2018-19 Quality Account

CONTENTS

PART 1: STATEMENT ON QUALITY

1.1 STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

I am delighted to present our Quality Accounts for 2018-19, which detail the Homerton University Hospital NHS Foundation Trust's position on quality over the last year, and which provides assurance that we continue to strive to provide the highest quality clinical care. We are proud to continue to perform well against our key performance and regulatory requirements while delivering high quality care for our patients and service users. The ongoing focus given to the quality improvement work is key to these achievements.

Our Improving Quality programme has continued to lead and support improvement projects throughout the year. This approach has increasingly been applied to improvement work within the Trust and it also influences the approach to change across the wider system, particularly within Hackney and The City. The Trust continues to be key partner in the work associated with the establishment and development of Neighbourhoods, enhancing the opportunity for multi-disciplinary working. The strong partnership approach also positively impacts on the management of urgent and emergency patients within the system, with all partners contributing to the success seen in the performance management of these pathways.

The internal quality transformation work has once again explored the benefits of technological and system advancements and considered how these could improve the way we are able to offer care and share information effectively. This has resulted in a shift to a paperless outpatients service with pathways managed entirely through the use of digital technology and enhancements to health systems, from referral to communication back to the GP. Our next area of focus now needs to result in ensuring such opportunities are available to patients.

The Trust also remains high performing in key areas of quality measures:

- A&E 4 hr waits – one of the best performing Trusts nationally
- Standardised Hospital Mortality Index (SHMI) –.one of the lowest in the country
- Referral to treatment (waiting times) – 96.7% of patients wait <18 weeks
- Diagnostic waiting times - 99.8% of patients wait < 6 weeks for diagnostic procedures
- Improving Access to Psychological Therapies (IAPT) -– 99.5% of patients wait <18 weeks to begin treatment
- Homerton attributable C Diff levels significantly below the national threshold set for the trust – 3 cases against a threshold of 10

We have also welcomed the Care Quality Commission during the past year when they carried out inspection visits to the acute services based on the hospital site. Four service areas were reviewed as part of this inspection and three of the four ratings were improved. Urgent & Emergency Services retained the Outstanding rating. Medical Care, including older people's care also received an Outstanding rating. Maternity and Surgery both improved and were rated Good. Overall the Acute services were rated as Good, combined with the previous inspections for Community services and Mary Seacole Nursing Home, the Trust overall was rated as Good. This is a significant achievement and recognition for all staff across the Trust, reflecting the quality of service they provide to patients and their families on a daily basis.

There are many examples of innovative and quality improvement examples that were successfully implemented in 2018/19 and these include:

- The Acute Pain Team was recognised as the Team of the Year by the National Acute Pain Symposium. The award is just the beginning for the service with further developments planned for the future including the development of pain link nurse roles, developing nurse led telephone clinics and growing and expanding the team further with the addition of two new trainee clinical nurse specialists.
- A range of new technological innovations have been introduced in outpatients aimed at improving quality, safety and efficiency. A new voice recognition system using Dragon, aids the information entry in electronic notes and letter production. Doctors now also able to access cardiology, endoscopy and radiology images directly from EPR via a new image archive, whilst a new app allows clinicians to safely take a clinical photograph with a smart phone. After scanning the QR code, the photo is directly uploaded into the appropriate record and then automatically deleted thus maintaining patient confidentiality.
- A newest part of the Trust's network of sexual health clinics opened at 80 Leadenhall in the heart of the City of London. The centre provides a range of services including testing for sexually transmitted diseases (STIs) and administering post-exposure prophylaxis preventing HIV infection (PEP). The clinic welcomed over 4,000 client visits in the first four months of opening.
- An innovative team of advisers from Redthread Youth Violence intervention Programme were introduced into the emergency department to offer support and counselling to young people who have or might be victims of violence.
- The Trust retained its Planet Mark accreditation for a second year by showing good practice in sustainability including achieving a 9.6% total carbon footprint reduction in 12 months and decreasing carbon emissions from buildings by 9.7%.
- The Trust dismantled its remaining smoking shelters and replaced them with additional bike racks.
- The Elderly Care Unit welcomed animal friends to patients. The "Pets As Therapy" scheme increases a person's level of interaction and can reduce agitation, something that can be particularly helpful for people with dementia who can show symptoms of distress and agitation when in hospital.
- The Care Certificate programme was expanded over the year with 104 members of staff completing the programme.
- The Trust introduced a scheme to provide employment experience opportunities to people with learning disabilities.
- The Trust has signed a commitment to supporting members of the armed forces as they seek new employment opportunities on leaving the services. The Armed Services Covenant ensures that Homerton pledges to recognise the value serving personnel, reservists, veterans and military families bring to the organisation as well as ensuring that no member of the Armed Services Community should face disadvantage.
- Homerton has joined other local public service leaders in signing a No Smoking pledge. The pledge has been designed by the Smokefree Action Coalition and is endorsed by NMHs England, Public Health England and Health Ministers.
- Talking Mats have been introduced by the speech therapy team. The mats are a tool which is used as a visual communication tool that is used with children and adults with a wide range of communication difficulties.
- New developments have improved the environment of Mary Seacole Nursing Home. The gardens were completely refurbished and new door pictures for wards were installed with old photographs reflecting local landmarks in Hackney.
- Lloyd Ward has been completely refurbished complete with a new reception area for visitors.

- We continue to actively participate as a member of NHS QUEST. This is a network of trusts and foundation trusts, working collaboratively to reduce avoidable harms in hospital, to stimulate innovation and to improve staff satisfaction.

We continue to share our examples of good practice both within Homerton at our Quality Sharing Days, Simulation Training Day and the annual Research & Development Day, all with attendance from local stakeholders and partner organisations. Additionally, a range of individuals, services and innovations have been recognised by reaching the final shortlists of several national awards.

Sharing learning in this way is not only a vital part of maintaining and improving our quality standards, but helps to inform our future aspirations. Our Quality Priorities set out areas of focus for the coming year, drawing on both local experience and requirements agreed with our commissioners, and national programmes of work.

Whilst every effort has been made to reflect accurately the position of the Trust against the measures reported on, there are a number of inherent limitations in doing this which may affect the reliability or accuracy of the data reported. These include:

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

The Board of Directors have sought to take all reasonable steps and to exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above.

As always, the Trust's key strategic quality priorities remain the focus of our goals and ambitions for the quality of care we deliver.

In making this statement I can confirm that, to the best of my knowledge, the information contained in this Quality Account is accurate.

Tracey Fletcher
Chief Executive
Homerton University Hospital NHS Foundation Trust

PART 2: PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

2.1 PRIORITIES FOR IMPROVEMENT DURING 2019/20

We have agreed our annual priorities for 2019/20 which support our Organisational Strategy and consider some of our challenges. The annual priorities were agreed following consultation with staff and stakeholders including Governors, City and Hackney Clinical Commissioning Group and Healthwatch. The quality priorities, the rationale for their selection and how we plan to monitor and report progress are outlined below. All quality priorities have a timescale for achievement by 31 March 2020 and progress to achieve them is to be monitored by our Trust Management Board.

Patient Safety (Safe)

Priority 1	To reduce the number of community and hospital attributed pressure ulcers – carried forward from 2018/19
Rationale	The Trust is unlikely to have achieved this priority in 2018/19 therefore has agreed to continue with this priority in 2019/20. The development of a pressure ulcer can cause significant long term harm both physically and mentally to a patient. This coupled with the impact of the resultant extended inpatient/community care provision can create avoidable financial pressures. There is continued national focus on the need to reduce the number of pressure ulcers. Work to reduce the rate of community acquired pressure ulcers link to the wider development of neighbourhoods in City and Hackney.
Monitoring	Improving Patient Safety Committee
Reporting	Total number of avoidable community and hospital acquired pressure ulcers at grade 2 and grade 3+ Numbers of pressure ulcer free days.

Priority 2	Appropriate identification and management of deteriorating patients - carried forward from 2018/19
Rationale	The Trust has agreed to continue with this important priority through the deteriorating patient group to build upon the work established in 2018/19. This priority will also include the timely identification and treatment of patients with sepsis.
Monitoring	Critical Care Committee, Improving Clinical Effectiveness Committee
Reporting	Implementation and measures established through the deteriorating patient group. Sepsis measures to mirror sepsis CQUIN.

Priority 3	Reducing physical violence and aggression towards patients and staff – New priority
Rationale	The most recent national staff survey shows that more than 15% of NHS employees have experienced violence from patients, their relatives or the public. Implementation of the NHS Violence Reduction Strategy is to be a priority for the Trust to reduce the impact on staff and patients through improved training and prompt mental health support for staff.
Monitoring	Health and Safety Committee
Reporting	Local implementation of the national strategy.

Clinical Effectiveness (Effective)

Priority 4	Improving management of end of life patients for adults - carried forward from 2018/19
Rationale	The Trust has agreed to continue with this important priority through the End of Life Board to build upon the work established in 2018/19 and the implementation of the End of Life Strategy 2018-21. The key elements of the strategy being personalised end of life care, supporting our staff, improving environment and communication & information. This will include the wider partnerships the trust has with community organisations including the local hospice.
Monitoring	End of Life Board
Reporting	Implementation and measures of strategy to be established through the end of life board.

Priority 5	Making Every Contact Count – New priority
Rationale	Making changes such as stopping smoking, improving diet, increasing physical activity, losing weight and reducing alcohol consumption can help people to reduce their risk of poor health significantly. Making every contact count (MECC) is an approach to behaviour change that utilises the day to day interactions that organisations and people have with other people to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations. Implementing MECC means providing their staff with the leadership, environment, training and information so that staff have the competence and confidence to deliver healthy lifestyle messages, to help encourage people to change their behaviour and to direct them to local services that can support them. Initially being implemented in maternity then the wider Trust. The delivery of MECC in the trust will contribute the wider prevention work stream priority across City and Hackney
Monitoring	Improving Quality Board
Reporting	Metrics based upon implementation programme.

Priority 6	Learning from complaints, incidents, claims and compliments – New priority
Rationale	It is fundamental that we listen to our patients and learn from their experiences. We will carry out an in depth review of complaints, incidents, claims and compliments to better develop actions to ensure learning is captured and fedback to staff and shared across the organisation and practice is changed to prevent recurrence.
Monitoring	Patient Safety Committee
Reporting	Metrics to be established.

Patient Experience

Priority 7	Improving the first impression and experience of the Trust for all patients and visitors - carried forward from 2018/19
Rationale	Creating positive first impressions of the Trust for patients and visitors who are visiting the Trust is important in building trust and confidence in our staff and services. Receptionists are on the front line in meeting and greeting patients and visitors and therefore play a pivotal role in this. We will continue to develop a range of measures to support receptionists and their managers create a positive first impression for every service user and visitor to the Trust at every visit.
Monitoring	Patient Experience Committee
Reporting	Metrics based upon results of 2018/19 priority outcome - to include training and compliance with first impression standards.

Priority 8	Getting Patients Moving – New Priority
Rationale	Move, groove and improve – Trust wide implementation of the 2018 national *EndPJParalysis* campaign. The campaign focuses on encouraging patients in hospitals, where possible, to stop wearing their pyjamas or hospital gown when they don't need to. This is because wearing pyjamas for many patients reinforces the 'sick role' and can prevent a speedier recovery. Obviously the patient and their condition need to be taken into consideration and this principle cannot apply to every single in-patient, however for many, it's a matter of enabling them to get up, get dressed and get moving.
Monitoring	Patient Experience Committee
Reporting	Metrics to be established.

Priority 9	Improvements in staff health and wellbeing – New priority
Rationale	Aiming to create a working environment which is beneficial to the health and wellbeing of our staff. All staff will be supported to maintain and improve their health and wellbeing and are encouraged to take reasonable steps to improve their own health and wellbeing. The goal is to inspire our staff to take a greater interest in their own health and wellbeing.
Monitoring	Workforce Committee
Reporting	Metrics to be established.

2.2 Statements of Assurance from the Board

We are required to include formal statements of assurances from the Board of Directors which are nationally requested to give information to the public. These statements are common across all NHS Quality Accounts.

2.2.1 Review of Services

During 2018/19 Homerton Hospital NHS Foundation Trust (HUHFT) provided and/or sub-contracted 68 relevant health services.

Homerton Hospital NHS Foundation Trust has reviewed all 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 Homerton for 2018/19.

2.2.2 Participation in clinical audit

National clinical audits are primarily funded by the Department of Health and commissioned by the Healthcare Quality Improvement Partnership (HQIP) which manages the National Clinical Audit and Patients Outcome Programme (NCAPOP). Although National Clinical Audits are not mandatory, organisations are strongly encouraged to participate in those that relate to the services they deliver. It is mandatory to publish participation in National Clinical Audits in a Trust's Quality Account. A high level of participation provides a level of assurance that quality is taken seriously and that participation is a requirement for clinical teams and individual clinicians as a means of monitoring and improving their practice. Local Clinical Audit is also important in measuring and benchmarking clinical practice against agreed standards of good professional practice.

The Trust participates in relevant national audits and confidential enquiries programmes as listed through the HQIP. All the programmes listed were assessed for relevance in 2018/19.

During 2018/19, 37 national clinical audits and five national confidential enquiries covered relevant health services that Homerton provides.

During that period HUHFT participated in 98% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and confidential enquiries that the Homerton was eligible to participate in during 2018/19 are listed in **Appendix A.**

The national clinical audits and confidential enquiries that Homerton participated in, and for which data collection was completed during 2018/19, are listed in appendix A 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.

The reports of 15 National Clinical Audits were reviewed by us in 2018/19 and the Trust intends to take the following actions to improve the quality of healthcare provided.

Table 1: Examples of changes from a national audit

Audit	Trust Actions
National Joint Registry (NJR)	Low consent rates documented for NJR data collection. Consent for NJR data collection now routinely collected at time of consent for surgery and consent rates audited locally. A British Orthopaedic Association review of arthroplasty during the last year was supportive of the department's current clinical practice.
National Lung Cancer Audit (NLCA)	All relevant clinicians contacted to ensure completion of spirometry and Eastern Cooperative Oncology Group (ECOG) performance score (using voice recognition template provided when possible). Continue to refer patients urgently to the relevant clinical teams for chemotherapy and radiotherapy. Ensuring regular presence of Thoracic Surgeon at Homerton "Diagnostic MDT" Discussions under way to obtain cover for Diagnostic MDT in the absence of the Chest specialist Radiologist
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Homerton neonatal unit overall performance is comparable or above national average in most areas investigated. Homerton performance is below national average in two areas measured: Lower admission temperature of babies born very preterm (less than 32 weeks gestation). Action taken - Education and awareness of maintaining normal temperature at induction and regular teaching. Monthly admission temperature tracking and discussion at clinical governance Follow-up at two years of age: around 45% of eligible babies were reviewed at two years of age (National average is 61%). Action taken - Business case to be submitted for a dedicated follow-up co-ordinator to ensure babies attend clinic follow-up at correct age.
Falls and Fragility Fractures Audit programme (FFFAP)	2018 Best Practice Tariff achievement is 58.3% - a significant increase from 2017 which was 46.5%. Key actions being taken are: • Ensuring completion of Abbreviated Mental Test Score in the Emergency Department before surgery. • Ensuring completion of the rapid assessment test for delirium in 7 days post-op with translators being used if there is a language barrier. • Reducing time to get to surgery. • Ensuring physiotherapy reviews for patients admitted on the weekend. • Reducing inpatient falls and improving after care, including prompt X-rays and diagnosis. • Reducing incidence of pressure ulcers.
MBRRACE-UK Saving Lives, Improving Mothers' Care	Action being taken includes the Venous Thrombo-Embolism audit being added to the 2019-20 audit plan for maternity services
Major Trauma Audit (TARN)	The following actions are being taken as result of the major trauma audit: Review and improvements in the Trust governance around major Trauma through the Trauma Operational Group Training and education including online competencies for nurses, Trauma Intermediate Life Support (TILs) training, Trauma Team Leaders education and Resuscitative Interventions Procedure training.

National Audit of Dementia	The following actions are being taken as result of the National Audit of Dementia: • Creation of 'delirium champions' on surgical wards with the wider hospital in phase II • Care plan to be made available electronically. • Offer multiple Dementia awareness training sessions – including the dementia and delirium study day – several sessions arranged for 2018 • Monthly audits to assess completion of the Disability Assessment for Dementia and fed back to the governance meeting. • Discussions with Ward Sisters and Heads of Nursing, Lead Therapists for advice around dementia and delirium care bundles being available in on the Electronic Patient Record. • Patient and carer information to be incorporated into dementia care support worker role. • Visual Identifier to be incorporated into 'care bundle' proposal for patients to have access to food throughout the day and night offered regularly. • Ongoing work with transport regarding delays to ensure that patients are discharged in the early part of the day.
NCEPOD Acute Heart Failure	The following actions are being taken as a result of the audit: • Provision of heart failure rehabilitation is provided where appropriate and when available • The aim is for information relating to correct diagnosis, cause of heart failure, current medications and need for monitoring is on the discharge summary. • The inpatient heart failure nurse gives the patient additional information regarding self-management, and liaises with the medical staff and community heart failure staff with regards to discharge planning • This criteria is met for all heart failure patients ascertained by the inpatient surveillance mechanism and in whom heart failure team advice is followed • The cardiology department aims to provide an echocardiogram on all inpatients within 48 hours of the request being made during weekdays

Local clinical audit

Clinical audit is central to improving the quality and effectiveness of clinical care, to ensure that it is safe, evidence based and meets agreed standards. All staff are encouraged to complete clinical audits or other similar projects to monitor and then improve services.

The reports of 158 local clinical audits were reviewed by us in 2018/19. A selection of these audits is outlined in the following table and the Trust intends to take the following actions to improve the quality of health care provided.

Table 2: Examples of actions that the Trust intends to take or has taken following local clinical audit recommendations

Audit title	Key actions following the audit
Maternity booking summaries – are they present in all antenatal notes?	Continue 100% compliance with booking summaries in antenatal notes. Ensure all booking summaries are placed behind the Antenatal Care tab in antenatal notes. Report printer issues as soon as possible to ensure summaries can be printed. If printing not possible, gain consent from woman to post summary to her home address (checking address details are correct) for her to add to her antenatal notes.
Audit of Referrals to Bariatric Assessment Clinic	Ensure vetting referral pathway is clear with all members of the team (bookings and bariatrics). Continue ongoing work of encouraging electronic referrals to the bariatric service.
An audit of *Molluscum contagiosum* against the UK BASHH guidance	Add *Molluscum contagiosum* guideline in to the HSHS guideline booklet
Audit of C&H wheelchairs currently in use in local nursing homes	Nursing Home managers to be informed regarding wheelchair service criteria for future reference. An Information sheet has been provided to Nursing Home managers.
Audit of GP Ultrasound referrals	Encourage addressing of clinical query on conclusion/summary. To develop an information sheet for GP's to ensure that referrals are improved with specific queries.
An Audit of VTE prophylaxis	Introduce a VTE score as part of standard 26 week midwife appointment. Update of midwifery guidelines
Postnatal readmission for hypertension audit	Send reminder to all GPs regarding community treatment of hypertension. Information to be added to CCG newsletter update
Review of the powered wheelchair assessment pathway	Wheelchair Service team agreement regarding the Powered Pathway. Implementation of the Powered Pathway
Perinatal mental health audit	Formalise discussion of medication in mental health with women of childbearing age. Incorporate a tick box into the mental health review template indicating discussion about medication with women of childbearing age.
Audit of nutrition screening in adult medical admissions 2016-2018: Re-audit after initial intervention and subsequent Quality Improvement Project Plan	Formalise training for nursing staff. Rewrite compulsory nursing training e-learning module on nutrition to emphasise the importance of getting an accurate weight for all patients
Women's Health Physiotherapy Documentation Audit	Gestation and expected date of delivery (EDD) documentation. Changed new paperwork to "Gestation/Post-Partum" and "EDD/Baby DOB" to accommodate post-natal patients too.
Speech and language therapy stammering Pathway for under 8 year olds in mainstream primary schools in Hackney	Raising awareness about stammering; its potential impact and the importance of referring a child to SLT early. Stammering advice leaflet and poster developed and distributed in team

Diabetic foot amputations	Education of A&E staff. Review of standard operating procedure for diabetic foot complications
Evaluating incidence of pain in Post Anaesthetic Care Unit (PACU)	Establish working group with anaesthetic department and PACU. Develop standardised recovery documentation
Audit of clinical practice at Homerton postnatal echo technician clinics	Parents' information leaflet. Design a leaflet with information on the procedure, discussion on results and medical follow up. Modify the neonatal clinic referral to highlight babies scheduled for outpatient echo.

2.2.3 Research

Clinical research remains high on the Government agenda with continued funding to Clinical Research Networks (CRN) ring-fenced for the promotion of research within the NHS. Research is written into the NHS Constitution and this has recently been reinforced through the CQC inspection process. In September 2018 the Care Quality Commission (CQC) signed off the incorporation of clinical research into its Well Led Framework (NHS Trusts)[1]. This formally recognises clinical research activity in the NHS as a key component of best patient care. Thus, clinical research is no longer perceived as just a 'nice to do' exercise in the NHS - it is now a key part of improving patient care. Furthermore, the government reflect this consensus through the continued funding of the National Institute of Healthcare (NIHR). Dame Sally Davies, Chief Medical Officer for England, stated that 'Research is central to the NHS… We need evidence from research to deliver better care. Much of the care that we deliver at the moment is based on uncertainties of experience but not on evidence. We can only correct that with research.'[2] Homerton is committed to this path growing research capacity year on year. During 2018 between 130 and 150 studies were recruiting at any given time, with a total of 222 studies recruiting patients during 2018.

We aim to open studies that are particularly relevant to the patients who are treated and cared for at Homerton Hospital and the wider population. We confirm with potential Principal Investigators that studies are in line with local clinical practice. During the lifecycle of each study the R&D team ensure that all governance and regulatory processes are approved and adhered to; recruit patients who are eligible for the trial; collect and maintain necessary data and accurately record the data; and finally confirm secure archiving of all necessary trial related documentation at the end of the study.

Participation in research remains important to patients with over 94% of a national consumer poll indicating that it is important for the NHS to carry out clinical research, with a similar number saying it was important so that new treatments could be offered by healthcare professionals[3].

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 3078.

This increase in recruitment has led to a consequential increase in the number of personnel in the research team. In 2018 we were fortunate to be able to support an apprentice as well as research nurses, research practitioners and administrative staff.

The team provide both an excellent and efficient service and Homerton performs consistently well and once again is top for value for money when compared to other mid-sized acute trusts in North Thames.

[1] Well Led Research in NHS Trusts: A Briefing for Clinical Research Network Staff about outputs from the work to establish research markers in CQC inspection

[2] Excerpt from video Enhancing patient care through research

[3] Results of Censuswide consumer poll of people in England in September 2014

R&D department is committed to growing research both locally and nationally and the department supports novice researchers setting out on an academic pathway. Currently there are three researchers, all in allied health professions, who are being funded through NIHR grants to achieve ether an MSc or PhD. Additionally four members of staff are being funded for PhD studies through research income. We also offer support and advice for those seeking funding for projects. Successful grants in 2018 include £500k for a fertility study under Dr Priya Bhide, and £1m for a study in neonatology under Dr Narendra Aladangady.

We further promote, develop and support researchers at the annual conference offering the opportunity to share research findings and hear the experiences of veteran researchers. The 2018 conference covered many topics and introduced us to our keynote speaker: Dr Chris Turner, University Hospitals Coventry & Warwickshire; who spoke about "Why Civility Counts in a Complex World" a salient and important discussion.

Patient involvement in research

Both nationally and locally we seek to gain opinions and views of patients involved in all aspects of research. We encourage researchers to involve patients/lay members of the public in the design of their research thus enhancing the acceptability of the research to service users. We also host a stall in the reception area of the Trust to engage and inform members of the public in the research being undertaken locally. Nevertheless, in our 2018 survey only 26% of our respondents were aware that Homerton were involved in research activity prior to being recruited to a study.

A taste of research activity at Homerton

STOPPIT 2 - Prematurity is thought to account for over 70% of twin neonatal deaths and adversely affects fetal survivors, with increased risks of future respiratory problems, motor and sensory impairment, learning difficulties and social and behavioural difficulties. Twins alone account for over 20% of neonatal unit cot stays, a significant excess given they comprise only 2% of all births. Together, the complications of preterm birth result in an estimated annual cost of £2.9 billion to the public purse in England and Wales (2006 prices).

There is a clear expressed need for innovative interventions to reduce preterm birth in both high-income and low-income countries. The 2011 National Institute for Health and Care Excellence (NICE) Multiple Pregnancy Guideline Group noted that bed rest at home or in hospital, progesterone, cervical cerclage and oral tocolytics are all ineffective at preventing preterm birth in twins, concluding that alternative effective interventions are urgently required.

STOPPIT-2 is a multicentre open-label randomised controlled trial of the Arabin pessary (CE marked device) versus standard treatment in women with twin pregnancy recruited from NHS antenatal clinics. The study is in two phases: a screening phase, in which women with a short cervix (cervical length of ≤35 mm) are identified, and a treatment phase, in which women with a short cervix will be randomised to either treatment with Arabin pessary or standard treatment.

The primary objective of this study is to test the hypothesis that the Arabin cervical pessary reduces spontaneous preterm birth in women with a twin pregnancy and a short cervix (≤35 mm).

The study, which commenced in January 2016, has consented 72 patients and has randomised 26 patients at Homerton. Homerton is the sixth recruiting site out of 56 participating Trusts nationwide and has played a key role in the achievement of the national target of 500 randomised patients.

Microbial Colonisation and Immune Responses in Preterm Babies - Necrotising Enterocolitis (NEC) and septicaemia disproportionately affect infants with extreme prematurity or low birthweight. Both carry high rates of mortality and morbidity and can impact significantly on neurodevelopmental outcomes in survivors. A number of previous studies have shown that the preterm microbiome is different from the microbiome of term babies with typically more potentially pathogenic bacteria seen.

There have been some studies that suggest these abnormal pathogenic bacteria are associated with an increased risk of NEC and septicaemia. Little is known about how the immune system develops in preterm babies and what factors alter immune responses. This local study looked at the relationship between the developing immune system and the preterm intestinal microbiome.

Babies admitted to the Homerton NICU and born between 23+0 to 31+6 weeks gestation were recruited with written informed consent. Stool samples were collected every day and weekly gastric aspirates were collected and stored to evaluate intestinal colonisation. Blood samples were also taken weekly and when babies were being evaluated for suspected infection to assess the immune responses. 143 babies and more than 6000 biological samples were collected during the study. To date, outputs from this study have been presented at: The European Federation of Microbiology (Valencia Spain); The Neonatal Society (Dublin, Ireland); The London Microbiome Meeting (GSST, London); The Pediatric Academic Society Meeting (Toronto, Canada) and the British Society of Immunology (London).

Discover Study - The DISCOVER study is a clinical trial of PrEP to test whether a combination of emtricitabine and tenofovir alafenamide (F/TAF) is as safe and effective as Truvada® (emtricitabine and tenofovir disoproxil fumarate, F/TDF) at reducing the risk of HIV infection when used as PrEP. F/TAF was recently approved for HIV treatment, but it is not yet known whether it is effective as PrEP

This international multi-site study is a double blind randomised controlled trial where participants in the study are randomly allocated to get either active Truvada® and placebo F/TAF or active F/TAF and placebo Truvada®. Neither the participants nor the study clinicians will know which drug the participant is taking until the end of the study. Participants are followed up three monthly for two years and are told which drug they were getting at the end of study follow up.

The eligible population for this study is men who have sex with men and transgender women who have sex with men. This study is funded by Gilead Sciences and enrolled 5000 patients at 92 study sites across the United States, Canada and Western Europe. Homerton recruited 49 patients in to this study and currently everyone in follow up.

APPIPRA - Rheumatoid arthritis (RA) is a chronic autoimmune disease and can affect any racial group with a higher rate in women. It causes painful, stiff and swollen joints that if left untreated can lead to deformity of synovial joints and significant disability.

There is no cure for RA but Professor Andrew P Cope and his team at Kings College London are trying to determine if it can be prevented with their trial 'Arthritis Prevention in the Pre-Clinical Phase of RA with Abatacept' (APIPPRA).

APIPPRA is one of 11 studies that Homerton is currently running within the Rheumatology Department. It is a randomised, multicentre, placebo controlled, double-blind clinical trial of abatacept. APIPPRA closed to recruitment earlier this year having met the target of 206 subjects, five of whom who were recruited here at Homerton.

Abatacept is a new drug in the class of 'selective costimulation modulators' and is already licenced for the treatment of RA. Participants were eligible if they have the presence of arthralgia and are positive for rheumatoid antibodies but do not yet have joint swelling. They were given a year's course of either a placebo or abatacept.

We are now in the follow-up phase of this trial and meet with each participant every three months for a further year. We are collecting data including DNA samples, routine bloods, x-rays, joint ultrasounds, Disease Activity Scores, clinical assessments and quality of life questionnaires.

Patients benefit from being seen by their clinicians at three monthly intervals and from the potential to receive a medication that is not routinely available to those with pre-clinical RA. Their participation will

help to determine the feasibility, efficacy and acceptability of abatacept for RA prevention for future patients in a similar position to themselves.

2.2.4 Goals agreed with Commissioners

Use of the Commissioning for Quality and Innovation (CQUIN) payment framework

The CQUIN payment framework aims to embed quality at the heart of commissioner-provider discussions and indicates that we are actively engaged in quality improvements with our commissioners. Achievement of the CQUIN quality goals impacts on income received by the Trust.

During 2018/19 the Trust continued to work with the Commissioning for Quality and Innovation (CQUIN) scheme to drive quality improvements across the organisation.

A proportion of the Trust income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2018/19 and for the following 12 month period are available electronically at: https://www.england.nhs.uk/nhs-standard-contract/

The monetary total for income in 2018/19 conditional on achieving quality improvement and innovation goals was £6.146m and the monetary total for the associated payment in 2017/18 was £5.464m.

In 2018/19, the Trust continued to hold three major contracts that encompassed a number of CQUIN schemes; the acute services contract, the community health services contract and the NHSE contract (which encompasses specialised services, public health services and acute dental services). However in 2017/18 last year, there was a significant change to the way CQUINS were delivered. For the first time, NHSE published a programme of two year CQUIN schemes. The purpose was to provide more certainty and stability on the CQUIN goals leaving more time for health communities to focus on implementing the initiatives. The current CQUIN programme runs from 2017-2019.

Appendix B provides details of the Trust's 2018/19 CQUINs.

2.2.5 What others say about Homerton

Care Quality Commission (CQC)

Homerton University Hospital NHS Foundation Trust is required to register with the Care Quality Commission. Its current registration status is 'registered with the CQC' with no conditions attached to registration.'

The Care Quality Commission has not taken any enforcement actions against Homerton University Hospital NHS Foundation Trust during the reporting period 2018/19.

There were no special CQC reviews or investigations during the reporting period for the Trust to participate in.

CQC Inspection of acute services.

An inspection of Homerton acute services was carried out by the CQC during April 2018, followed by a 'well-led' inspection in May 2018. The four core services inspected were Urgent and Emergency Care; Medical Care; Surgery; and Maternity care. The CQC took into account the current ratings of the other four services that were not inspected at the time and aggregated these with the services they did inspect, which resulted in the Trust achieving an overall rating of 'Good'. The core services of Urgent and Emergency Care and Medical Care, including older people's care each received the highest rating of 'Outstanding' overall.

The CQC found areas of 'Outstanding' practice across all the core services inspected which are highlighted in the inspection report. Examples of this include

Urgent and Emergency Care

- There was an active quality improvement programme in place which was monitored by two consultants
- The service performed consistently better than the England average for patients admitted, transferred or discharged within four hours between February 2017 and March 2018
- 95% of patients between March 2017 and February 2018 would recommend the service to friends and family
- There were good protocols in place for the recognition and management of sepsis

Medical Care

- The division that managed medical services also included the delivery of local community services which facilitated the integrated delivery of care for patients on their transfer from inpatient to community teams
- Flow through the medical wards was excellent, facilitated by effective streaming of patients through the assessment unit and on to the speciality wards. Despite a busy winter period, patient flow was well managed enough to not need to use the hospital escalation ward
- The Trust had one of the highest rates of referral for patients with sickle cell anaemia and thalassaemia in the UK. The Medical Day Unit provided specialised and targeted health promotion, diagnosis, treatment and follow up (as well as crisis support) for patients
- Medical wards had access to a number of clinical nurse specialists to meet the needs of local patients. This included access to a dementia support team, mental health liaison, critical care outreach and various oncology nurse specialists

The CQC highlighted a number of areas for improvement. These included:

- The need to improve the capacity and sustainability of the adult safeguarding team to ensure timely completion of safeguarding referrals and Deprivation of Liberty Safeguards (DoLS) assessments, monitor incidents, provide engagement with other agencies, and ensure the consistent delivery of training for staff
- Increase the mandatory training completion rates for medical staff in Surgery and Maternity to meet the Trust target of 90% and for nursing staff in Surgery who did not meet Trust targets for most mandatory training modules
- Eliminate the inconsistent hand hygiene practices carried out by doctors and midwives in maternity services
- Reduce the varying understanding and gaps in the compliance of the WHO surgical safety checklist and its use among staff in maternity services

An action plan has been developed to address the CQC's recommendations. Good progress is being made against the actions which are monitored and reported on, through divisional and Trust-wide committees.

2.2.6 NHS number and General Medical Practice Code Validity

The patient NHS number is the key identifier for patient records. Accurate recording of the patient's General Medical Practice Code (Patient Registration) is essential to enable the transfer of clinical information about the patient from a Trust to the patient's General Practitioner (GP).

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

The percentage of records in the published data for **April 18 – Mar19**:

- which included the patient's valid NHS number was:

SUS Dataset	Trust	London	National	Performance against London	Performance against National
Admitted Patient Care	99.0%	98.3%	99.5%		
Outpatients	99.7%	98.5%	99.6%		
A&E	94.7%	94.8%	97.6%		

- which included the patient's valid General Medical Practice Code was:

SUS Dataset	Trust	London	National	Performance against London	Performance against National
Admitted Patient Care	100.0%	99.9%	99.9%		
Outpatients	100.0%	99.9%	99.8%		
A&E	99.9%	99.2%	99.3%		

The Trust continues to focus on this area to ensure that high quality information is available to support the delivery of safe, effective and efficient clinical services and support accurate and complete data submissions.

2.2.7 Information Governance (IG)

Information Governance ensures necessary safeguards for, and appropriate use of, patient and personal information. The Information Governance Toolkit is a performance tool produced by the Department of Health (DH) and now hosted by NHS Digital. It draws together the legal rules and central guidance related to Information Governance and presents them in one place as a set of Information Governance requirements.

The Trust submitted evidence in support of all the mandatory elements of the new Data Security and Protection Toolkit in March 2019. The Trust did not meet the 95% mandatory IG training compliance standard and an improvement plan has been agreed with NHS Digital.

2.2.8 Clinical coding error rate

Clinical coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard recognised codes. The accuracy of this coding is a fundamental indicator of the accuracy of patient records.

Clinical coders collect, collate and code clinical information, relating to the diagnosis and operations for the patients admitted to the hospital. This data is essential for the effective management of the Trust, and also forms the basis for clinical audit, clinical governance reporting and payment.

Homerton was not subject to the Payment by Results (PbR) clinical coding audit during 2018/19 by the Audit Commission. The Audit Commission has closed.

The Clinical Coding department supports patients' care by providing ICD-10 DIAGNOSTIC codes and OPCS procedure codes that are used for a variety of purposes, including payment and Hospital Standardised Mortality Ratios. The department codes around 70,000 admitted spells (approx. 93,000 FCEs) a year across a wide range of specialities.

The Trust has an internal Clinical Coding Audit post that is responsible for auditing the accuracy of the Trust's clinical coding on a monthly basis. This is further supported through specific external audits undertaken by independent coding auditors to ensure that the accuracy of the Trust's coding is of a sufficient standard. In 2018/19, an external audit was undertaken in Trauma & Orthopaedics the results of which are set out below. The aims of these audits were to focus on improving the quality of our data and focus on providing a high quality, accurate coding service.

- Primary diagnosis correct 95.2%
- Secondary diagnosis correct 80.2%
- Primary procedures correct 85.1%
- Secondary procedures correct 83.9%

The results should not be extrapolated further than the actual sample audited. 167 FCEs were sampled.

2.2.9 Actions to improve data quality

Accurate and timely data is essential to provide robust intelligence and allow sound clinical and strategic decisions to be made. The Trust continues to ensure that high quality information is available to support the delivery of safe, effective and efficient clinical services and support accurate and complete data submissions.

A Data Quality Committee chaired by the Chief Operating Officer met four times last year. Through the use of data quality indicators for both acute and community services the committee is a vehicle for data quality improvement and awareness within the Trust. The committee promotes and maintains robust processes for creating and managing accurate information within the organisation and ensuring that information that leaves the organisation is of the highest quality.

The Trust will be taking the following additional actions to improve data quality in 2019/20.

- Engage in relevant national conferences and workshops in relation to clinical coding standards.
- Develop further new data quality indicators.
- Provide staff with any additional training and developmental support required or identified to maintain skills, knowledge and data management.
- Implement a formal internal rolling programme of audit.
- Maintain close working relationships with clinical services.
- Continue to use benchmarking data to enable the Trust to identify areas of opportunity i.e. where the Trust is benchmarked as being a negative outlier.
- Develop internal programme of quality improvement to ensure the availability of clinical information is enhanced, thus ensuring clinical coders have easy and quick access to all relevant clinical information.
- Engage an external auditor to undertake a comprehensive independent review of the Trust's clinical coding.

2.2.10 Learning from deaths

This is section of the Quality Report that NHS Trusts are required to include was introduced in 2017/18. In March 2017 the National Quality Board published a document called 'National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care'. The purpose of the guidance was to help initiate a standardised approach to learning from deaths.

All deaths are reviewed by the primary clinical team and also discussed at a multi-professional forum to learn from every death.

During 2018/19, 387 patients died at Homerton Hospital. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 91 in the first quarter
- 79 in the second quarter
- 112 in the third quarter
- 105 in the fourth quarter

By 31 March 2019, 296 case record reviews and 10 investigations have been carried out in relation to 387 of the deaths during 2018/19

In 11 cases a death was subjected to both a case record review and an investigation.

The total number of deaths reviewed was 296. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 75 in the first quarter
- 64 in the second quarter
- 98 in the third quarter

- 59 in the fourth quarter (as of 30th April 2019)

7 of the 387 (1.8%) of patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- 3 of the 75 deaths (4%) reviewed for the first quarter
- 1 of the 64 deaths (1.6%) reviewed for the second quarter
- 1 of the 98 deaths (1%) for the third quarter
- 2 of the 105 deaths (1.9%) for the fourth quarter (as of 30th April 2019)

2 representing 1.3% of the patient deaths during quarter 4 of 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

These numbers have been achieved using the CESDI score methodology supported by the learning from deaths guidance.

Please see below a summary of some of the learning identified following case record reviews and investigations for 2018/19:

- Lack of focus on advanced care planning in oncology patients
- Delayed transfers of care.
- Difficulty starting individualised end of life care plan when family may not agree
- Good palliative care input.
- Delays in transfers to Nursing Homes may add to risk of decline.
- Difficulty establishing preferred place of death/appropriate discharge location
- Death certification information/discharge letters not on EPR.
- Appropriateness of ITU interventions.
- Delays in discharge preventing meeting Preferred Place of Death (PPD).
- Communication with family as well as with professional teams.
- Delay in appropriately focused diagnosis and/or treatment.

Please see below a summary of the actions which the Trust has taken in 2018/19 and actions it proposes to take following the reporting period as a result of the learning.

- Implementation of an online mortality review tool.
- Developed a formal checklist for blood gases to ensure entire sample is reviewed in a systematic manner.
- Audit of NEWS scores
- Developed a Poster detailing all the vascular access mid lines and long lines utilised in the trust to be displayed in the CT control room.
- Review by Thrombosis Committee of the two thrombolytic agents in use in the Trust.
- Staff to receive training on pain in delirium.
- Review of written consent process in gynaecology
- Raised awareness about aortic dissection.

Please see below a summary of the impact of actions taken in 2018/19

Deteriorating Patients

It was recognised that there were a number of issues with the management of deteriorating patients, including delays in escalation to ITU, lack of or slow escalation, tolerance of abnormal physiology and poor handover. As a result, the Deteriorating Patients task and finish group was relaunched at the request of the Medical Director in September 2018, with a remit to look at education, NEWS 2

implementation, to review the hospital at night model and to develop guidelines for escalation and referral to critical care.

There have been a number of key achievements:

- Improved nursing escalation – from August to December 2018, the number of patients with a NEWS score of 5 or over who were escalated appropriately increased from 53% to 73%. The documentation is significantly better, and the changed assessment in EPR has also helped.
- There has been a reduction in delayed ITU referrals, reduction in inadequate medical team response and delayed nursing response, and fewer incidents recorded of staff tolerating patients with high oxygen requirements.
- Reduced number of bleeps going to the wrong place at night time.

The Group is led by the Medical Director, Chief Nurse and Clinical Lead for the Acute Care Unit, with support and input from the Chief Registrars, ITU, ED, IT, surgery, the Critical Care Outreach Team, the Simulation Lead, Education and Training and the Patient Safety Team.

Online Mortality Review Tool

The Trust ability to track and report on mortality reviews has improved since the introduction of the mortality review tool and additionally the number of reviews is increasing and all deaths are being reviewed in a multidisciplinary forum to facilitate learning.

Over the last year, the Trust has been developing an online Mortality Review Tool. The tool has been developed under the guidance and leadership of the Medical Director and the Specialty Mortality leads, who have played a crucial role in ensuring the tool is fit for purpose. The tool is a live web-based system, linked to EPR, which is designed to help clinicians review deaths in a systematic and consistent way. It is based on the existing paper-based tool, and is accessible to all staff involved in the mortality review process.

There are a number of advantages over the existing paper based system, including:

- Ability to identify and track themes and areas of good practice.
- Ability to record family concerns so that they can be linked to the review process
- Automatic link to EPR, so that teams can more easily identify the patient deaths requiring a mortality review
- Area to record details of SI investigations to better link up learning.
- Improved reporting so that data, themes and learning can be more easily identified, and so that reminders can be sent where reviews are overdue.

Following implementation of our online mortality review tool in October 2018 we have been better able to draw together more comprehensive learning and aim to strengthen the way we share learning. This will have the net effect of providing clarity around themes which may not have been joined up across the organisation previously.

The impact of the implementation of the online tool will in time allow identification of high impact communication streams and projects as a consequence of thematic learning as well as consolidating the existing newsletter process.

Coordinate My Care

The Trust collaborates actively with City and Hackney primary care colleagues to allow system wide participation in Coordinate My Care (CMC). CMC is used as the shared urgent care plan to improve patient care. A CMC care plan supports a patient if they have an urgent care need. Health care professionals should be more informed about the patient they are attending to and better able to provide care in accordance with the patient's needs and wishes. A CMC care plan should help to

avoid unnecessary hospital admissions as well as improving coordination of care for patients at the end of life by giving professionals the information they need at the first point of contact with a patient in an urgent care situation.

CMC has been adopted in City and Hackney for the following groups of patients:

- End of Life Care Register
- Proactive Care Practice Based Register (including High Intensity Users)
- Proactive Care Home Visiting Register
- C&H Nursing Home Patients
- Patients with Dementia under the Diagnostic Memory Service (ELFT)

The first phase has achieved the creation of care plans and work is continuing to ensure there is access to those care plans by the wider urgent care system and that the care plans are of sufficient quality to be fit for purpose.

2.2.11 Seven day services

NHS trusts are required to include a statement in their Quality Report regarding implementation of the priority clinical standards for seven day hospital services. Ten clinical standards for seven day services in hospitals were developed in 2013. These standards define what seven day services should achieve, no matter when or where patients are admitted. 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

Homerton made good progress with implementation of the four standards and has met both standards five and six.

Two main challenges exist with regard to standard two. Firstly given the relatively low numbers of patients developing appropriate consultant rotas across surgical specialities has been a challenge. Following recent work undertaken the Trust would expect performance to improve in future. Secondly the challenge exists with regards to overnight admissions in terms of prioritising the review of acutely unwell patients against chronological review of all admissions on the morning post take ward round. It is important to stress that those patients not reviewed within 14 hours missed the expected timely review by a short margin.

With regard to standard eight the Trust's current model is to have 12 hour consultant presence on the Acute Care Unit seven days a week. This means all admissions during this period are reviewed in real time and critically unwell patients are reviewed as regularly as necessary. This model ensures the daily review of over 90% of emergency admissions, however it doesn't cater for two structured ward rounds as stated in the standard. There is no current evidence that this leads to any detriment in patient care or missed opportunities for early recognition of deteriorating patients.

2.2.12 Speak up Safely

The Trust has a Freedom to Speak Up: Raising Concerns at Work (Whistleblowing) Policy and Procedure in place which details how staff can raise concerns informally and formally as well as the feedback mechanisms required when concerns are raised. It also includes protections for staff raising

concerns. The Trust Board of Directors receives a six monthly Raising Concerns at Work report which includes content from the Freedom to Speak Up Guardians as well as additional information on live/closed formal cases that have occurred in the reporting period.

In addition there are two Freedom to Speak up Guardians in the Trust to promote the need for staff to speak up where issues of concern arise as well as support them in doing so. In addition there are two designated Board Leads one Executive Director and one Non-Executive Director.

2.2.13 Rota gaps.

Homerton has had a Guardian of Safe Working in place since the implementation of the new junior doctors' contract in 2016. Their role is to monitor the exception reports that come in and ensure any issues are addressed in a timely manner. Currently we have a 92% fill rate across medical and dental. Any vacancies in rota's are filled on a temporary basis by bank or agency doctors, whilst the post is advertised and a substantive/fixed term doctor is appointed. In the last six months we have advertised on 50 occasions for junior or senior clinical fellow posts. The Trust Board of Directors receives reports from the Guardian of Safe Working which includes details on fill rate and actions taken across the trust to support junior doctors.

2.3 Reporting against core indicators

All NHS foundation trusts are required to report performance against a core set of indicators using data made available to the Trust by NHS Digital. Where the required data is made available by NHS Digital, a comparison has been made with the national average and the highest and lowest performing trusts. The data published is the most recent reporting period available on the NHS Digital website and may not reflect the Trust's current position (please note that the data period refers to the full financial year unless indicated). All data provided is governed by standard national definitions.

All Trusts are also required to include formal narrative outlining the reasons why the data is as described and any actions to improve.

1. Summary Hospital-level Mortality Indicator (SHMI) and patient deaths with palliative care

The SHMI reports on mortality at trust level across the NHS in England. SHMI is the ratio between the number of patients that die following hospitalisation and the number of patients expected to die based on the national average and on the particular characteristics such as comorbidities of our patients.

It reports on all deaths of patients who were admitted to hospital and either died whilst in hospital or within 30 days of discharge. The Standardised Hospital Mortality Indicator is unaffected by palliative care coding.

SHMI has three bandings: higher than expected, as expected as and lower than expected. If the number of deaths falls outside the 'as expected' range, then the Trust will be considered to have either a higher or lower SHMI than expected. A 'higher than expected' SHMI should not automatically be viewed as bad performance, but rather should be viewed as a 'smoke alarm', which requires further investigation. Conversely, a 'lower than expected' SHMI does not necessarily indicate good performance.

If you would like to know more about how these ranges are calculated, then please refer to the NHS Digital website at: https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts

Table 3: Summary Hospital Level Mortality Indicator data

Indicator	Reporting Period	Homerton Performance	National Average	Highest Performing Trust	Lowest Performing Trust
(a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period	Oct 2016 – Sept 2017	Value: 0.87 Banding: 3	Value: 1.01	Value: 1.25 Banding: 1	Value: 0.73 Banding: 3
	Oct 2017 – Sept 2018	Value: 0.69 Banding: 3	Value: 1.00	Value: 1.27 Banding: 1	Value: 0.69 Banding: 3
	Jan 2018 – Dec 2018	Value: 0.76 Banding: 3	Value: 1.00	Value: 1.23 Banding: 1	Value: 0.699 Banding: 3
(b) The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.	Oct 2016 – Sept 2017	45.4%	31.6%	11.5%	59.8%
	Oct 2017 – Sept 2018	43.6%	33.8%	14.3%	59.5%
	Jan 2018 – Dec 2018	46%	34%	15%	60%

Data source: Latest figures available on NHS Digital

Assurance statements

The Trust considers that this data is as described for the following reasons:

The data is produced using a recognised national agency and adheres to a documented and consistent methodology. The Trust recognises and is assured by its benchmarked position as having one of the lowest SHMI in the country.

The Trust intends to take the following actions to sustain and improve the SHMI, and so the quality of its services:

- Providing regular learning events and resources for all staff to facilitate learning from incidents and findings from unexpected deaths.
- Ensuring that all inpatient deaths are systematically reviewed, and that any failings in care that suggest a death may have been avoidable are identified, systematically shared, learned from, and addressed.

2. Patient Reported Outcome Measures (PROMS)

Patient Reported Outcome Measures (PROMS) is a tool used to identify the quality and effectiveness of care delivered to NHS patients based on the patients' perception. It covers four clinical procedures:

- Hip replacements (primary and revisions)
- Knee replacements (primary and revisions)
- Groin hernia
- Varicose vein (Homerton Hospital does not participate in this PROM as we do not provide this type of operation)

A patient will complete two questionnaires: one prior to surgery and one six months after surgery. These questionnaires ask patients about their health and quality of life (as well as the effectiveness of the operation) before and after surgery.

Completion of these questionnaires is voluntary and the patient's consent to participate must be granted in order for the data to be used.

Table 4: Average adjusted health gain for hip replacement, knee replacement and groin hernia surgery.

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
Total Hip Replacement Surgery	Apr 2016 – Mar 2017	**0.467**	0.437	0.329	0.533
	Apr 2017 – Mar 2018	**0.476**	0.458	0.357	0.550
Total Knee Replacement Surgery	Apr 2016 – Mar 2017	**0.334**	0.323	0.259	0.391
	Apr 2017 – Mar 2018	**0.332**	0.337	0.254	0.406
Groin Hernia Surgery	Apr 2016 – Mar 2017	**0.048**	0.086	0.006	0.135
	Apr 2017 – Mar 2018	**No data***			

Data source: Latest figures available on NHS Digital

*PROMs data was collected on groin hernia procedures in England, however following on from the NHS England Consultation on PROMs, collection of these procedures ceased on 1 October 2017. Finalised data for groin hernia procedures up until September 2017 has been published. Submission figures of less than 30 do not allow calculation of the adjusted health gain. HUHFT submitted 25 groin hernia records between April and Sept 2017.

Assurance statements

The Trust considers that this data is as described for the following reasons:

- Homerton Hospital has processes in place to ensure that relevant patient cohorts are provided with pre and postoperative questionnaires.
- There has been sustained improvement in outcomes for total hip and total knee replacements. This is consistent with data collected by the trust for improvement projects, such as the opening of the ring fenced elective orthopaedic ward, and patient feedback questionnaires.

The Trust intends to take the following actions to sustain and improve the PROMS, and so the quality of its services.

- Review of how we collect PROMS data. We are currently trialling an electronic system to collect PROMS. It is anticipated this will allow for a fuller dataset, i.e. increased six month PROMS completion and allow the service to be more responsive to patient feedback.
- Review of Enhanced Recovery Protocol to improve the patient's immediate post op recovery.
- Reviewing PROMs data and findings and discussing these within relevant departments.
- Reviewing PROMS data on a bimonthly basis through the Improving Clinical Effectiveness Committee.

3. 28 day emergency readmission rate

This indicator on the NHS Digital portal was last updated in December 2013 for the 2011/12 reporting period. Due to their 'statistical method' in continuous inpatient spell (CIP) construction, we are unable to replicate the data produced by NHS digital (the national standardisation process involves external data sources that we do not have access to). However, the information provided below is based on our internal dataset and NHS digital methodology without the standardisation applied.

Table 5: 28 day readmission rates for patients aged 0 – 15 and aged 16 and over.

Indicator	Reporting Period	Homerton Performance
The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 0-15	2016/17	3.63%
	2017/18	4.66%
	2018/19	4.36%
The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 16 or over	2016/17	12.7%
	2017/18	11.95%
	2018/19	12.60%

Data source: Latest figures available on NHS Digital

The Trust is unable to provide national comparative data for this measure due to data not being available on the NHS Digital website.

Assurance statements

The Trust considers that this data is as described for the following reasons:

The Trust has a robust clinical coding and data quality assurance process, and readmission data is monitored through the Trust Management Board on a monthly basis.

The Trust intends to take the following actions to sustain and improve the 28 day readmission rate, and so the quality of its services.

- Working together with partners across Hackney to develop the concept of 'neighbourhoods' which will allow better coordination and integration of geographically

based community services. A key metric for neighbourhoods will be to readmissions, as the aspiration is that better coordinated and integrated services should allow patients to be discharged more safely and cared for at home to prevent the requirement for readmission.

- We will work with the new Head of Information to develop our information capacity and systems, so that local services can drill down seamlessly from Trust wide through divisional to local level in order to permit more real time tracking and interventions to reduce readmissions.

4. Responsiveness to personal needs of patients.

The indicator value is based on the average score of five questions from the National Inpatient Survey, which measures the experiences of people admitted to NHS hospitals.

Table 6: responsiveness to the personal needs of patients

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
The Trusts responsiveness to the personal needs of its patients during the reporting period.	2016/17	**66.3**	68.1	60.0	85.2
	2017/18	**68.1**	68.6	60.5	85.0

Data source: National Inpatient Survey

Assurance statements

The Trust considers that this data is as described for the following reasons:

The Trust uses an approved contractor, Picker Institute to collect the required data which follows the methodology set out by the CQC.

Whilst we have improved since 2016/17 we have performed just below the national average for our responsiveness to the personal needs of our patients in 2017/18.

The Trust intends to take the following actions to sustain and improve the responsiveness to personal needs of patients, and so the quality of its services by:

- Improving communications between ward and community services to improve discharge planning
- Implementing improvements in the care of patients with dementia
- Implementing Learning Disability awareness training for staff
- Implementing actions in relation to nutrition and hydration overseen by the Nutrition Steering Group
- Implementing the 'Hearing the voice of the child' project on Starlight Ward
- Launching the trust End of Life care strategy

5. Staff recommending the Trust as a place to work or receive treatment to Family and Friends.

The National NHS Staff Survey provides the opportunity for organisations to survey their staff in a consistent and systematic way on an annual basis and benchmark their results against each other.

Obtaining feedback from staff, and taking into account their views and priorities is vital for driving real service improvements across the NHS.

Table 7: Staff recommending the Trust to family and friends.

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
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	2017	**73.4**	70.2	48.0	89.3
	2018	**75.1**	69.9	49.2	90.3

Data source: National Staff Survey

Assurance Statements

The Trust considers that this data is as described for the following reasons:

- The Picker Institute conducted the survey on behalf of the Trust and all full and part time staff employed by the organisation on the 1st September 2018 (with certain specific exclusions) had the opportunity to complete the survey electronically between September to December 2018. The Trust achieved a return rate of 52.4%, which represented a 2.4% point increase from 2017 (50%).
- We have performed above the national average for staff recommending friends and family as a place to be treated with the score improving by more than one percent since 2017.

The Trust intends to take the following actions to sustain and improve the percentage of staff recommending the Trust to their friends and family, and so the quality of its services.

We will act on this information responsively to drive further improvements in engagement levels by:

- Ensuring the organisation acts fairly: career progression.
- Reviewing the Staff Engagement Action Plan in light of the 2018 Staff Survey results (key features of the plan including those areas where results were not so positive when benchmarked against comparator).
- Responding to our latest staff survey under the themes of equality and diversity; career progression and recognition; leadership strategy; staff health and wellbeing; reward and recognition; and Trust values.

6. Patients recommending the Trust to Family and Friends

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. Listening to the views of patients and staff helps identify what is working well, what can be improved and how.

The FFT asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism

to highlight both good and poor patient experience. This kind of feedback is considered vital in transforming NHS services and supporting patient choice.

Table 8: Patients recommending the Trust to family and friends.

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
Percentage of patients who would recommend the Trust to their family and friends. (inpatient)	2017/18	94.5%	95.6%	54.5%	100%
	2018/19	93.7%			
Percentage of patients who would recommend the Trust to their family and friends. (A&E)	2017/18	93.0%	86.4%	59.2%	98.3%
	2018/19	92.7%			

The Trust is unable to provide national comparative data for this measure in 2018/19 due to data not being available on the NHS Digital website.

Assurance statements

The Trust considers that this data is as described for the following reasons:

- The Trust follows the guidance and methodology as set out by the Department of Health in the provision of data to Optimum Healthcare.
- A process is in place to ensure that data is quality assured prior to being uploaded onto the national reporting system UNIFY.

The Trust intends to take the following actions to sustain and improve the percentage of patients recommending the Trust to their friends and family, and so the quality of its services.

- Review of how data on Friends and Family is collected and utilised. This will be overseen by the Improving Patient Experience Committee.
- Use Perfect Ward and Chief Nurse Rounding to ensure that feedback is provided in clinical areas to patients on actions taken as a result of feedback.
- Triangulate FFT date with wider patient experience data to agree areas for further improvement.

7. Rate of admissions assessed for VTE

Venous Thromboembolism (VTE) is a significant cause of mortality, long-term disability and chronic ill-health problems – many of which are avoidable. 1 in 20 people will have a VTE at some time in their life and the risk increases with age. It is estimated that as many as half of all cases of VTE are associated with hospitalisation for medical illness or surgery. VTE is an international patient safety issue and its prevention has been recognised as a clinical priority for the NHS in England.

Table 9: Rate of admissions assessed for VTE

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust

The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	2016/17 (full year)	**96.2**	95.6	79.1	100
	April-June 2017/18	**97.0**	95.2	51.4	100
	July-Sept 2017/18	**96.7**	95.3	71.9	100
	Oct-Dec 2017/18	**97.4**	95.4	76.1	100
	Jan-Mar 2017/18	**96.6**	95.2	67	100

Data source: Latest figures available on NHS Digital

Assurance statements

The Trust considers that this data is as described for the following reasons:

- Homerton has consistently met or exceeded the national average for patients admitted who received a documented risk assessment for VTE. This is through an on-going programme for education, training and user prompts on the hospital-wide electronic medical record under the regular review of the Trust Thrombosis Committee.

The Trust intends to take the following actions to sustain and improve the percentage of patients risk assessed for VTE, and so the quality of its services.

- All hospital acquired VTEs are recorded on Datix and investigated through the incident review process.
- Trust Thrombosis Committee (TTC) reviews serious incidents and hospital acquired thrombosis to look for any systematic issues.
- Working with the GP Confederation that has been commissioned to provide a community anticoagulation service for Hackney to ensure patients receive an integrated service.

8. *Clostridium difficile* rate (*C. difficile*)

Acute hospitals in England are required to report all C.difficile toxin positive stool samples in those patients over two years of age. During the 2018/19 reporting period we have had three Homerton Hospital attributable cases against our national threshold of no more than 10 cases. This is significantly less than the 10 Homerton Hospital attributable cases in 2017/18. In addition the hospital has admitted patients who acquired *C.difficile* prior to admission. The Trust continues to report low number of cases when compared to other trusts across England. Review of these cases is still in progress by the Trust's clinical commissioning group. Patient management issues arising from the Root Cause investigations included the time from start of symptoms to taking a stool specimen & thus commencement of appropriate precautions. The *C.difficile* rate per 100,000 days as shown is sourced from the DH website and is up to end July 2018. It represents the latest published comparable data available. It shows a slight increase in our rates from the previous year. However we compared favourably to other London trusts and we are significantly below the national average.

Table 10: The rate per 100,000 bed days of cases of *C.difficile* infection.

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust

The rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	2016/17	**3.3**	14.9	66.0	0.0
	2017/18	**8.9**	13.7	82.7	0.0

Data source: Latest figures available from Public Health England data collection

Table 11: The total number of cases of *C.difficile* infection.

Indicator	Target 2018/19	2018/19	2017/18	2016/17
Number of Clostridium Difficile (C-diff) cases.	10	3	10	4

Data source: Latest figures available from Public Health England data collection

Assurance Statements

The Trust considers that this data is as described for the following reasons:

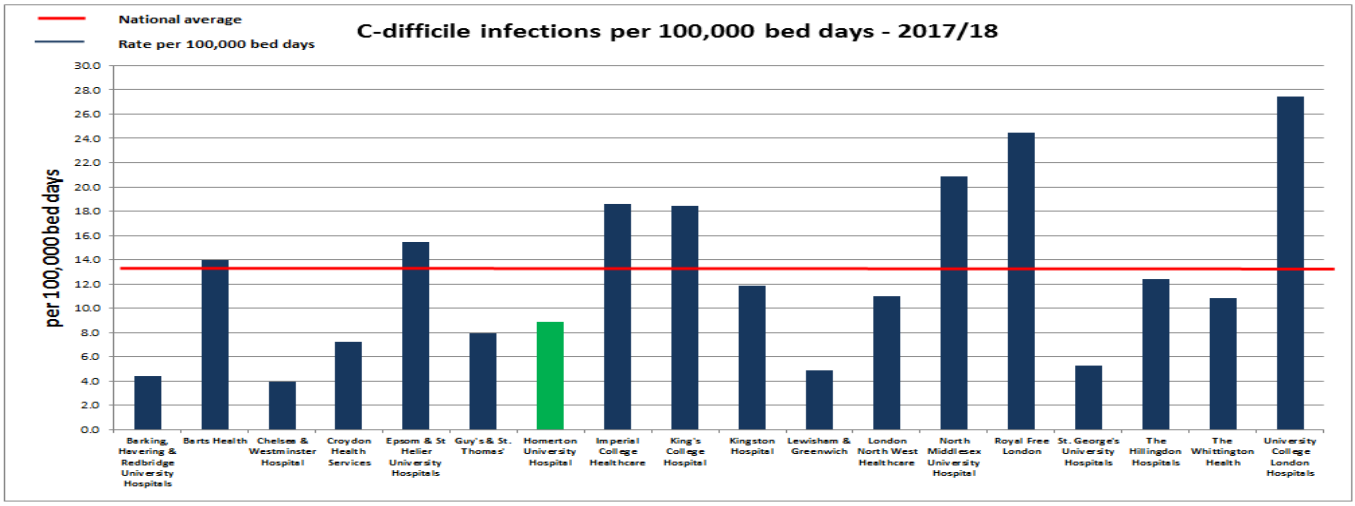
The data has been sourced from the Department of Health website and validated against the Trust's internal data derived from the pathology laboratory and inputted onto the Public Health England mandatory surveillance system. There is a defined process for checking data at a number of levels which include daily reports from the laboratory, reporting of cases as incidents with a post infection review and monthly sign off by the Director of Infection Prevention and Control.

The Trust continues to work hard at reducing the risk of C-difficile infection to our patients including continuously improving our already embedded processes for risk reduction by antimicrobial stewardship, prompt identification of possible cases and laboratory testing processes.

The Trust intends to take the following actions to sustain and improve the rate of *C-difficile* infection, and so the quality of its services.

- Raised profile of *C.difficile* mandatory induction & update training.
- Focus on timely isolation of all ward patients with diarrhoea whilst awaiting results.
- Focus on timely sample testing of all diarrhoeal stools enabling prompt identification of *C-difficile* positive cases.
- Environmental decontamination by deep cleaning and going forward hydrogen peroxide vapourisation (HPV).
- Focus on clutter reduction in ward environments to enable high standards of cleaning.
- Regular audits to ensure compliance with national and local guidelines.
- Daily antimicrobial stewardship reviews of antimicrobial prescribing.
- Root Cause Analysis investigation of every case to identify lessons to be learnt and feedback to the multidisciplinary teams and into the governance structure to ensure learning across the Trust.

Figure 1: *C.difficile* rate in London NHS Trusts 2017/18



9. Patient safety incidents

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare. Reporting them supports the NHS to learn from mistakes and to take action to keep patients safe. Patients should be treated in a safe environment and protected from avoidable harm.

Homerton actively encourages its staff to report all adverse incidents that have either caused harm or have the potential to cause harm during their care at the Trust. This is to ensure an open and transparent culture and promote organisational learning from safety incidents with the intention of preventing similar incidents from reoccurring in the future. Like NHS England, the Trust considers its high reporting culture as a 'positive indicator of its healthy safety culture, giving organisations the chance to learn and improve'.

Table 12: Reported Patient Safety Incidents

Indicator	Reporting Period	Homerton Performance	National Average*	Lowest Performing Trust*	Highest Performing Trust*
Number of patient safety incidents	Apr – Sept 2017	**2951**	5226	1133	15228
Rate of patient safety incidents (per 1000 bed days)		**52.9**	42.8	23.5	111.7
Number (%) of patient safety incidents resulting in severe harm or death		**11 (0.37)**	18	0 (0)	121 (1.97)
Number of patient safety incidents	Oct 2017 – March 2018	**3151**	5449	1311	19897
Rate of patient safety incidents (per 1000 bed days)		**56.9**	42.6	24.2	124.0
Number (%) of patient safety incidents resulting in severe harm or death		**4 (0.13)**	19	0 (0)	99 (1.56)

Data source: Latest figures available on NHS Digital
*based upon all the Acute (non-specialist) Trusts

Assurance statements

The Trust considers that this data is as described for the following reasons:

- The Trust has reported more incidents in the second reporting period above in comparison with the first reporting period.

- The Trust has a much higher rate of incidents reported per 1000 bed days than the national average.
- The Trust has a lower rate of serious harm and death incidents than the national average.
- The Trust aims to promote a just culture to ensure that staff feel confident to report incidents and this is reflected in the numbers of incidents reported, particularly near misses and incidents resulting in low harm.

In addition:

- The Trust has a robust process to ensure rigorous incident management. All incidents are reviewed at weekly divisional or corporate CLIP (Complaints, Litigation, Incidents and PALS) meetings and themes and trends reviewed at monthly divisional governance meetings. Trust Management Board receives quarterly updates from the Divisions.
- During 2018/19, the Trust has worked to improve the electronic incident reporting system (Datix) so that staff can report and investigate incidents more effectively. This has included training and engagement sessions with teams and individuals across the Trust.
- The Trust has strengthened its processes around Serious Incident (SI) and internal root cause analysis investigations, to ensure that reports are completed by appropriately trained investigators within agreed timescales.
- An Assurance Panel has been established to quality assure and approve all SI and RCA investigation reports. This is chaired by the Chief Nurse and attended by the Divisional Leads to ensure a robust approval process.

The Trust intends to take the following actions to sustain and improve this indicator further, and so the quality of its services.

- We continue to consider ways to improve our incident reporting processes through induction training and raising staff awareness to ensure staff feel confident and able to report incidents.
- Undertaking a full review of the incident reporting system (Datix) to identify areas for improvement across all the modules.
- In addition to induction training for new starters on incident reporting, the Quality and Patient Safety team will be delivering training on Datix and incident reporting to staff in both the acute and community settings. The aim is to further develop staff capacity and capability as well as confidence in reporting patient safety-related incidents.
- Further work to provide feedback to staff who report incidents, so that they can realise the benefits or improvements to patient safety and care that have resulted from the incident(s) they reported.
- Improving the ways in which learning from investigations is shared across the organisation, using better and more consistent use of existing channels including divisional and team meetings. The aim is to also look at other ways of sharing learning and promoting change, including closer working with the Quality Improvement team and the Training and Development teams.
- Continuing to build closer links with the legal, complaints and PALS teams to ensure that information is shared in a more useful and timely fashion, and so that themes that cut across complaints / incidents / claims etc can be identified.
- Ensuring that actions and lessons learned from investigations are followed up in a consistent and systematic way so that there is assurance across the Trust that actions have been completed.

PART 3: OTHER INFORMATION

This section of the Quality Account provides information on our quality performance during 2018/19. Performance against the priorities identified in our previous quality account and performance against the relevant indicators and performance thresholds set out in NHS Improvement's Risk Assessment Framework and Single Oversight Framework are outlined. We are also proud of a number of initiatives which contribute to strengthening quality improvement systems. An update on progress to embed these initiatives is also included in this section.

3.1. REVIEW OF QUALITY PERFORMANCE

Performance against priorities identified for improvement in 2018/19

We agreed a number of priorities for improvement in 2018/19 published in last year's Quality Account. These were selected in conjunction with internal and external stakeholders.

Patient Safety (Safe)

Priority 1 - To prevent the number of community and hospital attributed pressure ulcers. – Partially Achieved

Background

The development of a pressure ulcer can cause significant long term harm both physically and mentally to a patient. This coupled with the impact of the resultant extended inpatient/community care provision can create avoidable financial pressures.

Our target was to reduce the number of avoidable grade 3 and 4 pressure ulcers in both the hospital and community by 10% and to reduce the number of avoidable grade 2 pressure ulcers in both the hospital and community by 5%

Our success measures have been

For the full year there has been a quarter on quarter reduction in the number of grade 3/4 community and hospital acquired pressure ulcers. However the reported numbers remain high and the target of a 10% reduction in ulcers was met for hospital acquired but not community acquired.

For grade 2 attributable pressure ulcers there has also a reduction quarter on quarter however the target of a 5% reduction has been met for community acquired ulcers but not for hospital acquired.

What did we achieve to date?

The format of the Pressure Ulcer Scrutiny Committee (PUSC) has been revised and relaunched in January 2019 with the aim being to provide a more structured opportunity for shared learning, identification of contributing factors and how these can be addressed to aid reduction.

The Trusts processes for the identification and management of pressure ulcers has been reviewed and updated in line with the publication of the NHSI – Pressure ulcers: revised definition and measurement framework.

We can evidence progress through

- Revised terms of reference for PUSC
- Minutes of meetings held

- Revised guidance.

What will we do in 2019/20 to continue improvements?

- Continue with this important priority in 2019/20.
- Review of the effectiveness of the revised PUSC
- Development of a pressure ulcer dashboard on Datix
- Provision of information at ward and team level to support the strategic information currently provided
- Quarterly thematic review of contributing factors identified in PUSC to ascertain what worked and any further action required.

Priority 2 - Improve patients by appropriate management of their nutritional needs. – Partially Achieved

Background

Nutrition and hydration are key factors influencing the health and well-being of patients across all healthcare settings and the Trust's policy for the treatment of malnutrition in adults is based upon the NICE clinical guideline 32: nutritional support in adults; which states that "All hospital inpatients on admission and all outpatients at their first clinic appointment should be screened. Screening should be repeated weekly for inpatients and when there is clinical concern for outpatients".

Our target was to ensure that patients have MUST score assessed and appropriate nutritional management based on the result of the MUST score.

Our success measures have been

The MUST audit completed on the Acute Care Unit in May 2018 indicated 55% of patients were screened within 24hrs of admission against a target of 95). This is a decrease from results of a large audit completed in February 2018 which indicated a 70% uptake and 82% uptake in November 2017.

A subsequent MUST audit undertaken in August 2018 across 8 wards (80 patients) indicated a 73% record of MUST. MUST score is therefore not routinely being accurately recorded on the inpatients wards and work is continuing in collaboration with nursing staff to ensure this measure is assessed and recorded accurately.

The most recent MUST audit undertaken in April 2019 across 10 wards (219 patients) indicated a 75% recording of MUST.

Whilst improvements have been achieved since May 2018 MUST score is not routinely being accurately recorded on the inpatients wards and work is continuing in collaboration with nursing staff to ensure this measure is assessed and recorded accurately and acted upon appropriately.

What did we achieve to date?

A number of actions have been achieved such as:

- A standardised audit tool was produced in collaboration with nursing staff across 8 wards.
- Liaison has taken place with Practice Development Nurse's and training provision enhanced to include:
  - HCA (care certificate) training and essential skills training,
  - Mandatory Nutrition training for nurses increased to 60mins from 30mins

- New MUST training for Band 5 & 6 nurses lasting 1 hour
- Mandatory Nutrition training for nurses training length increased to 60mins
- Online Elsiver training has been established but low uptake as staff prefer face to face training

- The Nutrition Steering Group (NSG) has been re-established - this provides a forum for discussing and recording adherence to quality standards, such as MUST Electronic Recording of MUST - Change request submitted to EPR to indicate if weight recorded is estimated/self-reported or accurate.

We can evidence progress through

- Six monthly audits
- Nutrition steering group bi monthly Meetings

What will we do in 2019/20 to continue improvements?

- MUST 'snapshot' audits to be undertaken twice yearly, including Mary Seacole.
- Nutrition Steering Group to meet bimonthly
- Development of automated MUST Audit reporting per ward via EPR.
- MUST Quality Improvement (QI) projects to be undertaken with support from the QI Team to identifying the barriers and potential solutions to facilitate the improvement of MUST screening and recording.

Priority 3 - To improve identification and response to acutely deteriorating patients. Partially Achieved

Background

Severe sepsis and septic shock have a mortality of 25-35% with approximately 44000 deaths per year in UK (2014/2015 data). Improvement in outcomes of patients suffering from severe sepsis and septic shock can be attributed to timely early management, namely prompt assessment and senior review, initial treatment (sepsis 6) and source search and control.

We need to ensure we have robust systems in place to ensure that we consistently identify deterioration in inpatients in a timely way no matter the cause and ensure an appropriate rapid response. We strive to ensure we are continually reviewing our progress in this area and are committed to continuous quality improvement.

Our targets were:

- To establish a deteriorating patient task and finish group
- Ensure timely identification of patients with sepsis in emergency departments and acute inpatient settings
- Timely treatment of sepsis in emergency departments and acute inpatient settings
- Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours
- Reduction in antibiotic consumption per 1,000 admissions.

Our success measures have been

A multi-professional deteriorating patient task and finish group has been established reviewing the models and resources available to enhance the detection of, and response to, deterioration in adult medical and surgical inpatients out of hours.

Sepsis screening - The results April 18 to January 19 for both acute and emergency demonstrate that 98% of all patients that met the criteria for sepsis screening were screened for sepsis showing continuous improvement from last year. Year end results confirm the target was met.

Timely treatment – Whilst not achieved throughout the year there have been improvements in Q4 and the target was met with a performance of 92%. The likely reason for the drop in performance in Q2 and Q3 was a change in staff, both with new doctors starting in August and also the departure of the sepsis nurse. A new sepsis nurse has now been in post since December 2018.

Assessment of clinical antibiotic review - There has been a steady improvement in compliance with antibiotic review criteria over the financial year. Targets for the year have all been met.

Reduction in antibiotic consumption - Total consumption increased in Quarter 3 of this financial year, in comparison to Quarter 1 and 2, as is to be expected over the winter period. Overall however we met the target to achieve our 1% reduction in total antibiotic consumption in 2018/19 in comparison to 2017/18 total consumption.

What did we achieve to date?

The Deteriorating Patient Group has multi-professional representation from across all services involved in the detection and response to deterioration including Critical care, Surgery and Medicine. So far the group has:

- Completed a review of clinical incidents related to deterioration
- Completed regular audit of the escalation and response to abnormal National Early warning scores in adult inpatients
- Completed two detailed thematic analyses of case reviews of patients admitted as an emergency to critical care from adult inpatient wards.
- Used this data to inform an updated education plan around deterioration including in-situ simulation, seminars with all clinical departments and updated nurse study days
- Review of the workload and competences of all members of staff involved in providing care to inpatients in the hospital at night
- Options appraisal for different suggested staffing and models of care overnight
- Completed roll-out of the NEWS 2 system of physiological monitoring in January 2019 Completion and roll-out of new guidelines for escalation of deterioration and for referral to critical care

There has been continuous work and training around sepsis recognition and treatment.

A new sepsis nurse has now been in post since December 2018 and the effect of that is evident in the improvement in performance in the last quarter. There are a number of interventions undertaken to improve sepsis awareness including teaching on mandatory training for nurses and doctors, training sessions on wards, close work with PDNs and resus officer to facilitate sepsis training.

The microbiology team continues to monitor use of all antibiotics where indicated and works with pharmacy to provide an education and awareness raising programme, support the Antimicrobial Stewardship Virtual Ward Round, as well as providing feedback to clinical teams regarding progress. There has been a steady improvement in compliance with antibiotic review criteria over the financial year.

We can evidence progress through:

Progress for the deteriorating patient group can be evidenced by the rollout of new teaching sessions, minutes of the meeting of the group and the rollout of the new escalation pathways

What will we do in 2019/20 to continue improvements?

The Trust intends to continue with this important priority in 2019/20.

The deteriorating patient Group will continue to focus on regular data collection looking at escalation and response to deterioration.

Once a new model for hospital at night cover for adult inpatients has been agreed the team will focus on its rollout and reviewing its efficacy

The sepsis nurse role has shown to be invaluable as evidenced by the drop in our performance when the post was vacant. For 2019/20 we will continue with a number of interventions currently in place to increase sepsis awareness. Other future plans include, continuing to provide regular training to both doctors and nurses in ED; in ward SIM training; and raising awareness throughout the hospital with posters on all wards.

We will continue to provide educational initiatives and develop our Trust strategy via antimicrobial management group regarding antimicrobial stewardship, including daily antimicrobial stewardship ward rounds and use of carbapenem-sparing agents where appropriate. We will focus on the promotion of electronic tools (e.g. Medicine Powerplans for Sepsis) to improve antimicrobial stewardship and adherence to guidelines with incorporation of such tools for example into simulation training sessions on acutely deteriorating patients where relevant.

Clinical Effectiveness (Effective)

Priority 4 - To achieve the Quest best employer accreditation. - Not Achieved

Background

NHS Quest, of which Homerton is a member, has decided to add to its core role as a quality improvement network by developing an Employment Brand.

NHS Quest were initially attempting to support the ‘Best Employer Brand’ by developing an accreditation regime designed to assure employers they were focussing on the right things that would ensure they featured in the top 20% NHS trusts to work by 2020 as measured by the NHS staff survey.

Our success measures have been

This work has not progressed as envisaged and subsequently QUEST is currently reflecting on next steps in respect of how to effect quality improvements in this key area for member organisations. Homerton continues to be involved where appropriate.

What did we achieve to date?

2018 Staff Survey feedback indicates that Homerton broadly managed to continue with its previous ratings which indicate that it remains in the top 20% of NHS Trust to work for.

Specifically the 2018 Staff Survey indicates that 70% of staff would recommend the organisation as a place to work and 76% would be happy with the standard of care if a friend or relative needed treatment.

We can evidence progress through

- Staff Engagement Meetings and Action Plan.
- Equality & Diversity Meetings and Action Plan.
- Healthy Homerton Meetings.
- Staff survey completion and results

What will we do in 2019/20 to continue improvements?

The Trust is currently formulating an action plan to generate improvement at corporate and local levels with the aim of achieving an overall improvement in Trust ratings across a range of areas. Significantly priorities at corporate level have been identified as follows:

- Harassment and Bullying of Staff by Patients and Carers
- Equality, Diversity and Inclusion in employment
- Staff Health and Well Being
- Trust Values and Culture
- Appraisal rates consistently high across the organisation.

The Trust plans to include a priority related to staff health and wellbeing in 2019/20.

Priority 5 - Improving services for people with mental health needs who present to A&E – Achieved.

Background

It is widely recognised and accepted that people with mental health problems are up to three times more likely to present to an ED than the general population; and are also up to five times more likely to be admitted to an acute hospital. 'Frequent Attenders' to an ED continue to be a 'growing health concern' with research suggesting that each of these ED attendances are not always beneficial for the patient, yet are resource-intense both in terms of clinical time and financially. As such, clinicians in acute settings need to be adequately equipped to recognise urgent mental health needs as well as identifying underlying mental health conditions.

Our aim was to maintain a 20% reduction in attendances to ED for patients within a selected cohort of frequent attenders in 2017/18 and identify a new cohort of frequent attenders to ED during 2017/18 that could benefit from interventions to reduce by 20% their attendances to ED in 2018/19.

Our success measures have been

Maintain 20% reduction in attendances to A&E for patients within the selected cohort of frequent attenders identified in Year 1 (2017/18) – the Trust achieved an 80% reduction.

Identify a new cohort of frequent attenders to A&E during 2017/18 that could benefit from psychosocial interventions and work to reduce by 20%, their attendances to A&E during 2018/19 – the Trust achieved a 60% reduction.

What did we achieve to date?

A summary of the achievements to date is set out below:

- Identify subsets of patients who would benefit from assessment, review and care planning with specialist mental health staff
- Produce care plans for each patient in the cohort, engaging with local partner agencies
- Establish joint governance arrangements
- Establish local data collections to support the evaluation of the CQUIN project
- Provide assurance on EPR recording/coding for patients presenting with MH complaints
- Ensure a system is in place to identify new FA
- Continue to develop and embed service development plans to support sustained reduction in attendances for people with MH needs
- Identify whether the presentations of the patient cohort were recorded/coded correctly on the electronic patient record system
- Agree service development plan to support sustained reduction in attendances for people with MH needs

We can evidence progress through

- CQUIN updates
- Operational Meetings
- Steering Group meetings (HUH and ELFT)
- Urgent Care Quality Meeting
- ED attendance data

What will we do in 2019/20 to continue improvements?

- To continue to monitor, review and analyse frequent attenders and adopt a multi-disciplinary approach to managing this patient cohort.
- To continue developing our understanding on this cohort of patients and their health needs.
- To improve individualised care planning for identified frequent attenders.
- To ensure robust governance systems between acute and community settings and maintain information sharing mechanisms.
- To learn and share experiences on individual case management.

Priority 6 - Improving the management of end of life care for adults. - Achieved.

Background

This priority relates to the need that when a patient is dying that they and their family receive the best possible care. This involves ensuring they do not receive unnecessary medical interventions and that care is delivered in line with the 5 priorities of care identified by The Leadership Alliance for The Care of Dying People (One Chance to Get it Right June 2014).

Our targets were to ensure our patients who die within the hospital have an end of life care plan and a treatment escalation plan.

Our success measures have been.

Completion of an individualised end of life care plan ensures individualised needs are identified, regularly reviewed and any nursing interventions evaluated in a timely way. It ensures that the needs of the family are considered and met. This has been achieved in over 70% of cases over 2018/19.

Completing a Treatment Escalation Plan enables the documentation of communication with patients and families around recognition of dying, appropriate treatment options at this time, identification of preferred place of care and death and other priorities for the dying person and their family. With the TEP there is an End of Life Review completed, again ensuring psychological, spiritual and social needs have been considered. This has been achieved in over 70% of cases over 2018/19.

What did we achieve to date?

- In 2018 the Trust launched a revised end of life care strategy for 2018-2021.
- The Trust applied and was granted funding from Macmillan for a two year end of life facilitator post to take forward the strands of the strategy.
- The end of life care plan has been revised to better reflect the needs of the dying patient and their family. The Trust will be introducing a programme of teaching in relation to the new care plan. This went live on EPR in 2019.
- Following consultation with the ward staff, a two hour communication training programme for ward nurses and health care assistants has been delivered to staff on ECU and Edith Cavell.
- An End of Life Care Facilitator started in 2018 and has been establishing and promoting this new post and the Strategy throughout the Trust (inpatient and community).
- In December 2018 we started giving out a bereavement feedback survey to the next of kin of all adult patients that have died in the hospital.

We can evidence progress through

- Maintaining records of training done, attendance numbers and evaluations including doctors training, nurse's band study days, annual update training, ward based training and Simulation training.
- Audits demonstrating a continued increase each quarter in the number of patients at end of life with a TEP (and EOL Review) and nursing end of life care plan.
- Feedback received in the bereavement surveys.

What will we do in 2019/20 to continue improvements?

The Trust is taking forward the aims of the End of Life Strategy 2018-21. These are:

- Personalised End of Life Care
- Supporting our staff
- Improving environment
- Communication and Information.

We will deliver ward teaching re changes to the End of Life Care plan.

Conversations with patients and families about dying have been included in simulation training for nurses and health care assistants and this will continue and be developed for medical staff too.

Patient Experience

Priority 7 - Ensuring staff are actively hearing the Voice of the Child and this is integral to care. – Achieved.

Background

Two key drivers for ensuring that the voice of children and young people is heard, listened to and shape the way in in which Homerton provides services for them are:

In 2015 the CQC published a report which reviewed 50 inspection reports and concluded that the 'voice of the child' was deafeningly silent.

One of the guiding principles that the Trust has signed up to as member of the City and Hackney Safeguarding Children Board is developing a culture which ensures that children and young people are heard through professionals taking the time to listen to what children and young people are saying, putting themselves in the child or young person's shoes and thinking deeply about what their life might truly be like.

Our targets were to ensure; that the voice of the child is included in health visitors safeguarding supervision; children feel involved in decisions about their care; children feel safe as in-patients and staff attend me first training.

Our success measures have been

- 100% Health Visitors have the voice of the child documented on RIO as part of their supervision.
- Over 90% of children sampled felt involved in their care.
- A how safe do you feel pilot questionnaire has been developed.
- Over 30% of relevant staff have attended Me first training

What did we achieve to date?

- Standard Operating Procedure developed for documenting safeguarding supervision on RIO which includes guidance on documenting the voice of the child.
- 24 Safeguarding children supervision records were audited in Q's 3 & 4.
- HV participated in a Voice of the child audit. Report completed and findings have been used to form the basis of a workshop scheduled for 12th April 2019.
- Parents and children on Starlight Ward continue to be asked to complete the patient satisfaction survey using Optimum Technology.
- How safe do you feel questionnaire has been developed and piloted with 36 children aged 8-15 years (the denominator was not established), who were in patients on Starlight ward. The momentum for this work slipped in quarter 3 when the trust quality improvement lead left the organisation.
- Staff (nursing and medical) attended Me first Masterclass

We can evidence progress through

- Dip sample audits of supervision records
- In patient satisfaction feedback report
- 'How safe do you feel' questionnaire developed and piloted.

What will we do in 2019/20 to continue improvements?

Continue work on embedding the voice of the child in clinical practice as an objective in the Safeguarding Children 2019/20 work plan which will be monitored by the Safeguarding Children Operational Forum.

Priority 8 - Improving the first impression and experience of the Trust for all patients and visitors – Not Achieved.

Background

Creating positive first impressions of the Trust for patients, service users and visitors who are visiting the Trust is important in building trust and confidence in our staff and services. Receptionists are on the front line in meeting and greeting patients, service users and visitors and therefore play a pivotal role in this. We will develop a range of measures to support receptionists and their managers create a positive first impression for every patient, service user and visitor to the Trust at every visit.

Our targets were to initiate a quality improvement project with non-clinical outpatient staff, increase the numbers of staff attending the effective receptionist course and developing first impressions standards.

Our success measures have been

A Quality Improvement project has been established looking at measuring ourselves against best practice, identifying expected behaviours and barriers and enablers to delivering this and measures to support delivery.

There is an action plan for the First Impressions project and it included the need for 50% of the receptionist staff to undertake the Effective Receptionist training. The uptake of training was not fully taken up.

A draft set of first impression standards has been produced aiming to create a positive first impression which will help to provide consistency across the Trust.

What did we achieve to date?

First Impressions Workshop Sept 2018 attended by 20 receptionists from a range of teams including reception managers, Head of Learning and Head of Patient Experience. The session explored three questions to help inform an action plan.

- What does the Trust need to put in place to ensure that ‘first impression’ standards can flourish?
- What are the things that currently get in the way and prevent us from delivering a positive first impression?
- What are the factors that will help you deliver a positive first impression?

A draft First Impressions Standard was proposed and a number of areas agreed to support its delivery including recruiting staff with the right attitude, competencies and training, supporting staff to consistently exhibit behaviours.

We can evidence progress through

A draft set of First impression Standards has been developed including code of behaviours. An action plan has been created which will form the basis of the work plan for the first impression steering group to deliver. Additional Effective Receptionist courses have been commissioned for 2018/19.

What will we do in 2019/20 to continue improvements?

Refresh the action plan, meeting membership and key priorities. Review the Effective Receptionist training to ensure it is tailored to the new standards. The initiative will be project managed in line with the QI principles. A new OPD Manager has been appointed and will give the initiative a refreshed launch.

Priority 9 - For patients who on discharge are receiving one or more community services for their discharge to be seamless and communication between all services enhanced. – Achieved.

Background

Improving discharge from hospital is a key priority for the trust. This has previously been shown to be an area that could be improved on and that affects both patients and the effective operational performance of the hospital. While considerable work was done in 2017/18 with hospital services including wards and multi-disciplinary teams to better facilitate discharge, greater focus has now turned to enhancing the community-facing services involved in supporting discharge.

Our targets were to develop a patient information leaflet in relation to discharge services offered; implement a discharge to assess pilot; ensure continuing care assessments are completed in the community and ensure continuing care assessments are completed within 28 days.

Our success measures have been

A discharge patient information leaflet has been developed and is awaiting approval.

What did we achieve to date?

A patient information leaflet has been produced describing the range of the discharge related services.

The discharge to assess pilot has been implemented and assessed.

We have achieved our target of 85% continuing healthcare (CHC) assessments complete in the community, unless exempt by agreement.

We have achieved our target of 95% CHC assessments to be completed within 28 days.

We can evidence progress through

Minutes or action logs of meetings including Medical Productivity Group, CQUIN Board, Integrated Discharge Steering Group and Unplanned Care Board.

What will we do in 2019/20 to continue improvements?

- To ratify patient information leaflet
- To seek data for other D2A services as a comparator
- To maintain delivery of local CHC CQUIN
- To ensure on-going attendance and effective functioning of various groups identified above.

Priority 10 - To implement a complete electronic postnatal discharge process with a failsafe element to ensure timely and appropriate delivery of postnatal care to mothers and babies once transferred from hospital into the community setting. - Achieved.

Background

Datix incident reports identified a trend in 'missed' postnatal discharges from inpatient areas to community care to Homerton and out of areas (16 missed discharges in January 2018). This resulted in mothers and babies having delayed home visits and therefore the schedule of postnatal care in the community not being followed. This was of serious patient safety concern as mothers and babies were having essential care and screening tests delayed, which in turn has the potential for harm.

Following review it was identified that the missed discharges were occurring in both the transfers of care to Homerton's community services and out of Homerton area community services. It was also identified that the missed discharges were coming from all inpatient areas that process Incorrect Homerton community zone/out of area hospital identified by midwife to be notified of discharge.

There were a number of reasons why discharges were not reaching appropriate community teams, it was decided that a new process was to be implemented to cut out the manual process of paper notification and minimise the number of individuals involved in the process to reduce the risk of errors being made.

Our targets were to ensure postnatal discharges are sent electronically, daily failsafe checks were being made and missed discharges were reported on Datix – with the aim of having 0 missed discharges by March 2019.

Our success measures have been

As part of the new process, sending of the discharges electronically is mandatory as there is now no provision for paper copies to be collected. This has been successful with 100% compliance.

The daily failsafe check is completed by two different teams; Community complete the failsafe to check they have received all of the Homerton community discharges, and Delivery Suite complete the failsafe to check all of the out of Homerton community area have been sent. There was a decline in the compliance with this in Quarter 2, which was identified when missed discharge incidents were being reported. Both the Delivery Suite and Community leads have identified the issues which lead to not achieving 100% compliance with the daily failsafe.

Although the target of 0 missed was achieved in March 2019, prior to this there were low levels of incidents monthly. It is however evident that there has been a clear reduction since the implementation of the new process and failsafe.

The main reasons for discharges being missed were;

- Discharge not sent on day of discharge, and failsafe not done therefore missed discharge not identified
- Discharge sent to incorrect out of area hospital – no notification from other hospital or notification not acted upon due to the failsafe not being done

The missed discharges are generally identified by families calling the maternity helpline to inform them that they have not had their expected visit, or the health visitor informing us. All missed

discharges would be identified at the latest by the national Northgate Newborn Blood Spot (NBBS) failsafe system which would identify a delayed NBBS sample. All are logged via Datix and reviewed and actioned by the line manager of the area that the client was discharged from.

What did we achieve to date?

- Standard Operating Procedure implemented for new discharge process
- Datix reporting and investigation of any missed discharges
- Staff support in implementing the new process including training, discussion at team meetings, written feedback
- Monitoring of incident trends via the maternity trends report with feedback to staff
- Updates at team meetings
- Focus on ensuring failsafe completed daily, including further training
- Putting processes into place to ensure failsafe is completed when core members of the administration team are not working

In late Quarter 4, implementing the London-wide map to support ensuring discharges are sent to the correct hospital.

We can evidence progress through

Gradual reduction in missed discharges and maintenance of lower level of incidents. There is a continued focus on discharge incidents. In March 2019, we achieved the aim of 0 missed discharges.

What will we do in 2019/20 to continue improvements?

- Further work with administration teams to work towards the aim of 100% compliance with the daily failsafe, including further training and audit.
- Continued reporting via Datix of any missed discharge to identify any training or system issues.
- Continue to embed the use of the London-wide electronic map to support the staff to select the correct hospital for discharge.

3.2. Review National Performance Indicators

Performance against the relevant indicators and performance thresholds set out in NHS Improvement's Single Oversight Framework

The following indicators are set out in NHS Improvement's Single Oversight Framework. The Single Oversight Framework replaced the Risk Assessment Framework in November 2016. Please note Summary Hospital-level Mortality Indicator (SHMI) Clostridium difficile and Venous Thromboembolism (VTE risk assessment) are reported in Part 2.3: Reporting against core indicators.

Homerton endeavours to meet all national targets and priorities. Below is a summary of the national targets and indicators.

Cancer Waits

Table 13: 62 day cancer waiting time performance

Indicator	Target 2018/19	2018/19	2017/18	2016/17
Cancer: 62 day wait for first treatment (from urgent GP referral for suspected cancer)	85%	87.70%	81.70%	83.90%
Cancer: 62-day wait for first treatment (from NHS Cancer Screening Service referral)	90%	66.67%	100.00%	100.00%

Data source: Somerset Cancer database

The Trust has performed strongly against the 62 Day Cancer standard in 2018/19 and is a significant improvement against last year's performance. The Trust continues to place significant focus on the delivery of this standard via its fortnightly Cancer Access Board. It should be noted that the improved performance has coincided with the appointment of a new Head of Access. With regard to the screening target, it should be noted that although the performance is below the 90% standard, this relates to a total of three treatments, of which one treatment was recorded as a breach.

Referral to Treatment Time

Table 14: Referral to treatment time performance

Indicator	Target 2018/19	2018/19	2017/18	2016/17
Referral to treatment time (incomplete pathway) - within 18 weeks	92%	96.71%	96.18%	95.30%

Data source: Homerton EPR/RIO

The Trust has continued to perform strongly against the 92% standard and has met the standard for every month of 2018/19, despite increase demand for its outpatient services. Performance is monitored on a fortnightly basis as the Trust's Elective Access Board.

Accident and Emergency (A&E)

Table 15: A&E waiting time performance

Indicator	Target 2018/19	2018/19	2017/18	2016/17
A&E - total time in A&E under 4 hours (from arrival to admission/transfer/discharge)	95%	94.34%	94.73%	94.10%

Data source: Homerton EPR

The Trust has seen an improvement in its overall performance against the total time in A&E standard in 2018/19, although overall the Trust has not delivered the 95% standard. However, it is of note that the standard has been delivered in five months over the course of the year.

Diagnostic procedures

Table 16: Diagnostic procedure waiting time performance

Indicator	Target 2018/19	2018/19	2017/18	2016/17
Maximum 6 week wait for diagnostic procedures	99%	99.77%	99.97%	N/A

Data source: Homerton EPR

The Trust has consistently performed strongly against the six week wait standard for diagnostic tests despite on-going increases in demand. Whilst performance has been compliant overall on a monthly basis, there have been some instances where the standard has not been met within individual modalities. Performance is monitored on a fortnightly basis as the Trust's Elective Access Board.

Improved Access to Psychological Therapy (IAPT)

Table 17: IAPT waiting time performance

Indicator	Target 2018/19	2018/19	2017/18	2016/17
Proportion of people completing treatment who move to recovery (from IAPT* database)	50%	60.45%	56.65%	N/A
Waiting time to begin treatment (from IAPT minimum dataset) within 6 weeks	75%	96.50%	93.87%	84.4%
Waiting time to begin treatment (from IAPT minimum dataset) within 18 weeks	95%	99.52%	99.42%	99.1%

Data source: Patient Case Management Information System

The Trust has continued to deliver its core IAPT targets throughout 2018/19 and performance has improved compared to 2017/18 across the three core standards.

3.3. QUALITY IMPROVEMENT AT HOMERTON

'Quality Improvement' (QI) can be defined as an approach to improving service quality, efficiency and morale simultaneously, using improvement science. It is part of a broad range of activities known collectively as 'improving quality'. QI uses systematic methods to involve those closest to the quality issues in developing solutions to a complex problem. The systematic method used at the Trust is the Institute for Healthcare Improvement (IHI) Model for Improvement.

Building and fostering QI knowledge and skills

During 2018/19 the QI team priority has been building QI knowledge and skills in staff (clinical and non-clinical) whatever the service they deliver or the role they play. QI has been incorporated into the organisational development activities aimed at fostering an 'improvement mindset'. We have introduced a QI session into the induction of staff that have managerial or supervisory duties because we want every team to be empowered and supported to use QI to improve the care provided.

The Trust Leadership Level 2 programme 2018 for the first time included QI tools and approaches with bespoke teaching from the QI team as well as one to one coaching for each of the participants. The nurse preceptors also benefitted from QI teaching and support. Staff in both of these programmes completed high quality QI projects, produced posters and presentations sharing their findings widely through the QI Forum, audit days and Research and Development conferences. These projects delivered improvements in the efficiency of systems and processes reducing the time patients wait for care, decreasing the time taken to administer or dispense medication, improve patient and staff confidence and levels of feedback as well as safety through better reviews and assessments of patients.

The QI Forum was launched in June 2018 as a place for staff to share QI project activities with colleagues from across the Trust. Presentations and discussion highlight issues, findings and solutions that are transferable. As a regular participant fedback 'I like the learning – there's always something to take away'. The Improving Quality Board, co-chaired by the Medical Director and the Director for Organisational Transformation, is responsible for a strategic overview of the broad range of improvement activities from mortality reviews to themes from patient feedback and patient safety and effectiveness which shape QI project priorities.

Lessons from the QI team's work with preceptor nurses, as well as the 'Improving Trust and Confidence in Nurses' workstream, is being used to develop a Chief Nurse QI Fellow programme, specifically for Band 5 nurses. This will run from April 2019. Staff groups such as Allied Health Professionals and doctors in training are already in the forefront of putting QI into practice. The team provide teaching and advice to these groups as part of their induction, learning and development programmes. All staff undertaking QI projects are encouraged to align their projects with Trust and service priorities and to include patients/clients and service users as key partners.

Working in partnership

Partnerships are crucial to the Trust's QI approach. Homerton is part of UCLPartners (Academic Health Science Network) and shares QI projects using the LIFE collaboration and data analysis platform. The Trust subscription to the IHI also provides staff with access to e-learning and to international QI cases studies and resources.

Homerton is also an active participant in the QUEST network of 16 NHS organisations which are committed to focussing on improving quality and patient safety. The Trust contributes to the QUEST 'Best Employer Brand' initiative because we recognise that high levels of staff engagement improve the quality of patient care.

Homerton QI in the City and Hackney health economy and beyond

The QI team ethos is to bring QI support to wherever teams are based. For example, we have built on the 'lunch and learn' QI sessions for Adult Community Nursing teams and practice nurses in the south west of City and Hackney to improve communication between practitioners to provide seamless care to clients. The QI team is part of a project using Experience Based Co-Design principles and methods to develop and deliver better services and solutions with and for patients. This is an exciting opportunity to use QI principles in 'Neighbourhoods' or place based models of care.

One of three 'transformation' projects ongoing during 2018/19 related to mobile working in community service teams. This project took a holistic approach to examining how the benefits of mobile working could be realised in three services which included different care models e.g. adults and children's services and therapy and nursing teams. 'Time in motion' studies were conducted using validated tools together with assessing staff and patient/client experience and attitudes to the use of technology. Recommendations for action are informing the development of IT systems and place based 'Neighbourhood' care models. This work aligns with the North East London Sustainability and Transformation Plan: investment in and development of technology and delivering paper-free care at the point of use.

Homerton has a track record of developing technology enabled healthcare, such as electronic patient records and sharing information efficiently and securely across health organisations via the Health Information Exchange (HIE). In July 2018, Homerton organised and hosted an event for NHS partners in the Quest network focussing on this theme. Homerton Experience Day included immersive sessions for participants to see the HIE in action in the hospital and try out Voice Recognition software to produce clinic letters. We showcased the latest thinking from Homerton staff harnessing the power of wearable technologies to help patients manage long-term conditions and the proposed use of Artificial Intelligence to screen and triage referrals. The event included insights from Dr Simon Eccles, Chief Clinical Information Officer for Health and Care, the Northern Care Alliance (a Global Digital Exemplar) as well as an opportunity to explore the positives and pitfalls of technology in healthcare through a lively debate.

The Surgical Transformation Programme aims to increase efficiency and productivity in surgical services. Staff used skills developed in the Quest Improvement Science for Leaders (IS4L) to improve the percentage of patients undergoing gallbladder removal to go home safely on the day of the procedure. Theatres team members also took part in the 'Improving Theatre Safety Collaborative' which used a clinical communities model to drive and sustain improvements in outcomes.

Homerton has again been successful in winning a place on the IS4L programme in 2018/19. The team project is called 'Mind the Gap' and is focussed on decreasing the late diagnoses of speech, language and communication needs in children and young people living in Hackney.

QI Futures 2019/2020

Homerton's QI activities in 2019/2020 aim to support the Trust's ambition to be a provider of 'Outstanding' care. The QI approach is in line with the Care Quality Commission (CQC) guidance on trusts with a maturing QI function. Key priorities will be to develop and embed better use of data and qualitative information, improve how we work in partnership with patients and service users, sustain and spread successful QI projects and communicate and raise awareness of QI in innovative and compelling ways.

APPENDIX A. LIST OF NATIONAL AUDITS AND CONFIDENTIAL ENQUIRIES 2018/19

Audit Title	Eligible for participation	Did Homerton participate?	Number of cases submitted	Number of cases required	% of cases submitted
Adult Community Acquired Pneumonia (BTS)	✓	✓	-	73	-
Case Mix Programme (CMP)	✓	✓	578	578	100%
NCEPOD - Child Health Clinical Outcome Review Programme Long term ventilation on children, young people and young adults	✓	✓	-	4	-
Elective Surgery (National PROMs Programme)	✓	✓	294	375	78%
Falls and Fragility Fractures Audit programme (FFFAP)*	✓	✓	96	96	100%
Feverish Children (care in emergency department)	✓	✓	120	120	100%
Inflammatory Bowel Disease (IBD) programme	✓	✓	982	982	100%
Learning Disability Mortality Review Programme (LeDeR)	✓	✓	3	3	100%
Major Trauma Audit	✓	✓	136	-	-
Mandatory Surveillance of bloodstream infections and *Clostridium difficile* infection	✓	✓	54	54	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme(MBRRACE)	✓	✓	53	53	100%
NCEPOD - Medical and surgical clinical outcome review programme - Perioperative diabetes	✓	✓	3	4	75%
NCEPOD - Medical and Surgical Clinical Outcome Review Programme - Pulmonary embolism	✓	✓	-	-	100%
NCEPOD - Medical and Surgical Clinical Outcome review programme - Acute Bowel Obstruction	✓	✓	7	7	100%
NCEPOD - Medical and Surgical Clinical Outcome Review Programme - Acute Heart Failure	✓	✓	3	5	60%
Myocardial ischaemia National Audit Project (MINAP) *National Cardiac Audit Programme (NCAP)*	✓	✓	278	278	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)* *Secondary care*	✓	✓	90	90	100%
National Audit of Breast Cancer in Older People (NABCOP)	✓	x	-	-	-
National Audit of Cardiac Rehabilitation	✓	✓	224	420	53%
National Audit of Care at the End of Life (NACEL)	✓	✓	28	28	100%
National Audit of Dementia (in General Hospitals)	✓	✓	56	50	100%
National Audit of Intermediate Care (NAIC)	✓	✓	73	73	100%
National Audit of Seizures and Epilepsies in Children and Young People	✓	✓	36	49	73%
National Bariatric Surgery Registry (NBSR)	✓	✓	193	193	100%
National Bowel Cancer (NBOCA)	✓	✓	90	90	100%
National Cardiac Arrest Audit (NCAA)	✓	✓	17	17	100%
National Clinical Audit for Rhematoid and Early Inflammatory Arthritis Audit (NEIAA)	✓	✓	16	29	55%
National Comparative Audit of Blood Transfusion programme*	✓	✓	11	30	36%

Audit Title	Eligible for participation	Did Homerton participate?	Number of cases submitted	Number of cases required	% of cases submitted
National Diabetes Audit*	✓	✓	13958	13958	100%
National Emergency Laparotomy Audit (NELA)	✓	✓	63	63	100%
National Heart Failure Audit (NCAP)	✓	✓	301	301	100%
National Joint Registry (NJR)	✓	✓	198	198	100%
National Lung Cancer Audit (NLCA)	✓	✓	144	144	100%
National Neonatal Audit Programme (NNAP)	✓	✓	1395	1466	95%
National Oesophago-gastric Cancer (NAOGC)	✓	✓	47	47	100%
Non- invasive ventilation Adults (NIV) (BTS)	✓	✓	-	3	-
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)*	✓	✓	6537	6537	100%
Sentinel Stroke National Audit programme (SSNAP)	✓	✓	152	153	99%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance scheme	✓	✓	7	7	100%
Surgical Site Infection Surveillance Service	✓	✓	1	1	100%
Vital Signs in Adults (care in emergency departments)	✓	✓	122	120	100%
VTE risk in lower limb immobilisation (care in emergency departments)	✓	✓	150	150	100%

*Multiple work streams

1. *Adult Community Acquired Pneumonia. We are submitting data with a deadline of 31/05/2019. 100% data submission is anticipated.*
2. *NCEPOD - Child Health Clinical Outcome Review Programme Long term ventilation on children, young people and young adults- we are awaiting individual patient questionnaires. 100% data submission is anticipated.*
3. *Major Trauma: the expected number of cases is based on HES and EPR data and may not always reflect the true number of cases that are eligible for the audit. Therefore, it may appear that not enough cases were submitted for the audit. As we are a level 1 trauma centre, the majority of trauma cases would go elsewhere and would be captured through the Major Trauma data at tertiary centres. 100% data submission is anticipated for cases identified.*
4. *National Audit of Breast Cancer in Older People – The Trust did not submit the required data by the deadline.*
5. *NCEPOD - Medical and Surgical Clinical Outcome Review Programme - Pulmonary embolism – Only organisation questionnaire required and was submitted.*
6. *Non- invasive ventilation Adults (NIV) We are submitting data with a deadline of 31/06/2019. 100% data submission is anticipated.*
7. *LeDeR audit became mandatory on the 1st of March 2017 and we have had no patients who met the criteria to date.*
8. *National Comparative Audit of Blood Transfusion programme. Despite the numbers of eligible patients not all patients will have received either FFP or massive transfusions and therefore will not have required an audit response. All patients who met the criteria in the period were audited.*

APPENDIX B. 2018/19 CQUINS

No.	National Indicator	Description of Indicator	Indicator weighting acute & community £
1a	**Improvement of health and wellbeing of NHS staff**	Achieving a 5 percentage point improvement in two of the three NHS annual staff survey questions on health and wellbeing, MSK and stress.	127,754
1b	**Healthy food for NHS staff, visitors and patients**	Maintaining the four changes that were required in the 2016/17 CQUIN in both 2017/18 & 2018/19 and introducing 3 new changes	127,754
1c	**Improving the uptake of flu vaccinations for frontline clinical staff**	Year 1 – Achieving an uptake of flu vaccinations by frontline clinical staff of 70% Year 2- Achieving an uptake of flu vaccinations by frontline clinical staff of 75%	127,754
2a	**Timely identification of patients with sepsis in emergency departments and acute inpatient settings**	The percentage of patients who met the criteria for sepsis screening and were screened for sepsis	75,935
2b	**Timely treatment of sepsis in emergency departments and acute inpatient settings**	The percentage of patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour.	75,935
2c	**Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours following the review criteria**	Percentage of antibiotic prescriptions documented and reviewed by a competent clinician within 72 hours following the review criteria	75,935
2d	**Reduction in antibiotic consumption per 1,000 admissions and proportion of antibiotic usage (for both in- patients and out-patients) within the Access AWaRe category.**	1. Total antibiotic usage (for both in-patients and out-patients) per 1,000 admissions 2. Total usage (for both in-patients and out-patients) of carbapenem per 1,000 admissions 3. Total usage (for both in-patients and out-patients) of piperacillin-tazobactam per 1,000 admissions	75,935
4	**Improving services for people with mental health needs who present to A&E**	For 2018/19: 1. Sustain the reduction in year 1 of attendances to A&E for those within the selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions. 2. Identify a new cohort of frequent attenders to A&E during 17/18 that could benefit from psychosocial interventions and work to reduce by 20%, their attendances to A&E during 2018/19. In year 2, it is expected that the cohort will include groups who experience particular inequalities in access to mental health care (see below for further detail). Ensure that mental health attendances to A&E are recorded and submitted to the Emergency Care Dataset.	300,530
5	**Transitions out of Children and Young People's Mental Health Services (CYPMHS)**	This CQUIN aims to incentivise improvements to the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services (CYPMHS).	79,521
6	**Advice & Guidance**	The scheme requires providers to set up and operate A&G services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care. A&G support should be provided either through the ERS platform or local solutions where systems agree this offers a better alternative.	300,742
9a	**Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco screening**	Percentage of unique adult patients who are screened for smoking status AND whose results are recorded.	15,187

9b	**Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco brief advice**	Percentage of unique patients who smoke AND are given very brief advice	60,748
9c	**Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco referral and medication**	Percentage of unique patients who are smokers AND are offered referral to stop smoking services AND offered stop smoking medication.	75,935
9d	**Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol screening**	Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems	75,935
9e	**Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol brief advice or referral**	Percentage of unique patients who drink alcohol above lower-risk levels AND are given brief advice OR offered a specialist referral	75,935
10	**Improving the assessment of wounds**	The indicator aims to increase the number of full wound assessments for wounds which have failed to heal after 4 weeks	106,028
11	**Personalised care and support planning**	Embedding personalised care and support planning for people with long-term conditions.	106,028
LO CAL	**Continuing Healthcare Assessments, reviews and best practice management**	This CQUIN aims to improve the care and support provided to people in receipt of continuing health care funded by City and Hackney CCG.	106,028

No.	NHSE Indicator	Description of Indicator	Indicator weighting - 2%
GE2	**GE2: Activation System for Patients with LTC**	To ensure patients with long term conditions with higher levels of activation (the knowledge, skills and capacity to manage their own condition)	£42,875 0.31%
B13	**B13 – Automated Exchange Transfusion for Sickle Cell Care**	Patients with sickle cell disease require exchange transfusions to manage their condition. This can be done manually or using automated exchange. This CQUIN scheme aims to incentivise the use of automated exchange by specified specialist centres in order to improve patient experience and use of clinical resources.	£316,314.93 1.18%
B14	**B14 - Sickle Cell ODN**	To improve appropriate and cost-effective access to appropriate treatment for haemoglobinopathy patients by developing ODNs and ensuring compliance with ODN guidance through MDT review of individual patients' notes.	£77,738.42 0.29%
	Neuro-Rehab	• Reduce unnecessary duplicate referrals and the time spent in waiting for assessment • Reduce the number of 'rejected' referrals rejected simply because the information is not complete. • Improve patient experience data at a unit level • Bring Level 1/2a neuro-rehabilitation services more fully into a 'system' of care in each STP in the London.	£58,973.97 0.22%

	CQUIN – DENTAL		Indicator weighting 2%
	Activity reporting by Referral to Treatment (RTT) for each dental specialty	Collection and submission of data for dental pathways using the CQUIN RTT dashboard.	£32,388

	Acute Dental Systems Resilience Group	Participate in the Acute Dental Systems Resilience Group (SRG), including supporting data requests to contribute to a Pan London approach to demand and capacity modelling.	£32,388
	Use of the acute dental portal	Develop a central storage system for all documents/ correspondence relating to acute dental activity and data	£32,388
			£97,164

No.	**Public Health Indicator**	**Description of Indicator**	**Indicator weighting DESP 2.5% , Bowel 2%**
DESP	**Improve outcomes and reduce risk of complications for patients with diabetes through implementation of Making Every Contact Count (MECC) project with patients attending for diabetic eye screening.**	London DES services to implement tailored MECC projects that will contribute to improved health and wellbeing of service users and support uptake of approved Diabetes Structured Education programmes, through facilitating referral of patients with diabetes. To include: • Development and implementation of CQUIN project plan in collaboration with and in alignment with STP Diabetes programme priorities. • Service protocol to include defined target patients • MECC training to support staff interventions with patients and evaluation. • Mechanisms to track MECC interventions and numbers of referrals • End of project evaluation	£76,792
	Bowel Scope Patient Experience Survey	Improve patient experience of Bowel Scope through conduct of Patient Feedback Survey and Focus group for all those who attend bowel scope at North East London screening site. Results from surveys will feed into local screening service improvement plans	£56,019

No.	**STP Indicator**	**Description of Indicator**	**Indicator weighting acute & community £**
STP	**STP CQUIN**	This CQUIN seeks to engage providers within the ELHCP in order to play a full part in the development and implementation of the productivity, efficiency and quality improvement schemes as well as supporting the development of the ELCHP and wider system management. A number of specific indicators have been set out with milestones for achievement, however, there are pre-conditions requirements that need to be met first	£1.8m

APPENDIX C: GLOSSARY OF TERMS AND ABBREVIATIONS

CCG	Clinical Commissioning Group
C-Diff	Clostridium Difficile
CEO	Chief Executive Officer
CESDI	Confidential Enquiry into Stillbirths and Deaths in Infancy grading system
CLIP	Complains, litigations, Incidents Pals meeting
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission – The independent regulator of health and social care in England
CQUIN	Commissioning for Quality and Innovation
DNA	Did Not Attend
DH	Department of Health
ED	Emergency Department
EoL	End of Life
EoLC	End of Life Care
EPR	Electric Patient Record
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HQIP	Healthcare Quality Improvement Partnership
HUHFT	Homerton University Hospital Foundation Trust
IAPT	Improving Access to Psychological Therapies
ICEC	Improving Clinical Effectiveness Committee
IG	Information Governance
IGT	Information Governance Toolkit
IHI	Institute for Healthcare Improvement
ITU	Intensive care unit
MDT	Multidisciplinary Team
MSK	Musculoskeletal
NELA	National Emergency Laparotomy Audit
NEWS	National Early Warning Scores
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
NICU	Neonatal Intensive Care Unit
NIHR	National Institute for Health Research
NRLS	National Reporting and Learning System
PbR	Payment by Results
PE	Pulmonary Embolism
PrEP	Pre-exposure Prophylaxis
PROMS	Patient Reported Outcome Measures
PUSC	Pressure Ulcer Scrutiny Committee
QI	Quality Improvement
R&D	Research & Development
RA	Rheumatoid arthritis

RCA	Root Cause Analysis
RiO	RiO (Community EPR*) - RiO is a secure, Electronic Patient Record (EPR) which is used by Homerton's Community Services in Hackney and the City as their primary clinical system
Sepsis	A life-threatening illness caused by the body's response to an infection. 'Red Flag Sepsis' is one or more criteria identified using the UK Sepsis Trust Sepsis Risk Stratification
SHMI	Summary Hospital-level Mortality Indicator
SI	Serious Incident
SLT	Speech and Language Therapy
SOP	Standardised Operating Procedure
TTC	The Trust Thrombosis Committee
VTE	Venous Thromboembolism

ANNEX 1: STATEMENTS FROM CLINICAL COMMISSIONERS, LOCAL HEALTHWATCH AND OVERVIEW AND SCRUTINY COMMITTEES

The Trust is grateful to all our scrutiny committees including our commissioners for their work in reviewing and responding to our quality account 2018/19 report. As part of 2019/20 quality improvement work, we will consider the points raised with the purpose of making continuous improvements to the care we provide to our patients.

Overview & Scrutiny

Health in Hackney Scrutiny Commission
Hackney Council
Room 118, Town Hall
Mare St, E8 1EA

Reply to: jarlath.oconnell@hackney.gov.uk

8 May 2019

Ms. Catherine Pelley
Chief Nurse and Director of Governance
Homerton University Hospital NHS Foundation Trust
Trust Offices
Education Centre
Homerton Row, E9 6SR

Email to: c.pelley@nhs.net

Dear Catherine

Response to HUHFT's draft Quality Account for 2018/19

Thank you for inviting us to submit comments on the Quality Account for your Trust for 2018-19. We are writing to provide our insights arising from the scrutiny of the Trust's services over the past year at the Commission.

The Commission Members take a great interest in the performance of our key local acute trust and were pleased to learn about some of your key achievements over the past year. Your overall '*Good*' rating in May 2018 from the CQC across all services and the '*Outstanding*' ratings for Medical Care and for Urgent and Emergency Services is to be commended. We note also the additional new Improvement Priorities you have set for 2019/20.

During the past year we have continued to enjoy a good working relationship with the Trust and we greatly appreciate the willingness of the Trust's representatives' to attend our Commission meetings and contribute to our work.

Your Chief Executive attended our June and September meetings where we discussed a range of issues including the proposals for reconfiguring the pathology service. Local residents and GPs continue to have concerns about the Path Lab consolidation and the proposed revised structure across the NEL area, therefore we will continue to pursue this with you over the coming year.

In September your CE also took part in a high level discussion item on the Estates Strategy for North East London with senior executives from the CCG, the Council and ELFT and she also contributed to the debates at the Inner North East London JHOSC on both the NEL Estates Strategy and the implications for east London of the NHS Long Term Plan. We will continue to

pursue these discussions with you this year as hopefully outline proposals will emerge in particular for the St Leonard's site. We hope to organise an engagement event on this later in the year.

In November your CE took part in a discussion on the implementation of the Overseas Visitor Charging Regulations after the impact of these on vulnerable migrants was raised with us by Hackney Migrant Centre and local GPs. We have since had a response to our letter to the Secretary of State. The Health Minister has made clear that these rules must be implemented sensitively and sensibly and we would ask therefore that, while there is no direction on you to monitor these impacts, that you do so, because of the level of local concern about their impact.

We are also grateful to your Director of IT and Systems who has also contributed to our own review on '*Digital first primary care'* in his capacity as the lead officer for City and Hackney Integrated Commissioning IT Enabler Group.

We wish to make the following specific comments on your draft Quality Account noting that it is an early draft:

a) Re p.15 again this year there is an absence of data relating to the new requirement to report on 'Learning from Deaths'. How is this being rectified?

b) Re p.16 on 'Seven Day Services' you say that because the numbers are low it has been a challenge to develop appropriate Consultant rotas across the surgical specialities. One presumes the numbers are low because this is just starting? You also say that having a 12 hr Consultant presence is sufficient yet this is not in compliance with this particular NHS priority clinical standard.

c) Re p.16 you describe the two new 'Freedom to Speak Up Guardians' to support whistleblowers, but give no evidence about how busy they have been? Is this policy working?

d) There has been a lot of media coverage this year nationally of junior doctors experiencing bullying and working for dangerously long periods. On p.16 you describe the 'Guardian of Safe Working' which you now have in place in response to the new junior doctors' contract. Can you give us examples of how often s/he might have intervened on issues regarding your rota gaps?

e) The Trust is to be commended for your significant progress in reducing the C-Difficile rates to just 3 in 2018/19 and for being one of the best performing Trusts nationally on this indicator.

f) You are to be commended for making steady progress on End of Life Care issues but, re p.32, why have only 70% of cases had 'End of Life

Care Plans' or 'Treatment Escalation Plans' during 2018/19. What are the barriers here and how are you addressing them?

a) Re p.35 on the "improving first impressions" indicator why has there been such poor uptake of training by receptionists and surely this should be mandatory?

b) Your reporting on Priority 9 on seamless discharge makes no reference to the 'Discharge to Assess' pilot which we've been informed about by the Integrated Commissioning Unplanned Care Workstream. Why is this?

c) Re p.36 the series of missed post-natal discharges was serious and resulted in mothers and babies having delayed home visits and follow up. You implemented a new failsafe system. Is there now 100% compliance on this?

d) The Trust's improvement on IAPT waiting time targets is to be commended.

We look forward to taking up these issues with you over the next year on the Scrutiny Commission.

Yours sincerely

Councillor Ben Hayhurst
Chair of Health in Hackney Scrutiny Commission

cc Members of Health in Hackney Scrutiny Commission
Tracey Fletcher, Chief Executive, HUHFT
Cllr Feryal Demirci, Deputy Mayor and Cabinet Member for Health, Social Care, Transport and Parks Dr Sue Milner, Interim Director of Public Health, City and Hackney
Jon Williams, Director, Healthwatch Hackney

healthwatch Hackney

May 15th 2019

Dear Catherine,

Healthwatch Hackney contribution to the Homerton Hospital Quality Account 18-19

Thank you for sending us the draft Quality Account for review. Please find below our response to the Homerton University Hospital's Quality Account for 2018-19.

Co-production of Service Improvements for Patients

We would welcome a new approach to our engagement with your annual Quality Account. It seems under the current system we contribute each year to the Account, yet there is no clear feedback on how our proposals and recommendations are taken on board and influence service improvement for patients. As you know Healthwatch has the following statutory responsibilities, which require both submission of our proposals for service improvement and evidence that these have been acted on or reasons provided for not doing so:

a) promoting and supporting the involvement of local people in the provision and scrutiny of local care services;

b) enabling local people to monitor the standard of provision of local care services and whether and how local care services could and ought to be improved;

c) obtaining the views of local people regarding their needs for, and experiences of, local care services and importantly to make these views known;

d) making reports and recommendations about how local care services could or ought to be improved. These should be directed to providers of care services, and people responsible for managing or scrutinising local care services;

e) formulating views on the standard of provision and whether and how the local care services could and ought to be improved.

1) Presentation of the Quality Account

We would like to see a more accessible Quality Account, the Account from 16-17 was outstanding: interesting, an enjoyable read, well presented and accessible. This year's report and last year's has returned to previous style which is much less

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comprehensible and would be difficult to understand for people in the community without a clinical background. It is too long, and segmented in a way that prevents the easy access to the many achievements that you record.

It is not clear who the report is intended for, but it is written as an internal technical document for staff and to satisfy the requirements of NHS Improvement. We strongly believe the report should be written in a way that is accessible to local people, celebrates your achievements and identifies areas for improvement and the means of achieving those aspirations.

Our key areas for service improvements are as follows:

1) **Pressure ulcers** – we recommend that in the community, any signs or symptoms of early development of ulcers identified by care workers, is placed in nursing notes kept in the patients' residence, or shared with health professionals using a process agreed between care worker agencies and the HUH or primary care. Information for families about the identification of early signs of pressure ulcers in the community would be valuable.

2) **Deteriorating patients** – this terminology may be very distressing to patients and their families/carers. We recommend that other terminology is used in any documentation visible to patients/family and that information about this condition is provided in a ways that is accessible, understandable and meaningful to patients, families and carers.

3) **Sepsis** – it would be useful if the QA could report on HUH's progress with implementation of NEWS 2 and how this has so far impacted on the incidence of sepsis, including reported deaths from sepsis on the past three years.

4) **End of Life Care** – the use of the term End of Life Board sound strange. Adults are mentioned but not children our young people. Supporting family is not mentioned. Access to minutes of the Board meeting for Healthwatch would be useful to give us greater insight into the developing work being carried out.

5) **Making Every Contact Count** – great idea, but implementation and developing appropriate metrics would seem to be a difficult aspiration to achieve.

6) **Learning from Complaints** – we are concerned about the effectiveness of PALS and impact of joining this service to complaints. A certain amount of independence is needed for PALS to be effective. We welcome a more effective process to demonstrate how complaints can result in enduring improvements in patient care and treatment. Feeding this information back to

1) patients is also very important. This need to know that their contribution has had a real impact on services. HWH will be testing the system using a mystery shopper exercise. We would welcome participation in the learning from complaints process.

Other issues:

a) The research section 2.2.3. is very interesting but not accessible to public. Improvements to the layout and language could be make this section much more accessible. There should be evidence that patients participating in trials are given feedback about the impact and outcomes of trials.
b) Section 2.2.4. is not about enhanced quality arising from the CQUINS, but about payments for achievement of CQUINS.
c) Patient safety incidents charts on pages 24/25 appear to have data presented in reverse.
d) Discharge planning – in relation to patients with dual diagnosis of mental and physical health problems does discharge planning start when the patient is admitted to a HUH ward and what is the process to ensure post discharge support in relation to both physical and mental health?
e) Dissemination of Complaints Charter and Poster to all clinical spaces, e.g. wards, OPD, front desk, waiting areas.
f) Accountability for ensuring prescription of appropriate medicines. Is it possible for a doctor to diagnose a patients condition, e.g. a VTE, record this in the patient's notes but not take action to ensure that appropriate medication is prescribed and provided to the patient. This accountability gap needs to be removed.

Additional Recommendations from HWH

1) **Access to Community Equipment.**
Problems with access to equipment for some people in the community who require equipment for mobility, access and to ensure their safety, is causing delays due to problems with the supplier (Millbrook). Delays in access to equipment can result in poor discharge arrangements and have resulted in patients developing pressure ulcers. In some cases the wrong equipment has been provided. The contract is held by Hackney Council and the City of London.

HWH recommends to joint approach between HUH and HWH to both Health and Wellbeing Board to get their support to ensure proper governance of the Millbrook contract and consequently the enhancement of service quality for patients.

2) **Clinical Follow-Up in the Care of Young People in the Fracture Clinic**
The system for following up young people who are referred to the fracture clinic needs to be reviewed. If a young person is referred to the fracture clinic and fails to attend, there is no certainty that the person will be followed up through the parents and GP causing potential harm.

HWH recommends that the non-attendance of a young person at a fracture clinic, should be subject to positive action to ensure that the person has either been treated elsewhere or that the parents and GP are aware of the importance of attending for the referral appointment.

3) **Mental Health – Delayed Transfers**
In the 2018 Quality Account, we asked for evidence of urgent plans to stop extended waits for patients requiring psychiatric care. This issue was raised because of unacceptable delays in the transfer of some patients, because the person's home CCG has not agreed to spot purchasing of an ELFT bed, or a failure of locate a bed in the person's home borough. Such delays are a clear breach of the duty of 'parity of esteem'. Unfortunately, this problem continues, e.g. a patient recently waited in Homerton A&E for at least 15 hours for transfer to a bed in Lewisham Hospital.

HWH recommends that HUH and ELFT jointly agree that no patient requiring an urgent mental health will be left to wait in A&E as this is a potential source of harm to a person in a mental health crisis.

4) **Ensuring Implementation of Ward Round Decisions**
During ward rounds the consultant may request the junior doctor to implement decisions regarding prescriptions for drugs and other forms of treatment. The junior doctor is expected to implement decisions 'on the run' and may not be able to do so because of the pressure of ward round or demands on the doctor's time immediately after the ward round.

HWH recommends that doctors have protected time after a ward round to ensure that patients get the medication and aids that they needs, and that doctors are provided with IPADs (or similar) to enable them to quickly requests prescribed medications.

We hope you find our contribution and comments helpful.

Yours sincerely

Jon Williams

Executive Director

CC: Malcolm Alexander (HWH Board member)

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NHS
City and Hackney
Clinical Commissioning Group

Commissioners Statement for Homerton University Hospital NHS Foundation Trust 2018/19 Quality Account

NHS City and Hackney Clinical Commissioning Group (CCG) is the lead commissioner responsible for commissioning health services from Homerton University Hospital NHS Foundation Trust on behalf of the population of the City of London and the London Borough of Hackney.

Thank you for asking us to provide a statement on the Trust's 2018/19 draft Quality Account and priorities for 2019/20.

The Trust set itself ten challenging quality priorities for 2018/19. We note progress for the majority of these priorities and congratulate the Trust for aiming high. We support the Trust's work to develop metrics for the 2019/20 priorities to enable the Trust to celebrate success at the end of this year.

We congratulate the Trust on consulting with patients, staff and stakeholders on the 2019/20 priorities.

The Trust's recent CQC inspection illustrated the outstanding work taking place to improve quality of care with an overall rating of Good and improved ratings for maternity services and medical care, the latter now rated as Outstanding along with emergency care. We congratulate the Trust on their journey to move from Good to Outstanding and hope to support and contribute to this achievement going forward.

We are very pleased to see sustained improvement to patient experience scores as measured by the CQC National Inpatient survey linked to the work undertaken over the last few years to improve nurse communication skills and patient centered care. The Trust has performed strongly against the 62 Day Cancer standard in 2018/19 and there has been a significant improvement against last year's performance. The Trust has continued to deliver its core psychological therapies targets in 2018/19 and again performance has improved compared to 2017/18. We congratulate the Trust again for their performance in relation to the four hour A&E target. The Trust's approach to the new mortality review requirements is exemplary and a high percentage of unexpected deaths are investigated so that learning can take place.

The Trust has expanded research activity and increased the number of patients who are invited to take part and there is an impressive account of world class research activities taking place.

We commend the Trust on their focus on staff wellbeing and being responsive to staff feedback and once again the Trust has been very highly rated by staff on the care they provide and working at the Trust.

Last year we asked that the 2018/19 Quality Account provide greater emphasis on our City and Hackney plans for greater integration with our Local Authority partners and the development of our neighbourhood model. We are pleased to see references to wider system work throughout the document and are keen to see these developments progress further over 2019/20.

We are delighted to see further progress made by the Trust to embed quality improvement (QI) and the work of the QI team in the Trust, particularly the new QI programme for Band

NHS
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Clinical Commissioning Group

nurses and work being undertaken in surgical specialities. We encourage the Trust to make quality improvement everyone's business and to equip front line staff with the skills and capacity to develop this in 2019/20.

We confirm that we have reviewed the information contained within the Account, and checked this against and data sources where these are available to us, and it is accurate.

Overall we welcome the 2018/19 quality account and are excited at the prospect of another year working together to improve the quality of services for the population we serve.

Dr Mark Rickets

Chair, NHS City and Hackney Clinical Commissioning Group

Ms Jane Milligan

Accountable Officer, NHS City and Hackney Clinical Commissioning Group

Mr David Maher

Managing Director, NHS City and Hackney Clinical Commissioning Group

ANNEX 2: STATEMENT OF DIRECTORS' RESPONSIBILITIES

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance Detailed requirements for quality reports 2018/19
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2018 to [the date of this statement]
  - papers relating to quality reported to the board over the period April 2018 to 20/05/2019
  - feedback from commissioners received 17/05/2019
  - feedback from governors dated 30/04/2019
  - feedback from local Healthwatch organisations dated 15/05/2019
  - feedback from overview and scrutiny committee dated 08/05/2019
  - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31/10/2018
  - the national patient survey 01/06/2018
  - the national staff survey 26/02/2019
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 24/5/2019
  - CQC inspection report dated 10/05/2018
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, 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 report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the board

24.5.19 Date ..... Chairman

24.5.19 Date ..... Chief Executive

ANNEX 3: LIMITED ASSURANCE STATEMENT FROM EXTERNAL AUDITORS