (2020/21).

2. Quality Priority – Clinical Effectiveness

**CE 1: Learning from Deaths**

We have established a Learning from Deaths programme and audit at BHRUT which involves a senior clinician undertaking a structured review of patients’ care after they have died. We do this to understand the quality of care received and to note and share the good practice and areas for learning.

Our work from 2018 has seen the establishment of a dedicated faculty with its own staff to manage this process. Having established the faculty, we provide regular updates to clinical teams as to the quality of the care they provide.

In 2019/20 we plan to develop tools to support the implementation of a standardised local mortality review and we aim to work with our divisional quality teams to further refine the Learning from Deaths agenda.

**CE2: Demonstrate improvement to the care we provide as a result of learning from our clinical audit programme**

We have made significant changes to our clinical audit function in 2018 and now have a robust governance process with which to identify a need to conduct an audit, register and manage the resources needed and monitor progress.

Our next stage is to make the strong connection between our audit activity and the improvement work that we do. Our objective for 2019/20 is therefore to demonstrate a range of improvement initiatives that have taken place as a result of our audit programme. We will present this work, summarising each of the audits undertaken and the impact this has had on the quality and levels of safety in the care we provide.

**CE 3: Our method of improving services is being greatly supported through our partnership with the Virginia Mason Institute**

Our partnership with the Virginia Mason Institute brings a great deal of support and expertise to benefit the services we provide and the experience and outcomes of our patients.

This methodology supports our clinical teams to provide the care they feel passionately about delivering. We see a weekly growth in demand for the use of our services which challenges providing care at the time it is needed.

Using our improvement methods we have established an understanding of the issues we face in providing our services and the Trust will deliver a range of improvements during 2019/20 to both meet this need in an efficient way and improve the experience and outcomes of our patients.

We will present our progress in our monthly PRIDE Way team meetings and provide a detailed outline of the actions and benefits to patients within our 2019/20 quality account.

Further improvement initiatives will run in 2019 and we will provide a summary of this information and benefits. The Trust Board has committed to ensuring that the top 100 leaders in the Trust complete The PRIDE Way programme in 2019.

3. Quality Priority – Patient Experience

**Introduction**

The work undertaken this year (2018/19) has helped us to identify and improve on areas that require added focus.

Using the information and linking with our Patient Experience Strategy we have identified four main objectives for our work in 2019/20. We have discussed and consulted on these areas of work with our patient partners to seek their approval and support for our work together.
Our patients told us that they don’t always get useful information about their medications while on the ward. We will focus on how we provide this information and check levels of understanding.

Understanding key information about your medicines and receiving answers to questions is key to success and safety in treatment. It is also extremely important in promoting levels of self-care in a range of conditions.

“If I don’t know... how can I manage my condition in the best possible way?”

We will specifically be targeting patient knowledge of medications as the best test of whether our actions are working.

**The areas we will target include:**

- information provided to patients – the format and style, is this right for the individuals and their needs?
- understanding of what medication has been prescribed, what it does and how it affects their condition and overall health
- knowledge of side effects, what to watch for and what to do
- important considerations for special categories of medication such as the course duration and changes in dose that may be needed.

We want to get much better at providing this information and will be working with ward and pharmacy teams to deliver this objective.

**How will we measure our progress and improvement?**

We will be using the questions from the patient experience collaborative survey that relate to this measure to evidence our improvements. Our work in 2018/19 gives us an accurate measure of our position and a place to work from.

The table below sets out this current position (February 2019) and an ambitious target for each area.

The target has been agreed based on the highest performance in the previous year (7.39 in September 2018) and then includes an approximate 10% stretch target to this performance.

Our measures are based on the principles of patients’ response to a scale of approval. Measuring in this way ensures we look for real improvements as reported by our patients and carers rather measures of process such as the number of information leaflets given.

A score of 0 or 1 shows poor levels of approval whereas 10 demonstrates a high level of approval across all groups surveyed.

**PE 2: Noise at night**

The quality of sleep is very important to recovery and studies show improved healing and lower levels of anxiety in patients receiving good levels of uninterrupted sleep of the correct level.

Being in hospital can have a big impact on sleep from overall levels of noise to disturbance from various clinical tasks.

Feedback from patients shows that this is a real priority and we will be taking actions to promote higher levels and overall better-quality sleep.

‘Sleeping well’ will be our focus for inpatient wards and we will work with staff and patients to identify the main causes of disturbance, overall levels of noise and put
in place solutions to reduce the impact of noise and disturbance on sleep.

Our objective this year is to reduce the impact that noise at night has on our patients. We will be using the questions from the patient experience collaborative survey that relate to this measure to evidence our improvements.

The table above outlines our current position (February 2019) and a target position. The target has been agreed based on the highest performance in the previous year (9.25 in October 2018).

**PE 3: Mealtime assistant volunteer role**

One of the volunteer roles that has the biggest impact on patients is mealtime assistants.

These highly-valuable volunteers attend the wards at mealtimes to support patients. They help to serve meals, prepare patients for lunchtime (washing hands, sitting out of bed comfortably), provide someone to talk to during lunch which can encourage patients to eat, and in some circumstances they also help feed patients who require this level of support.

During the next year we are aiming to recruit a further 40 mealtime assistants to ensure that as many of our patients as possible are able to be supported by volunteers.

These additional 40 volunteers will work with our existing 80 ward befrienders who provide valuable support and encouragement to patients in our wards and departments.

We will be monitoring our progress through our patient experience dashboard, which is regularly reported and reviewed by internal and external committees.

**PE 4: Thematic review of complaints**

Over recent years, we have increased the ways in which patients, relatives and visitors can raise concerns with the Trust.

This open and transparent approach ensures that the public feel able to raise concerns and know that these will be taken seriously, investigated and acted upon, with full structured feedback provided in each case.

We welcome complaints as a source for feedback and learning but recognise a perception of a poor experience is at the centre of all of them, plus the need to complain adds stress and anxiety.

Identifying the key groups of complaint causes and delivering actions to improve upon them will be our aim in 2019/20.

We will carry out this work in collaboration with our clinical services to ensure they are aware of the areas that they need to address to provide better-quality services to our community.

Our process of understanding the reasons for complaints will identify the key groups for improvement. For each area we will agree a series of ambitions to gauge our improvement against. We will include reporting on these within our patient experience and engagement assurance group which is attended by clinical staff, volunteers and patient partners.
QUALITY ACCOUNT GOVERNANCE ARRANGEMENTS

The Chief Medical Officer is the lead Executive Director (board sponsor) with responsibility for the Quality Account.

Production of the Quality Account is the responsibility of the Chief Medical Officer’s Team in collaboration with the Quality and Safety teams. Clinical divisional leads are engaged to produce the content of the Quality Account by working with clinical staff to shape improvement indicators in line with the Trust’s focus on patient safety, experience and clinical outcomes.

The Chief Medical Officer oversees the Quality Account process and in turn, reports to the Executive Management Team, who then report to Trust Board. Data quality is assured through the Trust’s Data Quality Group and through audit processes (both internal and external). Progress reports on each of the quality improvement priorities are reported to the Quality Governance Steering Group.

STATEMENT OF ASSURANCE FROM THE BOARD

During 2018/19 BHRUT provided and/or subcontracted 78 relevant health services. BHRUT has reviewed all of the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant health services by BHRUT for 2018/19.

All the data received ensures the delivery of high-quality care, and covers the three dimensions of quality: patient safety, clinical effectiveness and patient experience.

Quality assurance data is collated and received by the Quality and Safety Committee via a dedicated dashboard. A robust process of monitoring takes place through the quality governance structure within BHRUT which includes the Quality Governance Steering Groups and the sub-groups, Divisional Quality and Safety Groups.

Clinical coding was subject to an audit during 2018/19. The results should not be extrapolated further than the actual sample audited and the services reviewed in the sample were Minor Head, Neck and Ear Disorders, and Unspecified Acute Lower Respiratory Infection.

Risks are reported on the Trust-wide risk register and high-level risk registers (containing risks scoring 15 and above) are monitored via the Quality Governance Steering Groups and the sub-groups, Divisional Quality and Safety Groups.

Strategic risks which prevent the Trust from achieving corporate objectives are recorded on the Board Assurance Framework which is monitored at Board.

At Board sub-committee level, risk management is managed via the Risk and Compliance Group, which undertakes scrutiny of risk management at division and specialty level.
Three: Review of Our Quality Performance 2018/19

Last year we set out to deliver improvements for the following three quality objectives, underpinned with five priorities:

Delivering high-quality care
- ensure we are systematic in responding to quality and safety concerns and reducing harm
- establish the principles of daily management, standard work and continuous improvement across the organisation, as part of embedding the PRIDE Way

Quality Priorities 2018/19

<table>
<thead>
<tr>
<th>Objective 1 - Delivering High Quality Care</th>
<th>How did we know if this was achieved?</th>
<th>How did we do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Priority 1: Ensure we are systematic in responding to quality and safety concerns and reducing harm</td>
<td>A 5:1,000 bed-days</td>
<td>✓</td>
</tr>
<tr>
<td>Increase total incident reporting rate - increase reporting of patient safety incidents</td>
<td>≥ 70%</td>
<td>✓</td>
</tr>
<tr>
<td>Increase the number of reported incidents not resulting in patient harm</td>
<td>&lt; 1%</td>
<td>x</td>
</tr>
<tr>
<td>Reduce the number of serious incidents resulting in harm</td>
<td>&gt;1%</td>
<td>x</td>
</tr>
<tr>
<td>Ensure serious incident a) Investigations closed within required timescales b) Investigations actions completed within required timescales</td>
<td>&gt; 90%</td>
<td>x</td>
</tr>
<tr>
<td>Zero Never Events</td>
<td>0</td>
<td>x</td>
</tr>
<tr>
<td>Reduce the number of medication errors leading to severe harm</td>
<td>0</td>
<td>x</td>
</tr>
<tr>
<td>Full adherence to duty of candour</td>
<td>100%</td>
<td>✓</td>
</tr>
<tr>
<td>No outstanding Central Averting System (CAS) alerts</td>
<td>0</td>
<td>✓</td>
</tr>
<tr>
<td>Complete Venous Thromboembolism (VTE) risk assessments</td>
<td>10%</td>
<td>✓</td>
</tr>
<tr>
<td>Safe staffing a) Achieve target of 90% for overall nursing list rate (inpatient areas) b) Achieve target of 90% for Registered Nurse list rate (inpatient areas)</td>
<td>&gt; 90%</td>
<td>✓</td>
</tr>
<tr>
<td>Reduce the number of Acinetobacter baumannii (C. diff) infections</td>
<td>&lt; 2</td>
<td>✓</td>
</tr>
<tr>
<td>Zero cases of MRSA bacteraemia</td>
<td>0</td>
<td>✓</td>
</tr>
<tr>
<td>Hand hygiene compliance</td>
<td>&gt; 90%</td>
<td>✓</td>
</tr>
<tr>
<td>E. coli bloodstream infections</td>
<td>To be tracked in line with revised Single Overnight Framework</td>
<td>No set target</td>
</tr>
<tr>
<td>Ensure that statutory notifications from the Cerner (Regulation 26) are provided to our partners to support learning to the Trust within 1 working day</td>
<td>100%</td>
<td>✓</td>
</tr>
<tr>
<td>To acknowledge GP service alerts within two working days and a full response to GP service alerts within 21 working days</td>
<td>Acknowledge 100%</td>
<td>✓</td>
</tr>
<tr>
<td>% baseline assessment of NICE guidance within 4 weeks</td>
<td>100%</td>
<td>✓</td>
</tr>
<tr>
<td>Increase the percentage of falls-free care (safety thermometer)</td>
<td>&gt; 90%</td>
<td>✓</td>
</tr>
<tr>
<td>Reduction in falls a) Falls with Harm (Mild, Moderate, Severe, Catastrophic) b) Falls per 1,000 bed-days</td>
<td>&lt; 3%</td>
<td>x</td>
</tr>
</tbody>
</table>

Running our hospitals efficiently
- continue to improve delivery of our constitutional standards

Becoming an employer of choice
- recruit and retain a flexible and diverse workforce
- involve patients and public in all our work

The following table provides a summary of progress for each of the areas listed above and is accompanied by a detailed section on each area within this chapter.
<table>
<thead>
<tr>
<th>What did we say we would do?</th>
<th>How did we know if this was achieved?</th>
<th>How did we do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce Hospital Acquired Pressure Ulcers</td>
<td>a. 100% reporting of all hospital acquired category 2, 3 and 4 pressure ulcers on or following admission, monthly b. Category 2 Hospital Acquired Pressure Ulcers c. Category 3 / DTU Hospital Acquired Pressure Ulcers d. Category 4 Hospital Acquired Pressure Ulcers</td>
<td>Achieved for parts b-d</td>
</tr>
<tr>
<td>Sepsis</td>
<td>a. Patients screened for sepsis b. Patients who meet the criteria receive antibiotics within 1 hour</td>
<td>a. 90% b. 90%</td>
</tr>
<tr>
<td>Ensure compliance in Safeguarding training</td>
<td>a. Safeguarding Adult Level 1 Training Compliance b. Safeguarding Adult Level 2 Compliance c. Safeguarding Children Level 1 Training Compliance d. Safeguarding Children Level 2 Training Compliance e. Safeguarding Children Level 3 Training Compliance f. Mental Capacity Act &amp; Deleg Training Compliance</td>
<td>a. 90% b. 90% c. 90% d. 90% e. 90% f. 90%</td>
</tr>
<tr>
<td>Ensure the Trust meets national standards for people living with dementia</td>
<td>The number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours: a. who have a diagnosis of dementia or delirium or to whom care finding is applied b. who, if identified as potentially having dementia or delirium, are appropriately assessed and c. where the outcome was positive or inconclusive, are referred on to specialist services</td>
<td>a. 90% b. 90% c. 90%</td>
</tr>
<tr>
<td>Improve our quality of care through the GRAFT NHS improvement programme. Of the services that have been reviewed</td>
<td>a. % with a nominated Lead b. % with an action plan in place c. % compliance to the plan</td>
<td>100% Achieved for parts a and b</td>
</tr>
</tbody>
</table>

**QUALITY PRIORITY 2: Establish the principles of daily management, standard work and continuous improvement across the organisation, as part of embedding the PRIDE Way**

- Clinical Audit programme completed as per plan (HQP Audits)
- Completion of all applicable NCEPDD questionnaires and studies
- Maintain or improve overall 30NAP score for ASU and IANAS
- Improve admission to critical ward in 30NAP audit
- Improve outcomes for patients who have knee and hip surgery

**OBJECTIVE 2 - Running Our Hospitals Efficiently**

**QUALITY PRIORITY 3: Continue to improve delivery of our constitutional standards**

- Delivering milestones to support the Trust A&E plan
- Trust Trajectory for A&E: maximum waiting time of four hours from arrival to admission/transferred/discharge
- Maximum time of 18 weeks from point of referral to treatment (RST) in aggregate – patients on an incomplete pathway
- All cancers – maximum 62-day wait for first line treatment from a. urgent GP referral for suspected cancer b. NHS cancer screening service referrals
- Maximum 6-week wait for diagnostic procedure

**OBJECTIVE 3 - Becoming an Employer of Choice**

**QUALITY PRIORITY 4: Recruit and retain a flexible and diverse workforce**

- Medical appraisal compliance
- Reduce sickness absence to the Trust target or below

**OBJECTIVE 4 - Working in Partnership**

**QUALITY PRIORITY 5: Involve our patients and public in all our work**

- Improving complaints responses
- Improved patient satisfaction (through FFT) – maternity positive responses
- Improved patient satisfaction (through FFT) – inpatient positive responses
- Improved patient satisfaction (through FFT) – A&E positive responses
- CQC inpatient survey
- Reducing reactivated complaints
- Staff, Friends and Family Test % recommended
- 2% improvement target
OBJECTIVE 1: DELIVERING HIGH QUALITY CARE
Priority 1: Ensure we are systematic in responding to quality and safety concerns and reducing harm

**WHAT WE SAID WE WOULD DO**
We said that we would increase the number of incidents reported to 45 per 1,000 bed days. Reporting incidents by bed day is a helpful method to compare hospitals’ performance regardless of size.

A high rate of incident reporting in low and no-harm categories is a positive patient safety culture.

**WHAT WE HAVE ACHIEVED**
We have used improvement methods as part of our work with the Virginia Mason Institute to improve incident reporting levels.

This has included reviewing access, timeliness of reporting and response within the organisation.

We continue to encourage staff to report all types of incidents, as without this knowledge it is not possible to learn and improve safety.

The result of this improvement work shows that we have significantly improved reporting levels and sustained them throughout the year.

**WHAT THE DATA SHOWS**
In 2018/19 we consistently achieved better than the Trust target with a steady increase in reporting over each quarter.

We increased the total incident reporting rate, as measured through reporting of patient safety incidents (see table below). These figures put the Trust in the top 10% nationally against peer acute Trusts.

**WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT**
- continue incident-reporting workshops and engagement events with multidisciplinary teams
- continue to highlight incident themes, learning and actions within patient safety forums with a focus on improvements as a result of incident reporting.

**HOW THIS BENEFITS PATIENTS**
Incident reporting is key to improving patient safety. This develops a culture to enable staff to be open and transparent about incidents.

It also enables a framework for learning by focusing on systems and processes that can be improved, as well as identifying themes and trends that can be reviewed to enable actions to be taken leading to better care and treatment.

---

**INCREASE TOTAL INCIDENT REPORTING RATE – INCREASE REPORTING OF PATIENT SAFETY INCIDENTS**

**What will we do?**

| Increase total incident reporting rate, as measured through reporting of patient safety incidents |
|---|---|---|---|---|---|
| Target | Q1 | Q2 | Q3 | Q4 | YTD |
| 45 / 1,000 bed-days (national average) | 51.94 | 57.46 | 59.51 | 52.65 | 55.39 |
| Outcome | Target achieved |

---

*Barking, Havering and Redbridge University Hospitals NHS Trust*  |  Quality Account 2018/19
INCREASE THE NUMBER OF REPORTED INCIDENTS NOT RESULTING IN PATIENT HARM

WHAT WE SAID WE WOULD DO
We said we would increase the number of incidents reported that do not result in patient harm. Incidents where harm does not occur represent opportunities for learning and the prevention of errors that could lead to harm.

The national average currently shows 74.3% of patient safety incidents reported result in no harm.

WHAT WE HAVE ACHIEVED
We achieved one quarter in which reporting of no-harm incidents was at the level of the target we set out to meet.

During the year we have undertaken a number of actions to improve this, which includes:
- incident-reporting training has continued monthly with all new junior doctors, which includes how to appropriately grade an incident
- an incident-reporting training module is on our online training portal which has a focus on severity, to ensure that the correct grading is applied to incidents reported
- we have a monthly quality and safety report which highlights incident grading statistics
- we hold weekly patient safety summits at both our sites where incidents are discussed in an open and transparent forum
- we have run incident-reporting weeks which focus on the reporting of incidents
- medical appraisals have a mandatory requirement to include incidents related to the practitioner.

WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT
- We will continue to run incident reporting weeks.
- We have seen significant improvement since introducing electronic observations within the organisation. This is due to the correct calculation of the National Early Warning Score (a tool to detect sick patients) and prompt response by medical and nursing staff.
- We are taking the above improvement further by developing this system to further benefit patients by including automated alerts on patient deterioration.
- We will undertake a review of themes of incidents to identify areas to focus on.

HOW THIS BENEFITS PATIENTS
We will continue to have a high incident-reporting rate by actively encouraging staff to report both clinical and non-clinical incidents, as this can be reflective of a good and open reporting culture.

This has a positive impact on the care received by patients, families, friends and carers.

<table>
<thead>
<tr>
<th>What will we do?</th>
<th>Increase the number of incidents not resulting in patient harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>YTD</td>
</tr>
<tr>
<td>Outcome</td>
<td>Q1</td>
</tr>
<tr>
<td>&gt;75%</td>
<td>71.66%</td>
</tr>
</tbody>
</table>

REDUCE THE NUMBER OF SERIOUS INCIDENTS RESULTING IN HARM

WHAT WE SAID WE WOULD DO
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”.

WHAT WE HAVE ACHIEVED
We aimed to reduce the number and harm associated with serious incidents.

WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT
- We have not seen a reduction in harm levels related to serious incidents reported however note serious incidents often result in harm which require detailed investigation SIs. We have undertaken actions to improve the process of serious incident investigation. By doing this we will improve the depth and timeliness of our...
investigation and opportunity to learn lessons, and therefore prevent further occurrences of the harm.

Our actions included:

- producing a round table checklist to ensure all relevant information is considered, to enable and support the declaration of a ‘Serious Incident’. This includes:
  - guidance on information to be reviewed (such as medical records, statements, policies/procedures)
  - guidance on questions to ask (such as what happened, how it happened – step by step)
  - level of harm to the patient(s) affected
  - initial conclusions on information review
  - immediate actions to prevent further incidents
  - guidance to ensure degree of learning is taken into account, as well as harm, to decide whether to declare a serious incident
  - implementation of electronic observation which has reduced harm to patients by calculating National Early Warning Score and promoting a response from medical and nursing staff.

- providing monthly Root Cause Analysis training
- providing continuous support to investigation officers from divisional Quality and Safety Advisers and Corporate Quality and Safety Team
- producing an automated report from Safeguard to ensure robust monitoring of submission deadline dates.

WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT

- audit use of the round table checklist to ensure it is being utilised and is helping round tables make the correct decisions
- continue the thematic review of serious incidents and create action plans to prevent future incidents
- review and embed the new Serious Incident Group process of reviewing incident action plans.

HOW THIS BENEFITS PATIENTS

By investigating incidents before they result in patient harm, it enables the Trust to implement actions that may prevent potential incidents from happening, as well as improving care delivered to patients.

### ENSURE SERIOUS INCIDENT:

**A. INVESTIGATIONS CLOSED WITHIN REQUIRED TIMESCALES**

**B. INVESTIGATIONS ACTIONS COMPLETED WITHIN REQUIRED TIMESCALES**

<table>
<thead>
<tr>
<th>What will we do?</th>
<th>Reduce the number of serious incidents resulting in harm</th>
<th>Number of Serious Incidents Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>&lt;85%</td>
<td>138</td>
</tr>
<tr>
<td>Q1</td>
<td>80.66%</td>
<td>35</td>
</tr>
<tr>
<td>Q2</td>
<td>97.00%</td>
<td>36</td>
</tr>
<tr>
<td>Q3</td>
<td>80.00%</td>
<td>36</td>
</tr>
<tr>
<td>Q4</td>
<td>76.66%</td>
<td>31</td>
</tr>
<tr>
<td>YTD</td>
<td>83.58%</td>
<td></td>
</tr>
<tr>
<td>Outcome</td>
<td>Target not achieved</td>
<td></td>
</tr>
</tbody>
</table>

WHAT WE SAID WE WOULD DO

We recognised the importance of timely investigations and completion of actions to prevent recurrence in this objective.

We aimed to see all investigations completed within the 60-day timeframe and to complete all required actions identified within the investigation.

WHAT THE DATA SHOWS

We met the 60-working-day requirement for investigation of serious incidents during 2018 and 2019. However, we did not meet the target in ensuring that investigations were completed on time.

WHAT WE HAVE ACHIEVED

We have taken a number of actions to support this improvement. These include:

- devising a new weekly report from our incident reporting system to highlight the progress and potential challenges within investigations which may impact on the completion date. These are reviewed within weekly governance team reviews
- implementing a round table review (rapid
WHAT WE SAID WE WOULD DO
We aimed to declare zero never events occurring within the organisation during 2018/19. Regrettably this target was not achieved as we declared three never events in 2018/19.

Never events are serious, largely preventable safety incidents that should not occur if the available preventative measures are implemented.

WHAT THE DATA SHOWS
- Two never events related to the unintentional connection of a patient requiring oxygen to an air flowmeter.
- One never event related to the retaining of a nasogastric tube guidewire (retained foreign object).

This will include the important areas of thorough investigation, strong patient and carer support with feedback, and completion of improvement action and audit to ensure embedded actions.

- We will put into place a monitoring system in which investigation actions are represented to ensure that learning has occurred and that this is evidenced.

HOW THIS BENEFITS PATIENTS
A timely investigation and meaningful actions ensure that patients and families are given the outcome of an investigation and are provided with a level of assurance that learning has taken place.

It also allows for an opportunity to keep in contact with patients and families during the investigation period, as well as more opportunity to meet with patients and their families to provide explanations and further evidence of learning.

WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT
- We will maintain the strict monitoring of investigations and completed actions to ensure safety risks are minimised. Within the 2019/20 objectives we will adopt an objective to address specific themes of serious incidents and deliver actions to prevent recurrence.
- Review meeting after an incident has occurred) checklist to ensure the declaration of a serious incident and immediate safety concerns are actioned promptly
- Devising a new investigator leaflet highlighting their roles and responsibilities as an investigator including the timeframes they need to follow
- Monitoring actions agreed within investigations via a weekly report which is reviewed by the team to assess progress. This report and the information contained is reviewed at the patient safety group and also at Trust Board Subcommittee level.

WHAT WE HAVE ACHIEVED
All of the never events that occurred have been investigated and detailed actions to prevent recurrence. The following section summarises the actions taken as a result of these events:

Medical air vs oxygen
- Removal of all medical air devices in ward areas to prevent repeat of this error
- Replacement of air flow meters with nebuliser boxes in all wards apart from designated air permissible areas. Air permissible areas have specific risk assessments completed
- Updated ‘safe to fly’ checklist to check presence of black flap on all air flow meters
- Updated medical gas policy regarding air flow meters
- Highlight of incident at Patient Safety Summit for Trust-wide dissemination and learning
- Worked with the new Healthcare and
Medicines play a crucial role in the treatment of our patients and form the most common treatment that we give to our patients. Medicines contribute to significant improvements in health when used appropriately. However, medicines can also be associated with harm and the common use of medicines means they are associated with more errors and adverse events than other aspects of healthcare.

Medication errors are patient safety incidents where there has been an error in the process of prescribing, dispensing, administering, monitoring or providing advice on medicines. Medication errors are a complex risk area and can adversely affect the health outcomes for our patients.

As most medication errors could be preventable, it is essential that the Trust monitors and manages and understands how medication errors occur so that we can improve the safety and quality of medicines we use for our patients. The Trust continues to encourage the reporting of medication errors and runs initiatives to focus on this from time to time.

The emphasis on reporting is now actively encouraging the reporting of more near misses. Reported incidents and medicines management audits are being used to draw out the themes from medication incidents.

The themes have been used to target initiatives such as multidisciplinary medicines management improvement walks to help raise awareness and look at the systems and processes for managing medicines – for example, to facilitate the safe and appropriate use of medicines; improve our safety and security around our medicines; and further improve our drug chart to support better prescribing and reduce medication incidents.

Medication errors can result in different levels of harm. Errors can be minor leading to no harm, ranging through to major errors causing serious harm and death and associated healthcare and costs.

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**Safety Investigation Branch (HSIB) national investigation into medical air connected rather than oxygen never events and contributed to investigation findings.**

**Nasogastric tube retained guidewire**

- updated insertion and management of nasogastric tube (adult) policy and nasogastric feeding tube standard operating procedure to include requirements regarding removal of the guidewire
- highlight of incident at Patient Safety Summit for Trust wide dissemination and learning;
- alert of the emergency department patient administration system for patients who regularly attend for re-insertion of nasogastric feeding tube
- internal patient safety alert to remind staff of the requirements for management of nasogastric feeding tubes

- new sticker on nasogastric feeding tube pack including guidewire removal to be signed with nurse in charge to countersign.

**WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT**

- We will undertake a review of the listed never events and risk assess these using a gap analysis, to understand potential barriers that may impact on the preventative measures for never event, that should be in place
- We will ensure that staff receive appropriate training to produce high-quality investigations following these incidents. We will ensure that patient safety alerts continue to be disseminated within the organisation and that actions are taken appropriately.

**HOW THIS BENEFITS PATIENTS**

These measures are designed to prevent future harm to patients.
Eliminating the prevalence of medication errors avoids the potential for adverse outcomes for our patients and by initially-targeting the potential for serious medication errors we can reduce the potential for major adverse effects on our patients.

**WHAT WE SAID WE WOULD DO**

The Trust pledged to reduce and eliminate the number of serious harm medication errors including no medication-related never events.

**WHAT THE DATA SHOWS**

In 2016/17 we had six medicine-related incidents that were classed as serious incidents including one never event related to medicines.

In 2017/18 the data shows that there had been significant progress in reducing the medication errors classified as serious incidents and there had been no serious incidents and no medication-related never events.

In 2018/19 we have reviewed how we categorise and manage medication incidents to try to improve our processes. The medication incident harm levels are reviewed by a small multidisciplinary group.

The data shows that we had one medication-related incident as potentially contributing to severe harm to a patient. The incident highlighted some broader issues to be addressed and this has been used to inform local actions and learning.

Overall we continue to make good progress in reducing the medication errors classified as serious incidents and there have been no medication-related never events.

**WHAT WE HAVE ACHIEVED**

To support the medicines safety agenda required to underpin the work towards reducing medication errors leading to severe harm we have:

- continued to encourage the reporting of medication-related incidents and use the thematic analysis to inform learning and improvement initiatives. We have shared the learning through a variety of routes from bulletins targeted at specific medication issues to medication-related training
- established regular medicines management improvement walks by multidisciplinary teams consisting of Pharmacy, Nursing, Midwifery and other staff. The walks focus on medicines management standards in clinical areas of the Trust and provide some external oversight, training and sharing of learning
- maintained monthly meetings of the Safe Medicines Practice group and task and finish groups to help address specific themes around medicines management
- established the use of the national Medicines Safety Thermometer tool to most of our ward areas to help us understand our medicines safety profile against other NHS trusts
- implemented the medication-related NHSE patient safety alerts in a timely manner
- audited areas regularly against our medicines management standards. Our standards are based on the legal, professional and best-practice guidance and the audit outcomes are widely circulated and discussed within the teams to help raise awareness and take the necessary corrective actions
- produced a number of guidelines to support the appropriate prescribing of medicines to help reduce errors.

**WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT**

We will continue our aim of maintaining zero medication errors leading to severe harm by:

- promoting the safe, appropriate and effective use of medicines
- further embedding the appropriate medicines management processes and standards required for medicines safety and will continue to work with our divisional teams to achieve this
- review the way we audit to help reduce the burden of audit
What We Said We Would Do

We said that we would be fully compliant with the Duty of Candour. When a patient has been adversely affected by an incident, staff have a duty to inform the patient, relatives and/or carers as appropriate. This may fall under the Being Open Process or Duty of Candour.

Depending on the level of harm or potential harm for the patient, it must include the details of what has happened and what needs to be done in response. Provision of reasonable support and an apology when things go wrong must be addressed.

What the Data Shows

Our performance monitoring shows that we were compliant with the statutory duty of candour in each quarter of 2018/19 (see table below).

What We Have Achieved

Although we have achieved this requirement in all cases we have undertaken additional actions to improve the quality of our response. The actions we have taken include:

- improving our incident reporting system regarding any incidents graded moderate or severe, which will automatically generate a Duty of Candour flag. This will then be reviewed to ensure that Duty of Candour is completed in a timely manner if it meets the requirement to do so
- the introduction of a round table meeting template, which is completed at all meetings in which moderate or severe harm has occurred. These short structured meetings, with all the key people involved, seek to understand what has happened, what the immediate actions to be taken are and how the investigation will progress. This includes the production of a daily report to ensure that teams and departments are providing patients with feedback that is timely and appropriate
- informing all patients or relatives of progress with investigations, along with provision of the final report, and the opportunity for patients or relatives to attend a being open meeting, to discuss anything in relation to the final investigation and report.

How this Benefits Patients

These measures ensure that patients and/or their families are informed about incidents and are involved in the investigation so that any questions can be answered.

Zero Outstanding Central Alerting System Alerts

What We Said We Would Do

We said that we would ensure compliance with all responses to the Medical and Healthcare products Regulatory Agency (MHRA) via the Government’s Central Alerting System (CAS). The Department of Health issues alerts to hospitals to alert them to important safety messages and actions.

Each alert has a time scale set to achieve these actions. Each alert represents actions to preserve patient safety.
WHAT WE HAVE ACHIEVED
We have had no breaches in relation to safety messages issued to the organisation.

WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT
We have introduced a new system to further improve the quality of our governance of the CAS alert process.

This means our teams upload and track CAS alerts in a more simplified and robust manner that clearly identifies progress in a clear report monitored through our quality governance meetings.

HOW THIS BENEFITS PATIENTS
CAS alerts ensure that important public health messages and other safety critical information and guidance are shared to organisations. This makes sure that the safety of patients is maintained, as well as improving local systems and processes in the improvement of patient safety.

<table>
<thead>
<tr>
<th>What will we do?</th>
<th>Complete VTE risk assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>Q1</td>
</tr>
<tr>
<td>95%</td>
<td>95.64%</td>
</tr>
<tr>
<td>Outcome</td>
<td>Target achieved</td>
</tr>
</tbody>
</table>

COMPLETE VTE RISK ASSESSMENTS

WHAT WE SAID WE WOULD DO
We said that we would ensure that 95% of patients have a completed venous thromboembolism (VTE) risk assessment.

Hospitals are set a national target to ensure that at least 95% of inpatients each month have a risk assessment completed.

WHAT WE HAVE ACHIEVED
Compliance was achieved in Q1, but unfortunately for Q2, compliance was 94.85%. This was due to a drop in performance for August 2018. We have improved our performance for Q3 at 96.18% and Q4 at 96.83%.

WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT
During 2019/20 we will introduce electronic VTE assessment via our electronic observation system (VitalPac). The VitalPac team is leading improvement activity in relation to overall assessment completion and introduction of the electronic assessment with support from VTE Nurse and Consultant Haematologist.

New guidance now requires that all adults above the age of 16 have a VTE risk assessment completed. VTE risk assessment will be included on VitalPac and recorded by clinicians once training has been completed.

The Trust is actively reviewing VTE population data, including the reporting of VTE in line with national guidance. The VTE Task and Finish was established in March 2019 with the first meeting held on Tuesday 30th April. We anticipate that this review will be completed by the end of June 2019.

HOW THIS BENEFITS PATIENTS
The VTE risk assessment and action as a result is an important patient safety and quality tool, which directly affects patient outcomes by reducing the occurrence of healthcare associated deep vein thrombosis and pulmonary embolism (HAT).
WHAT WE SAID WE WOULD DO

We said that we would continue to regularly review nurse staffing levels as part of a monthly report and continue the three-times-daily operational review process to ensure the correct levels of nursing staff across the organisation.

WHAT THE DATA SHOWS

Our data demonstrates that, overall, we achieved our target of 90% fill rate of nursing shifts (inpatient areas) and of 90% Registered Nurse fill rate (inpatient areas). (See table below).

WHAT WE HAVE ACHIEVED

This data demonstrates the achievement of our aim to provide the correct level of staffing. The delivery of this objective has been achieved through successful recruitment of nursing staff, supported by our in-house temporary staffing supplier.

A highly-effective preceptorship programme, which achieved a Nursing Times Award in 2018, provides mentoring and support for new staff and has resulted in improved retention of this staff group. The Trust has provided a range of development opportunities for nursing staff including rotation and apprenticeship programmes.

We will continue this programme of work into 2019/20 and will strengthen further our detection to variation in demand for nurses throughout the year using the Safer Nursing Care Tool.

The introduction of the Nursing Associate role has been greatly successful at the Trust. We have seen two cohorts of nursing associates training and over the next two years we will see 60 members of staff eventually joining the Nursing and Midwifery Council register.

WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT

We will continue to monitor and respond to required staffing levels in accordance with patient need as part of our safe staffing policy and process. We will make further developments this year in introducing new roles and ways of working, implementing a new rostering information system to inform decision making and providing training for all senior nurses in carrying out accurate assessments of patient need.

HOW THIS BENEFITS PATIENTS

The correct number and level of skill of our nursing staff are essential to meeting patient needs. Recruiting and retaining the right level of nursing staff with the right skills is the best way to deliver safe, high-quality care for our patients. Having a robust monitoring process in place enables us to react to changing needs on a daily basis and wider planning of the nursing workforce.

(Cases of C. difficile are subject to mandatory reporting to Public Health England and each hospital has a nationally-set trajectory for C. difficile cases which we must not exceed.)

WHAT WE SAID WE WOULD DO

Clostridium difficile infection (CDI) is a form of diarrhoea often associated with the administration of antibiotics.

We aim to ensure that we reduce the number of C. difficile cases to well below our trajectory, thus reducing the number of our patients who experience this debilitating infection, which...
WHAT WE HAVE ACHIEVED AND WHAT THE DATA SHOWS

- Our maximum allowed number of cases in 2018/19 is 29. Our total number of cases for the year is nine, which is below the annual threshold and shows an improvement from the previous year.
- We continue to work with clinical teams to improve antibiotic prescribing and compliance with 48-hour review of antibiotics in line with local antimicrobial stewardship objectives.
- The IPC team continues to provide support and guidance to clinical teams to ensure timely stool sampling and isolation of patients with diarrhoea.
- We continue our robust programme of audit in order to monitor standards of clinical practice including hand hygiene compliance (with policy) and prompt and appropriate isolation of patients.
- We have streamlined our environmental cleaning processes making it easier for staff to request appropriate environmental cleaning following the discharge of an infected patient.
- There is a dedicated phone line provided by the IPC team to provide support and guidance to clinical teams who have queries relating to the management of patients with infections.
- The IPC team working with our estates colleagues have introduced an environmental cleanliness assessment tool at the Queen’s Hospital site to monitor effective cleaning standards.
- We have introduced multidisciplinary ward rounds to discuss the individual management of each case of CDI aimed at prompt treatment and isolation of the affected patient in order to reduce the risk of cross-infection. This is also undertaken if we experience a cluster of cases of CDI on a ward and in this case it is to ensure that cross-infection has not occurred and to consider additional control measures to further limit spread.

WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT

- We have undertaken an in-depth review of each case of CDI using the multidisciplinary team to identify areas of good practice and also where we need to make improvements ie to learn lessons to prevent recurrence.
- We aim to maintain our reduction in cases of CDI by continuing to provide comprehensive support and guidance to our clinical colleagues together with regular training and audit.
- We will continue to learn from our review of CDI cases by circulating both good practice and lessons to be learnt within the relevant division.
- We will disseminate learning from our cases by presenting at the Patient Safety Summit held monthly.
- A clinical audit of stool sample date and time compliance will be undertaken post full OrderComms roll-out; this cannot be undertaken without full use of electronic test requesting for full audit trail. Full OrderComms use for in-patient Pathology requesting, including outpatient areas, is scheduled to go live in Q2 2019/20 following the roll-out of electronic phlebotomy; this is a BHR capital project.
- IPC are working with Pathology IMT create a series of automated reports that can be scheduled to run in the Pathology Data Management system to collate the relevant information i.e. C.Diff toxin results. Meeting took place 1st April 2019 to agree data specification and work is underway. Expected delivery of action is Q1 2019/20.

Full audit of PAS data has taken place and assurance has been given to the data quality. Completed Q4 2018/19.

HOW THIS BENEFITS PATIENTS

It provides patients with assurance of the high standards of clinical care that they and their families can expect to receive.

| What will we do? | Reduction in number of C. difficile infections | |
|------------------|-----------------------------------------------|
| Threshold        | Q1    | Q2    | Q3    | Q4    | YTD   |
| 29               | 1     | 3     | 2     | 3     | 9     |

Outcome: Threshold achieved
**What We Said We Would Do**

Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia is a form of bloodstream infection.

Cases of MRSA are subject to mandatory reporting to Public Health England and in recent years there has been a zero threshold for cases that occur as a result of healthcare.

Our numbers have reduced slightly on previous years and we aim to ensure that we continue to learn from those cases that occur in order to reduce the number of patients experiencing these serious infections which often results in a longer hospital stay.

**What We Have Achieved**

- We continue to routinely screen all patients for the presence of MRSA whether emergency or elective admissions in order to ensure prompt identification and treatment.
- We routinely undertake a post-infection review of all cases of MRSA with the clinical team responsible for the patient in order to identify if lapses of care have occurred. All learning from these cases is formally reported via our clinical governance system.

**What The Data Shows**

- Our emergency screening average over the 12 months covered by this report is 96% which is our internal target for compliance.
- Our elective screening average over the 12 months covered by this report is 97% with our target currently being the achievement of 100% compliance.

**What We Are Going To Do Next To Continue Improvement**

- We intend to undertake a project aimed at reducing blood culture contamination rates which are a contributory factor to some cases of MRSA and can result in a delay in prompt treatment of patients. This project will be undertaken with our Emergency Department where the majority of blood cultures are taken in order to promptly identify cases of sepsis.
- We will continue to support our pre-admission unit to achieve the 100% compliance rate for elective admission screening for MRSA.

**How This Benefits Patients**

- MRSA can colonise the skin and screening to identify those who are colonised helps to reduce the likelihood of them contracting an infection including wound infections and rarely, bloodstream infections.
- Bloodstream infections can be very serious and may increase the length of a patient’s hospital stay.
- Eliminating these infections will have very positive outcomes for patients.

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**Hand Hygiene Compliance**

**What We Said We Would Do**

We continue to be committed to ensuring the high standards of compliance with hand hygiene are maintained. We said that we would promote hand hygiene awareness during the WHO awareness week which we planned to continue for the month of May 2018. In addition, we continue to undertake monthly hand hygiene audits and provide feedback to improve standards.

**What We Have Achieved**

- We have exceeded our hand hygiene compliance target for 2018/19.
- Our Education programme is ongoing for corporate induction, nursing induction, Sodexo staff at Queen’s Hospital and for volunteers.
- Our hand hygiene audits results are now available on Intranet for all staff to have access to their relevant wards/department data. In addition, we continue to provide individual wards/department with report and feedback.
• We have extended our WHO Hand Hygiene Week to a whole month in May and we conducted a quiz, taking our UV light box to the wards and departments to check hand hygiene techniques and reviewed ward-based hand hygiene initiatives, awarding a prize to the ward with the most innovative ideas. Beech ward at King George Hospital was the lucky winner.

WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT

We will continue to undertake our current initiatives, constantly striving to raise awareness of the importance of hand hygiene.

WHAT WE SAID WE WOULD DO

ESCHERICHIA COLI (E. COLI) BLOODSTREAM INFECTIONS

WHAT WE SAID WE WOULD DO

E. coli is a type of bacteria common in human and animal intestines, and forms part of the normal gut flora (the bacteria that exist in the bowel). There are a number of different types of E. coli and while the majority are harmless some can cause serious food poisoning and serious infection.

WHAT WE HAVE ACHIEVED

We have a comprehensive surveillance system in place. We have uploaded on the Data Capture System monthly.

These initiatives include our monthly hand hygiene audits, training, surveillance and providing timely feedback for both good and poor results.

HOW THIS BENEFITS PATIENTS

Hand hygiene is the cornerstone of infection prevention and still remains the single most important tool in the fight against healthcare-associated infections.

It is integral to patient safety and when performed at the right time, using the correct techniques, hand hygiene benefits patients every day.

BHRUT participated in the NHSI Catheter Associated Urinary Tract Infection (CAUTI) Collaborative.

We will be completing the GNBSI (Gram-negative bloodstream infections) overview tool, published by NHS Improvement to risk-assess our Trust current status in order to contribute towards reducing GNBSI by 50%.

Using this tool will help us to inform future actions.

HOW THIS BENEFITS PATIENTS

This will improve patient safety through reduced infection rates, mortality rate, length of stay and appropriate antimicrobial prescribing.
WHAT WE SAID WE WOULD DO
We said we would review the care provided to all patients that die within the hospital. Where a concern is identified, we review each case within the national Serious Incident Investigation process.

WHAT THE DATA SHOWS
No Regulation 28 notices were received in 2018/19 directly to the organisation. The Coroner did make a notice to the Secretary of State of Health in Quarter 4 2018/19 which related to asthma in children.

WHAT WE HAVE ACHIEVED
The content has been shared with all local partners to ensure that treatment pathways and subsequent care for children with asthma are coordinated.

WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT
We will ensure that Serious Incident reports are completed with evidential-based action plans.

HOW THIS BENEFFITS PATIENTS
Learning from past clinical/nursing errors improves patient safety.

ACKNOWLEDGEMENT OF GP SERVICE ALERTS WITHIN TWO WORKING DAYS AND A FULL RESPONSE TO GP SERVICE ALERTS WITHIN 21 WORKING DAYS

WHAT WE SAID WE WOULD DO
The commitment in the last Quality Account was for 100% of GP service alerts to be acknowledged within two working days and for a full response to be made within 21 working days.

WHAT THE DATA SHOWS
Due to a change in reporting process, and a period of having no-one in the GP Liaison post, the details around GP alert performance in terms of response times were not retained through the year.

WHAT WE HAVE ACHIEVED
By the year end, we were pleased to have completed the transition of our system of management of GP alerts away from a locally-held spreadsheet run by the GP Liaison Manager, along with a new standard operating procedure for managing GP alerts.

This was a very positive step towards providing appropriate clinical escalation and better oversight, improving the robustness of our process, and so improving quality and safety.

It offers better visibility at key clinical oversight meetings, and a better framework for reporting, investigating, monitoring and evaluating emerging themes, as well as managing the specific issues reported.

The support of the Quality and Safety team will assist greatly in pursuing these issues to a successful resolution.

This included the drafting of a standard operating procedure to help our engagement with CCGs and GPs.
WHAT WE SAID WE WOULD DO
We said that we would complete baseline assessment of NICE guidance within four weeks of publication. Guidance is produced throughout the year and covers four key areas:

Technology Appraisal Guidance (TAG)
These assess the clinical and cost effectiveness of health technologies – such as new pharmaceutical and biopharmaceutical products – but also include procedures, devices and diagnostic agents. This ensures that all NHS patients have equitable access to the most clinically and cost-effective treatments that are available.

Interventional Procedure Guidance (IPG)
These recommend whether interventional procedures – such as laser treatments for eye problems or deep brain stimulation for chronic pain – are effective and safe enough for use in the NHS. They are for information to those clinicians who carry out the specified procedures and must be disseminated to the relevant staff within the Trust. They do not require that the Trust identify their current compliance.

WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT
We will build on the positive developments above and look to finalise and put into practice the new standard operating procedure. We intend for this to take a form where there is appropriate engagement and oversight for our CCGs, but whereby we do not lose one-to-one contact with GPs, which both they and we value.

We will propose revised performance metrics based on our agreement of this process, which should be realistic and deliverable.

The additional time released will enable our GP Liaison Manager to spend more time on strategic issues and relationship development, working with GPs to improve our relationships and working practices.

By the year end, we were pleased to have completed this transition, along with a new standard operating procedure for managing GP alerts.

This is a very positive step towards providing appropriate clinical escalation and better oversight, improving the robustness of our process, and so improving quality and patient safety.

HOW THIS BENEFITS PATIENTS
A more robust process, with greater clinical oversight and with the necessary prioritisation and escalation, means a better service for patients, a quicker route to resolution of problems and easier routes to identify underlying issues enabling us to take pre-emptive action, so issues are dealt with before more patients are impacted.

% BASELINE ASSESSMENT OF NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE (NICE) GUIDANCE WITHIN FOUR WEEKS
NICE (the National Institute for Health and Care Excellence) is an independent organisation which makes evidence–based recommendations on a wide range of topics, from preventing and managing specific medical conditions to improving health and managing medicines in different settings.

When new NICE guidance is published, the Trust requires the relevant lead to complete a Baseline Assessment Tool (BAT) to evidence our current compliance and what steps are needed (if any) to become fully compliant.

If an assessment is carried out and it is decided that a particular NICE guideline will not be implemented due to a clinical decisions or if the service is not provided, a risk assessment is required to be completed so that any mitigation can be taken to reduce to any risks to our patients from any non-compliance.

<table>
<thead>
<tr>
<th>What will we do?</th>
<th>To acknowledge GP service alerts within two working days and a full response to GP service alerts within 21 working days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>Q1</td>
</tr>
<tr>
<td>100%</td>
<td>No data via Safeguard</td>
</tr>
<tr>
<td>Outcome</td>
<td>Target not achieved</td>
</tr>
</tbody>
</table>
WHAT WE SAID WE WOULD DO

The NHS Safety Thermometer is a point-of-care survey developed by the NHS to provide a ‘temperature check’ on harm that can be used alongside other measures of harm to measure local and system progress in providing a harm-free care environment.

The national benchmark for harm-free care is 95%. The NHS Safety Thermometer allows teams...
to measure harm and the proportion of patients that are ‘harm free’.

The NHS Safety Thermometer is a quick and simple method for surveying patient harms and analyzing results to measure and monitor local improvement and harm-free care over time. It measures for areas of harm – pressure ulcers, falls, urinary catheter infections and venous thromboembolisms (VTE).

**WHAT THE DATA SHOWS**
The table below shows the Trust overall achievement of the safety thermometer. We are very pleased to see that we have maintained and improved upon the percentage of care that does not involve harm as recorded by this monthly survey.

This achievement has been made through considerable determination of our nurses to deliver high levels of safety to our patients.

Actions have been coordinated by our harm-free care group and champion scheme which see each ward and department with a nominated lead for harm-free care.

Progress and risk in these areas are reported to our senior nursing groups and Trust Board in a detailed report produced by our Director or Nursing for Harm-Free Care and Safeguarding.

<table>
<thead>
<tr>
<th>What will we do?</th>
<th>Increase the percentage of harm-free care, as measured through the safety thermometer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>Q1</td>
</tr>
<tr>
<td>95%</td>
<td>97.27%</td>
</tr>
<tr>
<td>Outcome</td>
<td>Target achieved</td>
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**REDUCTION IN FALLS**

**A. FALLS WITH HARM (MODERATE, SEVERE, CATASTROPHIC)**

**B. FALLS PER 1,000 BED DAYS**

**WHAT WE SAID WE WOULD DO**

Falls are a major cause of disability and mortality for older people. As well as the physical effects, falls can have a significant psychological impact on confidence and independence. It is therefore imperative that we both understand and minimise the risk of falling.

**WHAT WE SAID WE WOULD DO**

- Seek a 3% reduction in the number of falls overall as expressed by a rate per 1,000 bed days in comparison to 2017/18.
- Continue to provide falls prevention and management training through induction training and face to face training including Keeping In Touch days (KIT).
- Develop an e-learning package, which will be available via the BHRUT Education Staff Training (BEST) system.
- Pilot use of existing falls sensors.

**WHAT WE HAVE ACHIEVED**

- For the period 2018/19, we have achieved a 3% overall reduction in falls, when compared to the previous year (2017/18).

**Training:**

- Falls training continues to be delivered through the nurse and healthcare assistant induction days. Face-to-face training includes formally-booked sessions via BEST, delivered across both sites, classroom sessions via KIT days and pre-booked sessions delivered on individual wards. Classroom sessions also include Midwife Care Assistants and Foundation Year 1 doctors (FY1).
• For 2018/19, training is below trajectory. 653 out of a projected 732 staff have been trained. However, the drive continues on training awareness via the Harm-Free Care Report, Falls Steering Group, Falls Panels and Senior Sisters meeting.
• The e-learning package is in its final stages of review prior to going live. It will include training for FY1, nurses, midwives, health care/midwives’ assistants, Allied Healthcare professionals and learners.

Falls Incidents:
• All falls incidents resulting in moderate and above harm are investigated as per policy and action plans are developed for the area to learn from the incident findings. Plans are monitored by the Divisions.
• Patients and relatives are informed of any fall incident in the interest of open and honest care.
• Falls and falls with harm are analysed and reported on quarterly to identify themes and trends to support plans on prevention of falls. The reports are shared across the Trust and discussed at our Falls Steering Group and Harm-Free Care Champion Events.

Falls Sensor Pilot:
Two different falls sensor products have been trialled for comparison in the care of the elderly wards at Queen’s Hospital.

Data collection has been completed and analysed. The data will support charitable funding application for 20 falls sensor mats, units, and pagers for wider scope of use across BHRUT. The lead on the pilot is currently writing the case to put forward to charitable funds for purchase of the sensors.

WHAT THE DATA SHOWS
The average number of falls incidents per 1,000 bed days, reported in 2018/19 was 3.46 per 1,000 bed days (1,235 incidents), compared to 3.59 (1,275 incidents) for the previous year.

This represents a reduction of 3.13%, which means we have met our Trust target of achieving a 3% reduction in falls.

Falls with Harm

Falls resulting in moderate and above harm for 2018/19 were 0.13 per 1,000 bed days (49 incidents), compared to 0.07 per 1,000 bed days (24 incidents) for the previous year. While we have achieved the 3% target to reduce overall falls, falls with harm show a 104% increase,
against the Trust target to reduce falls with harm by 7% per 1,000 bed days in 2018/19. The average falls per 1,000 bed days in the NHS was 6.63 (RCP National Inpatient Falls Audit 2015). The onus is on individual trusts to decrease their rates through effective falls prevention and management.

**WHAT WE SAID WE WOULD DO**

We said that we would reduce the number of hospital-acquired pressure ulcers category 2-4 based on the target figures given. We would take a zero-tolerance approach to acquired pressure ulcers and investigate why these incidents had occurred.

**WHAT THE DATA SHOWS**

For the period 2018/19 we had a total of 136 patients who developed category 2-4 pressure ulcers that were deemed hospital acquired. This equates to an overall decrease of 21% on the targets shown below.

The Trust had a total of 32 investigations conducted for Red or Serious Incidents. Of these there were ten category 3, twenty deep tissue injuries (DTIs) and two category 4 incidents.

The Trust is learning from these incidents and putting action plans in place to address the issues found. Investigations for the two category 4 incidents identified that in one case everything was in place to protect the patient and the other investigation identified that there were lessons to be learned.

All category 2 acquired pressure ulcer incidents are also investigated and presented to a review panel.

This is for learning and identifying issues associated with these incidents; each ward has actions to complete to ensure interventions are put in place to prevent this happening again.
Equating this data to the number of incidents per 1,000 occupied bed days, shows that overall the Trust achieved an incidence of 0.38% and is showing a slight decrease in the trend for the 2018/2019 period.

WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT

- We are revising the way pressure ulcer prevention and management training is delivered in line with new guidance from NHS Improvement in 2018. This will take a structured approach working on staff’s current knowledge and then building on this through a fundamental, intermediate and advanced approach.
- We will continue to raise awareness of our staff to ‘React to Red’, which is the first sign that damage to the skin is occurring, and early assessment and prevention will help, if possible, prevent this from deteriorating.
- We will continue to investigate all incidents category 2 and above and these incidents are reviewed at a pressure ulcer review panel.

We will continue to share learning from these incidents.
- We will continue to ensure patients and family are kept informed of pressure damage.
- We will monitor new research and explore if this will benefit patients to help reduce pressure ulcers.
- We will continue to work with areas which are showing an increase in this type of damage. We will explore the reasons this is occurring and then develop action plans to address the issues found by the investigations undertaken.

HOW THIS BENEFITS PATIENTS

Pressure ulcers are distressing and often painful injuries. We are committed to reducing the number of these incidents within the Trust.

Preventing these injuries occurring means that there is better rehabilitation potential, earlier discharge from hospital, a better patient experience and ultimately a better quality of life for the patient.
SEPSIS
A. PATIENTS SCREENED FOR SEPSIS
B. PATIENTS WHO MEET THE CRITERIA RECEIVE ANTIBIOTICS WITHIN ONE HOUR

WHAT WE SAID WE WOULD DO
We said we would improve the care and management of patients with sepsis or suspicion of sepsis through timely recognition, escalation and subsequent delivery of antibiotics, within the national target of one hour.

WHAT WE HAVE ACHIEVED
Patients are routinely screened for sepsis and those who have sepsis or suspicion of sepsis receive antibiotics within the national target of one hour, 91.7% of the time.

We have a well-established steering group which oversees sepsis compliance and developments and enables consultation, communication and implementation of expected standards for the identification and treatment of sepsis across the Trust.

Sepsis standards within our Emergency Departments are monitored fortnightly to enable real time feedback, learning and rapid action for any shortfalls. Achieving delivery of timely sepsis treatment in ED is a constant challenge due to exceptional demand in the departments.

The appointment of a new ED Consultant Lead for sepsis has strengthened the team and the multidisciplinary approach.

We continue to drive sepsis e-learning and face-to-face training for healthcare professionals and have expanded the target audience to include healthcare assistants, operating department practitioners/assistants and allied health professionals. We have reviewed the placement and contents of the sepsis trolleys to ensure these are located in the correct areas and are fit for purpose.

We have worked closely with the UCL Partners Deteriorating Patient network, sharing knowledge and quality improvement initiatives.

We have implemented the new national early warning score (NEWS2) which prompts sepsis screening.

WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT
- Continue to monitor sepsis screening and antibiotic delivery to enable improvements and consistency in performance.
- Adjust the antibiotics available in the ED sepsis trolleys to ensure rapid access to the most-needed antibiotics.
- Combine the Sepsis Steering Group to form the Sepsis & Deteriorating Patient Group to expand the learning and work achieved by the Sepsis Steering Group with the aim of even earlier identification of the deteriorating patient.
- Appoint a dedicated ED Sepsis & Deteriorating Patient Nurse who will across our Emergency Departments to improve and sustain sepsis screening and delivery of sepsis care.

HOW THIS BENEFITS PATIENTS
Sepsis is a potentially life-threatening condition that arises when the body’s response to infection attacks its own organs and tissues. If not spotted and treated quickly, it can rapidly lead to organ failure and death. Recognising sepsis and delivering antibiotics and fluids within the first hour can halt the progression of sepsis and hugely improve outcomes.
ENSURE COMPLIANCE IN TRAINING OF SAFEGUARDING

WHAT WE SAID WE WOULD DO

- Develop a Safeguarding Audit Framework for 2019/20 to provide assurance that safeguarding policies and procedures are being adhered to.
- Annual Safeguarding & Learning Disability workshop arranged for October 2019.
- Launch the CSE Risk Assessment Tool.
- Continue to support young people in the transition from Children to Adult services.
- Evaluate the face-to-face scenario-based safeguarding and mental capacity training.
- FGM-IS implementation outside of Maternity Services.
- Safeguarding Adult Concern form to be triggered by completion of incident report.

WHAT WE HAVE ACHIEVED

- Safeguarding Audit Framework for 2019/20 has been developed and is due to be presented for approval by the Safeguarding Operational Group on 16 April 2019.
- Venue has been booked for the annual Safeguarding & Learning Disability workshop in October 2019.
- Focus groups set up to support young people in the transition from Children to Adult services have taken place in three local special education schools.
- Evaluation of mental capacity training is included in the Safeguarding Audit Schedule 2019/20.
- FGM-IS outside of Maternity Services was implemented on 1 April 2019.

• Meeting has been held with the Incident Reporting Manager to discuss a Safeguarding Adult Concern form being triggered by completion of an incident report.

WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT

- Monitor safeguarding training compliance locally on a weekly basis.
- Evaluate Safeguarding Children Level 3 training.
- Deliver learning disability awareness and Mental Capacity Act training to medical staff.
- Engage in the multi-agency Safeguarding Adults Board dissemination of learning day.
- Extend to local colleges/education services the focus groups set up to support young people in the transition from Children to Adult services.
- Monitor Safeguarding Children Supervision on a monthly basis.
- Develop a desktop display with the assistance of Communications Team with a key safeguarding message and contact details for the team.
- Develop a Safeguarding Children information leaflet for parents/carers.

HOW THIS BENEFITS PATIENTS

All of the above initiatives clearly demonstrate the ongoing development and progress that is in place across the Trust to ensure the safeguarding needs of children, young people and adults are responded to appropriately. All actions are aligned to the Trust’s Safeguarding Strategy 2018-20.
ENSURE THE TRUST MEETS NATIONAL STANDARDS FOR PEOPLE LIVING WITH DEMENTIA

WHAT WE SAID WE WOULD DO
From December 2018, the Dementia Service moved to the remit of the Director of Nursing, Safeguarding & Harm-Free Care; a benchmarking exercise against several national documents was undertaken. An action plan was developed to support the changes and improvements required to ensure the Trust meets national standards for people living with dementia.

WHAT WE HAVE ACHIEVED
• Business case drafted and funding has been secured for a Band 8a, Band 7 and two Band 2s to strengthen the current dementia team structure to ensure delivery of the new Trust Dementia Strategy 2019-2021.
• Tea parties held during Quarter 4 – Clementine wards, Ash ward and Ocean wards. Tea parties aim to promote social inclusion and engagement for patients their families and carers.
• Dementia Audit Framework drafted for 2019/20; to be presented to the Dementia Steering Group in April 2019 for approval.
• Dementia training needs analysis produced; to be presented to the Dementia Steering Group in April 2019 for approval.
• Celebrated World Delirium Day on 13th March 2019, with stalls in both Queen’s and King George Hospitals to raise awareness of delirium.

WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT
• Dementia Tier 3 training will commence in May 2019 for senior sisters/charge nurses working in Care of the Elderly.
• Develop a patient/carer/staff feedback form to evaluate the RITA screens, dog therapy, tea parties.
• Host dementia cafés; first one arranged at Queen’s Hospital in May 2019 followed by King George Hospital in June 2019.
• Undertake the first peer observation of the delivery of certain aspects of dementia-related care.
• Set up a Dementia Working Group for internal staff, external partners, patients and their caregivers; inaugural meeting to be held in June 2019.

HOW THIS BENEFITS PATIENTS
The developments within the Dementia & Delirium Service will contribute to securing patient/carer feedback that will help shape service delivery and enhance the delivery of person-centred care.

IMPROVE OUR QUALITY OF CARE THROUGH THE GIRFT NHS IMPROVEMENT PROGRAMME

WHAT WE SAID WE WOULD DO
The Getting It Right First Time (GIRFT) programme is delivered in partnership with the Royal National Orthopaedic Hospital NHS Trust and NHS Improvement. The programme is designed to improve the quality of care within the NHS by reducing unwarranted variations.

By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help to improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

Importantly, GIRFT is led by frontline clinicians.
who are expert in the areas they are reviewing. This means the data that underpins the GIRFT methodology is being reviewed by people who understand those disciplines and manage those services on a daily basis.

The GIRFT team visits every trust, carrying out the specialties they are reviewing, investigating the data with their peers and discussing the individual challenges they face. For more information, visit gettingitrightfirsttime.co.uk.

Using the GIRFT visits, we have been able to identify good care where it happens within the Trust, and also areas where we need to improve. These fall into categories such as clinical care, financial state of the service, and strategic plans for the future.

We have and are continuing to tackle the issues which have been raised, and are improving, as evidenced by the progress made.

We have achieved much of what we set out to do 2018/19, in that we have action plans in place for the different specialties, with progress charted.

**WHAT WE HAVE ACHIEVED**

GIRFT visits in 2018/19 were centred upon Orthopaedics (re-visit), General Surgery, Vascular Surgery and Critical Care.

In Orthopaedics, this re-visit identified 11 issues, of which five were clinical. Consolidating revision hip and knee replacements, elbow and ankle surgery has been achieved. Reducing the length of stay for primary hip and knee patients is being pursued. However, the Independent Sector Treatment Centre (ISTC) has taken many of the fitter patients, thus leaving the Trust with patients who would require longer stays.

This is also the case with improving theatre efficiency, as the more straightforward cases are not being done here. Theatre capacity for emergencies also impacts on the Trust not receiving best practice tariff.

Of note, we have now appointed a dedicated nurse and consultant to look into reducing infection rates with innovative ideas (two green, six amber, three red).

In General Surgery, six issues were identified, four clinical, one finance and one strategic. The clinical issues included having a ‘hot gallbladder’ pathway for our patients – this business case is being written. Emergency theatre access in a timely manner for our patients is an area for improvement, although not a major issue.

This will need to be addressed with the relevant departments who need to provide capacity in both physical theatre space and staffing. The mortality and morbidity risk of patients undergoing emergency laparotomies was highlighted as being insufficiently clear, nor documented including discussion with patients and relatives.

This has been addressed and the NELA risk score and p-possum risk score systems are now incorporated into the theatre booking form, recorded in the notes and consent forms. The uniformity between colorectal surgeon consultants regarding their protocol for patients and the use of the enhanced recovery programme (ERP) was highlighted as being patchy.

This is being addressed by the surgeons, who will revive the ERP that was in place before the loss of the ERP specialist nurse when the CQUIN was withdrawn.

Accurate coding is an issue and contributes to discrepancies, and a small project on looking into samples of appendicitis patients is underway. It has also been recommended that a hot-and-cold site model be considered for delivery of general surgery, but there are no strategic moves presently (one green, three amber, two red).

The Critical Care and Vascular visit reports are awaited. The visits that occurred prior to 2018 include neurosurgery, paediatric surgery, ENT and Ophthalmology. The issues raised in each of these visits are being worked through with a plan to deliver the clinical benefits within 2019, and financial benefits to follow soon after.

**WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT**

Further visits are due in 2019, including Breast Surgery, Endocrine Surgery, Anaesthesia, Acute Medicine, and Dental Services.

Good care has also been highlighted in these visits, and it is important to maintain this. However, GIRFT has certainly focused staff on delivering specifically-improved length of stay for patients, and increasing more efficient use of surgical capacity.

A big challenge for the future is to ensure that the data submitted for such analysis is as
accurate as possible, in order to maintain staff engagement in the process.

Indeed, GIRFT has also inspired consultants to look at their own practices more closely, for example the colorectal surgeons have now set up weekly meetings with the junior doctors for this purpose.

HOW THIS BENEFITS PATIENTS
Patients have benefited from efforts to shorten delay to surgery, shorten length of stay, increase theatre efficiency leading to shorter waiting times, and the consolidation and rationalising more complex surgery to limited number of patients.

Priority 2: Establish the principles of daily management, standard work and continuous improvement across the organisation, as part of embedding the PRIDE Way

CLINICAL AUDIT PROGRAMME COMPLETED AS PER PLAN (HQIP AUDITS)

WHAT WE SAID WE WOULD DO

We aimed to implement our Clinical 2018/19 HQIP Mandatory Annual Audit Programme. The Clinical Audit Team along with the Clinical Audit Chair would be supporting Clinicians with this implementation across the Trust.

The Clinical Audit Team was to engage with Clinicians to promote audit participation within the Trust. Monthly grand round meetings used as a platform for audit learning were to continue to happen within the Trust.

Clinical audit activity reports were to be developed and enhanced.

WHAT WE HAVE ACHIEVED

The management of audit processes and registration were to be reviewed in order to ensure standard criteria is met with all requested audits.

The Clinical Audit Team held a Clinical Audit Awareness Week during November to raise awareness of clinical audit with a number of educational stands and ‘drop in sessions’. A clinical audit competition was held, giving the opportunity for a number of audit submissions to be made and critiqued by a panel. The Division of Women and Children were the successful winners.

Monthly grand rounds that have been held at the Queens site have now been implemented at the King George site to facilitate learning from Clinical audits across BHRUT.
WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT

There will be an ongoing plan for 2019/20 to ensure that where learning and actions from audit are identified, there is evidence to show where such changes have occurred.

There will be a review undertaken during the year 2019/20 of how audits are registered, monitored and managed and how this system may be improved through the use of an alternative IT platform.

HOW THIS BENEFITS PATIENTS

Outcomes from clinical audits are used to give assurances in relation to our standards of patient care and the services we offer, and where gaps are identified, practice changes are then implemented.

**COMPLETION OF ALL APPLICABLE NCEPOD QUESTIONNAIRES AND STUDIES**

**WHAT WE SAID WE WOULD DO**

We aimed to achieve 100% compliance for all NCEPOD Study requests relevant to BHRUT.

**WHAT WE HAVE ACHIEVED**

All requests for NCEPOD Studies relevant to BHRUT have been met and submitted within expected time frames.

The Clinical Audit Department will continue to facilitate and support the process for NCEPOD requests to aim to achieve 100% compliance for studies undertaken that are relevant to BHRUT.

NCEPOD Studies are used as a tool to review services in relation to what level of standard is being achieved. Findings are shared with relevant Trusts which in turn identifies where services may need to be improved.

**WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT**

The Sentinel Stroke National Audit Programme (SSNAP) aims to improve the quality of stroke care by measuring both the structure and processes of stroke care against evidence based standards. These standards are informed by the National Clinical Guideline for Stroke, and national and local benchmarks.

We said that we would maintain or improve our overall SSNAP score for Acute Stroke Unit (ASU) and Hyper Acute Stroke Unit (HASU).

**WHAT WE HAVE ACHIEVED**

The Trust has seen a doubling of the numbers for stroke compared to 2016 due to the impact of the addition of West Essex patients being referred from 2017, without a significant increase.
in bed base or staffing numbers. It is recognised that there has been a significant change in medical workforce causing some instability, but this is slowly improving with interim clinical leads from medicine and nursing, which has proved to have had a positive impact on staff and service in general.

We also have new stroke-experienced senior nursing within the service. Nursing recruitment remains a challenge, but we have seen some improvement in recent months.

We have worked closely to improve the pathway through West Essex CCG, but we feel there is scope to improve the pathways that sit in the other CCGs, so we have developed a stroke strategy group; with representation from our community and commissioning colleagues, to review the pathway beyond the acute stroke units.

The thrombolysis pathway is more streamlined and we have been trying to ensure there is some consultant cover in ED at times of high demand. This has improved the door-to-needle time from 57 minutes to 37 minutes.

We also review and audit all of those patients not thrombolysed as part of our monthly mortality & morbidity meetings. This provides learning for all levels of staff.

There has been consistent overview of the inputting of data onto the SSNAP register by the senior nursing team since the end of 2017. Providing leadership and guidance when required, this has provided much-needed support for junior staff, which is reflected in the improve case ascertainment numbers and audit compliance levels.

WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT

We are working closely to improve the stroke pathway with all of our CCG colleagues. This includes reviewing the ESD service and inpatient rehabilitation provision for our local population.

There has been some progress made for those patients in the Wanstead/Woodford area, where there will be some investment into the ESD service at BHRUT to provide patients with an electronic summary discharge service which were not commissioned before.

We continue to work hard on an integrated approach with the CCG through the stroke strategy group. The public consultation of co-location of inpatients stroke rehabilitation beds completed three years ago has still not been implemented by both BHR and CCG. We feel this needs to be prioritised and for stroke rehabilitation to be located in a single unit.

BHRUT, with CCG support, need to commit to the developing mechanical thrombectomy pathway in stroke which can reduce bed stay by eight days and avoid lengthy rehabilitation bed stay.

There continues to be no seven-day therapy for the hyper acute unit. This has been raised at our annual review by the national lead. This will require significant culture change and some investment which has been raised to the division. The lack of weekend therapy continues to impact the numbers of assessments required at the beginning of the working week.

HOW THIS BENEFITS PATIENTS

The development of a thrombectomy service is in line with the clinical development in stroke. It provides those who are eligible with the chance to be symptom-free within hours, reduced length of stay, reduces mortality and improves outcomes. Seven-day therapy provides the opportunity for patients to be assessed and set their goals early in their recovery. This will improve outcomes and reduce dependency.

Having consistency of ESD provision reduces the inequality in provision across the patch, which will enable more patients to be discharged home earlier – and will therefore will reduce length of stay, reduce hospital-acquired infections and having rehab at home leads to better outcomes for patients.
WHAT WE SAID WE WOULD DO

BHRUT does not operate a specialist cardiac centre. Patients with acute cardiac needs are predominantly transferred to local specialist centres. As such, the Trust does not have the large capacity of specialty beds with which to accommodate an entirely cardiac specialty bed base. As an alternative, patients are accommodated within the acute medical units at both Queen’s and King George Hospitals. Where a higher level of observation is needed patients are accommodated within the coronary care units at both hospitals.

The cardiac service does undertake outreach to acute medical wards to provide patient review and advice to medical and nursing staff which is in line with national guidance. The Myocardial Ischemia National Audit Project (MINAP) serves as a valuable tool to benchmark our service quality and we continue to participate in this national audit.

WHAT THE DATA SHOWS

Provisional 2017/18 results show EQ 5D score for hips have gone up to 0.46 but down with knees to 0.30. Our adjusted health gain for hips for the Oxford Score has gone up from 19.80 to 21.07, which is our best score in five years.

For knees, the score has gone down to 14.04 from 16.66 but still ranks as our second-best score in five years.

For all scores in all years our private PROMS provider has only been able to obtain results from a fraction of our hip and knee replacement patients. The hip replacement data from 2017/18 is based on results from just 111 of the 334 hip replacements performed, and knee replacement data is based on results from 162 of the 341 knees performed.

WHAT WE HAVE ACHIEVED

We ensure that 100% of our patients have a pre-op score taken at pre-operative assessment but there continues to be an issue with our provider of questionnaires for six months post-op, where only one third of questionnaires get returned by patients.

Therefore, as our sample size will be smaller than most Trusts, this makes the statistical margin of error of our results much higher, with a significant negative bias. We have been working with our private PROMS provider to improve questionnaire completion and improvements have taken place in 2018/19.

All scores have been trending upwards over the past five years. All scores this year represent the best or second best (beaten by last year) result over the past five years and this is in part due to...
a gradual improvement in data collection over this time.

**WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT**

Data collection of PROMs results remains a problem. Although improvements have been made over the past five years, particularly within the Trust’s collection of preoperative data in preassessment, problems remain with the six-month post-operative data collection.

This is in part due to poor response rates from our patients to a mailed questionnaire.

Within the Trust multidisciplinary meetings and complex case meetings have been initiated to plan and review all hip and knee replacements performed within the Trust.

An assessment of the long-term results of our hip replacement implants is underway and should be ready for publication shortly, showing excellent revision rates (between 96 and 99% survival at eight years).

Despite this, there is an ongoing process of evaluating different available implants within the trust’s purchasing frameworks to ensure the best implants are available to us.

**HOW THIS BENEFITS PATIENTS**

Ongoing reviews of our results, processes and implants will benefit patients.

Efforts to improve our PROMs results by looking at our implants, our surgeons and our patient factors will lead to a sustained improvement in our service.

Arthroplasty planning and complex arthroplasty meetings have allowed us to review our surgery but also develop a collaborative approach to preoperative planning and surgery, with two or sometimes three consultants involved in complex cases.
**OBJECTIVE 2: RUNNING OUR HOSPITALS EFFICIENTLY**

Priority 3: Continue to improve delivery of our constitutional standards

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**WHAT WE SAID WE WOULD DO**

Local system A&E Delivery Board had four workstreams at the start of 2018/19. They were:

- Pre-Flow, led by commissioners and focusing on demand management
- In-Flow, led by BHRUT and focusing on the front door
- Through-Flow, led by BHRUT and focusing on the patients management processes on the wards
- Out-Flow, led by local authority and focusing on discharge pathways.

From November 2018, the Board has restructured the workstreams and formed the following five system-wide groups that do not focus on provider-specific but system-wide pathways:

- Ambulance Conveyance
- Community Capacity
- Hospital Flow
- Out Flow
- Frailty.

**WHAT WE HAVE ACHIEVED**

Previous workstreams run by BHRUT were In-Flow and Through-Flow.

In-Flow had a good multi-disciplinary engagement. Phase one actions were completed and a number of actions have progressed to stage 2 and 3. These actions and further improvement work continue to be managed by Acute Medicine Division.

Through-Flow had primarily focused on getting the Red2Green team in place as well as on monitoring the impact and progress of improvement actions relating to Delivery 2020 work with the Trust.

**WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT**

New Hospital Flow workstream is chaired by the Trust’s Chief Medical Officer and Chief Operating Officer.

The group is currently focusing on ensuring Red2Green methodology is embedded. The Trust undertook a ‘perfect week’ from 11th to 17th March 2019.

In addition to that, the emergency care intensive support team (ECIST) have visited the Trust in February 2019. They have produced a report on their findings and have offered further support to the Trust in relation to our improvement work. The outcomes, recommendations and findings from ‘perfect week’ and ECIST will inform further focus and priorities for 2019/20.

Main aims will be to:

- continue to embed Red2Green methodology and ensure divisional ownership
- achieve 30% discharged by noon each day
- reduce the percentage of stranded and superstranded patients
- ensure the workforce is aligned to patient needs.

**HOW THIS BENEFITS PATIENTS**

By having a system approach in looking at different pathways, we aim to reduce duplication in the system and streamline access to the right clinician.

In addition to emergency departments, patients as well as ambulance services will have further access to other services and alternative care pathways in our health economy where patients will be provided with the right care in a timely fashion.
WHAT WE SAID WE WOULD DO

Local system A&E Delivery Board agreed the trajectory for four-hour access standard, as is shown above.

The Board members are senior representatives from CCGs, local authorities, London Ambulance Service, community services provider NELFT, the Trust, primary care (UTC/ UCC) provider PELC, as well as the regulators, NHS England and NHS Improvement. All system partners play a part in ensuring the system trajectory is achieved.

WHAT WE HAVE ACHIEVED

- We have continued our ongoing work to improve and increase the number of patients seen within four hours of arrival.
- In addition to 24/7 Consultant cover in Emergency Department in Queen’s Hospital, we have now extended Consultant cover at King George Hospital Emergency Department covering between the hours of 8am and 2am.
- We have started the Red2Green transformation work in August 2018 with a very good progress coordinated by Red2Green Transformational Leads, supported by their facilitator team.
- We run weekly length of stay reviews followed by Home First system meetings on Queen's site and Delayed Transfers of Care (DTOC) meetings on King George site.
- System partnership working has improved with closer links and coordination with all system partners and regular communication lines.
- The Trust, CCGs and PELC have agreed and facilitated access to diagnostics for PELC to enable larger number of type 3 patients presenting to be seen and treated in clinically suitable and appropriate environment.
- Introduced point of care testing in Emergency Department in Queen's Hospital which has resulted in rapid diagnostics turnaround time. This in turn improved treatment time, reduced unnecessary referrals to majors and improved patient outcomes.
- We have implemented a dedicated escalation rota, incorporating departmental management team up to Divisional and executive level.
- We have run educational workshops for local general practitioners and pharmacists;
- We have started new medical workforce initiatives such as Emergency Department Academy and School of Surgery which are assisting in recruitment and retention;
- We have improved Emergency Department at King George Hospital by increasing the space and making it a much better and clinically suitable environment.
- We have improved functionality of two wards – one at each site in order to meet the change in clinical demand.

We ran a ‘perfect week’ in line with Red2Green/ SAFER principles in March 2019 with the aim of rapidly improving patient flow to produce a step-change in performance, safety and patient experience. As the result of the ‘perfect week’, we:
- improved Trust performance from 75.34% in week ending 17/02/19 to 83.92% in week ending 24/03/19
• reduced our stranded patients with LoS over seven days by 20% (from 421 at the end of February to 336 at the end of March) and our super-stranded with LoS over 21 days by 26% (from 167 at the end of February to 124 at the end of March) across our Red2Green wards
• returned to bed base with no outliers
• benefited from divisional silver and gold escalation structure and zero tolerance to delays.

WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT

We will continue to build on the success of the Red2Green initiative and the ‘perfect week’ outcomes. This will be done by embedding weekly flow rhythm across the organisation and supporting the ward to deliver on their Red2Green pledges.

Focus will be placed on reducing the number of stranded and super-stranded patients, improving pre-noon and pre-5pm discharges, as well as ensuring internal professional standards are reviewed, agreed, signed off and embedded.

Expansion of ambulance Rapid Assessment and First Treatment (RAFT) space on Queen’s Hospital site commenced, which will result in the increase of the number of trolleys from five to eight and the creation of a dedicated Fit2Sit area for nine patients, as well as dedicated phlebotomy and point-of-care testing rooms.

Plans are being developed to replicate the RAFT model on the King George Hospital site.

We will continue to work with system partners, and in particular ambulance services and CCGs, to maximise the potential of alternative care pathways in order to manage the increase in the ambulance conveyance demand.

We will continue to work with NELFT colleagues and the wider system to improve patient experience and reduce waiting times for patients presenting with mental health complaints. We will focus on adult as well as adolescent and paediatric patient groups.

We will continue to work as a system to improve the pathways for discharge from hospital (ED, assessment units and wards).

Our aim is to improve performance against the four-hour access standard as we have a system-wide acknowledgement of the shared ownership and commitment from all partners.

HOW THIS BENEFITS PATIENTS

We will see and treat patients quicker and in an appropriate and clinically suitable environment.

### Attendances and number of patients seen within four hours

![Graph](image)

### MAXIMUM TIME OF 18 WEEKS FROM POINT OF REFERRAL TO TREATMENT (RTT) IN AGGREGATE – PATIENTS ON AN INCOMPLETE PATHWAY

WHAT WE SAID WE WOULD DO

As part of our planning for 2018/19, we agreed as a system that we would return to delivering the 92% 18-week incomplete standard in April 2018 and maintaining this going forward. In line with our original two-year plan, our plan for 2018/19 was to:

• maintain delivery of the 92% 18-week incomplete RTT standard, subject to agreement with commissioners regarding funding this growth

• to have no patient wait more than 52 weeks for treatment (this excludes any patients who choose to wait longer, do not cooperate with offers of treatment or who are on clinically-
complex pathways)
• progress and participate with the design and roll-out of the system-wide referral management system programme
• continue to develop and refine our demand and capacity modelling at specialty/sub-specialty level and the upskilling of our staff in this area of work
• continue progress with our data quality improvement plans for RTT and activity

WHAT WE HAVE ACHIEVED
• review and redesign our partnership working with the independent sector.
In October 2018, we agreed to initiate a revised recovery plan with our commissioners and regulators.

Since then, we have reduced the overall number of patients waiting from over 41,000 in September 2018 to just above 39,000 in January 2019.

While we have not met the overall improvement trajectory, we have delivered significant improvements in the performance in a number of specialties, including oral/maxilla-facial surgery, neurology and endocrinology.

We have extended available capacity in-house and through outsourcing contracts for orthopaedics, ENT and neurosurgery.

As a health system, we have been working jointly to agree common pathways between primary care and secondary care as part of our ‘Improving Referrals Together’ (IRT) programme.

Working with commissioners, we have put in advice and guidance arrangements to enable GPs to request input on patients from our clinicians, without having to refer.

WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT
In the short term we will continue to focus on the following areas:
• maximising the use of independent sector capacity that is now in place (for orthopaedics, ENT, neurology, neurosurgery and gynaecology) and putting in place additional contracts to extend this where required
• progressing system-wide initiatives that form part of our system recovery plan, with priority work on Advice and Guidance and Single Point of Access (for pain services and rheumatology) in the short term.

Our system recovery plan means that we will be focusing on transforming how our outpatients work in the future. This includes:
• delivering clinically led pathway design across 12 specialties as part of IRT programme along with increasing effectiveness and access to Advice and Guidance;
• expanding the number and usage of Single Points of Access and enhanced triage to ensure that the right patients are seen in the best location for them;
• developing new models of care for Outpatients – for example, virtual clinics.

HOW THIS BENEFITS PATIENTS
Our use of the independent sector will provide extra capacity, allowing us to treat our patients more quickly.

Our system improvement plan has at its heart the intention to treat patients at the right time, in the right place by the right clinician. This will mean more timely diagnosis and treatment of patients and will deliver a more patient-focused service.

<table>
<thead>
<tr>
<th>What will we do?</th>
<th>Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway</th>
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<tbody>
<tr>
<td>Target Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>92% by March 2019</td>
<td>88.50%</td>
</tr>
<tr>
<td>Outcome</td>
<td>Target not achieved</td>
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</tbody>
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ALL CANCERS – MAXIMUM 62-DAY WAIT FOR FIRST TREATMENT FROM:
A. URGENT GP REFERRAL FOR SUSPECTED CANCER
B. NHS CANCER SCREENING SERVICE REFERRALS

WHAT WE SAID WE WOULD DO
We said we would meet the majority of the national targets for cancer waits.

WHAT WE HAVE ACHIEVED
We have improved our performance, meeting all standards during 2018/19 with the exception of the two-week waits in November 2018, January 2019 and breast screening in September 2018.

The 62-day standard has consistently been achieved since July 2017 and this has contributed to the North Central and East London sector performance.

Throughout 2018/19 we reviewed each tumour group pathway against best practice to identify areas for improvement. This includes improvements in booking processes (first appointment, admissions, imaging, admin) and reporting turnaround times for histopathology and imaging.

The Urology pathway has significantly improved in 2018/19 and this achievement has been recognised across London with the Urology Clinical Cancer MDT Lead and Cancer Manager running a workshop at a national event on 6th March to demonstrate what improvements have been made in the Urology pathway through working collaboratively with our primary care colleagues.

In addition, we have:
• sustained operational grip and commissioners’ engagement in cancer delivery
• maintained Divisional, clinical team and

GP engagements with improving pathways and patient experience enabling treatments earlier in their pathways
• run an annual Cancer MDT leads away day in March 2019, to continue with clinical engagement in cancer delivery
• created a cancer quality dashboard monitored weekly by Cancer Management team
• refreshed demand and capacity models to improve median waits across all tumour groups
• participated in ‘teachable moments’ project providing healthy lifestyle options for patients with “no cancer”. This is being hosted by Barts
• a structured and functional MDT coordinators and trackers with clear leadership and direction
• continued with a well-established and embedded governance structure for cancer which is across our local health community
• implemented the national directive for all Trusts to receive referrals from GPs through e-RS (e-referrals) from 1st October 2018 with 100% of practices sending through two-week referrals electronically. This has involved working collaboratively with our primary care colleagues
• developed a GP grid in collaboration with primary care which provides details on how to refer and what diagnostic tests should be used prior to first outpatient appointment, in addition to the patient information that should be given to patients so they are clear what to expect prior to referral
• developed a schedule in conjunction with primary care for educational sessions to GPs and practice managers to improve patient pathways and e-referrals
• recruited additional consultants to create more capacity such as colorectal, upper GI, skin and pathology
• reviewed each tumour group pathway against best practice to identify areas for improvement this includes improvements in booking processes (first appointment,
WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT

With the introduction of the breach reallocation process in April 2019, the focus on day 28 will continue, particularly for specific tumour groups, such as urology, gynae and lung pathway.

We will implement the 28-day faster diagnosis standards, enabling patients to receive a definitive diagnosis or ruling out of cancer within 28 days of a referral. This will be mandated for all Trusts from April 2020 with monitoring starting from April 2019.

HOW THIS BENEFITS PATIENTS

The faster diagnosis standard will speed up access to diagnosis for those with cancer, to ensure that patients who are not diagnosed do not wait and worry. This fits with the new NICE referral guidance lowering the threshold of suspicion for cancer referral and will centre the pathway on the patient and improve better communications between secondary, primary care and the patients.

MEET THE DIAGNOSTIC TARGET

WHAT WE SAID WE WOULD DO

At the start of the year we committed to meeting the diagnostic target for the whole of 2018/19. This is set to ensure that at least 99% of patients receive their diagnostic test within six weeks.

WHAT THE DATA SHOWS

Two significant issues developed over the course of the year that resulted in the deterioration in performance throughout the year.

Firstly, the Trust was unable to maintain normal capacity levels for routine endoscopy tests, following a fire in our Endoscopy Unit at Queen’s Hospital that affected the endoscope decontamination facilities.

Secondly, for MRI we experienced mechanical failures and subsequent capacity issues.

For endoscopy we have leased a mobile decontamination unit that has enabled the Trust to continue delivering the service, albeit with a reduced capacity.

To supplement this, we have been outsourcing to the independent sector and also have brought in ‘insourced’ resource to see patients in our facilities at the weekends.

For MRI, we have been outsourcing some cases to the independent sector but from the start of February, we have leased a mobile unit.

WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT

A significant strand of our proposed improvement for the forthcoming year is dependent on capital investment.

We have already invested in a new CT (computerised tomography) scanner at our King George site. We have secured investment for new audiology booths, a CT cannulation room and a refurbished endoscopy decontamination unit, which will all be in place at the beginning of 2019/20.

The Trust will continue to use the mobile MRI scanner and endoscopy insourcing to ensure that we return to delivering the diagnostic standard in the first half of 2019/20.

We have plans to invest further in our endoscopy service, by purchasing new endoscopes for King George and extending straight-to-test for a number of specialties.

We are also working with primary care colleagues, particularly on cancer pathways, to better standardise our patient pathways.
and ensure that patients are referred with an appropriate set of tests.

**HOW THIS BENEFITS PATIENTS**

We have invested in new audiology booths that will improve the experience and turnaround time for patients awaiting hearing tests. Our new CT scanner and CT cannulation room capabilities will also enable us to diagnose and, ultimately, treat patients more quickly.

New endoscopes will assure higher-quality images and more accurate diagnoses for our patients.

The pathway and service improvements, such as standardising pathways and diagnostics, and increasing straight-to-test are part of a series of improvements that we are making as part of working towards the new faster diagnosis standard.
MEDICAL APPRAISAL COMPLIANCE

WHAT WE SAID WE WOULD DO
We aimed to support the medical workforce in the completion of their annual medical appraisal and their five-yearly medical revalidation.

We also aimed to ensure that annual appraisals were completed before 31st March and that revalidation recommendations were submitted to the General Medical Council (GMC) both with confidence and before their individual deadlines.

The primary objective of this process is to ensure patient safety and to highlight clinicians who are in need of support in their clinical practice.

Further to this, annual medical appraisals offer an opportunity for clinicians to reflect upon their practice, their progress, their goals and weaknesses within their day to day work.

WHAT THE DATA SHOWS
In 2017/18 the overall medical appraisal rate was 94.5%. Our annual rate for 2018/19 is 96.3%. This is 1.9% higher than the previous year, and places us well above the national appraisal average of 90%.

Furthermore, this represents the highest appraisal rate within the Trust for a third consecutive year and we anticipate that this will be one of the highest completion rates reported within the London area.

Historically the overwhelming majority of medical appraisals were completed in the month of March. Under the guidance of NHS England the decision was made to bring appraisal dates forward, away from the very end of the fiscal year.
WHAT WE SAID WE WOULD DO
The Trust set out to reduce our sickness absence to 2.8%.

WHAT THE DATA SHOWS
Up until November 2018 the sickness absence rates were at or around 3.7%. However, as with other NHS Trusts in London there has been a rise in sickness absence rates during the winter period. In relation to short term sickness, colds and flu, and work-related stress.

WHAT WE HAVE ACHIEVED
There has been continued improvement in return to work interviews which are monitored by the Trust. Additional support has been provided in OH to introduce additional capacity in psychology to support members of staff returning to work following mental health-related stress.

WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT
• We are undertaking a review of all current wellbeing initiatives, due to the success of the commencement of the psychologists’ further increase in capacity.
• We are re-focusing on sickness health management training, supporting line managers on early interventions.

HOW THIS BENEFITS PATIENTS
Improved sickness rates improve staff engagement scores as a result of improved team working. Also there is a reduction in the usage of temporary staff, which improves continuity of care.
OBJECTIVE 4: WORKING IN PARTNERSHIP
Priority 5: Involve our patients and public in all our work

IMPROVING COMPLAINTS RESPONSIVENESS

WHAT WE SAID WE WOULD DO
We said we would develop an online satisfaction survey for those who have made a complaint. This should enable a greater collection of data.

We said we would redesign the complaint-handling workshops to incorporate the Patient Advice and Liaison Service (PALS) in the delivery to give staff a wider understanding of how to provide help.

We said we would work further on the thematic analysis of complaint trends within divisional and Trust integrated reports, identifying actions that will help reduce patient concerns.

WHAT WE HAVE ACHIEVED
The online satisfaction survey is still in development with the expectation of going live in April 2019.

The complaint and PALS workshops have been redesigned and a full year of dates has now been published covering training across alternate sites on a monthly basis.

Trend analysis is now provided across the Trust to Divisions and included in integrated reports.

WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT

PALS staff are attending wards daily and interacting with all patients where appropriate, this will continue with expansion into the Emergency Departments on both sites.

We will align Complaints Core Team staff to specific Divisions, with weekly Division complaints meetings where Core Team staff discuss recent trends identified and any recommended actions required.

We will develop an online PALS query form in line with the complaints form already accessible via the website and produce a new PALS leaflet where a cut-out card with contact details can be carried in purses and wallets.

HOW THIS BENEFITS PATIENTS
Encouraging more proactive staff and making PALS staff more visible will enable quick resolution of issues for patients.

Aligning the Core Complaints Team to work more closely with Divisions will allow for early identification of trends to assist with learning.

New leaflets will allow the cards to be carried more easily by patients.

IMPROVED PATIENT SATISFACTION (THROUGH FRIENDS AND FAMILY TEST) – POSITIVE RESPONSES

WHAT WE SAID WE WOULD DO
The Trust reviews all internal targets for Friends and Family Test (FFT) positive recommendations and response rates on an annual basis. Targets are set based on performance in the previous year but also include a stretch target where appropriate to ensure that the Trust is continually aiming to improve performance.

WHAT WE HAVE ACHIEVED
One of the ways in which we identify, measure and monitor patient experience across our services is through the Friends and Family Test (FFT). The FFT is a tool that allows people who use our services to provide feedback on their
experience. It is a standard question which anyone who uses NHS services is asked.

The FFT is an NHS England requirement for all NHS-funded services. We ask patients, family members and carers: “How likely are you to recommend our ward/service to friends and family if they needed similar care of treatment?” – this is the FFT question.

Each year we set an internal target for the percentage of patients who would recommend our services. We want to ensure we are continuously striving to improve and on this basis, we set very challenging targets that we aim to meet over the year.

This year we have been successful in achieving and maintaining the FFT positive recommendation for inpatient services and for A&E. In both of these areas, the Trust has met the target, consistently showing a sustained improvement.

Unfortunately, the Trust has not met the target for maternity (labour) which is 98.5%. Within maternity services, women are asked to complete the FFT question at four touchpoints during their care: antenatal, labour, postnatal and community postnatal.

Each month we review the negative recommendations to understand the reasons women may not be satisfied with the service they have received.

Overall, we do not receive negative recommendations (unlikely or extremely unlikely to recommend) but receive neutral responses (neither likely nor unlikely to recommend or don’t know).

Review of the data shows that although we have not met the target on a quarterly basis, we are meeting this more frequently on a monthly basis with four out of five months between April-December 2018 labour meeting the target.

During the year the Trust also took part in a patient experience national collaborative.

Part of this work was undertaking real-time measurement to understand more about patient’s experience of our services.

Patient experience team members attended the eight pilot wards, twice per month to speak with 50% of the patients admitted.

The questions asked were collated in 10 domains which are things patients have told us are important to them. These are:

- Consistency and co-ordination
- Respect and dignity
- Involvement
- Doctors
- Nurses
- Cleanliness
- Pain control
- Medication
- Noise at night
- Kindness and compassion.

The results from the ward visits were put into a report format that was provided to ward staff within 24 hours – enabling them to understand how things were on the ward at that time rather than at a later date.

There were considerable improvements overall including:

- Improvements across five domains (consistency & co-ordination, involvement, medication, noise and night and kindness & compassion)
- Consistent data collection across months provided trusted data
- Statistically-significant improvement in medication and noise at night domains
- Excellent feedback for our nursing teams – domains linked to nursing had consistently good results (respect & dignity, nurses, kindness & compassion)
- Recommendation question has increased from baseline of 8.46 to 9.25 – significant improvement
- All pilot wards were able to demonstrate improvements.

**WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT**

Although the patient experience collaborative has formally ended, the methodology has shown such improvements that we have continued this work on our pilot wards. We are currently evaluating this more fully to identify whether this is something that should be rolled out across the Trust.

There is currently a central NHS England review of the FFT methodology and we are awaiting further guidance on how this will be delivered from 2019. This will inform our own patient experience feedback mechanisms.

2019-2020 is the final year of our patient experience strategy. We will be monitoring our
success at delivering the strategy and will also be considering the next steps for patient experience at BHRUT.

Over the last two years we have developed and implemented a highly successful patient partner programme in the Trust. Our patient partners are seen as an essential resource to help us improve every area of our work.

Moving forward, we would like to expand this more – expanding our use of co-design and co-production.

**HOW THIS BENEFITS PATIENTS**

It is essential that the Trust has robust systems and processes for understanding our patient’s experiences.

This ensures that we are able to review, share good practice and take action where necessary to improve. Having a systematic approach to obtaining feedback ensures that the data and information collected can be trusted and that we can use it for the purposes of continuous improvement.

---

**WHAT WE SAID WE WOULD DO**

Each year the Care Quality Commission (CQC) carries out a national inpatient survey to explore the experiences of patients who were admitted to an NHS hospital in England.

The last report we have available was undertaken in September 2017 and related to patients who had been inpatients at our hospitals in July 2017. The results from this survey were received in June 2018.

The CQC national surveys are an excellent method of obtaining patient feedback. However, due to the time between the survey being completed and the results being received by the Trust, we also use a number of other ways of hearing about our patient’s experiences.

All patients who use our services are encouraged to complete a patient experience survey which includes questions relating to dignity and respect, care and compassion, nurse communication, doctor communication and involvement in care.

On some of our wards we also complete a more detailed discussion with patients to understand more about their experience – what went well and what we can improve.

We use all of these feedback methods to understand what it is like to be a patient in our hospitals and we base our work projects and annual objectives directly on the feedback received.

**WHAT THE DATA SHOWS**

This year, the Trust overall score for the CQC National Inpatient Survey was 8 out of 10 – which was an improvement on the 2016 score of 7.8 out of 10.

The target was 7.9 out of 10 and this was met.
The Trust position in comparison to our results in 2016 is outlined in the table below:

<table>
<thead>
<tr>
<th>Difference from 2016 results</th>
<th>Number of questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change</td>
<td>11</td>
</tr>
<tr>
<td>Improved</td>
<td>33</td>
</tr>
<tr>
<td>Worse</td>
<td>9</td>
</tr>
<tr>
<td>Question was not asked previously</td>
<td>9</td>
</tr>
</tbody>
</table>

The 62 questions asked are aligned to 11 sections and the CQC categorised this Trust as about the same as other Trusts for 10 sections. We were categorised as better than other Trusts for one section but not worse than other Trust for any section.

<table>
<thead>
<tr>
<th>Section</th>
<th>Trust Score</th>
<th>Compared with other Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Emergency/A&amp;E department Answered by emergency patients only</td>
<td>8.3/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Waiting lists &amp; planned admissions Answered by those referred to hospital</td>
<td>8.8/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Waiting to get a bed on a ward</td>
<td>6.8/10</td>
<td>About the same</td>
</tr>
<tr>
<td>The hospital and ward</td>
<td>7.7/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Doctors</td>
<td>8.4/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Nurses</td>
<td>7.7/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Care and treatment</td>
<td>7.8/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Operations and procedures Answered by patients who had an operation or procedure</td>
<td>8.1/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Leaving hospital</td>
<td>6.7/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Overall views of care and services</td>
<td>5.2/10</td>
<td>Better</td>
</tr>
<tr>
<td>Overall experience</td>
<td>8.0/10</td>
<td>About the same</td>
</tr>
</tbody>
</table>

However, there were areas highlighted that require improvement. These included:
- involving patients in decisions about their care
- discharge planning/information provided at point of discharge
- environment (noise, cleanliness, food).

**WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT**

It is important to note that the results of the CQC national inpatient survey are received a considerable time after the survey takes place. However, some of the results are supported by other feedback mechanisms that the Trust utilises including complaints, PALS and FFT.

The areas identified as requiring improvement are reviewed on a regular basis as part our current analysis of feedback received. Patient experience continues to be driven forward in line with the Trust Patient Experience Strategy 2016-2019.

Our focus is on:
- listening and responding to feedback
- patient partners
- accessibility.

Our strategy informs the work we undertake as a corporate team and is monitored and reported on a regular basis to the Patient Experience and Engagement Assurance Group.
<table>
<thead>
<tr>
<th>Strand</th>
<th>Pledges</th>
</tr>
</thead>
</table>
| Patient Partners | • Form a Patient Partnership Council  
• Introduce “hello my name is” as a minimum standard for initial contact for all staff in our trust  
• Empower patients to have a voice and an active role in shaping services for the future  
• Increase the number of volunteers  
• Introduce “what matters to me” – opportunities for patients to discuss personal priorities for their clinical needs |
| Accessibility | • Improve adherence to Accessible Information Standard  
• Improve accessibility for blind and visually impaired service users  
• Achieve the Deaf Charter Mark  
• Improve services for patients with dementia and their carers  
• Improve the journey and facilities for users with disabilities |

**REDUCE REACTIVATED COMPLAINTS**

**WHAT WE SAID WE WOULD DO**

Continue to improve on the quality of complaint responses.

**WHAT WE HAVE ACHIEVED**

The quality of complaint responses continues to improve; this is identified in the continued reduction of reactivated complaints.

**WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT**

- Continue to monitor the complaint responses by way of quality assurance through the Core Complaints Team
- Identify where there needs to be further improvement and work with Divisions to support new staff through PALS and complaints training workshops.

**HOW THIS BENEFITS PATIENTS**

Complainants should only need to write to the Trust once to raise their concerns about issues connected to their care.

All relevant information is required to be clear in responses, written in layman's terms without acronyms and be factual.

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**STAFF FRIENDS AND FAMILY TEST % RECOMMENDED**

**WHAT WE SAID WE WOULD DO**

Improving staff experience supports us to achieve our corporate objectives of becoming an employer of choice and delivering high-quality patient care as well as realising our Trust vision of “Delivering Outstanding Care to Our Community Delivered with PRIDE”.

Being well-led hospitals is a key strategic intent. We recognise and act on the evidence that positive staff experience enhances patient experience.

The annual NHS Staff Survey is our single most important source of data and intelligence on our staff experience and opinion.

It includes the staff Friends and Family Test for recommending our hospitals as places for care.

We recognise and understand the evidence that conclusively establishes the positive relationship between staff engagement, quality of care, patient experience and overall organisational
performance. How we respond to what our staff tell us in the annual NHS Staff Survey is an important part of our overall approach to improving performance and staff confidence in our care.

We said we would act in response to the findings to improve staff experience.

WHAT THE DATA SHOWS

Our 2018 findings, published in 2019, showed that our journey of improvement needed to continue for our staff as well as our patients.

Our response rate decreased slightly to 46% with 2,803 completed surveys compared to 47% and 2,869 completed surveys in 2017. The average response rate for acute Trusts nationally was 44%.

Overall our findings show a slight deterioration in staff experience which we have committed to addressing in earnest. We have a number of initiatives which began to embed in 2018/19, including London Leadership Academy-sponsored inclusion projects and ongoing promotion and practice of a restorative approach to addressing workplace concerns.

We have focused work on retention as well as managers’ and leaders’ development. We now have established mentoring and coaching opportunities which we continue to gross as well as master classes in key leadership skills and topics.

We also offer an Elements Programme to learn and develop key in-house leadership skills and approaches.

We are also continuing to work towards being a more inclusive organisation. Our Ethnic Minority Network is well established and forums for disabled staff and Lesbian, Gay, Bisexual, Transgender/Transsexual plus (LGBT+) staff were introduced in January 2019.

Across the Trust many initiatives to improve staff experience are in place such as the new approach to resolving workplace concerns based on restorative practice.

Our new managers’ induction commenced in March 2018 and we continue to keep a focus and priority on the delivery of our retention plans. We have reviewed our approach to flexible working and will shortly be introducing a new more permissive approach with immediate oversight as part of the process by our Employee Relations Team.

Our equality, diversity and inclusion activities and actions continue to gain momentum as we take forward our ‘Inclusion through Improvement’ projects supported by the London Leadership Academy, also a key part of our response to our Workforce Race Equality Standard (WRES) data.

We are developing local support and change champions through our Personal, Fair and Diverse campaign and Black and Minority Ethnic (BME) network.

We repeated our Dignity at Work Month in June 2018 to continue the momentum. We have also been an NHS Employers Diversity and Inclusion Partner in 2018/19. This scheme supports us to progress and develop our equality performance over a period of 12 months, and is closely aligned to the NHS Equality Delivery System (EDS2).

All of the above is reflected in our new 2019/20 action plan across equality, diversity and inclusion. The plan also reflects the powerful conversations with our staff on how we can improve their experience of working with us.

WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT

We are now in the process of analysing our 2018 annual NHS Staff Survey findings. We will act decisively in response to the findings on where we need to improve.

Making workplaces better takes demonstrable commitment, time and sustained energy at all levels to change and challenge negative behaviour.

We recognise that cultural change is one of the most difficult leadership challenges and takes time. We have now embarked on a culture change programme supported by NHS Improvement which will deliver real improvements to our culture and in turn staff friends and family test scores.

HOW THIS BENEFITS PATIENTS

Research evidence conclusively establishes the positive relationship between staff engagement, quality of care, patient experience and overall organisational performance.

Our annual NHS Staff Survey findings give a valuable insight into what our staff think about these key aspects of working in our hospitals.
Improving our staff’s experience supports us to achieve our corporate objectives of becoming an employer of choice and delivering high-quality patient care as well as realising our Trust vision of “Delivering Outstanding Care to Our Community Delivered with PRIDE”.

Evidence shows that organisations with higher engagement levels with their people outperform others by over 20%.

Furthermore, links have been made between highly-engaged staff and lower patient mortality, higher levels of patient satisfaction and better results on quality of services and efficient use of resources.
COMMISSIONING FOR QUALITY AND INNOVATION PAYMENT FRAMEWORK (CQUIN)

A proportion of the BHRUT income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between BHRUT and our commissioners through the CQUIN payment framework.

The targets agreed were consistent with the delivery of BHRUT’s strategic objectives and are delivery-driven at the team, directorate and board level. Clinical teams monitor their own performance against each CQUIN.

This occurs via a number of local forums and through staff supervision.

The total amount of income in 2018/19 conditional upon achieving quality improvement and innovation goals was £6,939,334.

The monetary total for achievement of goals in 2018/19 will be published at the end of June 2019* and the monetary total for achievement of goals in 2017/18 was £8,330,956. Please see Appendix A for a list of our 2018/19 CQUINs.

Further details of the agreed goals for 2018/19 and for the following 12 month period are available on request via Louise.Head@nhs.net. The CQUIN targets for 2019/20 build on, and are consistent with, both local and national strategy.

* This figure was not available at the time of publication of this Quality Account

REGISTRATION WITH THE CARE QUALITY COMMISSION (CQC)

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

The commission inspects hospitals and other health and social care providers to make sure they meet fundamental standards of quality and safety, and then publishes its findings.

BHRUT is required to register with the CQC under section 10 of the Health and Social Care Act 2008 and its current registration status is registered without conditions.

The CQC has not taken enforcement action against BHRUT during 2018/19. BHRUT were not required to participate in special reviews or investigations by the CQC during 2018/19.

The CQC inspected Barking, Havering and Redbridge Trust between 23rd January 2018 and 15th March 2018, with the final report published on 22nd June 2018.

Four core services were reviewed, which were: Urgent and Emergency Care, Medical Care (including older people’s care), Surgery and Maternity Services, under the five domains of safe, effective, caring, responsive and well led.

This was the first time that the use of resources element was assessed. This assessment is undertaken by NHS Improvement and was completed on the 5th April 2018. It was published by CQC alongside the other Trust level ratings.

Overall the Trust was rated as “Requires Improvement”. Four “must do” actions were identified and 55 “should dos” recommended, to avoid breaching any legal requirement in the future, and to improve the quality of the care and services.

The Trust was rated as inadequate for the use of resources.
### Ratings for Queen's Hospital

<table>
<thead>
<tr>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent and emergency services</strong></td>
<td><strong>Requires Improvement</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Requires Improvement</strong></td>
<td><strong>Requires Improvement</strong></td>
</tr>
<tr>
<td><strong>Medical care (including older people's care)</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
</tr>
<tr>
<td><strong>Surgery</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Requires Improvement</strong></td>
<td><strong>Requires Improvement</strong></td>
</tr>
<tr>
<td><strong>Critical care</strong></td>
<td><strong>Requires Improvement</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Required Improvement</strong></td>
<td><strong>Required Improvement</strong></td>
</tr>
<tr>
<td><strong>Maternity</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
</tr>
<tr>
<td><strong>Services for children and young people</strong></td>
<td><strong>Requires Improvement</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Mar 2017</strong></td>
<td><strong>Mar 2017</strong></td>
<td><strong>Mar 2017</strong></td>
<td><strong>Mar 2017</strong></td>
<td><strong>Mar 2017</strong></td>
</tr>
<tr>
<td><strong>End of life care</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
</tr>
<tr>
<td><strong>Outpatients and diagnostic imaging</strong></td>
<td><strong>Good</strong></td>
<td><strong>N/A</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Mar 2017</strong></td>
<td><strong>Mar 2017</strong></td>
<td><strong>Mar 2017</strong></td>
<td><strong>Mar 2017</strong></td>
<td><strong>Mar 2017</strong></td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td><strong>Requires Improvement</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Required Improvement</strong></td>
<td><strong>Required Improvement</strong></td>
</tr>
</tbody>
</table>

### Ratings for King George Hospital

<table>
<thead>
<tr>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent and emergency services</strong></td>
<td><strong>Requires Improvement</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
</tr>
<tr>
<td><strong>Medical care (including older people's care)</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
</tr>
<tr>
<td><strong>Surgery</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
</tr>
<tr>
<td><strong>Critical care</strong></td>
<td><strong>Requires Improvement</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Requires Improvement</strong></td>
<td><strong>Requires Improvement</strong></td>
</tr>
<tr>
<td><strong>Services for children and young people</strong></td>
<td><strong>Requires Improvement</strong></td>
<td><strong>Requires Improvement</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
</tr>
<tr>
<td><strong>End of life care</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
</tr>
<tr>
<td><strong>Outpatients and Diagnostic imaging</strong></td>
<td><strong>Requires Improvement</strong></td>
<td><strong>N/A</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Mar 2017</strong></td>
<td><strong>Mar 2017</strong></td>
<td><strong>Mar 2017</strong></td>
<td><strong>Mar 2017</strong></td>
<td><strong>Mar 2017</strong></td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td><strong>Requires Improvement</strong></td>
<td><strong>Good</strong></td>
<td><strong>Good</strong></td>
<td><strong>Required Improvement</strong></td>
<td><strong>Required Improvement</strong></td>
</tr>
</tbody>
</table>
OUR PROGRESS ON OUR CQC ACTION PLAN

Points raised by the CQC during the inspection are addressed within a Trust action plan.

The action plan outlines a timeframe for achievement and actions required.

Delivery against the four “must dos” have been completed, and these actions are being monitored by the Divisions.

Delivery against the 55 “should dos” are being monitored by the Divisions and a monthly report provided to the Quality Governance Steering Group (QGSG).

There is an overarching action plan for the use of resources.

We have introduced a new technology programme, which is online governance, risk and compliance solution that provides a framework to manage, monitor and report on regulatory regimes, quality standards, business objectives, plans and risks. There is a designated CQC module, which allows all areas within the Trust to upload evidence to the key lines of enquiry (KLOES).

CLINICAL AUDIT

Clinical audit is part of quality improvement processes to ensure best practice in the delivery of healthcare services. There is an expectation that all healthcare professionals will be involved in clinical audit.

Clinical audit is used to constantly evaluate our services and to provide evidence that the Trust is meeting the expected quality standards. The process will also highlight where agreed service standards are not being adhered to, thus providing a framework for improvement.

BHRUT is required to participate in national clinical audits relevant to the health services BHRUT provides. These audits are conducted by third-party organisations and facilitate service delivery comparisons against national standards and with other organisations.

The Healthcare Quality Improvement Partnership (HQIP) is an independent organisation working in conjunction with the Academy of Medical Royal Colleges and the Royal College of Nursing. The Partnership commissions, manages, supports and promotes national programmes of quality improvement.

During 2018/19, 61 HQIP national clinical audits and two national confidential enquiries covered the relevant health services that BHRUT provides. It should be noted, however, that participation in the BAUS Female Stress Urinary Incontinence Audit has not been undertaken following suspension of the vaginal mesh procedure and owing to the belief that only data on this procedure was required.

These audits and enquiries were relevant to the NHS services provided by BHRUT. During that period BHRUT participated in 98.3% HQIP national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

Appendix B is the planned programme of mandatory national clinical audits (HQIP) and national confidential enquiries (NCEPOD) that BHRUT will be participating in during 2019/20.
The HQIP national clinical audits and national confidential enquiries that BHRUT was eligible to participate in during 2018/19 are shown in Appendix C.

The HQIP national clinical audits and national confidential enquiries that BHRUT participated in, and for which data collection was completed during 2018/19 are listed in Appendix C alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

BHRUT also undertakes a number of local audits that are conducted and evaluated in-house.

These local audits cover a wide range of topics – for example, improvement of patient care, outcomes or experiences or more efficient use of resources.

In addition, a local audit is often initiated following a service complaint, clinical incident or a risk management issue. A summary of the total clinical audit participation for 2018/19 is shown below.

<table>
<thead>
<tr>
<th>National HQIP Clinical Audits</th>
<th>Number of Audits / Quality Improvement Projects registered on the Safeguard System for Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>63 (two of which require data collection after March 31st 2019)</td>
</tr>
<tr>
<td>Non-HQIP National Audits</td>
<td>17</td>
</tr>
<tr>
<td>Local Clinical Audit</td>
<td>230</td>
</tr>
</tbody>
</table>

A table highlighting the HQIP audits and National Confidential Enquiries into Patient Outcomes (NCEPODs) participated is shown in Appendix C.

A table highlighting BHRUT's National HQIP Clinical Audit and NCEPOD plan is highlighted in Appendix B.

HQIP NATIONAL CLINICAL AUDITS

The reports of at least four HQIP mandatory national clinical audits were reviewed by BHRUT in 2018/19.

Listed on the next page are examples of these, and BHRUT intends to take the following actions to improve the quality of healthcare provided:
### NATIONAL CLINICAL AUDITS

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Audit Title</th>
<th>Review/Conclusion/Learning</th>
</tr>
</thead>
</table>
| Paediatrics | National Paediatric Diabetes Audit | 1. Better coverage of thyroid and coeliac Ds ensure samples are taken on admission, retest if the samples are insufficient - audit three monthly.  
2. HbA1c > 60 refer to nurse led clinic: improve capacity of the NCL - to lower the threshold for referral to nurse led clinic from the current value of 75mmol/mol to 64 mmol/mol.  
3. Introduction of high BMI clinic: Preach healthy lifestyle, regular exercise from the time of diagnosis. Community based activities by dietitian - address high BMI in each consultation.  
Additional dietitian input for high risk group and develop a community based clinic to promote healthy lifestyle.  
4. Funding for CGMS: very young children on pump and children with recurrent hypoglycaemia do not comply with advice because of fear of hypos. CGMS alleviates these. Pursue with business case.  
5. Negotiation with NLTJ and Trust Managers to increase funding for psychology service.  
6. Recruit a Band 2/3 support worker: this will then free up time of PDSN with education and assessment. |
| Haematology | SHOT - Serious Hazards of Transfusion (SMOT/UK National Haemovigilance Scheme) | 1. There was an increase in total reports from the previous year due to an increased awareness of incidents and increased reporting.  
2. With the blood track system now operating with WFP, incidents are now alerted electronically where awareness was previously lacking.  
3. All SMOT incidents are escalated to the divisional Quality and Safety meetings for Cancer and clinical support. All are thoroughly investigated and outcomes are reported back to SMOT. Any trend is identified and actions taken accordingly. Lessons are learned from all the incidents. Any member of staff involved in any incident is retrained as competency assessed. Sessions are asked to cascade to all staff any actions such as reinforcing correct procedures. Guidelines are monitored to ensure that the correct processes are outlined clearly. Each incident is different and actions are based on the investigations and causes of each. |
| Respiratory | National Lung Cancer Audit (NLCA) | 1. Overall resection rate continues to improve to 27% [18% last year].  
2. Re-section rate for NSCLC is 27.6%.  
3. Half of our cancer patients are stage 4 on presentation.  
4. Nearly 64% of NSCLC have advanced stage on presentation.  
5. Poor recording of FEV1, Smoking, P5, CNS Contact input, [14%].  
6. Need to improve reporting TMM staging [22% currently, 27% previous year].  
7. Smoking status entry very low [20%, previously 3%].  
8. Histological diagnosis has significantly improved to 80% [81% last year].  
9. 56% of small cell cancer patients have chemotherapy [53% last year].  
10. Number of clinical/Radiological diagnosis has come down to 31% [91%].  
11. Trust to review Bereavement Service. Regular Bereavement Service representation - achieved.  
12. To comply with National Optimal Pathway for Lung Cancer: Triage of all referrals, [Twice a week], Change in clinical pathway, Improve Pathology and Radiology turnaround time, SLA with BARTS for PET.  
13. Improvement in HNCA completion Rates. Continue to improve HNCA completion.  
15. Achieve all cancer targets.  
16. Clinical Trials’ recruitment and awareness.  
17. Full Hospital Needs Assessment on all patients.  
18. MDT attendance to be improved.  
19. CNS have started to use online Somerset Performa to document HNCA for all patients. Needs to be extended to all patients - Lung CNS will need additional admin time. |
| Neonatology | Neonatal Audit Programme: Neonatal Intensive and Special Care (NNAIP) | 1. Five aspects measured demonstrated a good practice and the result indicating that the Trust are performing above the National average.  
2. Four aspects measured show the Trust is behind the National average and requires improvement. These measures have been reviewed by the team and appropriate actions have been taken to improve services in the following areas: Antenatal steroids, Antenatal magnesium sulphate, temperature on admission and breastfeeding at discharge home. |

### LOCAL CLINICAL AUDITS

The reports of at least 10 clinical audits were reviewed by BHRUT in 2018/19. Listed on the next page are examples of these, and BHRUT intends to take the following actions to improve the quality of healthcare provided:
<table>
<thead>
<tr>
<th>Specialty</th>
<th>Audit Title</th>
<th>Action to improve quality of care/ change to practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care</td>
<td>Arterial Line Wastage Re-Audit</td>
<td>3. One-to-one education with nursing staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Introduction of VAMP system</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Introduction of low volume ABG syringes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. Introduction of low volume blood collection bottles</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>Management of labour and delivery of stillborn in patients with one or more</td>
<td>3. Collaboration with Consultant each time a decision is made about the care of the woman</td>
</tr>
<tr>
<td></td>
<td>caesarean section</td>
<td>4. Prescribing Misoprostol as per protocol using reduced dose for scarred uterus</td>
</tr>
<tr>
<td>ENT</td>
<td>Retrospective audit of patients admitted with necrotizing otitis externum</td>
<td>5. Improving documentation</td>
</tr>
<tr>
<td>Critical Care</td>
<td>Weaning from mechanical Ventilation</td>
<td>6. Re-audit in one year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7. Review trust guideline by the GDDG to comply with NICE and RCOG recommendations</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>Serious Incident Re-audit</td>
<td>2. Better documentation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Practice of swallo pre administration of antibiotics</td>
</tr>
<tr>
<td>Therapies</td>
<td>SLT service for dementia at KGH: communication, mealtimes and oral care</td>
<td>4. Implement a nurse/physio led protocol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Daily screening of patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. Thirty minutes SBT and document outcome of SBT</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>To take home antibiotics audit</td>
<td>3. Safety Culture assessment/survey undertaken within the department</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Human Factors training now included in the annual mandatory training</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Quality Improvement should be an integral part of II recommendations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. Consider patient evaluation of our process from their prospective Ask at the end of the being open meeting what could be improved with the investigation process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7. Reinforce the dissemination of learning from claims and complaints</td>
</tr>
<tr>
<td>Therapies</td>
<td>SLT to develop a mouthcare training package and present it to ward staff</td>
<td>2. Design training package for staff and relatives on swallowing difficulties/feeding difficulties/ oral care in dementia</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>Rate of re-operation of patients aged over 70 years who had cannulated screw</td>
<td>3. Relatives of patients with dementia should have access to written information leaflets available on the ward/Develop written information leaflets available on the ward for relatives of patients with dementia</td>
</tr>
<tr>
<td></td>
<td>fixation of fracture neck of femur</td>
<td>4. Patients with dementia who have access to a menu that supports them to choose what they would like to eat. In cases where they are not able to choose even with support, relatives should be consulted so that patients are not given food they do not like - Develop accessible menu for patients</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>Non-cervical screening related referrals to colposcopy - An audit of referral</td>
<td>5. Staff caring for patients with dementia should feel equipped to involve patients with dementia in making decisions about their care. This may include having access to resources regarding decisions such as procedures and discharge destination. Refer further with medical teams about barriers/facilitators to involving patients with dementia in decisions about their care.</td>
</tr>
</tbody>
</table>
Introduction
Research and innovation (R&I) is an important aspect to improve the quality of care we provide to our service users. Through research, we can acquire the evidence we need to find out which treatment works best.

This helps us to provide improved treatments and services to our patients. A recent survey carried out here at BHRUT in 2017, aimed to determine how service users and visitors to the Trust felt about clinical trials. A validated questionnaire was used; one of the main questions was “Do you think that patients should be asked to take part in medical research?” 168 out of 181 patients and visitors answered ‘yes’, demonstrating the desire people have to be given the choice.

The R&I Department is keen to ensure the service it delivers meets the needs of our service users and that we are able to offer our patients choice and access to clinical research. “Clinical Research” is required to determine the safety and efficacy of medications, devices, diagnostic products and treatment regimens intended for use in the everyday clinical setting. Studies may be designed to answer questions around the prevention, treatment, diagnosis or relieving symptoms of a disease. All studies that run in the Trust do so in accordance with the relevant regulatory approvals.

Two-year programme
Under the remit of the Medical Director, the R&I Department has embarked on improving the research services offered to our patients. This has enabled greater access to research with patients being offered new medications and interventions to improve quality of care and the patient experience. A new management structure is in place and a full review of the challenges the department faces continue to be explored and appropriate development plans put in place.

Staffing
The R&I Department is overseen by the Medical Director and consists of the following team members: Associate Director of R&I and Chief Medical Officer’s Services, Lead Research Nurse, R&I Manager, Finance Manager, research nurses and Allied Health professionals, study investigators and support services.

The North Thames Clinical Research Network (CRN)
The CRN contributes to the infrastructure that allows high-quality clinical research to run in the NHS and provides the costs of using the staff that support the delivery of research.

It offers specialist training so that patients can be confident that the research they are participating in is carried out by trained, experienced research staff. BHRUT is affiliated to the North Thames CRN.

Under the UCLPartners Harmonisation arrangement, the Trust works closely with the CRN to ensure that we meet the agreed benchmarks for getting studies set up within 40 days and that we are able to recruit our first patient to these studies within 30 days. Quarterly performance reports are submitted to the Department of Health and these are published on our website.

Present research studies
We are currently open and recruiting to 11 commercial research studies and 77 non-commercial research studies. We have 106 studies (both commercial and non-commercial) in follow up and are in the process of setting up 10 non-commercial studies and six commercial studies.

The number of patients receiving relevant health services provided or subcontracted by BHRUT in 2018/19 that were recruited during this period to research approved by an NHS Research Ethics Committee is 1,214.

Our research portfolio stretches across a number of clinical specialties including Accident and Emergency, Anaesthetics, Cancer, Cardiology, Critical Care, Dermatology, Ear, Nose and Throat, Gastroenterology, Gynaecology, Infectious Diseases, Liver, Neonatal Medicine, Neurosciences, Neurosurgery and Neuroradiology, Obstetrics, Ophthalmology, Paediatrics, Pharmacy, Rheumatology and Stroke.
INFORMATION GOVERNANCE

In our 2017/18 Quality Account we said we would continue to highlight data quality issues, monitor improvements, offer data assurance, develop our data quality strategy and work closer with operational teams to work towards making BHRUT one of the best data quality trusts in London.

WHAT WE HAVE ACHIEVED

We have continued to work in line with our Data Quality Strategy, thus becoming an information-rich Trust. The Data Quality department has been working towards improving our national score in the national Secondary Uses Service (SUS+) Data Quality Dashboards. These dashboards allow all NHS Trusts to assess our data in SUS+ to ensure that it is comprehensive and compliant with data standards.

We have attained a top three performing trust position for our data quality score in the London area for the time period of September to November. As of November, BHRUT’s Data Quality Valid score is 98.9%, compared with the London average score of 96.8%, and national score of 96.6%. This shows the comparison to national and region level data maintained.

Our aim is to create the right infrastructure and departmental processes with the information that underpins it to be of a high-quality standard which can offer assurance on the data of our clinical services and the Trust.

Data Quality Corrections

Our Data Corrections team has been focusing on merging any A&E duplicate registrations within 24 hours of the new registration number being raised.

This is assisting our clinical teams with ensuring patient safety, bringing both health records together within 24 hours of admission.

The team is continuing the good work of monitoring inpatient whiteboards to inform and advise ward and admission teams of data quality errors before the patients leave the Trust.

Assurance & Audit teams

From last year, the Assurance team has added a further 20 KPIs. This now takes us to more than 75 DQ KPIs which are now audited for the Trust. The team is also working closely with divisions to assist in operational DQ gaps. This includes process mapping to assist with data input and the Trust’s Financial Recovery Plan.

RTT reporting

Working with the Outpatients management team, the RTT Validation team and the Operational Trust Board, BHRUT has resumed nationally reporting RTT data. We have a dedicated team who validate and audit RTT pathways, and provide RTT training to all levels of hospital staff.

WHAT WENT WELL

We have continued to provide financial divisional data quality monthly reports. We have developed these reports to now include any CCG challenge that the Trust will incur.

These reports are also shared with contracts, performance and financial teams and show patient safety/financial/information governance risks and gains for the divisions. Teams can then amend any processes that lead to data quality errors.

We have created a number of new focused data quality dashboards for both Cancer Outpatients and Theatres teams. These dashboards now have all operational data quality issues flagged and sent to the teams on a daily basis. We also offer the assurance by monitoring changes and highlight any recurring issues.

WHAT THE DATA SHOWS

We continue to produce a number of data quality reports that are shared with operational managers which allow us to see what division and specialty the data quality error belongs to.

We have introduced a high-level data quality dashboard which is presented at a number of user groups.

We continue to use the HED (Healthcare Evaluation Data) system to assist BHRUT by highlighting any issues there may be with Trust KPIs. These may be related to patient safety, operational efficiency, clinical quality or financial opportunity.

The BHRUT Information Governance Assessment Report overall score for 2018/19 was 99% and was graded ‘green’.
WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT

BHRUT will be taking the following actions to improve data quality.

- We have created the DQ manuals for every ward, and all processes and policies within the DQ manual are being implemented.
- Electronic Discharge Summaries (EDS) continue to be monitored against our contractual obligations and clinical review. We are also now rolling out test day surgery EDS on the day case wards.
- The NHS Digital Data Quality Maturity Index continues to be monitored, and our score is still in the high rank for London Trusts.

Trust Data Quality Maturity Index

<table>
<thead>
<tr>
<th>Trust Name</th>
<th>DQMI (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST</td>
<td>98.1 99.2 97.5 97.9 97.9</td>
</tr>
</tbody>
</table>

NHS NUMBER AND GENERAL MEDICAL PRACTICE CODE VALIDITY

BHRUT submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data. Percentage of records in the published data:

Included a valid patient NHS number:

<table>
<thead>
<tr>
<th>Number of Invalid NHS Number and % Valid Apr 18 - Dec 18</th>
<th>Number of Invalid</th>
<th>% Valid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident &amp; Emergency</td>
<td>3,503</td>
<td>98.10%</td>
</tr>
<tr>
<td>Inpatients</td>
<td>486</td>
<td>99.60%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>872</td>
<td>99.80%</td>
</tr>
</tbody>
</table>

Included the patient’s valid general medical practice code:

<table>
<thead>
<tr>
<th>Number of Invalid GP Practice and % Valid Apr 18 - Dec 18</th>
<th>Number of Invalid</th>
<th>% Valid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident &amp; Emergency</td>
<td>27,195</td>
<td>85.10%</td>
</tr>
<tr>
<td>Inpatients</td>
<td>956</td>
<td>99.20%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>2,171</td>
<td>99.60%</td>
</tr>
</tbody>
</table>

CLINICAL CODING

Clinical coding is the translation of medical terminology to describe a patient’s complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format which is nationally and internationally recognised.

For the clinical coding data to accurately reflect our activity, clear, accurate and timely recording of clinical information in the patient’s notes, clear procedures for collecting and processing the data and appropriate training and accreditation of staff are necessary.

BHRUT’s several external and internal clinical coding audits carried out in 2018/19 along with the Information Governance Clinical Coding Audit carried out in January 2019 show that the Trust has a high standard of coding in terms of accuracy and depth of coding.

The depth of coding has significantly and steadily increased in the recent years, mainly due to engagement with clinicians and coding service improvement.

WHAT WE SAID WE WOULD DO

- Achieve 100 per cent compliance with coding on monthly submissions
- Reach at least Level 2 clinical coding accuracy
on information governance
• Code 35–45 finished consultant episode per clinical coder a day
• Increase engagement with clinicians
• Run a validation programme to improve Trust’s data and financial income
• Continue with training programme
• Continue with audit programme
• Recruit to 100 per cent to minimise agency spending.

We have submitted 100 per cent of coded activity where data was available every month for the last 12 months.

This means that we have captured 99.9% per cent of our admitted patients’ clinical activity and have accounted for all the resources used for patients.

Due to regular data validations, the Trust has recovered significant additional income in the sum of millions of pounds for the 2018/19 financial year.

**Information governance audit 2018/19**

A total of 200 FCEs coded on 10th September 2018 under various specialties were randomly selected to be audited. The error percentages correspond to mandatory level for primary diagnosis and primary procedures and correspond to advisory level for secondary diagnosis and procedures. The levels are described on tables 1 and 2 below:

**Table 1**

<table>
<thead>
<tr>
<th>Level of Attainment</th>
<th>Mandatory</th>
<th>Advisory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Diagnosis</td>
<td>≥90%</td>
<td>≥95%</td>
</tr>
<tr>
<td>Secondary Diagnosis</td>
<td>≥80%</td>
<td>≥90%</td>
</tr>
<tr>
<td>Primary Procedures</td>
<td>≥90%</td>
<td>≥95%</td>
</tr>
<tr>
<td>Secondary Procedures</td>
<td>≥80%</td>
<td>≥90%</td>
</tr>
</tbody>
</table>

(Ref. Data Security Standard 1 Data Quality: Clinical Coding Audit Guidance – Acute and Mental Health Trusts)

**Table 2**

<table>
<thead>
<tr>
<th></th>
<th>Total from audited FCEs</th>
<th>Incorrect</th>
<th>Total correct</th>
<th>% Correct</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Coder Error</td>
<td>Non-Coder Error</td>
<td></td>
</tr>
<tr>
<td>Primary Diagnosis</td>
<td>200</td>
<td>13</td>
<td>187</td>
<td>93.50</td>
</tr>
<tr>
<td>Secondary Diagnosis</td>
<td>1101</td>
<td>58</td>
<td>60</td>
<td>94.55</td>
</tr>
<tr>
<td>Primary Procedures</td>
<td>156</td>
<td>5</td>
<td>6</td>
<td>96.15</td>
</tr>
<tr>
<td>Secondary Procedures</td>
<td>272</td>
<td>21</td>
<td>21</td>
<td>92.28</td>
</tr>
</tbody>
</table>

These figures correspond to an overall Level 2 attainment in the IG Toolkit requirements (IG 505) with Level 3 being attained on secondary diagnosis and secondary procedures. BHRUT was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) are shown in Table 3:

**Table 3**

<table>
<thead>
<tr>
<th>Area</th>
<th>% of spells changing payment</th>
<th>% of spells changing HRG</th>
<th>% of clinical codes incorrect</th>
<th>Primary diagnosis incorrect</th>
<th>Secondary diagnosis incorrect</th>
<th>Primary procedure incorrect</th>
<th>Secondary procedure incorrect</th>
<th>% of spells with other data incorrect</th>
<th>% other data items incorrect</th>
</tr>
</thead>
<tbody>
<tr>
<td>CZ21V</td>
<td>10.9</td>
<td>10.9</td>
<td>20.1</td>
<td>17.6</td>
<td>20.1</td>
<td>19</td>
<td>26.1</td>
<td>4.3</td>
<td>1</td>
</tr>
<tr>
<td>DZ22B</td>
<td>20.6</td>
<td>20.6</td>
<td>16.6</td>
<td>15.7</td>
<td>16.7</td>
<td>30</td>
<td>0</td>
<td>0</td>
<td>1.1</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>15</td>
<td>17.2</td>
<td>16.7</td>
<td>18.5</td>
<td>22.6</td>
<td>17.2</td>
<td>17.2</td>
<td>2.5</td>
</tr>
</tbody>
</table>
It should be noted that this year’s audit has been targeted on specific HRGs and is not a representative sample.

The results should not be extrapolated further than the actual sample audited and the services reviewed in the sample were Minor Head, Neck and Ear Disorders, and Unspecified Acute Lower Respiratory Infection. The target areas for the sample were:

- Minor Head, Neck and Ear Disorders 19 years and over with CC (CZ21V)
- Unspecified Acute Lower Respiratory Infection with CC (DZ22B).

**WHAT WE HAVE ACHIEVED**

- Achieved 100% completion of coding on monthly submissions
- Reached predominantly advisory level in clinical coding accuracy on external and internal audits
- Met all our KPIs, including 35-45 episodes coded per day by senior coders
- We have significantly improved our engagement with clinicians and other members of staff via regular audits and validations, coding open days and internal Trust communications. This is rated at Level 3 (highest possible) in IG Toolkit
- We have a validation programme with all the clinical specialties to improve the depth of coding which has led to positive financial results
- The service now runs a full training programme which, alongside the service’s training needs, provides coding training for external candidates bringing additional income to the Trust. This is rated at Level 3 (highest possible) in IG Toolkit
- Provided regular business support, including clinical coding and PbR expert advice to clinical divisions
- Updated and maintained the OP sheets for every specialty, validated Outpatient data as well as provided bespoke coding/PbR advice to consultants
- Despite a national shortage of clinical coders we managed to hire two trained coders.

**WHAT WE ARE GOING TO DO NEXT TO CONTINUE IMPROVEMENT**

- We will continue with our data validation, audit and training programme
- We will continue to provide business support to divisions with coding, data quality and PbR advice
- Promotional work to raise the profile of clinical coding and data quality will continue
- We will continue the recruitment process for permanent members of staff to reduce our agency spend and improve the quality of our data.

**MEDICAL EDUCATION**

Medical Education has continued to work in close collaboration with our external stakeholders – Health Education England, NHSI and the General Medical Council – throughout 2018/19, focusing on improving the trainee experience and developing our non-training grades.

Our Director of Medical Education has led on the ‘Medical Education Transformation Plan’. The Medical Education Transformation (2018) Plan was presented to the Trust Executive Committee in May 2018 in response to recurrent adverse feedback from medical trainees on the national GMC NTS survey.

Its principal objective was to achieve specific GMC mandated quality standards of education and training delivery. In addition, the broader remit was a strategic intent of achieving step-by-step fundamental and sustainable improvements, across all the specialties, to national standards initially and thereafter a consistently safe environment in which trainees learned at BHRUT with excellent quality regionally and nationally recognised teaching.

The plan took a pragmatic three-stage, three-year approach (mandatory, quality and excellence) with an early aim of achieving the GMC mandatory requirements in year one.

The key elements of the plan are:

- a three-stage stepwise and structured approach, based on GMC standards, to achieve sustainable improvement
- a peer review process (internal quality visits) of specialties’ educational performance
- involvement of trainees and non-clinical managers in the peer review process
- new league tables, to create transparency in demonstrating comparative performance of specialties in delivering good training
- twice-yearly ‘opinion’ polls of trainees’ experience at BHRUT
- a new trainee council
- a database of detailed profiles of all
educators, meeting training standards set by the GMC
• new incentives for trainers, specialties and divisional management teams – clearly set out to encourage maintenance of high educational standards for trainees
• greater support to underperforming specialties
• an annual education conference and multi-professional awards ceremony for best supporting colleagues as nominated by trainees and the Medical Education team.

The Trust has received eight Health Education England (HEE) quality visits throughout 2018/19. This is similar to other organisations within the North Central and East London sector.

Their visits have focused on the Gastroenterology Department at Queen’s Hospital and also included a review of Acute & Elderly Medicine and Anaesthetics.

HEE concerns related to clinical supervision of junior training doctors with Gastroenterology, in relation to senior clinical supervision in and out of hours; management of outlier patients and the lack of consistent, consultant-led teaching programmes.

HEE were also concerned about the General Medical Council National Training Survey (GMC NTS) results for Gastroenterology, which had deteriorated over the previous two years.

The review of Acute Medicine, and Anaesthetics was a follow-up to an education leads conversation (ELC) held at the Trust in October 2018. The purpose of this review was to establish the Trust’s progress in relation to local specialty induction, rota management, and financial allocation of the HEE Learning and Development Agreement (LDA).

There is an ongoing HEE improvement action plan in place as a result of these previous HEE reviews and GMC Training Survey Results 2018.

The principle objective of the action plan is to ensure that the Trust provides a safe and enjoyable learning environment for postgraduate medical trainees and meets the mandatory requirements set by HEE.

This action plan is being closely monitored and coordinated by the Medical Education team. There has been significant and satisfactory progress against the action plan, reducing the risk of any potential withdrawal of training posts by HEE. HEE plan to undertake a follow-up review visit at the end of April 2019.

WHAT WE HAVE ACHIEVED

• We have successfully delivered our commissioned simulation training requirements across the Medical Undergraduate Programme, Foundation Training Programme, Core Medical Training, Anaesthetics, General Practice and Paediatrics meeting the enhanced curricula requirements aligned to the Trainees’ Annual Review of Competence Progression.
• We have also delivered bespoke in-situ simulation training addressing patient safety issues in Intensive Care Medicine, Theatres, Acute Medicine, Geriatric Medicine, Paediatrics and Emergency Medicine.
• Success with the improved surgical training pathway; we move to phase 2 which is the ST2 trainees rotating to Queen’s Surgery from October 2019.
• Delivery of seven bespoke work experience workshops for sixth form students that live locally.
• Improved medical student teaching by enhancing the delivery of our observational skills clinical examinations.
• Dedicated practical skills sessions within our protected Foundation Training Programme, providing improved trainee experience and patient safety outcomes.
• Improved engagement with our consultant colleagues through hosted evening events with our newly appointed chief registrars.

All of the above achievements are underpinned by the team’s commitment to work cohesively and collaboratively with our external stakeholders, and our Divisions, to ensure ongoing training and patient safety improvements, aligned to our Trust objectives and Pride Way standards. We will continue to monitor our improvements through our GMC training survey outcomes and quality visit reports.

As a department we are moving forward with digitalizing our services and we are currently progressing with two exciting innovative projects.

These include an app which will allow doctors to access vital tailored information that is relevant to them, whether this be training materials, important numbers, access to GMC survey and notifications which are pushed to their devices as a targeted way of getting into communication with them. Secondly we are developing
The Trust is committed to ensuring that all junior doctor rotas are 100% filled with zero gaps. We collect data on any rota that contains at least one junior doctor in training. Many of these rotas also contain doctors who are not on a training programme.

There has been an improvement in the resources available to fill the rotas, Trust-wide. This has resulted in less gaps on rotas and a decrease in the need to find bank and agency cover.

Acute Medicine will benefit from more doctors on rotas and an improvement in rota design and management. There is a work group looking into this.

The rota management has improved across many divisions. There is a movement from a reactive to a more proactive position.

The Trust has been late advertising for locum cover for rota gaps throughout the year, compared to competing Trusts. This produces difficulty filling the gaps and this was particularly evident in Acute Medicine in December and January.

The feedback from the junior doctors is that if they are notified earlier about locums, they would be more likely to provide cover. There is more widespread use of the Trust software system for managing medical rotas, ‘HealthRoster’.

There are still areas that rely on multiple electronic systems, with medical staffing managers utilising Excel spreadsheets to manage rotas, rather than ‘HealthRoster’.

The School of Surgery has made a significant impact in filling gaps across multiple surgical directorates and also in Haematology and Oncology. Replication of this initiative can have significant benefits for Acute Medicine.

There is reliance across multiple divisions, including Anaesthesia and Paediatrics, to use consultants to fill rota gaps. This is of concern and may not be sustainable.

The performance of the agency tasked with finding locum cover has improved, by sending more appropriate curricula vitae at an earlier stage to rota managers.
highlight any concerns surrounding the patient’s death.

This process is now completed electronically, which has enhanced the quality of information received and provides the GPs with a mortality summary sent electronically.

Any concerns raised through this checklist and in addition any patient who dies following a planned admission, who has a mental illness on admission, has a recognised learning difficulty or is under the age of 16, are also subject to a SJR.

Other patients that will undergo a SJR include those where the family has raised a concern or complaint, patients who are part of a serious incident investigation or patients who die from a condition for which the Trust has been notified of a higher-than-expected mortality risk.

**ACTIONS IMPLEMENTED**

- We have an agreed Learning from Deaths Policy, which has been implemented across the Trust.
- We have a Mortality Assurance Group who implement and deliver this policy. They are drawn from all specialties from the Trust and include divisional representatives from the six divisions.
- We have a Mortality Faculty who undertake SJRs. We carry out targeted case reviews of outlier mortality groups and lead improvement work from the learning stimulated by these reviews.
- We have developed a more structured system for mortality review across the Trust and highlighted areas of learning from this for specific specialties.

The Trust measures of mortality (SHMI and HSMR) have reduced in the last year and we are now within the expected limits for these mortality indicators (see charts below).

The Trust has on average 600 deaths per quarter (Table 1).

This is a slightly higher crude mortality rate than other similar-sized Trusts.

This represents differences in the nature of our local population and the prevalence of a large number of nursing homes in the surrounding area than other Trusts of a similar size. We aim to ensure that all of our patient deaths are subject to an initial checklist review.

Through the implementation of the mortality review process we have identified a number of deaths where concerns have been raised due to problems in patient care.

We use a Likert rating system to highlight if we think that problems in care contributed to the patient’s death. Where a concern is raised the SJR is subject to a second review for validation and if both reviewers then agree on the level of concern it is subject to an SI.

A patient who dies as a consequence of a recognised complication of treatment can
be argued to have a death that is potentially ‘avoidable’ and hence we take a more in depth review of the case.

For 2018/19, we have recognised five cases (0.3% of deaths) where problems in care may have contributed to the patient’s death (Table 1, below). All such cases have been subject to round table reviews and where appropriate have been escalated to an SI.

What learning have we identified?
From reviewing case records we have identified a number of common themes that have been targeted across the year and we have identified areas of practice that have shown consistent improvement.

Work undertaken at looking at why we were an outlier from deaths from pneumonia has highlighted the lack of application of best practice in the delivery of an early care bundle for patients diagnosed with community-acquired pneumonia. As a consequence for this, the use of the CURB 65 screening tool has been encouraged, mandatory training on the management of pneumonia has been introduced and the delivery of this care is being re-audited.

It has also stimulated reviews of where the high-risk pneumonia patients come from and led to recognition of the high contribution of patients from nursing homes to mortality in this group. As a consequence, we are now looking to how we can work with our community providers to address this issue.

As our reviews develop, we are identifying themes that are more related to everyday basic standards of care. Through the SJR we have identified issues such as the quality of medical records, challenges around the use of the Sepsis 6 and CURB 65 proformas and issues around the management of end-of-life care. Where care is less than optimal we are using the case reviews to start informing discussions about where the failures lie and how we can target improvement work.

The impact so far has been highlighted in areas such as pneumonia and sepsis where we have undertaken specific quality improvement projects aimed at improving the care in these patient groups. We have also identified some areas of significant concern, leading to significant incident investigations which have been used to support the ongoing investigations.

The embedding of learning from reviews performed by the Mortality Faculty needs to be shared more effectively. We are developing a more robust process for methodical mortality reviews across the organisation.

This has been outlined in a Trust paper “Sharing the Learning” in which we describe how the divisions are expected to assure the Trust about local mortality review processes by specialty.

In addition, we have developed tools to support the implementation of a standardised local
We are committed to ensuring that patients admitted as an emergency receive high-quality consistent care whatever day they enter hospital.

Ten clinical standards for seven-day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. These standards define what seven-day services should achieve, no matter when or where patients are admitted.

The four priority standards

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

- Standard 2 – time to first consultant review
- Standard 5 – access to diagnostic tests
- Standard 6 – access to consultant-directed interventions
- Standard 8 – ongoing review by consultant twice daily if high dependency patients, daily for others.

These standards ensure that patients:

- don’t wait longer than 14 hours to initial consultant review
- get access to diagnostic tests with a 24-hour turnaround time – for urgent requests, this drops to 12 hours and for critical patients, one hour
- get access to specialist, consultant-directed interventions
- with high-dependency care needs receive twice-daily specialist consultant review, and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds

Ref: Seven day services in the NHS (NHS Improvement)

The Trust has participated in a biannual assessment and audit of position against the provision of the four key seven-day standards across the Trust.

Where relevant, the Trust will deliver timely access to care as part of a network, for example, renal replacement services, acute myocardial infarction.

The Trust is commissioned to provide specialist services for Hyperacute Stroke services, Vascular services, Specialist Cancer Care and Neurosurgery.

The Trust was required to meet the four key standards for these services by 1 November 2017. Both stroke and vascular services have required a strategy to meet the standards. This was achieved for stroke services in November 2017.

The service changes required to meet the standards for vascular services have been delayed and will be reviewed as part of the imminent vascular services GIRFT (‘getting it right first time’) review in February 2019.

The last formal national audit was carried out in April 2018.

Going forward, trusts will be required to self-assess and report against these standards with
Fundamental to our vision to provide outstanding care to our community, delivered with PRIDE, is staff having the confidence to speak up when improvements need to be made and concerns addressed.

Similarly, delivery of our objectives is assured when we have a culture that supports staff to speak up, confident their concerns will be listened to and acted.

We want to create an inclusive and positive culture where speaking up is the norm and business as usual.

Such a culture is a key indicator of the CQC well-led key line of enquiry. There is also now a clear understanding that a positive organisational culture, where staff are confident and comfortable to speak up knowing they will be supported, enables the delivery of high-quality care.

Raising concerns is vital to patient safety and national freedom to speak up data now shows a correlation between highly-rated NHS organisations and positive speaking-up cultures.

Following a procurement exercise we have contracted with an independent Guardian for 2018/19.

In their Well-Led report published in June 2018, the CQC stated: “The Trust Freedom to Speak Up Guardian service was not operating sufficiently enough in ensuring staff were able to confidently and impartially raise concerns and access support. There was insufficient assurance that outcomes of the service and concerns raised were being effectively followed through”.

The report also stated: “The trust should ensure the Freedom to Speak Up Guardian service is effective in providing support for Trust staff to be able to confidently speak up freely. The Trust should ensure that service outcomes and concerns raised are effectively monitored and managed”.

**Standard 2 – Time to first consultant review**

The BHRUT delivery of standard 2, review by a consultant within 14 hours of admission to hospital falls just below the national data (70% BHRUT vs 72% nationally).

Numbers of patients in individual specialties were small but key areas for improvement include Acute Medicine, General Surgery and Gynaecology.

**Standard 5 – Access to diagnostic tests**

The delivery of standard 5, access to diagnostic services, is compliant across all areas with the exception of echocardiography at weekends.

The specialist service delivered by trained technicians is not available seven days a week, but the approval of new ultrasound machines and the enhanced training of emergency department clinicians will allow basic echocardiography to be undertaken in the emergency department.

In addition, a consultant cardiologist now visits both hospital sites seven days a week and can undertake echocardiography if required.

**Standard 6 – Access to consultant-directed interventions and Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others**

Standard 6 is delivered through local service provision or networked provision of services within the STP.

The delivery of standard 8 remains challenging – i.e. all patients with high-dependency needs should see a consultant twice daily and those with a clear pathway of care should be reviewed by a consultant (or senior delegated doctor) once a day.

All patients in critical care areas are reviewed within the standard – i.e. over 90% of patients are seen by a consultant twice a day. Patients in ward areas are not all consistently seen once a day by a consultant, this is specifically the case at weekends.

Work is ongoing to determine which patients require a consultant review as this is only required by the standard for those patients who will benefit from a consultant input.
We understand this feedback stems from a specific incident at the time of inspection.

However, we recognise the importance of being responsive and the following are examples of how we are working in new and improved ways with our Guardians:

- monthly reports and meetings;
- 38 promotion or communication visits by our Guardians across our two hospitals in year;
- utilising the Guardians as a listening service for staff.

The monthly reports and meetings enable us to monitor progress and understand the reasons for contacts. Our Freedom to Speak up: Raising Concerns (whistleblowing) Policy applies to all staff. This was reviewed and ratified in October 2018.

The policy provides detail and contacts for the different routes staff have for speaking up. It confirms how feedback will be given to those who raise concerns.

The policy also includes a section on the Public Interest Disclosure Act and confirms that staff who act honestly and reasonably are given automatic protection for raising a matter internally.
## Glossary of Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Quality Commission (CQC)</td>
<td>The independent regulator of all health and social care services in England. It looks at the joined up picture of health and social care. Their aim is to ensure better care for everyone in hospital, in a care home and at home. They provide the Essential Standards for Quality and Safety against which organisations must demonstrate compliance.</td>
</tr>
<tr>
<td>Clinical Audit</td>
<td>Clinical audit is a process that has been defined as a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.</td>
</tr>
<tr>
<td>Clinical Commissioning Groups (CCGs)</td>
<td>CCGs commission the majority of health services, including emergency care, elective hospital care, maternity services, and community and mental health services, since the implementation of the Health and Social Care Act 2012 on 1st April 2013. There are 211 CCGs, each commissioning care for an average of 296,000 people.</td>
</tr>
<tr>
<td>Clostridium difficile</td>
<td>A type of bacterial infection that can affect the digestive system.</td>
</tr>
<tr>
<td>Commissioners</td>
<td>The organisation that commissions care for patients.</td>
</tr>
<tr>
<td>CQUIN (The Commission for Quality and Innovation)</td>
<td>The CQUIN payment framework was introduced in 2009 to make a proportion of providers’ income conditional on demonstrating improvements in quality and innovation in specified areas of care. The framework helps make quality part of the commissioner-provider discussion everywhere. The framework has been designed based on feedback from partners in the NHS.</td>
</tr>
<tr>
<td>Duty of Candour</td>
<td>Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress.</td>
</tr>
<tr>
<td>Getting it Right First Time*</td>
<td>National programme to help identify best practice in surgical specialties.</td>
</tr>
<tr>
<td>Learning from Deaths</td>
<td>National programme to review the way NHS Trusts review and investigate the deaths of patients in England.</td>
</tr>
<tr>
<td>National Institute of Clinical Excellence (NICE)</td>
<td>NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.</td>
</tr>
<tr>
<td>National Reporting and Learning System (NRLS)</td>
<td>NRLS is a central database of patient safety incident reports. Since the NRLS was setup in 2003, over four million incident reports have been submitted. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care.</td>
</tr>
<tr>
<td>Never Events</td>
<td>Never Events are the &quot;kind of mistake [i.e., medical error] that should never happen&quot; in the field of medical treatment. The NHS in England is one of the only healthcare systems in the world that is both open and transparent about patient safety incident reporting, particularly around Never Events. We are clear that we need to openly tackle these issues, not ignore them.</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute of Clinical Excellence. An independent organisation that produces clinical guidelines and quality standards on specific diseases and the recommended treatment for our patients. The guidelines are based on evidence and support our drive to provide effective care.</td>
</tr>
<tr>
<td>Ombudsman</td>
<td>The Parliamentary and Health Services Ombudsman consider complaints that government departments, a range of other public bodies in the UK, and the NHS in England, have not acted properly or fairly or have provided a poor service.</td>
</tr>
<tr>
<td>Patient pathways</td>
<td>The route that a patient will take from their first contact with an NHS member of staff (usually their GP), through referral, to the completion of their treatment. It also covers the period from entry into a hospital or a Treatment Centre, until the patient leaves.</td>
</tr>
<tr>
<td>Rapid Process Improvement Week (RPIW)</td>
<td>A five-day workshop focused on a particular process in which people who do the work are empowered to eliminate waste and reduce the burden of work. These are run underneath one of our organisational value streams.</td>
</tr>
<tr>
<td>Referral to Treatment (RTT) waiting times</td>
<td>RTT waiting times monitor the length of time from referral through to elective treatment.</td>
</tr>
<tr>
<td>Root Cause Analysis (RCA)</td>
<td>Root Cause Analysis investigation is a well-recognised way of identifying how and why patient safety incidents happen. Analysis is used to identify areas for change and to develop recommendations which deliver safer care for patients.</td>
</tr>
<tr>
<td>Round table</td>
<td>Using evidence to improve productivity and efficiency is not as straightforward as it might appear, as a round table of experts brought together to discuss the issue found.</td>
</tr>
<tr>
<td>Secondary Uses Service (SUS)</td>
<td>The Secondary Uses Service (SUS) is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.</td>
</tr>
<tr>
<td>Sepsis Six</td>
<td>Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis.</td>
</tr>
<tr>
<td>Seven day services</td>
<td>Ensuring patients admitted as an emergency, receive high quality consistent care, whatever day they enter hospital.</td>
</tr>
<tr>
<td>Single Oversight Framework</td>
<td>Sets out how NHS Improvement oversee NHS trusts and NHS foundation trusts, helping us to determine the level of support we need.</td>
</tr>
<tr>
<td>The PRIDE Way</td>
<td>The PRIDE Way gives us a toolkit so we can all make improvements in the same way. It’s underpinned by the way we behave and act to support our teams and each other.</td>
</tr>
<tr>
<td>Viapac</td>
<td>Viapac is a mobile software information system for monitoring the vital signs of adults, including pregnant women, and children in hospital. Using manually entered or automatically captured vital sign data, it is designed to quickly identify deterioration in their condition and alert clinical staff. Viapac can also be used to guide decisions about when people are well enough for discharge.</td>
</tr>
</tbody>
</table>
# APPENDIX A: 2018/19 CQUIN PAYMENT FRAMEWORK

## NATIONAL CQUINS 2018/19 - NELC & Essex CCG

<table>
<thead>
<tr>
<th>Item No.</th>
<th>CQUIN</th>
<th>Description</th>
<th>Total Weighting</th>
</tr>
</thead>
</table>
| 1        | NHS Staff Health & Wellbeing | 1. Improvement of health and wellbeing for NHS staff  
2. Healthy Food for NHS staff, visitors and patients  
3. Improving the uptake of flu vaccinations for front line staff | 0.30% |
| 2        | Reducing the Impact of Serious Infections | 1. Timely identification of sepsis in emergency departments and acute inpatient settings  
2. Timely treatment for sepsis in emergency departments and acute inpatient setting | 0.30% |
| 3        | Improving services for people with mental health needs to present to ED | 1. Acute Provider and Mental Health Trust to track people who attend ED 10-15 times a year or more  
2. Identify patients who would benefit from psychosocial interventions  
3. Improvements in Mental Health Coding | 0.30% |
| 4        | Offering Advice & Guidance | 1. Set up and operate advice & guidance services for non-urgent GP referrals for a group of specialties responsible for receiving 75% of total GP referrals by start of Q4  
2. Ensure all Quality standards for provision of A&G met | 0.30% |
| 5        | Preventing Ill Health by Risky Behaviours | 1. Tobacco Screening  
2. Tobacco Brief Advice  
3. Tobacco Referral and Medication Offer  
4. Alcohol Screening  
5. Alcohol Brief Advice or Referral | 0.30% |

## NHSE SPECIALIST CQUINS

<table>
<thead>
<tr>
<th>Item No.</th>
<th>CQUIN</th>
<th>Description</th>
<th>Total Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Enhanced Supportive Care for Cancer Patients</td>
<td>To improve access to Enhanced Supportive Care for patients with a diagnosis of incurable cancer</td>
<td>0.70%</td>
</tr>
<tr>
<td>7</td>
<td>Standardised Dose Banding for SACT</td>
<td>Standardisation of chemotherapy doses through nationally consistent dose banding for 19 identified drugs</td>
<td>0.21%</td>
</tr>
<tr>
<td>8</td>
<td>Hospitals Medicines Optimisation</td>
<td>Adoption of best value generic/biologic products for both new and existing patients</td>
<td>0.87%</td>
</tr>
<tr>
<td>9</td>
<td>Haemoglobin-opathy Networked Care</td>
<td>Attending networking meetings, agreement of pathways and protocols for patients and creation of an Operational Delivery Network (ODN)</td>
<td>0.22%</td>
</tr>
</tbody>
</table>

## NHSE DENTAL CQUIN

<table>
<thead>
<tr>
<th>Item No.</th>
<th>CQUIN</th>
<th>Description</th>
<th>Total Weighting</th>
</tr>
</thead>
</table>
| 10       | Secondary Dental Care | 1. Collection & Submission of Data on priority pathways procedures by Tiers using the CQUIN dashboard  
2. Participate in the Acute Dental Systems Resilience Group (SRG) to contribute to a PAN London approach to demand modelling  
3. Active participation in consultant led MCN with collaborative - improving the patient pathways | 2% |
### APPENDIX B: NATIONAL HQIP MANDATORY CLINICAL AUDIT PROGRAMME 2019/20

<table>
<thead>
<tr>
<th>Division</th>
<th>Specialty</th>
<th>Audit Title</th>
<th>Workstream</th>
<th>National Clinical Audit Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Medicine</td>
<td>Emergency Care</td>
<td>Care of Children (Care in Emergency Departments)</td>
<td>N/A</td>
<td>Royal College of Emergency Medicine</td>
</tr>
<tr>
<td>Acute Medicine</td>
<td>Emergency Care</td>
<td>Major Trauma Audit</td>
<td>N/A</td>
<td>The Trauma Audit and Research Network (TARN)</td>
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<tr>
<td>Acute Medicine</td>
<td>Emergency Care</td>
<td>Assessing Cognitive Impairment in Older People (Care in Emergency Departments)</td>
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<td>Royal College of Emergency Medicine</td>
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<tr>
<td>Anaesthetics</td>
<td>Anaesthetics</td>
<td>National Emergency Laparotomy (NELA)</td>
<td>N/A</td>
<td>Royal College of Anaesthetists</td>
</tr>
<tr>
<td>Surgery</td>
<td>Breast Services</td>
<td>National Audit of Breast Cancer in Older People (NABCO)</td>
<td>N/A</td>
<td>Royal College of Surgery</td>
</tr>
<tr>
<td>Specialist Medicine</td>
<td>Cardiology</td>
<td>National Audit of Cardiac Risk in Management (CARD)</td>
<td>N/A</td>
<td>National Institute of Cardiovascular Outcomes Research (NICOR)</td>
</tr>
<tr>
<td>Specialist Medicine</td>
<td>Cardiology</td>
<td>Myocardial Ischaemia National Audit Project (MINAP)</td>
<td>N/A</td>
<td>National Institute of Cardiovascular Outcomes Research (NICOR)</td>
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<tr>
<td>Specialist Medicine</td>
<td>Cardiology</td>
<td>National Heart Failure Audit</td>
<td>N/A</td>
<td>National Institute of Cardiovascular Outcomes Research (NICOR)</td>
</tr>
<tr>
<td>Specialist Medicine</td>
<td>Cardiology</td>
<td>National Audit of Cardiac Rehabilitation</td>
<td>N/A</td>
<td>University of York</td>
</tr>
<tr>
<td>Anesthetics</td>
<td>Critical Care</td>
<td>Card Miti Programme</td>
<td>N/A</td>
<td>Intensive care National Audit and Research Centre (ICNARC)</td>
</tr>
<tr>
<td>Specialist Medicine</td>
<td>Diabetes and Endocrine</td>
<td>National Diabetes Audit-Adults</td>
<td>N/A</td>
<td>National Diabetes Audit</td>
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<tr>
<td>Specialist Medicine</td>
<td>Diabetes and Endocrine</td>
<td>National Diabetes Audit-Adults (NHS Digital)</td>
<td>N/A</td>
<td>NHS Digital</td>
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<tr>
<td>Specialist Medicine</td>
<td>Diabetes and Endocrine</td>
<td>National Diabetes Audit-Adults (NHS Digital)</td>
<td>N/A</td>
<td>NHS Digital</td>
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<tr>
<td>Anesthetics</td>
<td>Anaesthetics</td>
<td>Perioperative Quality Improvement Programme</td>
<td>N/A</td>
<td>Royal College of Anaesthetists</td>
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<tr>
<td>Specialist Medicine</td>
<td>Diabetes and Endocrine</td>
<td>National Diabetes Audit-Adults (NHS Digital)</td>
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<td>NHS Digital</td>
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<tr>
<td>Corporate</td>
<td>Safeguarding</td>
<td>Learning Disability Mortality Review Programme (LaDeMR)</td>
<td>N/A</td>
<td>University of Bristol North Fry Centre for Disability Studies</td>
</tr>
<tr>
<td>Acute Medicine</td>
<td>Acute Assessment</td>
<td>TAIMA</td>
<td>N/A</td>
<td>NHS England</td>
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<tr>
<td>Corporate</td>
<td>Education</td>
<td>National Cardiac Arrest Audit (NCASA)</td>
<td>N/A</td>
<td>Intensive care National Audit and Research Centre (ICNARC)</td>
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<tr>
<td>Acute Medicine</td>
<td>Elderly Care</td>
<td>National Audit of Intermediate Care</td>
<td>N/A</td>
<td>NHS Benchmarking Network * please note that data collection for this is no longer being undertaken and therefore participation is not required</td>
</tr>
<tr>
<td>Acute Medicine</td>
<td>Elderly Care</td>
<td>National Audit of Dementia (In General Hospital)</td>
<td>N/A</td>
<td>Dementia Care in General Hospitals</td>
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<tr>
<td>Specialist Medicine</td>
<td>Cardiology</td>
<td>National Audit of Dementia (In General Hospital)</td>
<td>N/A</td>
<td>Royal College of Psychiatrists</td>
</tr>
<tr>
<td>Neonatology</td>
<td>Neonates</td>
<td>National Audit of Neonates</td>
<td>N/A</td>
<td>University of Liverpool</td>
</tr>
<tr>
<td>Surgery</td>
<td>General Surgery</td>
<td>National Bowel Cancer (MINDS)</td>
<td>N/A</td>
<td>NHS Digital</td>
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<tr>
<td>Surgery</td>
<td>General Surgery</td>
<td>National Oesophago-gastric Cancer (NOGCA)</td>
<td>N/A</td>
<td>NHS Digital</td>
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<tr>
<td>Surgery</td>
<td>Trauma and Orthopaedics</td>
<td>Surgical Site Infection Surveillance Service</td>
<td>N/A</td>
<td>Public Health England</td>
</tr>
<tr>
<td>Cancer and Clinical Support</td>
<td>Radiology/Pathology</td>
<td>National Records of Transfusion (NRT) UK National Haemorrhage Scheme</td>
<td>N/A</td>
<td>National Records of Transfusion (NRT)</td>
</tr>
<tr>
<td>Specialist Medicine</td>
<td>Radiology</td>
<td>Inpatient Robber Audit</td>
<td>N/A</td>
<td>Parliament UK</td>
</tr>
</tbody>
</table>

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84  | Barking, Havering and Redbridge University Hospitals NHS Trust  | Quality Account 2018/19
<table>
<thead>
<tr>
<th>Division</th>
<th>Specialty</th>
<th>Audit Title</th>
<th>Workstream</th>
<th>National Clinical Audit Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer and Clinical Support</td>
<td>Infection Control</td>
<td>Mandatory Surveillance of Bloodstream infections and Clostridium difficile infection</td>
<td>N/A</td>
<td>Public Health England</td>
</tr>
<tr>
<td>Women and Children</td>
<td>Neonatology</td>
<td>National Neonatal Audit Programme – Neonatal intensive and special care (NIPAC)</td>
<td>N/A</td>
<td>Royal College of Paediatrics and Child Health</td>
</tr>
<tr>
<td>Specialist Medicine</td>
<td>Neurosurgery</td>
<td>Neurological National Audit Programme</td>
<td>N/A</td>
<td>Society of British Neurologians</td>
</tr>
<tr>
<td>Women and Children</td>
<td>Obstetrics and Gynaecology</td>
<td>Maternal, Newborn and Infant Clinical Outcome Review Programme</td>
<td>N/A</td>
<td>MBRRACE-UK National Perinatal Epidemiology Unit</td>
</tr>
<tr>
<td>Women and Children</td>
<td>Obstetrics and Gynaecology</td>
<td>Maternal, Newborn and Infant Clinical Outcome Review Programme</td>
<td>N/A</td>
<td>MBRRACE-UK National Perinatal Epidemiology Unit</td>
</tr>
<tr>
<td>Women and Children</td>
<td>Obstetrics and Gynaecology</td>
<td>National Diabetes Audit - Adults</td>
<td>N/A</td>
<td>National Institute for Diabetes Audit - Adults</td>
</tr>
<tr>
<td>Women and Children</td>
<td>Obstetrics and Gynaecology</td>
<td>National Maternity and Perinatal Audit (NMPA)</td>
<td>N/A</td>
<td>Royal College of Obstetricians and Gynaecologists</td>
</tr>
<tr>
<td>Women and Children</td>
<td>Obstetrics and Gynaecology</td>
<td>Maternal, Newborn and Infant Clinical Outcome Review Programme</td>
<td>N/A</td>
<td>MBRRACE-UK National Perinatal Epidemiology Unit</td>
</tr>
<tr>
<td>Women and Children</td>
<td>Obstetrics and Gynaecology</td>
<td>Maternal, Newborn and Infant Clinical Outcome Review Programme</td>
<td>N/A</td>
<td>MBRRACE-UK National Perinatal Epidemiology Unit</td>
</tr>
<tr>
<td>Surgery</td>
<td>Ophthalmology</td>
<td>National Ophthalmology Audit Programme (NOAP) – Pediatric Eye Disease</td>
<td>Adult Ophthalmology</td>
<td>Royal College of Ophthalmologists</td>
</tr>
<tr>
<td>Women and Children</td>
<td>Paediatrics</td>
<td>National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) – Pediatric Asthma in Secondary Care</td>
<td>N/A</td>
<td>Royal College of Physicians</td>
</tr>
<tr>
<td>Women and Children/ specialist Medicine</td>
<td>Paediatrics/ Neurology</td>
<td>National Audit of Severe and Epilepsies in Children and young people (Epilepsy)</td>
<td>N/A</td>
<td>Royal College of Paediatrics and Child Health</td>
</tr>
<tr>
<td>Women and Children/ Paediatrics</td>
<td>Paediatrics</td>
<td>National Paediatric Diabetes Audit (NPDA)</td>
<td>N/A</td>
<td>Royal College of Paediatrics and Child Health</td>
</tr>
<tr>
<td>Surgery</td>
<td>Urology</td>
<td>BAUS (British Association of Urology) – Adult Diabetes and Dialysis</td>
<td>N/A</td>
<td>British Association of Urologists</td>
</tr>
<tr>
<td>Cancer and Clinical support/ Palliative Care Team</td>
<td>National Audit of Care at the end of life (NACEL)</td>
<td>N/A</td>
<td>N/A</td>
<td>NHS Benchmarking Network</td>
</tr>
<tr>
<td>Cancer and Clinical support</td>
<td>Pharmacy</td>
<td>Reducing the impact of serious infections (Antimicrobial Resistance and stewardship)</td>
<td>Antibiotic Consumption</td>
<td>Public Health England</td>
</tr>
<tr>
<td>Cancer and Clinical support</td>
<td>Pharmacy</td>
<td>Reducing the impact of serious infections (Antimicrobial Resistance and stewardship)</td>
<td>Antibiotic Consumption</td>
<td>Public Health England</td>
</tr>
<tr>
<td>Specialist Medicine</td>
<td>Respiratory</td>
<td>National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) – COPD Secondary Care</td>
<td>Secondary Care</td>
<td>Royal College of Physicians</td>
</tr>
<tr>
<td>Specialist Medicine</td>
<td>Respiratory</td>
<td>National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) – COPD Secondary Care</td>
<td>Secondary Care</td>
<td>Royal College of Physicians</td>
</tr>
<tr>
<td>Specialist Medicine</td>
<td>Respiratory</td>
<td>National Lung Cancer Audit (NCLA)</td>
<td>N/A</td>
<td>Royal College of Physicians</td>
</tr>
<tr>
<td>Specialist Medicine</td>
<td>Respiratory</td>
<td>National Skin Cancer Audit (NSCA)</td>
<td>N/A</td>
<td>Royal College of Physicians</td>
</tr>
<tr>
<td>Specialist Medicine</td>
<td>Rheumatology</td>
<td>Falls and Fragility Fractures Audit Programme (FFAP)</td>
<td>Fracture Injury Service Database</td>
<td>Royal College of Physicians of London</td>
</tr>
<tr>
<td>Surgery</td>
<td>ENT/Max Facs</td>
<td>Head and Neck Cancer Audit</td>
<td>N/A</td>
<td>Ongoing Care</td>
</tr>
<tr>
<td>Corporate</td>
<td>Safeguarding</td>
<td>National Child Mortality Database</td>
<td>N/A</td>
<td>University of Bristol Neonatistry Centre for Disability Studies</td>
</tr>
<tr>
<td>Specialist Medicine</td>
<td>Rheumatology</td>
<td>National Clinical Audit of Rheumatoid Arthritis and Early Inflammatory Arthritis (CAREIA)</td>
<td>N/A</td>
<td>British Society for Rheumatology</td>
</tr>
<tr>
<td>Specialist Medicine</td>
<td>Stroke</td>
<td>Second Stroke National Audit Programme (NSAP)</td>
<td>N/A</td>
<td>Royal College of Physicians</td>
</tr>
<tr>
<td>Acute Medicine</td>
<td>Elderly Care</td>
<td>Falls and Fragility Fractures Audit Programme (FFAP)</td>
<td>Inpatient Falls</td>
<td>Royal College of Physicians of London</td>
</tr>
<tr>
<td>Surgery</td>
<td>Trauma and Orthopaedics</td>
<td>Elective Surgery (National Priority Programme)</td>
<td>N/A</td>
<td>NHS Digital</td>
</tr>
<tr>
<td>Surgery</td>
<td>Trauma and Orthopaedics</td>
<td>Falls and Fragility Fractures Audit Programme (FFAP)</td>
<td>Inpatient Falls</td>
<td>Royal College of Physicians of London</td>
</tr>
<tr>
<td>Surgery</td>
<td>Trauma and Orthopaedics</td>
<td>National Joint Registry (NJR)</td>
<td>N/A</td>
<td>Royal College of Physicians of London</td>
</tr>
<tr>
<td>Surgery</td>
<td>Urology</td>
<td>BAUS Urology Audit - Radical Prostatectomy Audit</td>
<td>N/A</td>
<td>British Association of Urologists</td>
</tr>
<tr>
<td>Surgery</td>
<td>Urology</td>
<td>BAUS Urology Audit - Cystectomy</td>
<td>N/A</td>
<td>British Association of Urologists</td>
</tr>
<tr>
<td>Surgery</td>
<td>Urology</td>
<td>BAUS Urology Audit - Neurothoracic</td>
<td>N/A</td>
<td>British Association of Urologists</td>
</tr>
<tr>
<td>Surgery</td>
<td>Urology</td>
<td>BAUS Urology Audit - Pancreatic and Intraductal Pancreatic Neoplasms (PEN)</td>
<td>N/A</td>
<td>British Association of Urologists</td>
</tr>
<tr>
<td>Surgery</td>
<td>Urology</td>
<td>National Prostate Cancer Audit</td>
<td>N/A</td>
<td>Royal College of Surgeons of England</td>
</tr>
<tr>
<td>Surgery</td>
<td>General Surgery/MST</td>
<td>National Endocrine and Thyroid National Audit</td>
<td>N/A</td>
<td>British Association of Endocrine and Thyroid Surgeons</td>
</tr>
<tr>
<td>Acute Medicine</td>
<td>Emergency Care</td>
<td>Medical Health Care in Emergency Departments</td>
<td>N/A</td>
<td>Royal College of Emergency Medicine</td>
</tr>
<tr>
<td>Surgery</td>
<td>Vascular Surgery</td>
<td>National Vascular Registry</td>
<td>N/A</td>
<td>Royal College of Surgeons of England</td>
</tr>
<tr>
<td>Surgery</td>
<td>Vascular Surgery</td>
<td>BAUS Vascular Audit - Endovascular</td>
<td>N/A</td>
<td>British Association of Vascular Surgeons</td>
</tr>
<tr>
<td>Surgery</td>
<td>Vascular Surgery</td>
<td>BAUS Vascular Audit - Neurothoracic</td>
<td>N/A</td>
<td>British Association of Vascular Surgeons</td>
</tr>
<tr>
<td>Surgery</td>
<td>Vascular Surgery</td>
<td>National Prostate Cancer Audit</td>
<td>N/A</td>
<td>Royal College of Surgeons of England</td>
</tr>
<tr>
<td>Surgery</td>
<td>General Surgery/MST</td>
<td>National Endocrine and Thyroid National Audit</td>
<td>N/A</td>
<td>British Association of Endocrine and Thyroid Surgeons</td>
</tr>
<tr>
<td>Acute Medicine</td>
<td>Emergency Care</td>
<td>Medical Health Care in Emergency Departments</td>
<td>N/A</td>
<td>Royal College of Emergency Medicine</td>
</tr>
<tr>
<td>Surgery</td>
<td>Vascular Surgery</td>
<td>National Vascular Registry</td>
<td>N/A</td>
<td>Royal College of Surgeons of England</td>
</tr>
</tbody>
</table>
### APPENDIX C: NATIONAL HQIP MANDATORY CLINICAL AUDIT PROGRAMME 2018/19

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>National Clinical Audit Organisation</th>
<th>Eligible (Yes/No)</th>
<th>Data Collection required 2018/19</th>
<th>Cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Stress Urinary Incontinence Audit</td>
<td>British Association of Urological Surgeons</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>Gynecology Mesh incontinence surgery suspended therefore 2 cases undertaken. No other cases submitted due to belief that only vaginal mesh procedure data required</td>
</tr>
<tr>
<td>Radical Prostatectomy Audit</td>
<td>British Association of Urological Surgeons</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>Not routinely done at BHRUT but post-op follow-up submission is 100%</td>
</tr>
<tr>
<td>Cystectomy Audit</td>
<td>British Association of Urological Surgeons</td>
<td>Yes</td>
<td>April 19 - March 19</td>
<td>Not routinely done at BHRUT but post-op follow-up submission is 100%</td>
</tr>
<tr>
<td>Nephrectomy Audit</td>
<td>British Association of Urological Surgeons</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>Not routinely done at BHRUT but post-op follow-up submission is 100%</td>
</tr>
<tr>
<td>Pericardial Nephrectomy Audit</td>
<td>British Association of Urological Surgeons</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>30 case - 100% 1st January 2018 - 31st December 2018</td>
</tr>
<tr>
<td>National audit of Cardiac Rehabilitation</td>
<td>University of York</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>For the period of 1/04/18 - 11/12/2019 currently certified green against the 8 minimum standards. Review of current certification due May 2019. audit ongoing</td>
</tr>
<tr>
<td>Cardiac Rhythm Management</td>
<td>National Institute for Cardiovascular Outcomes Research (NICOR)</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>ongoing</td>
</tr>
<tr>
<td>Case Mix Programme</td>
<td>Intensive Care National Audit and Research Centre (ICNARC)</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>100% submission</td>
</tr>
<tr>
<td>Adult Community Acquired Pneumonia</td>
<td>British Thoracic Society</td>
<td>Yes</td>
<td>Dec 2018 - March 2019</td>
<td>20 cases but ongoing admission until May 2019</td>
</tr>
<tr>
<td>Elective Surgery (National-Project Programme)</td>
<td>NHS Digital</td>
<td>Yes - Orthopaedics</td>
<td>April 2018 - March 2019</td>
<td>ongoing</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit Programme (ENFAP)</td>
<td>Royal College of Physicians of London</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>ongoing</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit Programme (ENFAP) Impedent Falls</td>
<td>Royal College of Physicians of London</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>100% Case review</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit Programme (ENFAP) National Hip Fracture Database</td>
<td>Royal College of Physicians of London</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>867 patient details submitted (including late data collection quarter 3 and 4 2017)</td>
</tr>
<tr>
<td>Inflammatory Bowel Disease Registry, Biological Therapies Audit</td>
<td>Inflammatory Bowel Disease Registry</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>ongoing</td>
</tr>
<tr>
<td>Learning Disability Mortality Review Programme (SDMU)</td>
<td>University of Bristol North East Centre for Disability</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>100% Case review</td>
</tr>
<tr>
<td>Major Trauma Audit</td>
<td>The Trauma Audit and Research Network</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>Jan-Jul 2018 - Hospital case ascertainment 72-76%, Hospital data accreditation 94.8%. Jan-July 2019 Hospital case ascertainment 71-76%. Hospital data accreditation 95 &amp; 96%</td>
</tr>
<tr>
<td>Perinatal, Mortality and Morbidity Confidential Enquiries</td>
<td>MBRRACE-UK National Perinatal Epidemiology Unit (NPETU)</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>awaiting data request from MBRRACE</td>
</tr>
<tr>
<td>Maternal Morbidity Confidential Enquiries</td>
<td>MBRRACE-UK National Perinatal Epidemiology Unit (NPETU)</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>awaiting data request from MBRRACE</td>
</tr>
<tr>
<td>Maternal Mortality Surveillance and Mortality Confidential Enquiries</td>
<td>MBRRACE-UK National Perinatal Epidemiology Unit (NPETU)</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>ongoing</td>
</tr>
<tr>
<td>Perinatal Mortality Surveillance</td>
<td>MBRRACE-UK National Perinatal Epidemiology Unit (NPETU)</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>100%</td>
</tr>
<tr>
<td>Suicide by Children and Young people in England (CYP)</td>
<td>National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (NCISH)</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Suicide, Homicide and Sudden Unexplained Deaths</td>
<td>National Confidential Inquiry into Suicide and</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Audit Title</td>
<td>National Clinical Audit Organisation</td>
<td>Eligible (Yes/No)</td>
<td>Data Collection required 2018/19</td>
<td>Cases submitted</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------</td>
<td>-----------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Safer Care for Patients with Personality disorder</td>
<td>National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (NCHIP)</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>The Assessment of risk and Safety in Mental health Services</td>
<td>National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (NCHIP)</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Myocardial Ischaemia National Audit Project (MI-NAP)</td>
<td>National Institute for Cardiovascular Outcomes (NICO)</td>
<td>Yes</td>
<td>April 2018-March 2019</td>
<td>536 of 675 = 80.8%</td>
</tr>
<tr>
<td>National Audit of Anxiety Depression: Psychological therapies for anxiety and depression</td>
<td>Royal College of Psychiatrists Centre for Quality Improvement (CQI)</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>National Audit of Anxiety and Depression: Core</td>
<td>Royal College of Psychiatrists Centre for Quality Improvement (CQI)</td>
<td>Yes</td>
<td>April 2018-November 2019</td>
<td>The organisational checlist has been completed for both sites.</td>
</tr>
<tr>
<td>National Audit of Breast Cancer in Older People (NABCOOP)</td>
<td>Royal College of Surgeons</td>
<td>Yes</td>
<td>April 2018-March 2019</td>
<td>100%</td>
</tr>
<tr>
<td>National Audit of Dementia</td>
<td>Royal College of Psychiatrists</td>
<td>Yes</td>
<td>April 2018-March 2019</td>
<td>N/A</td>
</tr>
<tr>
<td>National Audit of Intermediate Care (NACIC)</td>
<td>NHS Benchmarking</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>National Audit of Percutaneous Coronary Intervention (IPC)</td>
<td>National Institute for Cardiovascular Outcomes (NICO)</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>National Audit of Pulmonary Hypertension</td>
<td>NHS Digital</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>National Audit of Sepsis and Septicane in Children and young people</td>
<td>Royal College of Pediatrics and Child Health</td>
<td>Yes</td>
<td>April 2018-March 2019</td>
<td>Rheology: 247, 100% compliance</td>
</tr>
<tr>
<td>National Audit of Severe Acute Malnutrition</td>
<td>British Obesity and Metabolic Surgery Society (BOMSS)</td>
<td>Yes</td>
<td>April 2018-March 2019</td>
<td>N/A</td>
</tr>
<tr>
<td>National Bowel Cancer Audit (NBOCA)</td>
<td>NHS Digital</td>
<td>Yes</td>
<td>April 2018-March 2019</td>
<td>100%</td>
</tr>
<tr>
<td>National Asthma and Chronic Obstructive Pulmonary Disease (COPOS)</td>
<td>Royal College of Physicians</td>
<td>Yes</td>
<td>April 2018-March 2019</td>
<td>Data collection not until after March 2019</td>
</tr>
<tr>
<td>National Asthma and Chronic Obstructive Pulmonary Disease (COPOS) Audit Programme: Paediatric asthma secondary care</td>
<td>Royal College of Physicians</td>
<td>Yes</td>
<td>April 2018-March 2019</td>
<td>N/A</td>
</tr>
<tr>
<td>National Asthma and Chronic Obstructive Pulmonary Disease (COPOS) Audit Programme: Pulmonary Rehabilitation</td>
<td>Royal College of Physicians</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>National Asthma and Chronic Obstructive Pulmonary Disease (COPOS) Audit Programme: Adult asthma secondary care</td>
<td>Royal College of Physicians</td>
<td>Yes</td>
<td>April 2018-February 2019</td>
<td>45 cases</td>
</tr>
<tr>
<td>National Clinical Audit of Care at the end of Life (NACEL)</td>
<td>NHS Benchmarking</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>National Clinical Audit of Consultation (NACCL)</td>
<td>British Society for Rheumatology</td>
<td>Yes</td>
<td>May 16, 2019</td>
<td>604 patients recruited between 9 May 2018</td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion Programme: management of Massive haemorrhage</td>
<td>NHS Blood and Transplant</td>
<td>Yes</td>
<td>April 2018-March 2019</td>
<td>5 Cases - 100%</td>
</tr>
<tr>
<td>National Clinical Audit of Psychosis (NPSY)</td>
<td>Royal College of Psychiatrists</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>National Clinical Audit of Specialist Rehabilitation for patients with Complex needs following Major Injury (NCAIRM)</td>
<td>London North West Healthcare NHS Trust</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion Programme: Use of fresh frozen plasma and cryoprecipitate in neonates and children</td>
<td>NHS Blood and Transplant</td>
<td>Yes</td>
<td>April 2018-March 2019</td>
<td>5 cases 100%</td>
</tr>
<tr>
<td>National Congenital Heart Disease (CHD)</td>
<td>National Institute for Cardiovascular Outcomes (NICO)</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>National Diabetes Audit Footcare</td>
<td>NHS Digital</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>National Diabetes Audit Hip (NDAH)</td>
<td>NHS Digital</td>
<td>Yes</td>
<td>September-October 2018</td>
<td>Ongoing</td>
</tr>
<tr>
<td>National Diabetes Audit Knees (NDAK)</td>
<td>NHS Digital</td>
<td>Yes</td>
<td>May 16, 2019</td>
<td>Ongoing</td>
</tr>
<tr>
<td>National Diabetes Audit Patination (NDAp)</td>
<td>NHS Digital</td>
<td>Yes</td>
<td>April 2018-March 2019</td>
<td>Ongoing: automatic data extraction</td>
</tr>
<tr>
<td>National Diabetes Audit Care (NDAc)</td>
<td>NHS Digital</td>
<td>Yes</td>
<td>April 2018-March 2019</td>
<td>Ongoing</td>
</tr>
<tr>
<td>National Diabetes Audit - Pregnancy in Diabetes Audit</td>
<td>NHS Digital</td>
<td>Yes</td>
<td>April 2018-March 2019</td>
<td>100%</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
<td>Royal College of Anaesthetists</td>
<td>Yes</td>
<td>April 2018-March 2019</td>
<td>Ongoing</td>
</tr>
<tr>
<td>National Endometriosis Surgery Audit (NESA)</td>
<td>NHS Digital</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>National Heart Failure Audit</td>
<td>National Institute for Cardiovascular Outcomes (NICO)</td>
<td>Yes</td>
<td>April 2018-March 2019</td>
<td>554 patient episodes referred to NICOR</td>
</tr>
<tr>
<td>Audit Title</td>
<td>National Clinical Audit Organisation</td>
<td>Eligible (Yen/No)</td>
<td>Data Collection required 2018/19</td>
<td>Cases submitted</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
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<td>-----------------</td>
</tr>
<tr>
<td>National Joint Registry</td>
<td>Health Care Quality Improvement Partnership (HQP)</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>Ongoing</td>
</tr>
<tr>
<td>National Lung Cancer Audit (NLCA)</td>
<td>Royal College of Physicians</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Maternity and Perinatal Audit (NMPA)</td>
<td>Royal College of Obstetricians and Gynaecologists</td>
<td>Yes</td>
<td>August 2018 - January 2019</td>
<td>100%</td>
</tr>
<tr>
<td>National Neonatal Audit Programme - Neonatal Intensive and Special Care</td>
<td>Royal College of Paediatrics and Child Health</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>128 cases 100%</td>
</tr>
<tr>
<td>National Oesophageal/gastrointestinal Cancer Audit (NOGCA)</td>
<td>NINO Digital</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>Ongoing</td>
</tr>
<tr>
<td>National Ophthalmology Audit</td>
<td>Royal College of Ophthalmology</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>224 cases submission - postoperative data submission 89%, post op data submission 71%</td>
</tr>
<tr>
<td>National Paediatric Diabetes Audit (NPDA)</td>
<td>Royal College of Paediatrics and Child Health</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>172 cases submitted</td>
</tr>
<tr>
<td>National Prostate Cancer Audit</td>
<td>Royal College of Surgeons of England (Clinical Oncology Unit)</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>100%</td>
</tr>
<tr>
<td>National Vascular Registry</td>
<td>Royal College of Surgeons of England</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>304 but March data is still ongoing</td>
</tr>
<tr>
<td>Neurosurgical National Audit Programme</td>
<td>Society of British Neurological Surgeons</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Vital signs in adults (Care in Emergency Departments)</td>
<td>Royal College of Emergency Medicine</td>
<td>Yes</td>
<td>August 2018 - January 2019</td>
<td>KGH - 119 cases, Queen's - 50 cases</td>
</tr>
<tr>
<td>POMM-UK Assessment of side effects of depot and LA antipsychotic medication</td>
<td>Royal College of Psychiatrists (CCGQ)</td>
<td>No</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>VTE Risk in lower limb immobilisation (Care in Emergency Departments)</td>
<td>Royal College of Emergency Medicine</td>
<td>Yes</td>
<td>August 2018 - January 2019</td>
<td>QH submitted 38 cases, KGH 20 cases</td>
</tr>
<tr>
<td>POMM-UK Monitoring of patients prescribed lithium</td>
<td>Royal College of Psychiatrists (CCGQ)</td>
<td>No</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>POCT UK Rapid HbA1c</td>
<td>Royal College of Psychiatrists (CCGQ)</td>
<td>Yes</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>POCT UK Prescribing Clasping</td>
<td>Royal College of Psychiatrists (CCGQ)</td>
<td>No</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Child Mortality Database</td>
<td>University of Newcastle-Newcastle Centre for Disability</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>Data collection not until after March 2019</td>
</tr>
<tr>
<td>UK Cystic Fibrosis Registry</td>
<td>Cystic Fibrosis Trust</td>
<td>Yes</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Feverish Children (Care in Emergency Departments)</td>
<td>Royal College of Emergency Medicine</td>
<td>Yes</td>
<td>August 2018 - January 2019</td>
<td>KGH - 120 cases, Queen's - 83</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP)</td>
<td>Royal College of Physicians</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>242 unclear numbers with validation in May 2019</td>
</tr>
<tr>
<td>Serious Hazards of Transfusion (SHOT) UK National haemovigilance Scheme</td>
<td>Serious Hazards of Transfusion (SHOT)</td>
<td>Yes</td>
<td>April 2018 - March 2019</td>
<td>18 reports - 100%</td>
</tr>
</tbody>
</table>
### NCEPOD studies

<table>
<thead>
<tr>
<th>Title of study</th>
<th>Participation</th>
<th>Percentage of compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowel Obstruction</td>
<td>Yes</td>
<td>Completed 100%</td>
</tr>
<tr>
<td>Pulmonary Embolism</td>
<td>Yes</td>
<td>Completed 100%</td>
</tr>
<tr>
<td>Long Term ventilation</td>
<td>Not eligible</td>
<td>N/A</td>
</tr>
</tbody>
</table>
## APPENDIX D: PERFORMANCE AGAINST NATIONAL TARGETS

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infection Control</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of <strong>Clostridium difficile cases</strong></td>
<td>&lt;29</td>
<td>9</td>
<td>15</td>
<td>29</td>
<td>36</td>
<td>33</td>
<td>N/A</td>
</tr>
<tr>
<td>Number of <strong>MRSA blood stream infection cases</strong></td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>5</td>
<td>6</td>
<td>N/A</td>
</tr>
<tr>
<td>% of cancer patients waiting a maximum of 31 days from diagnosis to first definitive treatment</td>
<td>96%</td>
<td>98.36%</td>
<td>98.52%</td>
<td>98.67%</td>
<td>96.10%</td>
<td>98.00%</td>
<td>96.10%</td>
</tr>
<tr>
<td>% of cancer patients waiting a maximum of 31 days for subsequent treatment (anti-cancer drugs)</td>
<td>98%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>99.80%</td>
<td>99.70%</td>
<td>99.60%</td>
<td>100.00%</td>
</tr>
<tr>
<td>% of cancer patients waiting a maximum of 31 days for subsequent treatment (surgery)</td>
<td>94%</td>
<td>99.17%</td>
<td>99.56%</td>
<td>99.15%</td>
<td>96.10%</td>
<td>98.30%</td>
<td>87.80%</td>
</tr>
<tr>
<td>% of cancer patients waiting a maximum of 31 days for subsequent treatment (radiotherapy)</td>
<td>94%</td>
<td>99.66%</td>
<td>99.89%</td>
<td>99.47%</td>
<td>98.70%</td>
<td>98.70%</td>
<td>95.30%</td>
</tr>
<tr>
<td>% of cancer patients waiting a maximum of 62 days from urgent GP referral to treatment *</td>
<td>85%</td>
<td>86.67%</td>
<td>86.21%</td>
<td>74.22%</td>
<td>74.00%</td>
<td>81.20%</td>
<td>84.20%</td>
</tr>
<tr>
<td>% of cancer patients waiting a maximum of 62 days from the consultant screening service referral to treatment</td>
<td>90%</td>
<td>93.68%</td>
<td>96.78%</td>
<td>95.16%</td>
<td>93.70%</td>
<td>94.00%</td>
<td>96.20%</td>
</tr>
<tr>
<td>% of cancer patients waiting a maximum of 2 weeks from urgent GP referral to date first seen</td>
<td>93%</td>
<td>93.88%</td>
<td>96.79%</td>
<td>95.20%</td>
<td>94.50%</td>
<td>91.30%</td>
<td>90.50%</td>
</tr>
<tr>
<td>% of symptomatic breast patients (cancer not initially suspected) waiting a maximum of 2 weeks from urgent GP referral to date first seen</td>
<td>93%</td>
<td>97.78%</td>
<td>97.89%</td>
<td>93.47%</td>
<td>93.20%</td>
<td>80.10%</td>
<td>80.40%</td>
</tr>
<tr>
<td><strong>Access to treatment</strong></td>
<td>18 weeks referral to treatment - total incomplete</td>
<td>92%</td>
<td>84.01%</td>
<td>90.80%</td>
<td>88.20%</td>
<td>Not reported</td>
<td></td>
</tr>
<tr>
<td><strong>Access to A&amp;E</strong></td>
<td>% of patients waiting a maximum of 4 hours in ED from arrival to admission, transfer or discharge *</td>
<td>95%</td>
<td>80.68%</td>
<td>81.84%</td>
<td>85.65%</td>
<td>87.90%</td>
<td>85.38%</td>
</tr>
<tr>
<td><strong>Cancelled operations</strong></td>
<td>Number of in-patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital</td>
<td>0</td>
<td>1135</td>
<td>651</td>
<td>974</td>
<td>524</td>
<td>494</td>
</tr>
<tr>
<td><strong>Cancelled operations not performed within 28 days</strong></td>
<td>Number of patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital, and were not treated within 28 days</td>
<td>0</td>
<td>205</td>
<td>77</td>
<td>42</td>
<td>38</td>
<td>39</td>
</tr>
</tbody>
</table>

* These indicators have been subject to an independent auditor’s assurance report in our 2018/19 Quality Account.
APPENDIX E: NHS OUTCOMES FRAMEWORK INDICATORS

The NHS Outcomes Framework is a set of indicators developed by the Department of Health to monitor the health outcomes of adults and children in England. The framework provides an overview of how the NHS is performing. It is important to note that the most recent national data available for the reporting period is not always for the most recent financial year. We have noted underneath the indicator description where this is the case. It is not always possible to provide the national average, worst and best performers for some indicators due to the way the data is provided.

<table>
<thead>
<tr>
<th>Domain</th>
<th>No.</th>
<th>Indicator</th>
<th>2018/19</th>
<th>National Average</th>
<th>Where Applicable - Best Performer</th>
<th>Where Applicable - Worst Performer</th>
<th>Trust Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing people from dying</td>
<td>1</td>
<td>Summary Hospital-level Mortality Indicator (SHMI) - value and banding</td>
<td>0.96</td>
<td>1.0</td>
<td>Band 2 - As Expected</td>
<td></td>
<td>BHRUT considers that this data is as described for the following reasons:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Oct 2017 - Sep 2018</td>
<td></td>
<td></td>
<td></td>
<td>Mortality assurance is a constant focus for the organisation. Information related to this area is monitored monthly with appropriate improvement action taken where required.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Band 2 - As Expected</td>
<td></td>
<td></td>
<td></td>
<td>BHRUT continues to work to learn from mortality and harm through a range of improvement projects which are included within this account.</td>
</tr>
<tr>
<td>Enhancing quality of life for people with long-term conditions</td>
<td>2</td>
<td>Percentage of patient deaths with palliative care coded</td>
<td>0%</td>
<td>31.1%</td>
<td>Royal Surrey County Hospital NHS Foundation Trust</td>
<td></td>
<td>BHRUT considers that this data is as described for the following reasons:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Jul 2017 - Jun 2018</td>
<td></td>
<td>Foundation Trust</td>
<td></td>
<td>We are applying this code appropriately as it has been confirmed by our coding audit. An increase in this rate reflects the specialist palliative care team activity in supporting our patients.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.99</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>Domain</td>
</tr>
<tr>
<td>--------</td>
</tr>
</tbody>
</table>
|        | 9   | Responsiveness to inpatients' personal needs | 62.4    | 68.6            | 85                              | 60.8                            | BRHUT considers that this data is as described for the following reasons:  
- Two hourly care rounds have been introduced  
- Personal care packs about to be rolled out  
- Increased the number of volunteers and ward champions to support patients.  
- Mealtime assistants in place  
- Dedicated, protected mealtimes in place. |
|        | 10  | The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends | 59.9%   | 71.3%            | 87.3%                           | 39.8%                           | BRHUT considers that this data is as described for the following reasons:  
This score has decreased in year. The improvement between 2015/16 and 2017/18 has not been maintained. We have committed to act decisively and proactively in response to the 2018 findings to improve staff experience and their view of our hospitals as places to receive care and work. A collaborative approach with divisions has been implemented to identify key themes and actions to improve these. These will be rolled out in year. |
| Ensuring that people have a positive experience of care | 11  | Rate of C. Difficile per 100,000 bed days | 2.52 (9 cases) | N/A              | N/A                             | N/A                            | BRHUT considers that this data is as described for the following reasons:  
Achievement of this target has proved a challenge and work continues to implement a wide range of actions to prevent, detect, isolate and manage this condition further. |
|        | 12  | Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) | 95.88%  | N/A              | N/A                             | N/A                            | BRHUT considers that this data is as described for the following reasons:  
This value represents continued achievement of the minimum requirement of the VTE assessment national target. |
|        | 13  | Rate of patient safety incidents that resulted in severe harm or death per 1000 bed days | 0.21 (Count of incidents = 33) Oct. 2017 - Mar 2018 | 0.19 (Based on 134 Acute non-specialist Trusts) | 0.0 (Count of incidents = 0) Oct 2017 - Mar 2018 2 Acute Trusts (non-specialist) | 0.55 (Count of incidents = 99) Oct 2017 - Mar 2018 United Lincolnshire Hospitals NHS Trust (Acute non-specialist) | BRHUT considers that this data is as described for the following reasons:  
The Trust has seen a slight increase in the number of incidents resulting in severe harm or death per thousand bed days. The Trust continues to theme incidents to identify key trends, and to share recommendations and learning from serious incidents trust wide to inform improvements to systems and processes. |
Barking and Dagenham, Havering and Redbridge CCGs (BHR CCGs)
Commissioner Statement 2018/19

Barking, Havering and Redbridge University Hospitals NHS Trust

NHS Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups welcome the opportunity to review the Quality Account (the Account) for Barking, Havering and Redbridge University Hospitals NHS Trust (the Trust) and are pleased to provide this statement.

We confirm that we have reviewed the information contained within the Account and checked this against data sources, where these are available to us as part of existing contract assurance and monitoring processes, and can confirm that we believe it is accurate in relation to the services provided by the Trust.

We have noted the number of examples provided within the Account which attest to the Trust’s achievements in improving the quality of care and patient experience during 2018/19.

The CCGs do acknowledge the significant amount of work the Trust has undertaken to improve the quality of its services and is pleased to note that the Trust has performed very well against all cancer standards - especially the 62-day waiting standard which the Trust has sustained throughout the year. This is a commendable achievement.

Accountable Officer: Jane Milligan
Managing Director: Ceri Jacob
Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

Chairs:
Dr Jagan John, Barking and Dagenham Clinical Commissioning Group
Dr Atul Aggarwal, Havering Clinical Commissioning Group
Dr Anil Mehta, Redbridge Clinical Commissioning Group
The CCGs are pleased to note the detailed priorities for 2018/19 and are in full agreement with these as they are in alignment with system quality improvement aims. Whilst recognising that some may be challenging, the CCGs fully support this proactive stance to improve patient quality and safety and are committed to working collaboratively to achieve them as appropriate.

The Trust had a focused inspection by the Care Quality Commission (CQC) during 2017/18 and received the report in June 2018. Although the overall rating remained as “Requires Improvement” the report was positive with three services, Medical Care, Surgery and Maternity, being given improved ratings, with “Good” ratings overall. The CCGs are in full agreement of the Trust’s ambition to improve the overall rating and can confirm that progress has been made to meet the “Must Do” actions the CQC recommended.

The CCGs, whilst disappointed that performance against the four-hour emergency access target for admission or discharge following arrival in the Emergency Department has been less positive, commend the Trust for their ongoing commitment to improving the quality of care being provided to patients using these services. The CCGs also acknowledge the Trust has worked well with system partners to find ways to improve performance and highly praises the Trust workforce for their commitment and dedication during a very challenging winter period.

The Trust have not managed to achieve the referral to treatment standard as capacity challenges have made delivery of this target difficult. There is a recovery plan in place which should see an improvement in delivery of all outpatient services.

The CCGs would like to reflect that while the Trust continues to focus strongly on Infection Prevention and Control (IPC), noting there is a national zero tolerance for cases of MRSA, the Trust declared 5 cases in 2018/19 which is a reduction of 1 compared to the previous year. Commissioners have requested the Trust take a more robust approach in their actions to reduce blood culture contamination. They intend to undertake a project within the Emergency Department where the majority of blood cultures are taken to identify cases of sepsis.

The Trust has performed very well in the identification and management of sepsis, achieving the targets for screening and has made good progress overall in treating patients with sepsis. This is a significant achievement considering the challenges the Trust faces within its Emergency Departments.

Commissioners have seen a number of organisation-wide initiatives which have resulted in changes to culture, practice and patient outcomes. Of note is the approach the Trust has taken to meet the requirements for “Learning from Deaths” with a robust and effective mortality review process with the addition of clear reporting figures which commissioners have assured.

We congratulate the Trust on its highly successful nursing recruitment and preceptorship programme which is very innovative and is the first programme of its kind in the country.

Commissioners also acknowledge the work the Trust has completed in the management of pressure ulcers and would fully endorse the progress of this clinical patient safety priority. This is a system wide quality priority for 2019/20 and we welcome the Trust’s support in achieving this.

The CCGs would wish to highlight that there were a number of never events reported by the Trust this year. However the CCGs have worked closely with the Trust to understand why these have happened and what measures need to be in place to prevent these happening again.
The CCGs commend the Trust as it continues to demonstrate a high level of commitment to improving patient and staff experiences of the organisation through its PRIDE initiative and note the success this is delivering in improvements to patient care.

We would like to take this opportunity to thank all the staff at the Trust for their continued commitment and hard work to delivering patient care and to give our full assurance as your lead commissioner that you continue to have our full support.

A priority for us as a health and care system is to strengthen clinical engagement and leadership and to continue to improve collaborative and supportive relationships that will deliver our ambition of an integrated care system by October 2019.

Ceri Jacob  
Managing Director  
Barking and Dagenham, Havering and Redbridge CCGs (BHR CCGs)

Jane Milligan  
Accountable Officer  
NHS North East London Commissioning Alliance (City and Hackney, Newham, Tower Hamlets, Waltham Forest, Barking and Dagenham, Havering and Redbridge CCGs)

Atul Aggarwal  
Chair  
Havering CCG
I am writing to confirm that Healthwatch Barking and Dagenham have received a copy of the BHRUT Quality Account for the year ending March 2019.

During this year, we have continued to work as a critical friend carrying out our role as an independent voice of local people accessing services across the health and social care system. We attend the Healthwatch Leads Meeting with the BHRUT patient experience team and are kept updated on various developments that the trust is undertaking.

We would like to congratulate the trust on the awards received by the Sustainability team at the Sustainable Health and Care Awards, being named “Preceptorship of the Year” at the Nursing Times Workforce Awards and Nick Haliasos, for the £57,000 grant he secured to bring Artificial Intelligence (AI) to the Trust.

The areas within the Quality Account we would like to comment on are as follows:

**Reduction in missed medication**
The quality account states “Medication is a very important part of every patient’s treatment while in hospital. Occasionally we do not provide patients with their medication in a timely way due to a variety of factors which include communication on the ward, availability of the medication, patient difficulty with swallowing which requires obtaining liquid or other forms of the medicine, patient’s understanding of the need for the medication which results in refusal in taking the medication.”

It would be interesting to see which factors have contributed to missed medication. Although there is a plan in place, we would be keen to know if patients are asked if they are able to swallow tablets at the point at which medication is prescribed, to mitigate against this issue occurring. This could assist in omitting the issue early in the pathway rather than later. This may help towards the trust’s target of reducing the omission of medicines by at least 10%.

Our role as a Healthwatch is to champion the views of local people on health and care services and challenge service providers and commissioners with evidence. We are glad to see patient experience as one of the top priorities highlighted in this year’s Quality Accounts.

**Understanding my medications**
Although the quality accounts states that “Information provided to patients – the format and style, is this right for the individuals and their needs?” will be a target area, it would be beneficial to pilot some of the styles and formats to see what works. For example: using simple English and pictures would help those who do not understand English or have a learning disability. This could mean having more than one format.

**Noise at night**
The goal to improve noise at night after receiving patient feedback shows that the trust is engaging with individuals to improve their experience. Will the trust be undertaking any comparisons between wards, in
order to learn from each other? It would be beneficial to state what areas patients rate as having the most disturbance and identify whether this is due to, for example, staff talking to each other, equipment or other patients making noise.

**Mealtime Assistant Volunteer Role**

It’s great to see such good achievement in regards to volunteering and that befriending on the wards is having a positive impact on the patients. We wholeheartedly commend the trust in continuing to recruit more volunteers and building on this achievement.

**Thematic review of complaints**

Last year ‘The Quality Account’ stated “There were 664 complaints received during 2017/18”. We asked the trust to consider highlighting the areas of concern and which service/department these were in relation to. We also asked how the trust would be looking at improving the services where a theme emerges and if any mechanism had been put in place to involve patients when looking at those services? Therefore, we welcome the plan of the thematic review of the complaints as a priority this year.

**Comments on the review of Quality Performance 2018/2019**

**All Cancers- Maximum 62-Day wait for first treatment from: Urgent GP referral for suspected cancer and NHS Cancer screening service referrals.**

We are pleased to see that the target for this was achieved. Evidence collected from a focus group delivered by BHR Healthwatch highlights the need for improvements to be made for patients receiving chemotherapy treatment. We are aware that the trust is reviewing the recommendations.

We would like to take this opportunity to highlight that this needs to be priority as diagnosis and treatment are both part of the cancer pathway.

**Friends and Family test**

It is very positive to see that the target was achieved for Accident and Emergency. The Quality Accounts refer to the Maternity department not achieving its target and that women tend to tick either the ‘neither likely or neither unlikely’ when responding to the friends and family test.

The quality statement does not give enough information as to which area of the pathway this relates to. If it’s the whole maternity pathway another mechanism of feedback needs to be explored and further investigation is needed to look at the reasons behind the feedback.

In the next Quality Accounts, it would be useful to see a breakdown of the actions that have been taken in regards to the feedback that patients have provided and how this influenced any changes to service delivery in particular departments.

**Staff: Friends and Family Test**

We note that the percentage of staff responding to the survey has dropped from 47% in 2017 to 46% in 2018. We also recognise that the national average for this was 44% and the trust have highlighted a number of initiatives which should help with the target next year.

In the next Quality Accounts, it would be useful to see a breakdown of the actions that have been taken in regards to the feedback that staff have provided, has this influenced any changes to service delivery in particular departments?

**Sepsis**

We are pleased to see that the target to “Improve the care and management of patients with sepsis or suspicion of sepsis through timely recognition, escalation and subsequent delivery of antibiotics, within 1 hour” was achieved and hope that the trust continues to meet the target.
Learning from deaths
We acknowledge that the trust is proud of the work that has been achieved from the implementation of the “Trust Policy Learning from Deaths” we would be interested in knowing how families’ experiences have influenced the work being carried out in this area especially around end of life care.

Yours Faithfully,

Manisha Modhvadia Healthwatch Officer
On behalf of Healthwatch Barking and Dagenham
Mid and South Essex Acute Commissioning Team response to Barking, Havering and Redbridge University Hospitals NHS Trust Quality Report 2018/19

Mid and South Essex Joint Committee (JC) since 2017/18, has devolved authority from mid and south Essex CCGs to commission “in hospital” services on their behalf. As the lead Essex commissioner of services provided by Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) the JC welcomes the opportunity to comment on this quality report.

The JC is commenting on a draft version of this quality account, however, to the best of the JC’s knowledge, the information contained within this report is generally accurate and is representative of the quality of services delivered. Any queries will have been fed back to BHURT prior to publication for consideration of inclusion, along with missing data in the final report.

Additional requirements for insertion within 2018/19 Quality Reports are:-

- a statement regarding progress in implementing the priority clinical standards for seven day hospital services and
- Freedom to Speak up - details of ways in which staff can speak up if they have concerns over quality of care, patient safety or bullying and harassment within the trust.

Both of these are included with the 2018/19 Quality Account

The JC notes that BHRUT were inspected by the Care Quality Commission (CQC) in January 2018, with the outcome published in June 2018, BHRUT rating remains as “requires improvement” overall. Within the report there are some areas that have seen improvement – in particular Medical Care.

When looking to see if priorities for 2018/19 have been met, it worth noting that this has been another challenging year with increasing demand for services, BHRUT have achieved around half of the quality priorities that it set. A number of key targets remain unmet, such as 4 hours in A&E and Referral to Treatment, but a reduction in the number of *c difficile* cases down to 9 is encouraging. BHRUT aim to continue to strive to improve putting in additional measures with increased monitoring working to reduce impact on patients, where targets have not been met.

BHRUT summary hospital-level mortality indicator (SHMI) is noted as with expected limits, this is an improvement on where the trust was in 2017/18.

A comprehensive description of your participation in and learning from clinical audit and research is produced, plus a summary of findings and learning from all clinical audits undertaken.

In conclusion Mid and South Essex Joint Committee considers Barking, Havering and Redbridge University Hospitals NHS Trust Quality Report for 2018/19 as providing an accurate and balanced
picture of the reporting period. The JC via its Acute Commissioning Team will continue to seek assurance on performance and delivery of care by regular monitoring through agreed contract processes.

Rachel Hearn
Director of Nursing and Quality
Acute Commissioning Team and Mid Essex Clinical Commissioning Group

April 2019
ANNEX 2: STATEMENT OF DIRECTORS’ RESPONSIBILITIES

Our 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 Accounts, which incorporates the legal requirements in the Health Act 2009, the National Health Service (Quality Accounts) Regulations 2010 and the National Health Service (quality accounts) Amendment Regulations 2011.

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

The Quality Account has been prepared in accordance with Department of Health guidance and presents a balanced picture of our performance over the period covered.

The content of the Quality Account is not inconsistent with internal and external sources of information including:

- Board minutes and papers for the period April 2018 to March 2019
- papers relating to quality reported to the Board over the period April 2018 to March 2019
- feedback from clinical commissioning groups
- feedback from governors
- feedback from local scrutinisers, including Healthwatch and local authority Overview and Scrutiny Committees
- BHRUT’s complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2017/18
- the Head of Internal Audit’s Annual Opinion, April 2019
- National Inpatient Survey 2018/19
- NHS National Staff Survey 2018
- CQC inspection report
- the General Medical Council’s National Training Survey 2018/19
- Mortality rates provided by external agencies (Health and Social Care Information Centre, HED and Dr Foster)

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

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

The Directors have reviewed the Quality Account and 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

Joe Fielder
Chairman

Date: 10th May 2019

Chris Bown
Interim Chief Executive

Date: 9th May 2019
ANNEX 3: INDEPENDENT AUDITOR’S LIMITED ASSURANCE REPORT

INDEPENDENT AUDITOR’S REPORT TO THE DIRECTORS OF BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITAL NHS TRUST ON THE QUALITY ACCOUNT

We are required to perform an independent assurance engagement in respect of Barking, Havering and Redbridge University Hospital NHS Trust’s Quality Account for the year ended 31 March 2019 (“the Quality Account”) and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The NHS (Quality Accounts) Regulations 2010, the NHS (Quality Accounts) Amendment Regulations 2011 the NHS (Quality Accounts) Amendment Regulations 2012 and the NHS (Quality Accounts) Amendment Regulations 2017 (“the Regulations”).

Scope and subject matter
The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority indicators:

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge; and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

We refer to these national priority indicators collectively as ‘the indicators’.

The Trust has voluntarily disclosed the indicators listed in part 3 of Detailed requirements for quality reports 2018/19 published by NHS Improvement in part 3 of the Quality Account and has selected the indicators for external assurance in line with the guidance in Detailed requirements for external assurance on quality reports 2018/19, also published by NHS Improvement.

Respective responsibilities of the directors and auditors
The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health and NHS Improvement have issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the 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; and
- the Quality Account has been prepared in accordance with Department of Health and NHS Improvement guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors’ responsibilities within the Quality Account.
Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations and supporting guidance;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance (‘the Guidance’); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and consider whether it addresses the content requirements of the Regulations and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- the trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the CQC National adult inpatient survey 2018 national patient survey, dated 13 June 2018;
- the 2018 NHS Staff Survey national staff survey;
- Care Quality Commission Inspection, dated 22 June 2018;
- the 2018/19 Head of Internal Audit’s annual opinion over the trust’s control environment, dated 24 May 2019; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, ‘the documents’). Our responsibilities do not extend to any other information.

This report, including the conclusion, has been prepared solely for the Board of Directors of Barking Havering and Redbridge University Hospital NHS Trust as a body to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Barking Havering and Redbridge University Hospital NHS Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

**Assurance work performed**

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.
A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the Regulations.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Barking, Havering and Redbridge University Hospital NHS Trust.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations and supporting guidance;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

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28 May 2019
USEFUL CONTACT NUMBERS

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Accessibility

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Barley Lane,
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Ilford IG3 8YB.

These are the main hospitals we run services from. Our teams also provide services at other sites and clinics across our community.

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How to provide feedback on this Quality Account:

We hope you find this report useful and informative. We welcome your feedback on how we can improve our Quality Account next year.

If you would like to give us feedback on our Quality Account 2018/19 please contact:

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