NHS
Homerton
University Hospital
NHS Foundation Trust

Homerton University Hospital NHS Foundation Trust
Quality Report 2019/20

INTRODUCTION

The aim of this report is to provide a review of the quality of the care and the services that are delivered by the Homerton University Hospital NHS Foundation Trust. The Trust acknowledges that the content and wording used within this document may appear bureaucratic, but it is written in a manner that complies with our statutory duty under the Health Act 2009 and the National Health Service Regulations.
The Trust welcomes this opportunity to communicate our progress and commitment to key elements of quality; -

- Patient Safety,
- Clinical Effectiveness, and
- Patient Experience.

1.0 PART 1: STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE OF THE NHS FOUNDATION TRUST

This report for the financial year 2019/20 has been prepared during the coronavirus pandemic which spread to London early in 2020 and reached full force in March leading to dramatic changes to all NHS services and to the national lockdown which is still largely in place. As we write, a slow resumption of services is just beginning as the number of Covid-19 infections tails off (at least for a while).
Covid-19 had a marked effect on our finances and performance only in the last month of 2019/20, so it may be invisible in much of what follows in this report which gives an account of our activities for the year as a whole. However, it has been such a challenge and had such far-reaching consequences, we start with it.

In the space of a very few days, our hospital and community services had to be transformed both to provide for the rush of admissions of Covid-19 patients and to protect staff and patients from infection. All non-urgent admissions and surgery and most outpatient appointments and clinics were cancelled and our main theatres were reconfigured to provide critical care beds for patients requiring ventilation. In the community, services were reorganised to provide care by telephone and video, as well as at home, in a way which protected the vulnerable and our staff, yet met continuing needs. With many staff having to isolate themselves for a period in order to limit infection, many staff had to work outside their normal services.

We have never seen anything like this emergency in our lifetimes. We pay tribute to staff throughout the Trust for their determination and commitment to do their best for our patients and our communities despite the risks. We also mourn the deaths associated with the pandemic of many patients and of three members of our staff – Mr Abdul Chowdhury, Michael Allieu and Sophie Fagan.

The year before the pandemic had seen continuing public concern about the challenges affecting the NHS, with rising waiting times both in Accident and Emergency and in other services. There was a continuing need to find new efficiencies in order to deliver high quality care to increasing numbers of patients with progressively more complex needs. The implications of Brexit for our staff and for future staffing were also much debated, though the practical consequences were largely deferred until 2021 by the agreement on a transitional period.

In the circumstances the Trust continued to make good progress both in maintaining relatively low waiting times for its patients, maintaining and in some respects improving our quality of care, and in helping to develop a more integrated health and care system in City and Hackney with our local Clinical Commissioning Group (CCG), other health care organisations and GPs, the London Borough of Hackney and the City of London Corporation.

The safety and quality of care is our first responsibility. This depends of course on the quality of the frontline clinical teams who deal directly with patients. But it also depends on the supporting services for example from pharmacy, pathology, procurement and estates.
We measure ourselves by our patient feedback in regular surveys and by monitoring our performance on waiting times and a range of other quality indicators against other similar trusts. We also have a structured process to learn from serious incidents and from complaints.

There remain areas in which we want to improve but we are pleased that on many of the objective measures we have continued to do well compared with our peers. Like all NHS trusts we are subject to examination by the Care Quality Commission. Following an inspection visit in January 2020, the acute site was rated Outstanding overall. In the course of 2019/20 the Mary Seacole Nursing Home was also subject to inspection. The report on Mary Seacole rated it Good in all respects.

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

2.1 PRIORITIES FOR IMPROVEMENT

The Trust is required annually to set challenging priorities to improve the quality of care provided to our patients. The Trust quality priorities for 2019/20 were agreed following a consultation with staff and stakeholders; including Governors, City and Hackney Clinical Commissioning Group and Hackney Healthwatch. The priorities were designed to support the three key work streams in delivering high quality care:

- Improving Patient Safety
- Improving Clinical Effectiveness
- Improving Patient Experience

The 2019/20 quality priorities were reviewed during the year and progress monitored by the relevant oversight committee and reported to the Trust Management Board.

The table 1 below summarises the review outcome of each quality priority, see section 3.1 of this report for a detailed overview of the progress made during 2019/20;

	Priority	End of year review outcome		
		Goal achieved	Close to achieving goal	Comment
1	To reduce the number of community and hospital attributed pressure ulcers		✓	Carried forward from 2018/19
2	Appropriate identification and management of deteriorating patients	✓		Carried forward from 2018/19
3	Reducing physical violence and aggression towards patients and staff		✓	New for 2019/20
4	Improving management of end of life patients for adults	✓		Carried forward from 2018/19
5	Making Every Contact Count		✓	New for 2019/20
6	Learning from complaints, incidents, claims and compliments		✓	New for 2019/20
7	Improving the first impression and experience of the Trust for all patients and visitors		✓	Carried forward from 2018/19
8	Getting Patients Moving		✓	New for 2019/20
9	Improvements in staff health and wellbeing		✓	New for 2019/20

Table 1: Quality priorities for 2019-20

The Trust conducted a consultation with staff and stake holders in February 2020 to identify the quality priorities for the next 12 months. As part of the consultation process for the chairs of the three key monitoring committees – Improving Patient Safety, Improving Clinical Effectiveness and Improving Patient Experience were consulted to consider which of the 2019-20 priorities would continue into 2020-21.

In addition to reviewing the 2019-20 priorities, a long list of potential new quality priorities for 2020-21 was drawn up based upon feedback from the three oversight committees. These potential new quality priorities were then included in a consultation process supported by an online survey which allowed free text comments for further feedback.

The survey was sent by email to members of the three Trust governance committees (Improving Patient Safety Committee, Improving Clinical Effectiveness Committee and Improving Patient Experience Committee) and to all Trust staff. The survey was also promoted through internal Trust newsletters. Additionally the survey was distributed for onward circulation to the council of Trust governors

including members of Hackney Healthwatch, Hackney Council Voluntary Services, Hackney Local Authority, East London Foundation Trust and City and Hackney CCG.

Over 300 completed survey responses were reviewed using a weighted scoring system to identity quality priorities for 2020/21, including the option to carry over any of the priorities from the previous year. The quality priorities carried over into 2020/21 were;

1. To reduce the number of community and hospital attributed pressure ulcers.
2. Reducing physical violence and aggression towards patients and staff
3. Improving the first impression and experience of the Trust for all patients and visitors.
4. Making Every Contact Count and linking to 'Improving the first impression and experience of the Trust for all patients and visitors'.
5. Learning from complaints, incidents, claims and compliments
6. Getting Patients Moving
7. Improvements in staff health and wellbeing

From the results of the survey, additional priorities were agreed (table 2) with timescale for achievement by 31 March 2021 and progress to achieve them is to be monitored by our Trust Management Board;

	Additional Priority	Monitoring Committee	Rationale	Metrics
8	Extending the appropriate identification and management of deteriorating patients to support paediatric and maternity patients.	Improving Clinical Effectiveness	The Trust recognises and seeks to extend the progress of Deteriorating Patient Group into paediatric and maternity services.	Extended for 2019/20
9	Safe management of medicines within the organisation	Improving Patient Safety	Support and improve the safe and secure handling of medicines, learning from medication incidents and embedding best practice.	To be confirmed
10	Improve multidisciplinary falls assessments and individualised management plans of inpatients and the support given to both patients and staff post fall	Improving Patient Safety	Falls working group to review the documentation, physical and psychological support for patients and staff.	To be confirmed

Table 2: Additional quality priorities for 2019-20

2.2 STATEMENTS OF ASSURANCE FROM THE BOARD

NHS foundation trusts are required by the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to include formal statements of assurances from the Board of Directors which are nationally requested to give information to the public. Therefore, the exact structure and content of these statements as specified by the regulations are common across all NHS Quality Accounts.

2.2.1 REVIEW OF SERVICES

During 2019/20 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 2019/20 represents 100% of the total income generated from the provision of relevant health services by Homerton for 2019/20.

2.2.2 NATIONAL AND LOCAL 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 HQIP. All programmes listed were assessed for relevance in 2019/20.
During 2019/20, 37 national clinical audits and 4 national confidential enquiries covered relevant health services that Homerton provide.

During that period HUHFT participated in 100% national clinical audits and 100% national confidential enquiries which the Trust was eligible to participate in.
National clinical audits and confidential enquiries that Homerton participated in, and for which data collection was completed during 2019/20, are listed in table 3 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.

National Audits reviewed 2019/2020

AUDIT TITLE	ELIGIBLE FOR PARTICIPATING	PARTICIPATED	PERCENTAGE OF CASES SUBMITTED
Assessing Cognitive Impairment in Older People / Care in Emergency Departments Royal College of Emergency Medicine (RCEM)	√	√	100%
Care of Children in Emergency Departments Royal College of Emergency Medicine (RCEM)	√	√	100%
Case Mix Programme (CMP);Intensive Care National Audit and Research Centre (ICNARC)	√	√	100%
Child Health Clinical Outcome Review Programme 1 National Confidential Enquiry into Patient Outcome and Death (NCEPOD) -Long-term ventilation in children, young people and young adults-	√	√	100%
Elective Surgery - National PROMs; Programme NHS Digital	√	√	96.75%
Endocrine and Thyroid National Audit; British Association of Endocrine and Thyroid Surgeons (BAETS)	√	√	*
Falls and Fragility Fractures Audit programme (FFFAP); Royal College of Physicians (RCP)	√	√	100%
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	√	√	84%
Major Trauma Audit; Trauma Audit Research Network (TARN)	√	√	100%
Mandatory Surveillance of bloodstream infections and clostridium difficile infection Public Health England (PHE)	√	√	*
Maternal, Newborn and Infant Clinical Outcome Review Programme: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK)	√	√	100%
Medical and Surgical Clinical Outcome Review Programme 1 National Confidential Enquiry into Patient Outcome and Death (NCEPOD)- Dysphagia in Parkinson's Disease	√	√	100%
Medical and Surgical Clinical Outcome Review Programme; National Confidential Enquiry into Patient Outcome and Death (NCEPOD)-Pulmonary Embolism	√	√	100%

Medical and Surgical Clinical Outcome Review Programme- Acute Bowel Obstruction	√	√	100%
Medical and Surgical Clinical Outcome Review Programme - hospital management of out-of-hospital cardiac arrest	√	√	100%
Mental Health - Care in Emergency Departments Royal College of Emergency Medicine (RCEM)	√	√	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP); Royal College of Physicians (RCP)	√	√	100%
National Audit of Breast Cancer in Older People (NABCOP); Royal College of Surgeons (RCS)	√	√	*
National Audit of Cardiac Rehabilitation (NACR) University of York	√	√	94%
National Audit of Care at the End of Life (NACEL); NHS Benchmarking Network	√	√	100%
National Audit of Dementia (Care in general hospitals); Royal College of Psychiatrists (RCPsych)	√	√	*
National Audit of Seizure Management in Hospitals (NASH3) University of Liverpool	√	√	100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12); Royal College of Paediatrics and Child Health (RCPCH)	√	√	100%
National Bariatric Surgery Registry (NBSR); British Obesity and Metabolic Surgery Society (BOMSS)	√	√	75%
National Cardiac Arrest Audit (NCAA) Intensive Care National Audit and Research Centre (ICNARC) / Resuscitation Council UK National Cardiac Audit Programme (NCAP); Barts Health NHS Trust	√	√	100%
National Cardiac Audit Programme (NCAP) NICOR- Myocardial Ischaemia National Audit Project (MINAP)	√	√	100%
National Diabetes Audit – Adults ;NHS Digital	√	√	100% Core and retinal
National Early Inflammatory Arthritis Audit (NEIAA); British Society for Rheumatology (BSR)	√	√	55%
National Emergency Laparotomy Audit (NELA) Royal College of Anaesthetists (RCOA)	√	√	100%
National Gastro-intestinal Cancer Programme; NHS Digital	√	√	100%
National Joint Registry (NJR);Healthcare Quality Improvement Partnership (HQIP)	√	√	*

National Lung Cancer Audit (NLCA); Royal College of Physicians (RCP)	√	√	100%
National Maternity and Perinatal Audit (NMPA); Royal College of Paediatrics and Child Health (RCPCH)	√	√	100%
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	√	√	*
National Smoking Cessation Audit British Thoracic Society (BTS)	√	√	100%
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis); Public Health England (PHE)	√	√	Suspended until 2021
Sentinel Stroke National Audit programme (SSNAP); King's College London	√	√	88%
Serious Hazards of Transfusion: UK National Haemovigilance Scheme - Serious Hazards of Transfusion (SHOT)	√	√	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA) Society for Acute Medicine (SAM)	√	√	100%
Surgical Site Infection Surveillance Service Public Health England (PHE)	√	√	*
UK Parkinson's Audit Parkinson's UK	√	√	100%

Table 3: National clinical audits applicable to the Trust - source internal Trust records

It should be noted that the publication of several national audit reports was delayed during 2020, as the programmes were suspended due to the impact of Covid pandemic. We will continue to review our participation rates when the national reports are published (these are indicated by * in the table 3).

There were 19 national clinical audits that were not applicable to the Trust, see table 4.

AUDIT TITLE	REASON
BAUS Urology Audit - Female Stress Urinary Incontinence 2 British Association of Urological Surgeons (BAUS)	This is not carried out at Homerton
BAUS Urology Audit - Cystectomy British Association of Urological Surgeons (BAUS)	This is not carried out at Homerton
BAUS Urology Audit - Nephrectomy 2 British Association of Urological Surgeons (BAUS)	This is not carried out at Homerton
BAUS Urology Audit - Percutaneous Nephrolithotomy 2 British Association of Urological Surgeons (BAUS) BAUS Urology	This is not carried out at Homerton
BAUS Urology Audit - Radical Prostatectomy 2 British Association of Urological Surgeons (BAUS)	This is not carried out at Homerton
Mental Health Care Pathway - CYP Urgent & Emergency Mental Health Care and Intensive Community Support National Collaborating Centre for Mental Health (NCCMH)	This is related to Mental Health Trusts
Mental Health Clinical Outcome Review Programme 1 National Confidential Inquiry into Suicide and Homicide in Mental Health (NCISH)	This is related to Mental Health Trusts
National Clinical Audit of Anxiety and Depression 1 Royal College of Psychiatrists (RCPsych)	This is related to Mental Health Trusts
National Audit of Pulmonary Hypertension (NAPH) NHS Digital	This is not carried out at Homerton
National Ophthalmology Audit (NOD) 1, 2 Royal College of Ophthalmologists (RCOphth)	This is not carried out at Homerton
National Paediatric Diabetes Audit (NPDA) 1 Royal College of Paediatrics and Child	This is not carried out at Homerton

Health (RCPCH)	
National Prostate Cancer Audit 1, 2 Royal College of Surgeons (RCS)	This is not carried out at Homerton
National Vascular Registry 1, 2 Royal College of Surgeons (RCS)	This is not carried out at Homerton
Neurosurgical National Audit Programme 2 Society of British Neurological Surgeons	This is not carried out at Homerton
National Clinical Audit of Psychosis 1 Royal College of Psychiatrists (RCPsych)	This is related to Mental Health Trusts
Paediatric Intensive Care Audit Network (PICANet) 1, 2 University of Leeds / University of Leicester	This is not carried out at Homerton
Perioperative Quality Improvement Programme (PQIP) Royal College of Anaesthetists	The programme is not in-line with Homerton Services
Prescribing Observatory for Mental Health (POMH-UK) 3 Royal College of Psychiatrists (RCPsych)	This is related to Mental Health Trusts
UK Cystic Fibrosis Registry Cystic Fibrosis Trust	This is not carried out at Homerton
Head and Neck Audit (HANA) 2 Saving Faces	Audit delayed and no longer a quality accounts audit
National Audit of Intermediate Care (NAIC) NHS Benchmarking Network	Audit cancelled

Table4; National audits not applicable to the Trust – source internal Trust records

Implementation of actions implemented following the publication of the national audit 2019/20

Examples of actions that the Trust intends to take or has taken following the review of the 23 national audit reports published during 2019/20 are summarized in table 5 below.
However, it should be noted that due to a reporting lag the data referenced in national clinical audit reports could have been collated during the 2017/18 financial reporting year.

AUDIT TITLE	GOOD PRACTICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
National GastroIntestinal Cancer Programme - National Oesophago-gastric Cancer (NOGCA)	Imaging and history review after defined interval is carried out: safety net via Consultant paper clinics. Cases are referred to another Trust for chemotherapy. Any 2 day breaches are reviewed as RCA's, Staging is discussed in MDT's	• New straight to test UGI pathway to be developed • Clarify responsibility for uploading HGD cases	• UGI being rolled out • HGD upload responsibilities established
Feverish Children (care in emergency departments)	The principle success of this project was that we performed consistently above the national average for the majority of the standards reviewed. Excellent risk assessment of feverish children. There was overall good safety netting advice provided to parents of children (81%)	• Promote QI change methodology as potential lag time of 2 months • RCEM audit questions do not correlate accurately to RCEM standards/ NICE standards.	• Staff are documenting risk for sepsis as low/ medium or high risk: as currently no live EPR alert • CEWS being used as proxy marker of illness. • Integrated results from this RCEM QIP with Tiny Hands QIP and making changes to EPR for paediatric patients.
Vital Signs in Adults (care in emergency departments)	Good performance against the national average Good system for identifying abnormal signs and triggering	• Challenges in the measuring of vital signs within 15 minutes • Improve reassessment of vital signs • Input AVPU scores	• Device integration into the electronic patient record being carried out • Mandatory input of AVPU scores in EPR • Discharge vitals that are abnormal to

	sepsis alerts		create an EPR trigger to prompt senior review
VTE risk in lower limb immobilisation (care in emergency departments)	There have been steady improvements in performance with above average results for risk assessment, factsheet.	• Increase the risk assessments being performed and failure to document. • A number of low risk patients are not receiving fact sheets. • Improve the responsiveness of the EPR to electronic changes/solutions.	• Continuing the QIP in its current iteration by appointment of a junior doctor to oversee the QIP. • Inclusion of the VTE prophylaxis as part of induction. • EPR changes being made so that risk assessment is embedded in the prescription process.
National Comparative Audit of Blood Transfusion programme Audit of the use of FFP , Cryoprecipitate and other blood components in the under 18's	We have policy/guideline for transfusing neonates (100%) patients had a test performed	• Consider developing a specific policy for children receiving blood transfusion, covered by an overarching Trust policy	• The policy for children receiving blood transfusion is covered in the ''The Care of a Patient Receiving a Transfusion of Blood Components''
National Joint Registry (NJR) Operates continuous data collection	A British Orthopaedic Association review of arthroplasty during the last year was supportive of the department's current clinical practice. National outcome shows that the Trust is within expected range for 4 out of 6 standards	• Opportunity to improve 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.
National Diabetes Audit - Adults National Diabetes Inpatient Audit (NaDIA) - reporting data on services in England and Wales	The Homerton Hospital is staffed a level better than a national average with specialist nurses, specialist diabetes dietitians and podiatrists. It has an average level of diabetes consultants. The hospital already had an electronic patient record and electronic prescribing in place when the audit was carried out in 2017. The trust has a policy for the self-management of diabetes, and the audit shows that a high percentage of wards follow the self-administration of insulin policy. Regular ward nurse diabetes training is in place. The safety initiatives of hypo boxes on the wards and of insulin passports have been introduced. The Homerton has rather lower percentage of emergency diabetic emissions than occurs	• The number of 'good diabetes days' (this relates to measures of glycaemic control') was 3.3 at the Homerton Hospital compared to a national average of 4.6. • Mild hypoglycaemia and severe hypoglycaemia were somewhat more common on wards at the Homerton Hospital than nationally. • Globally many measures of patient experience are scored low at the Homerton Hospital, ranging from choice of suitable meals through to staff being definitely, or to some extent, able to answer patients' diabetes related questions.	• The level of inpatient diabetes nurse specialist provision has been increased since the 2017 audit. As a result of the National inpatient audit results over the years. • The Homerton Hospital separately audits the episodes of hypoglycaemia occurring on the ward. These are reducing year on year. The diabetes nurse specialists are supporting the ward nurses to treat diabetic hypoglycaemia more effectively. • There is an association between low scores in measures of inpatient experience and indices of deprivation. This has been a theme throughout several diabetes inpatient audits and is common to other hospitals working in areas of high deprivation and the Trust continue to monitor the results for opportunities where these can be made.

	nationally.		
National Lung Cancer Audit (NLCA)	The Trust continue to refer patients urgently to the relevant clinical teams for chemotherapy and radiotherapy and are within expected range for many of the standards	• Improve data completion rate • Further cover of chest specialist in MDT meetings	• All relevant clinicians contacted to ensure completion of spirometry and Eastern Cooperative Oncology Group (ECOG) performance score (using voice recognition template provided when possible) • There is 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 and falls within expected range overall.	• Lower admission temperature of babies born very preterm (less than 32 weeks gestation). • Increase the follow up rates of babies at 2 years	• Education and awareness of maintaining normal temperature at induction and regular teaching. Monthly admission temperature tracking and discussion at clinical governance • Action taken - Business case submitted for a dedicated follow-up co-ordinator to ensure babies attend clinic follow-up at correct age.
National Emergency Laparotomy Audit (NELA) Audit operates continuous data collection	All joint surgical and anaesthetic audit meetings have had a NELA component since 2014, good collaboration on NELA / Sepsis projects. Critical Care Committee has overview of care. The hospital has good NEWS2/ escalation processes in place The National Mortality Case Review program is in place, A NELA flowchart has been, incorporated into the EGS guidelines, , We have a clear policy that those with P-POSSUM over 5% there's a P-POSSUM and NELA score box, as a reminder, on our paper anaesthetic charts. We have a sepsis program in the trust and a national CQUIN to report on timeliness of antibiotics. Night-time surgical cover has recently been improved by switching from staff grade locums to in-house surgical SpR cover	• NELA data to be shared with Executive Boards • To discuss NELA in a more structured approach at the Joint surgical and Anaesthetic meetings and ensure NELA is covered in absence of lead at the critical care committee. • Raise awareness of NELA app. • Improve case ascertainment (HUH 85.1%, national 84%) • Consider Consultant surgical review of patients arriving late afternoon / evening – 2017/2018 data	• NELA being discussed at board with Medical Director with NELA to be a standing agenda item. • Structure of approach at NELA meeting has been discussed. • App being promoted at the induction process and ensure staff have the app for rapid risk scoring and able to provide real time data. • Presented those missed cases and advised staff of guidelines. • Surgical team reviewing any potential reasons forelays to theatre. • Firmer guidelines on reasons to admit to ITU being reviewed and discussed.
Falls and Fragility Fractures Audit programme (FFFAP)	Best Practice Tariff achievement has significantly improved	• Ensuring completion of Abbreviated Mental Test Score in the Emergency Department before surgery.	• Reminding staff of the 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. • Reducing incidence of pressure ulcers	• Reminding staff on the completion of the rapid assessment test for delirium in 7 days post-op with translators being used if there is a language barrier. • Reviewing processes to reduce time to get to surgery. • QI work to reduce incidence of pressure ulcers
National Cardiac Arrest Audit (NCAA)	Our rate of in-hospital cardiac arrests is one of the lowest for acute trusts that report to NCAA	• Improve the submission of Ethnicity data to national audit programme	• Reminder has been sent to staff to ensure that this element of record keeping is completed
NACR - National Cardiac Rehabilitation	Central to the SOP and delivery plan, all suitable patients are offered an assessment. Patients also receive an assessment following completion of the CR programme. The service meets National BACPRC guidelines and will eventually be accredited via NACR. Actively engaged with the Pan London Cardiac Clinical Network, where good practice is shared and BHF attend. Also recently involved in pan London process mapping exercise, which has aimed to benchmark Pan London Services.	• Unable to offer single sex programme due to staffing, funding, pace • The Heart Manual isn't appropriate for every patient. Therefore some patients have the choice of venue Cardiac Rehab or nothing. • Identify potential data entry errors and review capacity. • Sharing good practice	• All patients who don't attend are being surveyed to identify barriers. • Other options available such as digital Cardiac Rehab being explored to offer choice to all patients attending Cardiac Rehab with any funding requirements explored. • Appropriate consideration of the clinical time to support more patients participating in Cardiac Rehab at home. • Support with data entry, in addition to the Cardiac Rehab Nurse as time consuming
National End of Life Care Audit	Trust achieved the national average or above in 4 of the areas audited.	• Improve communication with patients and relatives when dying • Improve communication about hydration and nutrition • Address spiritual, social and cultural needs • Consider piloting face to face care 6 days per week	• Piloting of 6 day a week working including the cancer nurse specialists. • Training programme being developed to develop competencies. • Discussions with universities re accreditation of programme

Table 5; actions identified from national audit reports

Local Audits reviewed 2019/2020

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 improve services. The reports of 163 local clinical audits were reviewed by us in 2019/20. A selection of these audits and the actions that Trust intends to take to improve the quality of health care provided are in table 6 below;

AUDIT TITLE	GOOD PRACTICE	AREAS FOR IMPROVEMENT	ACTIONS COMPLETED
Point Prevalence Audit of Antibiotic Prescribing Homerton University Hospital	The stop/review on chart has been 100% compliant since Feb 2016	• Support areas using restricted antimicrobials without Microbiology input • Improve the number of valid stop/review date documented • Immediate feedback given to teams • Ensure that prescriptions not crossed off from drug chart once treatment finished • To review the 48h alert for IV antibiotics	• Established Joint ward rounds with Diabetes, Vascular surgery, Microbiology discuss cases and agree management • Development of automatic reports allowing timely feedback to individual teams and prescribers with assistance from the informatics team. • Training provided on EPR use and documentation • Exploration of how to use documentation of antibiotic review in the system • Training sessions provided to areas with low compliance
Massive Obstetric Haemorrhage	Improved use of transaemic acid	• Cause of MOH to be documented on discharge summaries of patients with MOH.	• Training re: MOH proforma and discharge summaries at Induction.
Intermittent Auscultation Audit	There has been an improvement in intermittent ausication of the fetal heart during the first stage of labour, FHR recorded 5 m intervals in second stage of labour and maternal pulse documented in line with guidance	• Review of Partogram • Recording maternal pulse FHR frequency per guidance	• Incorporated into "fresh eyes" initiative that has been implemented • Reminder to midwives: Tip Of The Fortnight, • Training, safety huddles • Reviewed IA training
Review of current Malaria treatment pathways and practices	Majority of Falciparum Malaria cases were admitted and managed appropriately in keeping with local and national guideline	• Review Malaria HAMU SOP, EPR template, Quality improvement project for guideline compliance of the returned traveller	• SOP written with an EPR template • Registered with Life QI and carrying out project over 10 months. • Delegated project NS who will complete project as part of QIP
Intrauterine Devices Placed at the Time of Elective Caesarean Section	audit report no perforations	• Information needs to be given to patients	• An information leaflet was created for all pregnant women regarding their postnatal contraceptive options and will be incorporated in their antenatal packs. This leaflet encourages women to discuss postnatal contraception with their midwife and doctor • An additional information leaflet was created for women undergoing elective caesarean section detailing intrauterine device placement at the time of caesarean. • In conjunction a checklist was made

			for women to sign prior acknowledging their understanding of the procedure, risks and benefits.
Rate of complication after laser ablation of anaogenital, hpv related, pre-cancer lesions	Report reviewed and opportunities to improve identified in action plan	• Communication with patients to be improved • Information to be kept to identify patient information • Direct access to clinics to be created	• Leaflets about surgery and complications have been created, informing patients about them • Specific anal stenosis information sheet has been created, • Direct access to specialized clinic has been created to avoid long waiting time for patients to get a second opinion (such as in case of ano-rectal physiology clinic)
Coding practices in dermatology	Improved compliance in surgical entries containing code from previous audit	• To ensure that staff are aware of coding compliance	• Coding has been incorporated into trainee induction • A laminated list of has been placed the biopsy room
Calls on cardiac ward	94% of falls had a medical exam completed by the FYI post fall. (Sample 82)	• Advice on when to call out the Orthopaedic trauma team • Advice on head injury, head bang, anti-co-agulation and analgesia • Await feedback from the strategic falls group	• Guidance has been developed for staff
Surgical Prophylaxis	Areas of excellence: Obstetrics and Gynaecology: An improvement from 16% compliance in 2012 to 83% compliance in this study.	• Microguide amendments/ new guidance • Consideration of Teicoplanin before anaesthesia	• Review of Surgical prophylaxis guidelines in Adult Antimicrobial policy completed. • EPR prescribing powerplans for each specialty is being considered • Further analysis of knife to skin group
ECG Audit	Audit standards met for the following: all available ECGs examined in the 62 cases, where one or more was found, were labelled with patient identifying details, date and time of the examination.	• Review availability of equipment • Checklist to be made available • To ensure templates are made available • To ensure ECG results are interpreted	• Equipment availability of ECG on the Medical Day Unit and other common locations has been reviewed • Checklist for medical admissions arriving to ACU highlighting any absences of baseline bedside investigations now includes an ECG • A generic electronic medical clerking proforma /template and PTWR template including ECG interpretation has been devised.
Care planning- use of care plans	This audit has highlighted some good practice as well as where improvement is needed. It is clear that where a care plan has been initiated, it was personalised to the patient's needs and a date for review was recorded, which will prompt the updating of it.	• All care plans to be recorded • To ensure that discussion with the patient/family can be added to the form	• The care plan has been redesigned to ensure that the patient's/family discussions are recorded
Voice of the child audit	The audit shows that Health Visitors generally have awareness of the need to involve children in decision-making about their future and to reflect this by listening to and	• Disseminate emerging themes from audit • To develop Trust Wide training or guidelines on the Voice Of the Child • RIO electronic team to integrate Voice Of the	• Voice Of the Children Training for health visitors given • RIO record for Voice Of the Child has been incorporated

	recording the Voice Of the Child routinely. The questionnaire responses from HVs show many Health Visitors were highly confident to capture the Voice Of the Child.	Child in RIO templates	
Prospective Audit on Diabetic foot amputations in City & Hackney with root cause analysis	Areas of excellence identified by the audit; o Patients correctly assessed by community podiatry team and offered treatment as per NICE guidelines o Patients correctly escalated to community foot protection team and multi-disciplinary foot clinic/vascular services once problem develops o Patients correctly identified and escalated to diabetic foot co-ordinator by A&E as recommended by the Standard Operating procedure for the Diabetic foot	• Education of relevant staff • Reinstate routine diabetic foot checks of newly admitted diabetics	• Diabetic foot complication education completed • Escalation process reviewed • Training for deteriorating wounds completed • SOP developed on diabetic foot complications • Diabetic foot assessment, foot complication and escalation process for deteriorating wounds training has been given • Recruitment of staff undertaken for diabetic foot assessments on newly admitted diabetics
The effect of length of hospital stay on 30-day readmission and 1-year mortality of in-patients with decompensated heart failure	Report reviewed and opportunities to improve identified in action plan	• Early intervention and early contact to in-hospital and community heart failure teams • Include early specialist input for heart failure patients in particular with those in higher risk (indicated above) • Ensure patients are medically optimized prior to discharge	• Local guidance developed for management of heart failure patients to enable health professionals to follow easily in timely manner
WHO Safety Checklist	Many areas of the Team Brief and sign in sign out were 100% compliant	• The time when to initiate the sign-out checklist needs to be revised to ensure full participation of all team members. • The actual surgical procedure should be printed on the operating list. • Review of the current electronic documentation system to include a tick box for team brief and debrief to document the completion action.	• The policy has been revised of when to initiate the sign out • The audit results were presented with what is required • Documented discussion with IT around EPR for changes being implemented
Evaluating Incidence of Pain in Post Anaesthetic Care Unit	All patients had analgesia prescribed on discharged back to the ward	• Establish working group with anaesthetic department and PACU	• Discharge Criteria developed • Standardised recovery documentation developed

	environment.		• Awareness of importance of pain assessment within PACU and ward has been raised
Fever in the returning traveller	100% antibiotic prescription as per Homerton University Hospital antimicrobial prescribing guidance	• Protocol for the initial management of fever in the returning traveller • Education of relevant staff	• A protocol has been developed and implemented for the assessment and management of febrile returning travellers in the Emergency Department part of an ongoing ED QIP. • Ongoing teaching on febrile returning travellers as part of regular teaching programme for Core and Higher Specialist Trainees in ED. • Inclusion of audit findings and review of assessment of febrile returning travellers in Foundation and Core Medical Trainee teaching sessions delivered by the Infection Department
Fractured Neck of Femur Boast 1	The Trust are meeting lots of criteria. Significant changes have been made since audit through publication of the internal guideline on managing hip fractures.	• To improve compliance with guidance • Continued effort should be made to improve and meet targets.	• Internal guideline on managing hip fractures published. • Discussion took place with leads in A+E and ACU about initial management and use of guideline
Consent Audit 2018	Report reviewed and opportunities to improve identified in action plan	• Better training of new staff • Regular updates on consent forms for experienced staff • More time allocated to checking forms in clinic appointments on scan lists and when prepping notes • For patients who are not coming to a pre-treat appointment with the nurses (IVF 2nd or 3rd cycle and IUI/H) doctors could ask patients to complete IUI and IVF consents and file in the notes ready for their treatment cycle	• Training for staff developed and implemented • consent forms and feedback to staff reviewed • Checklist being completed by nurse including all relevant forms even when patients not coming for a pre-treat • Consents being collected by doctor at the end of the clinic appointment.
Reducing re-attendance rates in ED	The majority of attendances, whether it was the initial presentation or a subsequent re-attendance, were discharged Those that weren't discharged were either admitted to OMU or under the medical team. Those who re-attended more than 4 times were mostly discharged.	• Improve level of information provided on conditions • Doctors to advise patients of routes of attendance i.e. GP and ED when deteriorating and awareness of the NCN's role	• Leaflets have been devised for most common attendances • Teaching sessions have been incorporated
Neonatal Positioning	Over the 5 years the Trust has largely improved in positioning between December 2014- August	• Review positioning in the mornings on the unit to whether we could optimise this.	• Champion nurses in positioning supporting junior members of staff • Allied Health Professionals (AHP) and Senior Nurses exploring re the

	2017 and the maintained optimal positioning scores during August 2017- May-June 2019; with one decline in April 2018. The Trust has achieved optimal positioning scores 2/4 times over the last 2 years (with one close to optimal, scoring 8.95). This also indicates we are able to achieve optimal positioning with using sheets alone together with staff training.	• Identify Champion nurses to lead with informal positioning audit to increase awareness • Opportunities for inform practical training (using tool)	common theme of positioning being worse in morning and action plan for how this could improve going forward
Monthly Blood Collection Audit	Compliance has improved from 94% in May 2019 to 100% in September 2019	• Staff not aware training had expired.	• Staff now retrained and some booked for lectures/OSCE .

Table 6: actions implemented following the review of national audit recommendations

2.2.3 PARTICIPATION IN CLINICAL 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 reflects this consensus through the continued funding of the National Institute of Healthcare (NIHR). Dame Sally Davies, Chief Medical Officer for England until September 2019, 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 the reporting year 2019-2020 between 130 and 150 studies were recruiting at any given time, with a total of 219 studies recruiting patients during 2019/20.

It is our vision to ensure that research is an integral part of the functioning of the Trust, working with staff and patients to improve the health of our community. We aim to ensure that staff patients and families understand the importance of research and research is seen and a benefit and not a compromise to NHS clinical activity. We value those involved in research by offering support and training.

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

2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 1689. This was out of a total of 3596 patients who were deemed eligible and were screened for inclusion. This decrease in recruitment is consistent with local and national trends during this reporting period due to changes in the national research landscape and the limited pool of specialties at Homerton.

The end of this reporting period saw the Covid19 pandemic. The research team was responsive to the crisis initially by supporting the clinical teams within midwifery and then quickly refocusing the remaining team towards recruitment to the Urgent Public Health studies. These included the high profile RECOVERY and REMAP-CAP studies that identified the positive effect of dexamethasone when included in the COVID 19 patients pharmaceuticals. Other studies included Clinical Characterisation Protocol for Severe Emerging Infection (CCPSE) to which 452 patients have been recruited, UKOSS- a maternal prevalence study, GenOMICC, a study looking at the genomic make up of patients becoming critically ill with COVID19 and CAPTURE- a trial looking at a near patient testing device.

As the Trust is returning to business as usual we are looking to rationalise our studies to focus on those with higher recruitment or are more beneficial to the patient or Trust. Thus far this year (April- August) 550 patients have been screened with 523 going on to be involved in studies.

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[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

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2.2.4 GOALS AGREED WITH COMMISSIONERS

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 2019/20 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 2019/20 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 2019/20 and of the following 12 month period are available electronically at: https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/

The monetary total for income in 2019/20 conditional on achieving quality improvement and innovation goals was £3.3m
In 2019/20, 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). The current CQUIN programme runs for 2019/20 only.

2.2.5 WHAT OTHERS SAY ABOUT THE HOMERTON

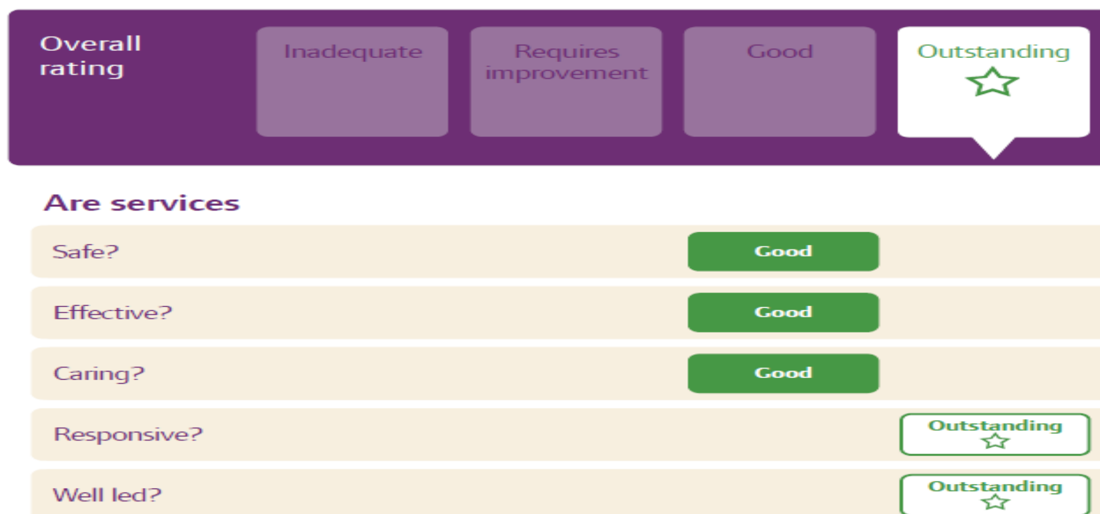
Care Quality Commission (CQC)

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 2019/20.

CQC Inspection of acute hospital site services.

A focussed inspection of Homerton acute services was carried out by the CQC during January 2020 covering three core services; older peoples services in medical care, maternity services and end of life care. The CQC took into account the current ratings of the other services that were not inspected at the time and aggregated these with the services they did inspect, which resulted in the acute hospital site achieving an overall rating of 'Outstanding'. The outcome of the inspection is in the CQC rating grid below;



The Trust received one requirement notice associated with the 'Requires improvement' rating for safe domain for Maternity. This rating was given mainly due to lack of interface between the maternity and Trust IT systems. The Trust was aware of the issue at the time of the inspection and was recorded on the risk register. The Trust was working to address this prior to the inspection and will continue to work on this with our external providers.

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.

The CQC also undertook an inspection of Mary Seacole Nursing Home in February 2020 which was rated "good" across all five key lines of enquiry.

2.2.6 NHS NUMBER AND GMC 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 2019/20 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 19 – Mar20**:

- 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%	98.9%	99.7%		
A&E	96.2%	92.5%	97.7%		

Table 7: Validity of NHS numbers

- 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	99.9%	99.8%	99.7%		
Outpatients	100.0%	99.8%	99.6%		
A&E	99.9%	99.1%	97.9%		

Table 8: Validity of GMC practice codes

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.

There had previously been one Data Quality (DQ) Committee which covered both Acute and Community Services however, last year two separate committees were established, each of which meets bi-monthly.

There are locally agreed core DQ indicators for both the Acute and Community services which are monitored and discussed during the relevant committee meetings. The committees are a vehicle for data quality improvement, promoting and maintaining robust processes for creating and managing accurate information. Therefore, ensuring that information that leaves the organisation is of the highest quality. The implementation of new data quality indicators will also be monitored the committees.

There are numerous DQ reports which are sent to services at regular frequency to improve the data completeness on clinical systems. There are on-going DQ checks, updates and staff training as and when new errors come to light.

2.2.7 INFORMATION GOVERNANCE ASSESSMENT REPORT

The Trust uses the Data Security and Protection Toolkit (DSPTK) is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards.

Due to Covid19, NHS Digital has deferred the submission date of the annual to 31.09.2020; the trust has decided to plan its submission for this date. The current status of the Trust's DSPTK is non-compliant with an action plan in progress.

2.2.8 CLINICAL CODING

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 treatments 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 2019/20.

2.2.9 ACTIONS TO IMPROVE DATA QUALITY

The six dimensions of data quality: Completeness, consistency, accuracy, timeliness, uniqueness and validity are monitored on regular basis in order to provide intelligence for clinical and strategic decision making. 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.

During 2019, decision was taken to have two Data Quality Committees: one for Acute services and the other for Community services, so that both acute and community services have focused space and time to review and discuss the DQ issues and steps to improve them. The committee meets every month alternating between acute and community services. The Data Quality committee is chaired by Head of Information Services. The committee reviews both local and national indicators. 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.
Deep-dive audits are periodically conducted within specific areas with reports produced of current state and key recommendations. Regular daily, weekly and monthly processes are in place to monitor key areas such as the recording of patient demographics, the timely production of discharge summaries, and the correct recording and coding of clinical events.
Homerton University Hospital NHS Foundation Trust will be taking the following additional actions to improve data quality are;

- Information team have regular meetings with Clinical Systems team to review and resolve the current technical and reporting issues within main clinical systems
- Data Quality team have regular meetings with Clinical Systems team to review and improve existing correction processes and to discuss emerging issues and ways to create a correction work flow.
- Part of the Data Quality update at Informatics committee; provide benchmarked data for key indicators against London and National figures.

2.2.10 LEARNING FROM DEATHS

During 2019/20 421 of the Homerton University Hospital NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

Reporting quarter 2019/20	Number of deaths	Number of completed reviews
Quarter 1	84	72
Quarter 2	82	77
Quarter 3	108	101
Quarter 4	147*	128

*Table 9: mortality reviews completed per quarter -*includes Covid-19 deaths*

Part of the mortality review process includes assigning likelihood that there were issues in the level of care that may have attributed to the death of the patient. These scores are estimated using the CESDI (Confidential Enquiry into Stillbirth and Deaths in Infancy) methodology which is defined as;

- CESDI 0 - No suboptimal care
- CESDI 1 - Suboptimal care, but different management would not have made a difference to the outcome
- CESDI 2 - Suboptimal Care – different care might have made a difference
- CESDI 3 - different care would reasonably be expected to have made a difference.

Following the reviews 9 patients (2%) of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient (CESDI 2).

At the Homerton, the CESDI score is agreed by the responsible Consultant and medical team and findings are documented on an electronic tool and shared through the governance process. The majority of all cases (as above) were reviewed either in a multidisciplinary forum or by a second independent reviewer who was not involved in the care of the patient.

If a CESDI score 1 or above is obtained the case will be discussed in a multidisciplinary forum which includes identifying areas of good practice as well as opportunities for improvement. Themes are extracted and presented in the quarterly Board report and discussed in the Mortality Leads meetings and where appropriate actions are attached and completed.

To provide assurance of the review process, a minimum of 50% of reviews scored as CESDI 0s are audited independently. However, many teams choose to review all of their cases by an independent assessor or in a multidisciplinary forum.

All reviews scored as CESDI 2's and above are investigated via the Trust's Serious Incident review process. For the purpose of this report the learning of all CESDI reviews that scored 2s are below; (note there were no CESDI 3 reviews)

Summary of learning from case record review identified over the period 2019/20:

- Lack of timely recognition of the dying patient
- Junior doctors lack of confidence in having end of life conversation
- Out of hours palliative care provision
- Early reviews done by Critical care outreach team for deteriorating patient
- Appropriate involvement sought of other specialities

- Clear hand over to the weekend team about escalation / de-escalation of care given and subsequent weekend reviews done
- Patient wishes regarding end of life care and place of death taken into account
- Delay in appropriately focussed diagnosis and / or treatment
- Lack of a community advance care plan for those patients who would potentially have benefitted from one
- CMC accessed and checked by teams to align with decisions made pre admission
- Delayed transfer of care to another care facility due to a lengthy (fast track) process
- ICD deactivation in the deteriorating patient and staff confidence
- Delay in death verification out of hours
- Inappropriate interventions minimised at end of life

A summary of the actions taken in 2019/20 and those to be implemented in 2020/21:

- Palliative care / end of life care training for junior doctors and nurses, including simulation training
- Expansion of palliative care team input
- Redesign of the fast track process in collaboration with other stakeholders (launched in September 2019)
- Design of flowchart for the deactivation of implantable cardioverter defibrillators for EoL patients
- Additional training for staff on death verification planned for July 2020
- Development of an agreed Standard operational procedure & Governance Protocol for the use of Coordinate my care (CMC) in City & Hackney

Summary of the key achievements completed during 2019/20:

1. <u>Deteriorating Patient Group</u>

An additional deteriorating patient doctor post for out of hours cover started in August 2019 which complements the already existing critical care outreach service during the day.
Launch of a deteriorating patient flag on the electronic patient record (Whiteboard) to further facilitate early recognition and escalation where appropriate of patients – links in with the deteriorating patient Senior House Officer (SHO) role.

2. <u>Co-ordinate my care (CMC)</u>

A working group with representation from primary and secondary care has been established which has progressed work on shared decision making on CMC and designed a Standard Operating Procedure & Governance Protocol for use of CMC in City & Hackney.

Coordinate My Care (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. Healthcare professionals will 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 A&E attendances and emergence admissions by giving professionals the information they need at the first point of contact with a patient in an urgent care situation.

3. Development of the Mortality Review Policy and mortality reviews

A Trust Mortality Lead was appointed in August 2019 and has updated the Mortality review policy in 2019 with enhanced focus on shared learning across professional boundaries.
Engagement with the mortality review process has improved across a range of specialities with an increased number of MDT discussions and reviews and there are now shared forums for learning that are open to other specialties. Work has progressed with involvement of a multidisciplinary attendance at meetings.

4. Focus on Palliative care support / teaching and training including for the COVID pandemic

Out of hours support is provided by a dedicated Palliative Care Consultant over the phone
Development and circulation of guidelines on managing common symptoms in the context of COVID 19
Weekend cover by a senior nurse in Palliative Care during the COVID pandemic
Change of workflows to case find patients that would benefit from palliative care (symptom) support, not only end of life care
Short focused teaching at the bedside delivered on recognising dying and symptom management

2.2.11 SEVEN DAY 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

The Trust repeated the case note review exercise reviewing 100 patients admitted to the hospital in July 2019.

Standard 2: Standard 2 – Time to first consultant review

87% of patients received a review within 14hrs. Considerable improvement was noted in those who received a review within that timeframe at the weekend (96%). 13 patients (13%) were not reviewed within 14 hours. All of these patients had a National Early Warning Score (NEWS) score of < 5 on admission. This is important as it demonstrated that none of the patients whose review occurred outside the 14 hr window were critically unwell.

Challenges to meeting the target included:

- A small group of medical patients admitted late in the day after 8pm (when there is no medical consultant on site) who had their review the following day after the night patients had been seen. This order allows the night staff to leave the ward at the end of their shifts having appropriately handed over their work. This number remains very small and the current model is felt to be the safest way to run the acute medical take.
- Challenges remained in ensuring that surgical patients all received a review in the given

timeframe. Further work was planned to look at these patients in more detail in Q4 of 19-20 which unfortunately could not progress because of the COVID pandemic.

Clinical Standard 8: Once/ Twice daily Consultant reviews as appropriate

We met this standard for once-daily and twice-daily review patients admitted both during the week and weekend. This was the case in the last round of reviews as well. The decision of whether a patient requires twice daily review or once daily was based on the clinical needs of the patient using the standards set out in the national 7 day services guidance.

The Trust continues to meet standards 5 and 6.

Future Plans

We would aim to continue work looking at the pathways of care for surgical patients over the next 12 months and if anything further could be done to improve performance with regard to standard 2 as a result.

2.2.12 SPEAK UP SAFELY

Speaking up and ensuring a culture of staff speaking up is at the heart of the Trust's refreshed People Plan.
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.

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.

In addition the Trust has developed a number of staff networks that have widespread staff membership and provide further routes through which staff can raise concerns.
The Trust is also supportive of Trade Unions and actively supports staff to raise concerns via the local trade union representatives.

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 96% (previous year 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 27 occasions for junior or senior clinical fellow posts. We have a reduction in advertising due to the impact of Covid-19. 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 and the exact form of each of these statements is specified by the quality accounts regulations.

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; NHSI Quality indicator ref 12**

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

The data in table 9 below describes the SHMI has been sourced from HED, Trust benchmarking tool. The data period is from Mar'19 to Feb'20. Our Trust SHMI score is 76.14 which equates to NHS Digital Band 3 (lower than expected deaths when compared to the national baseline).

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	Jan2019 – Dec 2019	Value 72 Banding:3	Value: 1.00	Value: 68.9 Banding: 3	Value: 120 Banding:1
	Jan 2018 – Dec 2018	Value: 76 Banding: 3	Value: 1.00	Value: 69.9 Banding: 3	Value: 123 Banding: 1
	Oct 2017 – Sept 2018	Value: 69 Banding: 3	Value: 1.00	Value: 69 Banding: 3	Value: 127 Banding: 1
	Oct 2016 – Sept 2017	Value: 87 Banding: 3	Value: 1.01	Value: 73 Banding: 3	Value: 125 Banding: 1
(b) The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for	Mar 2019 – Feb 2020	51%	37%	59%	10%
	Jan 2019 – Dec 2019	48%	36%	60%	10%
	Jan 2018 – Dec 2018	46%	34%	60%	15%

the Trust for the reporting period.	Oct 2016 – Sept 2017	45.4%	31.6%	59.8%	11.5%
	Oct 2017 – Sept 2018	43.6%	33.8%	59.5%	14.3%

Table 10: SHMI scores since 2016 to 2019 (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.

SHMI is not designed for the type of pandemic activity seen during COVID 19 and initially COVID 19 activity will be excluded as per NHS Digital.

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

- **Continued use of the electronic Mortality tool and appointment of a Mortality Lead**

The electronic mortality tool is now well embedded and used by all specialties.
A Trust Mortality Lead was recruited in August 2019. The Mortality lead has now established links with all departments including identifying a Departmental Mortality Lead and as well as overseeing the process is able to provide advice and guidance regarding the Mortality review process for all deaths and education as required. Together with individual Mortality Leads in all departments, existing practice is reviewed with the aim to create a consistent system for learning from deaths and sharing that learning across the Trust. Engagement with the mortality review process has improved across a range of specialities with an increased number of Multiple Disciplinary Team (MDT) discussions and reviews and there are now shared forums for learning that are open to other specialties. Work has progressed with involvement of a multidisciplinary attendance at meetings.

In 2018/19, 332 out of 436 deaths (76%) had a Consultant led CESDI score applied, this number has risen to 410 out of 421 deaths (97%) in 2019/2020. For 2019/2020 for the first time it is possible to also list the number of multidisciplinary discussions or independent reviews that occurred. These happened in 378 out of 421 deaths (90%) with some for Quarter 4 still outstanding. Many teams choose to discuss all of their patients even if the case is allocated a CESDI score of 0 (no suboptimal care) as often whole team learning and understanding can be gained also from those cases.

- **Progress made with reviewing mental health and learning disabilities deaths**

Patients with confirmed learning disabilities who die are subject to an additional review, as well as the Trust's mortality review process. The national Learning Disabilities Mortality Review (LeDeR) programme aims to ensure that reviews of deaths lead to learning which will result in improved health and social care services for people with learning disabilities.

There were no deaths during Quarter 1 2019/20 of patients with identified learning disabilities flagged on EPR, 1 death in Quarter 2, two in Quarter 3 and 3 in Quarter 4. These were reported to LeDeR.
From July 2019, a named individual within East London NHS Foundation Trust has been identified to be included in reviews of deaths with mental health flag recorded on EPR.

2. Patient Reported Outcome Measures (PROMS) – NHSI Quality indicator ref 18

Patient Reported Outcome Measures (PROMS) is a questionnaire based tool used to identify the quality and effectiveness of care delivered to NHS patients based on the patients' perception. All patients are asked to participate in the scheme which 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.

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
Total Hip Replacement Surgery	Apr 2019-Mar 2020	**Not available at time of publication**			
	Apr 2018-Mar 2019	**0.546**	0.500	0.360	0.550
	Apr 2017 – Mar 2018	**0.478**	0.458	0.357	0.550
	Apr 2016 – Mar 2017	**0.467**	0.437	0.329	0.533
Total Knee Replacement Surgery	Apr 2019-Mar 2020	**Not available at time of publication**			
	Apr 2018-Mar 2019	**0.339**	0.300	0.250	0.400
	Apr 2017 – Mar 2018	**0.332**	0.337	0.254	0.406
	Apr 2016 – Mar 2017	**0.334**	0.323	0.259	0.391
Groin Hernia Surgery	Apr 2019-Mar 2020	**Not available at time of publication**			
	Apr 2018-Mar 2019	**No data***	Insufficient numbers to be included		
	Apr 2017 – Mar 2018	**No data***	Insufficient numbers to be included		
	Apr 2016 – Mar 2017	**0.048**	0.086	0.006	0.135

Table 11: PROMS data for hip, knee and hernia surgery.

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 regular basis through the Improving Clinical Effectiveness Committee.

3. 28 day emergency readmission rate - NHSI Quality indicator ref 19

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.

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	2019/20	4.97% (National average 10.02%)
	2018/19	4.36%
	2017/18	4.66%
	2016/17	3.63%
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	2019/20	9.12% (National average 8.30%)
	2018/19	12.60%
	2017/18	11.95%
	2016/17	12.7%

Table 12: 28 day readmission rates for patients aged 0 – 15 and aged 16 and over

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.

- Information team has developed an electronic readmissions report that enables local services to drill down seamlessly from Trust wide through divisional to local level.
- The utilisation of the readmission report has been discussed within the Trust's Improving Clinical Effectiveness Committee with a view that the Divisional Leadership teams will oversee

the specialties in the real time tracking and interventions to reduce readmission rates.

4. Responsiveness to personal needs of patients – NHSI Quality Indicator 20

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.

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.	2018/19	63.4	67.2	58.9	85.0
	2017/18	68.1	68.6	60.5	85.0
	2016/17	66.3	68.1	60.0	85.2

Table 13; responsiveness to personal needs – source NHS Digital; NHS Outcomes framework

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.

With the increase in demand for our services, we continue to report a high number of patient satisfactions. The Trust acknowledges that sometimes it may not be as responsive as it would like to, especially when the system is under pressure.

However our FFT data indicates high scores; consistency and upward curve the past year in responding to the needs of our patients.

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

- The Trust actively supports staff completing quality improvement projects to ensure that care is tailored to individual needs.
- Task and finish group on discharge developed discharged booklet which is personalised to individuals and ensure every aspects of patient's care was addressed pre and post discharge.
- The introduction of Swan Scheme on all wards has seen staff more aware, sensitive and respect for the dying. End of Life patients receive personalised care.
- Service specific user engagements guarantee patients have the opportunity to discuss their views and concerns on what really matters to them to/with the right people.

5. Staff recommending the Trust as a place to work or receive treatment to Family and Friends. – NHSI quality indicator 21

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.

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	2019	**78**	69.0	N/A	N/A
	2018	**75.1**	69.9	49.2	90.3
	2017	**73.4**	70.2	48.0	89.3

Table 14: Staff survey response – "happy with standard of care" (Picker)

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 2019 (with certain specific exclusions) had the opportunity to complete the survey electronically between September to December 2019. The Trust achieved a return rate of 56%, which represented 3.6% point increase from 2018 (52.4%).
- 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 2018.

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:

- Introduce the People and Culture Plan – 2020 to 2023 - The plans and projects that will deliver the improvement in our people's experience be made of three key elements.
  - Creating a Values-led Organisation for all our People
  - Equality and Inclusion for our People
  - Strategy and Communication

6. Rate of admissions risk assessed for VTE - NHSI Quality Indicator 23

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.

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	2019/20	Q1	**95.6**	95.6	69.8	100
		Q2	**95.9**	95.5	71.7	100
		Q3	**96.2**	95.3	71.6	100
		Q4	**93.6**	*	*	*

assessed for venous thromboembolism during the reporting period.	2018/19	Q1	**95.5**	95.6	75.8	100
		Q2	**97.0**	95.5	68.7	100
		Q3	**96.9**	95.7	54.9	100
		Q4	**96.2**	95.7	74.3	100
	2017/18	Q1	**97.0**	95.2	51.8	100
		Q2	**96.7**	95.3	71.9	100
		Q3	**97.4**	95.4	76.1	100
		Q4	**96.6**	95.2	67.0	100
	2016/17	Full year	**96.2**	95.6	79.1	100

*Table 15: VTE risk assessment data (NHS Digital); *Q4 publication delayed due to Covid*

Assurance statements

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

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.

During the year 19-20 the trust continued to ensure that more than 95% of patients admitted to hospital had a VTE risk assessment completed as per NICE guidance. Over the course of the year we focused on improving the quality of these assessments. Findings from previous Root cause Analyses performed for patients who had developed VTE associated with a hospital stay showed that sometimes the process of completing the risk assessment is not directly tied to the prescription of appropriate VTE prophylaxis.
To respond to this in March 2020 we launched a redesigned VTE risk assessment form as part of our electronic patient record which provided enhanced clinical information such as relevant blood test results within the form and which contained the prescription embedded within it. This will ensure that the quality of the risk assessment process remains consistently high and that the actions of risk assessment and responding to that risk with the appropriate prescription of thromboprophylaxis remain linked in each case.

Our priority for the following year is to review performance following this change and to audit, at appropriate intervals, the quality of the risk assessment given by case note review.

7. Clostridium difficile rate - NHSI Quality Indicator 24

Clostridium difficile infection (CDI) remains an unpleasant, and potentially severe or even fatal, infection that occurs mainly in elderly and other vulnerable patient groups, especially those who have been exposed to antibiotic treatment.
The laboratory at the Trust processes stool samples for *C.difficile* testing from both inpatients and community (GP) patients and all *C.difficile* toxin positive results are reported to Public Health England (PHE).
Before 19/20 the national definition of a ‘hospital onset’ (attributable) case of *C.difficile* was defined as ‘all *C.difficile* positive stool samples from patients admitted to the Trust, except those collected during the first 3 days of admission’.

In 19/20 the definition of Trust-attributable cases changed to:

- HOHA=Hospital Onset Hospital Acquired = cases detected in the hospital two or more days after admission
- COHA = Community Onset Healthcare Associated = cases occurring in community/within 2 days of admission when patient has been an inpatient in reporting Trust in previous 4 weeks
- COIA = Community Onset Indeterminate Association = cases occurring in community/within 2 days of admission when patient has been an inpatient in reporting Trust in previous 12 weeks but > most recent 4 weeks.
- COCA = Community Onset Community Associated = cases occurring in community/within 2 days of admission when patient not an inpatient in reporting Trust in previous 12 weeks.

With this new definition all HOHA and COHA cases are defined as 'trust-attributable'.
The case limit for 19/20 was 12 Trust-attributable cases. There were only 8 Trust-attributable cases (7 HOHA and 1 COHA) in 19/20.

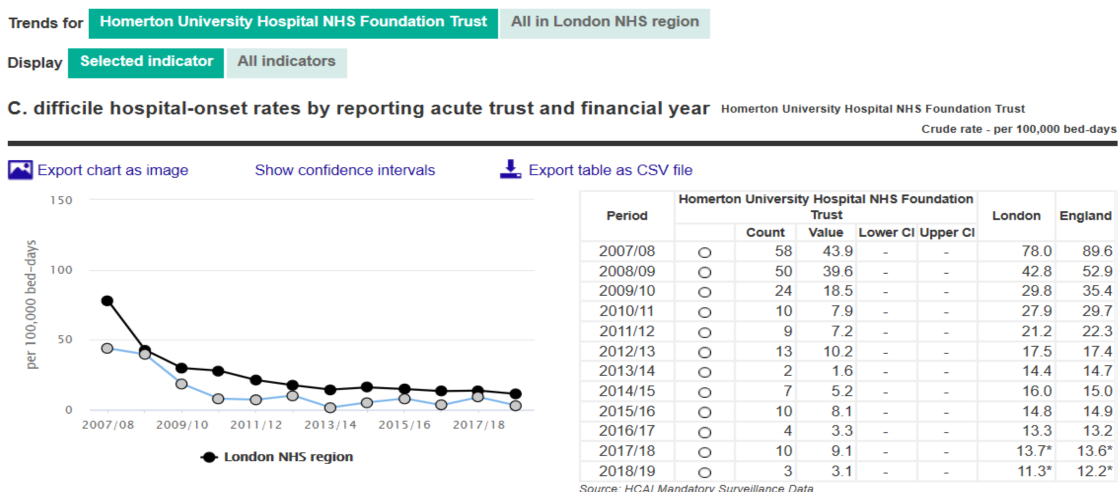
Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
The rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	2018/19*	3.1	12.2	26.4	1.7
	2017/18	***8.9***	13.7	82.7	0.0
	2016/17	***3.3***	14.9	66.0	0.0

Table 16: The rate per 100,000 bed days of cases of C.difficile infection 'within the Trust'

*Note: * 'within the Trust' is taken to mean the 'hospital-onset' rates of C.difficile pre-19/20 & HOHA + COHA for 19/20 NB these figures will not be directly comparable due to the change in definitions*

The Trust continues to have very low rates of *C.difficile*, having the 5th lowest hospital-onset rate of any acute trust in England in 18/19. Given there were 3 'hospital-onset' cases in 18/19 and 8 HOHA/COHA cases in 19/20, it is anticipated that the Trust's rates for 19/20 should remain low when the national indicators are published.

The Trust hospital-onset rates for the past 12 years are reported in the graph and figure below:



Period		Homerton University Hospital NHS Foundation Trust Count	Value	Lower CI	Upper CI	London	England
2007/08	○	58	43.9	-	-	78.0	89.6
2008/09	○	50	39.6	-	-	42.8	52.9
2009/10	○	24	18.5	-	-	29.8	35.4
2010/11	○	10	7.9	-	-	27.9	29.7
2011/12	○	9	7.2	-	-	21.2	22.3
2012/13	○	13	10.2	-	-	17.5	17.4
2013/14	○	2	1.6	-	-	14.4	14.7
2014/15	○	7	5.2	-	-	16.0	15.0
2015/16	○	10	8.1	-	-	14.8	14.9
2016/17	○	4	3.3	-	-	13.3	13.2
2017/18	○	10	9.1	-	-	13.7*	13.6*
2018/19	○	3	3.1	-	-	11.3*	12.2*

Source: HCAI Mandatory Surveillance Data

Assurance statements

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

The data for results up to 18/19 has been taken from the Public Health England (PHE) 'Fingertips website (accessed on 28/07/20): https://fingertips.phe.org.uk/profile/amr-local-indicators/data#page/3/gid/1938132910/pat/158/par/NT_trust/ati/118/are/RQX/iid/91968/age/205/sex/4/cid/1/page-options/ovw-do-0_car-do-0

The unbenchmarked data for 19/20 is the data taken from the Trust's Winpath system and submitted, after Chief Executive sign off, to the PHE surveillance website on a monthly basis. This data is cross-checked by the DIPC pre-sign off on a monthly basis by comparing a spreadsheet of the monthly Winpath laboratory data (extracted by the Microbiology laboratory manager) with the data submitted to the PHE website by the Infection Prevention & Control nurses.

All Trust-attributable *C.difficile* cases are reported as incidents and followed up by the ward team & Infection Prevention & Control team in partnership using a Post Infection Review (PIR) tool. The PIRs are then reviewed and signed off by the Trust's Assurance Panel.

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 prompt laboratory testing processes.

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.

The Trust intends to take the following actions to continue to decrease the rate of Trust-attributable *C-difficile* infection where there are lapses in care identified. However it must be recognised that some cases of *C.difficile* infection are not avoidable.

- *C.difficile* awareness teaching is included in the Infection Prevention & Control mandatory induction & annual update training.
- Focus on timely isolation of all ward patients with diarrhoea (where there is a possible infective cause) whilst awaiting *C.difficile* testing results.
- Focus on timely sending of diarrhoea samples for testing for *C.difficile* enabling prompt identification of *C-difficile* toxin positive cases.
- Environmental decontamination by 'terminal' cleaning of the patient's bed space on side room transfer (if applicable) and after discharge from side room
- 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 using a Post Infection Review (PIR) investigation tool 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.

8. Patient Safety Indicators – NHSI Quality Indicator 25

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'.

Indicator	Reporting Period	Homerton Performance		National Average*	Lowest Performing Trust*	Highest Performing Trust*
Number of patient safety incidents	Apr 2019 – Sept 2019	**2772**		6276	1392	21,685
Rate of patient safety incidents (per 1000 bed days)		**65.39**		50	26.3	103.8
Number (%) of patient safety incidents resulting in severe harm or death		Severe	**4(0.1)**	14.6 (0.0018%)	0 (0%)	76(0.4%)
		Death	**0(0%)**	4.8 (0.0005%)	0 (0%)	24(0.7)
Number of patient safety incidents	Oct 2018-March 2019	**2917**		5841	1278	22,048
Rate of patient safety incidents (per 1000 bed days)		**64.82**		46	16.9	95.94
Number (%) of patient safety incidents resulting in severe harm or death		Severe	**6(0.2%)**	13.7(0.00185)	0 (0%)	62(0.3%)
		Death	**3(0.15)**	5.1(0.00075)	0 (0%)	23(0.3%)
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)

Table 17: reported patient safety incident data uploaded to NRLS; (NHS Digital)

Assurance statements

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

The Trust submits all eligible incidents to the National Reporting and Learning System. The latest information available from NRLS covers the first half of 2019/20 (April – September 2019). For this period, Homerton was noted as a relatively high reporting Trust when compared nationally (see figure 4 below).

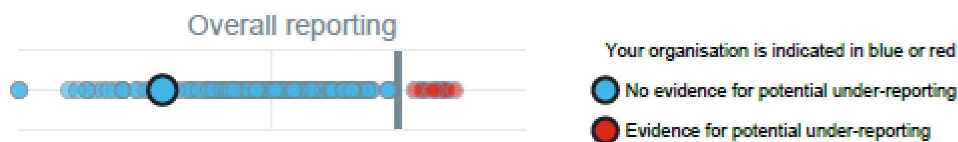


Figure 4: reporting to the NRLS April – September 2019

During this period, there were 65.39 incidents reported per 1000 bed days, an increase from 63.02 incidents per 1000 bed days over the same period in 2018.

The latest available NRLS data also shows that there has been some improvement in the timeliness of incidents being uploaded to the NRLS system. On average, 50% of incidents were submitted 54 days after the reported incident date, an improvement from April – September 2018 when 50% of incidents were uploaded 65 days after the reported incident date. This delay is partly due to the fact that the Trust only uploads incidents to NRLS once they have been finally approved on Datix, but the improvement is also a reflection of the work that has taken place with incident handlers to ensure incidents are investigated and closed off in a timely manner.

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.
A number of broad areas of work will be prioritised during 2020/21, including:

- Implementation of the Patient Safety Strategy, and in particular ensuring the Trust is fully prepared for the introduction of the new Patient Safety Incident Response Framework, which will replace the SI Framework during 2021. This will require a significant programme of work involving staff across the whole organisation
- Continuing the Datix improvement project, focusing on developing and improving the complaints, claims and risk register modules, and introducing the dashboards module more widely across the organisation.
- Further strengthening the way in which learning from incidents and investigations is shared and in particular working more effectively with the legal, complaints and PALS teams to ensure that information is shared in a useful and timely fashion, and so that themes that cut across complaints / incidents / claims etc can be identified.
- We will undertake a review of the way in which patients and their families are involved in the investigation process, including looking at the Duty of Candour process and the ways in which investigation reports are shared with the family. This objective has been carried over from last year's plan.
- Working to develop a more comprehensive training programme for staff around different aspects of patient safety, including Duty of Candour, human factors and investigation techniques.
- Ensuring that the team remains flexible and responsive so it can respond to any future challenges presented by COVID-19 and continue to support the rest of the organisation as required.

9. Patient Experience: Friends and Family Test

Since 2013/14, providers of NHS healthcare have been asked to consider reporting on the patient element of the Friends and Family Test in the quality accounts (as part of the letter referred to on page 4 of this document). As this is not a statutory requirement, the patient element of the Friends and Family Test it is not reported in the same way as the indicators above.

Homerton Hospital ensures that our patients and their families have the best possible experience of our treatment and care.
Receiving feedback is vital in improving our services and supporting patient choice and to support this, alongside our existing feedback collection methods, we are exploring alternative means of participation in all of our patient experience work, to offer greater options for service users to provide feedback on their experience of care.

We strive to improve patient experience and has successfully maintained a high rating and work continues to guarantee that patient experience on the care delivered meets the expectation of those who use our services.
In 2019/20, 18,688 people told us about their care and treatment as part for the Friends and Family Test Overall 93% of patients have had a positive experienced whilst using our service.

Domain	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020
Caring	92.31	91.70	91.08	91.87	93.66	91.55	92.21	92.96	92.39	94.30	93.83	92.47
Decisions About Care	91.92	92.12	90.87	92.05	92.55	91.36	91.85	91.90	91.44	92.43	92.61	90.76
Effective	87.45	85.63	84.06	82.85	86.34	83.16	82.54	82.80	83.47	84.50	85.83	82.62
Respect and Dignity	95.66	95.96	94.58	94.57	96.07	94.61	95.16	95.37	95.42	96.93	96.14	94.22
Responsive	89.68	81.57	83.45	79.55	74.94	74.70	83.83	84.16	83.90	89.37	87.84	84.16

Table 18: Friend & Family Test domains heat map

Assurance statements

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

On average data from our real time patient experience data showed 95% of patients reported being treated with dignity and respect (96% Picker 2019) and 92% (86% Picker 2019) of patients responded positively to being involved in decisions about their care. Trust overall percentage for poor experience benchmarked is lower than National average.

Our annual national Picker patient survey results showed notable improvement in most areas.
According to the report on inpatient survey, patients who received hospital based care from our Trust rated their experiences highly and in a number of areas better than the care delivered at other trusts across England.

Whilst the data demonstrates very high levels of satisfaction, the Trust is aware that the response rate

in very few areas is low, therefore may not be an accurate or reliable indication for those areas.
To ensure completeness of understanding, the information should be looked at alongside complaints and safety incidents.

The changes and improvements that have been made to date include:

- Production of monthly patient experience dashboard, displayed in all areas.
- Visual identifiers are used across inpatient wards for patients with dementia. The identifier (Forget Me Not flower) is intended for staff to think about their intervention with the patient e.g. that the patient may need additional reassurance or support.
- The Carers Passport was introduced following consultation with carers. The passports can be issued to carers of someone with LD or dementia who would like to visit outside of visiting hours to help support with communication and emotional needs
- The Trust has embedded use of the Royal College Nursing/Alzheimer's Society 'This is me' booklet which outlines details about the patient, important routines likes/dislikes, treasured possessions and key information about their background – e.g. where they grew up, important people in their lives etc.
- Patient experience feedback is now fully used as part of the Trust's wider improvement plan. For example, Trust's priorities for Improving First impression and Experience for Patient and Visitors, there is an on-going work in ensuring all patients are welcomed, treated appropriately and care taken to ensure they've given full information about their visit and on-going care.
- End of Life Care strategy –with the introduction of Swan Scheme on all wards End of Life patients receive personalised care

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

- To encourage more people to tell us about their experiences by providing a patient engagement and feedback module.
- Encourage individual departments to effectively manage the feedback for their areas of responsibility. Patient experience team will support this by providing customised training for managers and leads.
- Enable service nominated individual to produce specific dashboard that will give them an overall impression of the feedback received, and will also guide the service to look deeper into issues raised and discuss at departmental meetings. Individual services will work with patient experience to develop action plan.
- Understanding what matters to staff; with the people plan to include health and wellbeing programme for staff
- Develop patient stories; create a central storage and access point that will enable an overview of the impact. Understand the experience of being a patient with an overall aim of demonstrating how we can play a critical role in optimizing the power of the story in the patient's journey towards physical and psychological healing.
- Develop an integrated process of ensuring that evidence of lessons learned and changes to practices are captured, recorded and disseminated in a systematic way both centrally and locally across patient experience feedback, incidents, PALS, complaints, claims and Safeguarding.
- Patient experience and user engagement forum is underway which brings together individual service engagement programs and plans. This will see users and other stakeholders give their views on patient safety, satisfaction and experience to help identify actions for improvement. Impact will be measured by an ongoing monitoring from improving patient experience committee.

- Ensure there is mixed methods to feedback that will continue to promote and encourage patients, visitors and families to provide feedback on their experiences using a range of feedback options.

3.0 Part 3: Other information

3.1 Overview of the progress with the Trust's 2019/20 quality priorities

The following summary slides describe the progress of each quality priority, the actions taken to drive the priorities and the key risks identified going forward;

1. To reduce the number of community and hospital attributed pressure ulcers

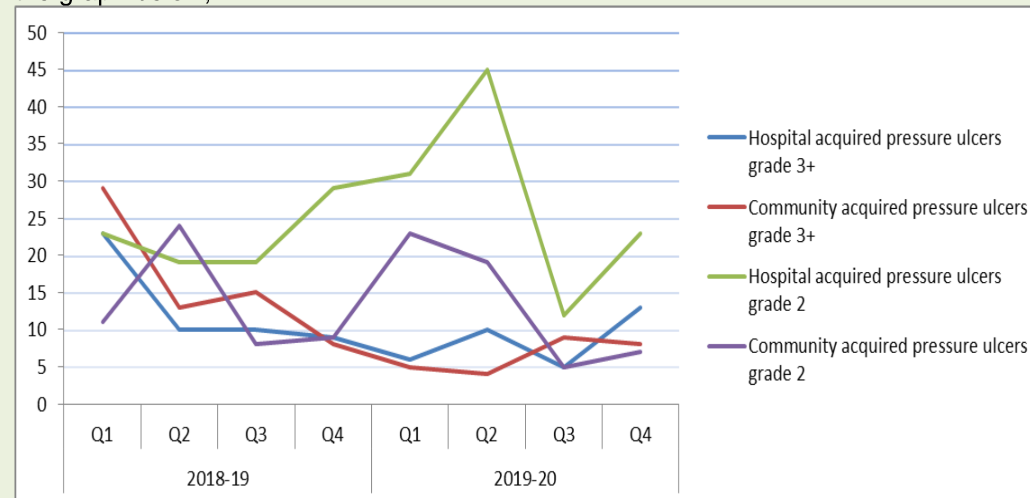
Back ground
Carried forward from 2018/19

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.

Final position statement – April 2020

- The pressure Ulcer Scrutiny Committee (PUSC) meets monthly and reports to the Quality and Safety Board.
- Agreed objectives for 2019/20 relating to the reduction both hospital and community acquired pressure ulcers scored at grade 3+ and grade 2+
- HUH participated in the NHSI collaborative to support clinical practice improvement in the management of pressure ulcers.
- Tissue Viability (TV) team and the senior nursing management team attended 3 national study days
- Data reviewed in relation to the number and grade of pressure ulcers and the key themes. Initial action plan implemented for 2 ward areas and a community cluster; ECU, ACU and Cluster 4.
- TV team participated in the "Stop the Pressure Ulcer Day"

Grade 3+ and grade 2+ metrics monitored over 2018/19 and 2019/20 are displayed on the graph below;



Actions to sustain

- Action plan to improve the assessment of patient's skin in accordance to national guidance, ensuring the assessment is correct and escalation is appropriate.
- Quality rounding with the ward sister and TVN has been trialled on several wards. Involves assessment of the patient, care given and review of documentation.

Key risks going forward

- Modification in data collection methodology.
- Improvements to reports generated from Datix
- Replacement of the national Safety Thermometer monthly audit.
- Timely completion of root cause analysis

Outcome

Priority to be carried forward into 2020/21

Continued oversight to be provided by the Improving Patient Safety Committee

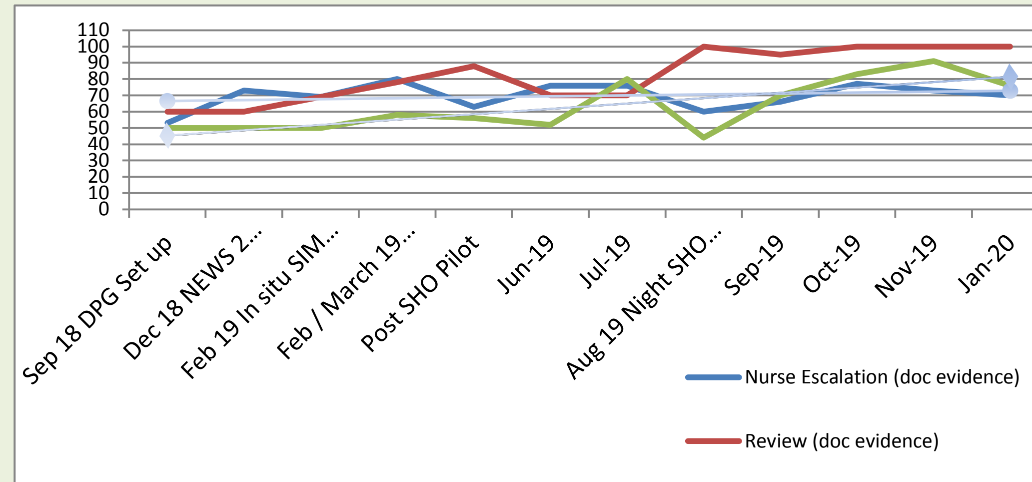
2. Appropriate identification and management of deteriorating patients

Back ground
Carried forward from 2018/19

The Deteriorating Patient Group (DPG) to build upon the work established in 2018/19.

This priority will also include the timely identification and treatment of patients with sepsis
.

Final position statement – April 2020



During 2019/20 the DPG have:

- Launched a New Deteriorating Patient SHO rota to ensure added capacity and skill to respond to Deterioration. This has led to significant Improvement in the number of patients reviewed who have deteriorated and in the timing of that review.
- Launched the NEWS 2 system for tracking physiological deterioration across the Hospital
- Launched a New Electronic Patient view allowing overview from EPR of all patients with raised NEWS 2 scores across the hospital
- Begun a quality improvement project focused on the quality of Non Invasive ventilation care given on the wards
- Implemented redesigned working rotas to respond to the Coronavirus pandemic
- Rapidly launched a new service to offer CPAP therapy to COVID patients including training medical and nursing staff to deliver this.
-

Actions to sustain

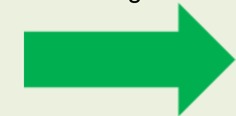
- Review the data for COVID 19 patients who were offered CPAP and ensure learnings captured for future potential waves of infection.
- Following a pause over the COVID 19 pandemic aim to relaunch Deteriorating Patient Group and continue with the measurement of escalation and response data

Key risks going forward

- Further waves of COVID infection could challenge the resources needed for further new quality improvement.
- The process of learning from the pandemic is required to enable the DPG key actions for the next 12 months

Outcome

Priority to be modified to support maternity and paediatric services during 2020/21.



DPG will continue to support this objective and report progress to the Improving Clinical Effectiveness Committee.

3. Reducing physical violence and aggression towards patients and staff

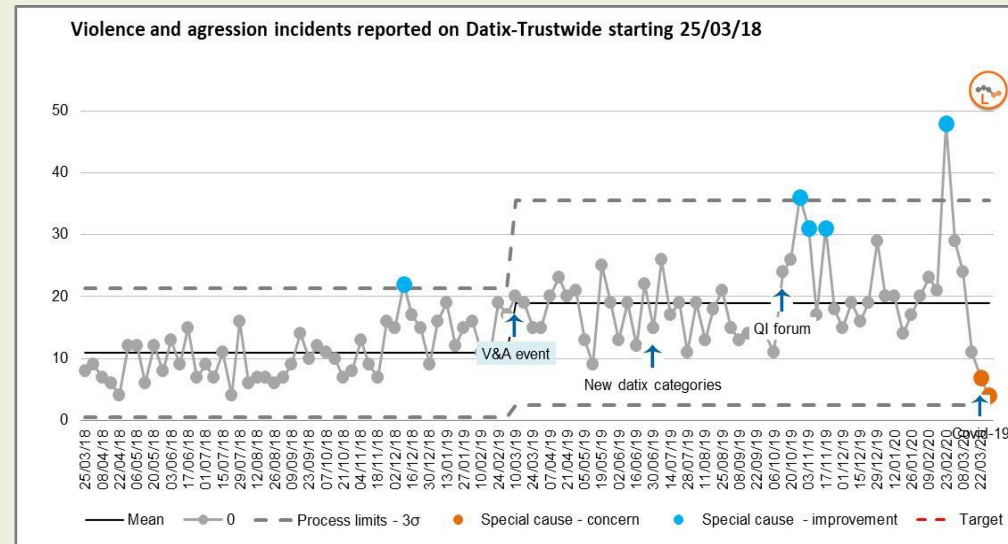
Back ground
Carried forward from 2018/19

The most recent national 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.

Final position statement – April 2020

- STOP violence against our staff campaign launched March 2019, body cameras issued to security staff
- V&A quick reporting form introduced June 2019
- QI forum in October 2019 in partnership with ELFT
- Annual staff survey – 'You said – we did'
- 15 yellow and 3 red cards issued since January 2019
- Working with the Metropolitan police to complete risk assessments for staff
- Maybo enhanced conflict resolution training now delivered in-house to clinical and non-clinical frontline staff with patient contact.

Raising staff awareness and improved reporting procedures has resulted in a 47% increase in the number of incidents reported during 2019/20 when compared to 2018/19



Actions to sustain

- Continued V&A reporting on Datix
- Staff being clear about individuals, line managers and senior manager's responsibilities.
- Identifying V&A champions in each area to support staff.
- Continue bespoke training for front line staff.
- Providing all our staff access to consistent support

Key risks going forward

- Raised awareness of the issue may result in an increase in the number of incidents reported on Datix.
- Delivering Maybo training on-going,

Outcome

Priority to be carried forward into 2020/21

Continued oversight to be provided by the Improving Patient Safety Committee

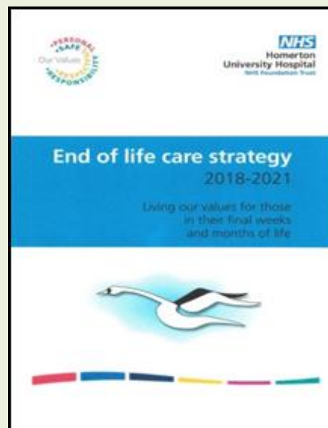
4. Improving management of end of life care for adults

Back ground
Carried forward from 2018/19

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

Final position statement – April 2020

- National Audit Care at the End of Life 2019 demonstrated significantly improved scores in all 5 areas measured when compared to 2018.
- Few responses on quality survey from family members. However, these are discussed at End of Life Board.
- Education and training sessions delivered to over 80 nurses since November 2019 on how to implement the Swan scheme as stated in the Trust's EoL strategy.
- Rapid discharge QI project is aimed to facilitate a smooth and timely discharge for patients who have been identified to be in the final hours, days or weeks of life, and where patients and families wish for care to be delivered at home
- Improved identification and handling of complaints related to EoL patients due to changes introduced on Datix



Actions to sustain
- Audits of treatment escalation plans and end of life care plans.
- Feedback from bereavement survey.
- QI projects on EoL discharges and roll out of the Swan scheme
- Introduction of Palliative Outcome Measures January 2020.

Key risks going forward
- Percentage of staff receiving end of life training
- Impact of moving to a 6 day service
- Further roll out of the Swan scheme postponed because of Covid-19 – this has been addressed in 20/21.

Outcome

Significant progress made quality priority not to be carried forward into 2020/21. Service rated Good by CQC.

EoL and palliative care team will continue reporting to the Clinical Effectiveness Committee.

5. Making Every Contact Count (MECC)

Back ground

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.
Implementing MECC in partnership with the Commissioners 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.

Final position statement – April 2020

1. Completed scoping interviews/activity
a) Interviews complete with stakeholders from partner organisations
b) 12 workshops/facilitated discussions with resident groups and frontline health and care staff were delivered.
c) Defined the scope (staff groups, topics, settings) for the co-design and testing phase.
2. Developing a logic model and evaluation framework
a) Continue to take a pragmatic approach, balancing the need for 'good enough' evidence of the impact of the programme against the resources/time required to gather this evidence

3. MECC training provider procured
a) Developed a service specification, conducted a market testing exercise (to inform what we could get for our budget) and a competitive tender exercise.
b) Provider will lead on co-design and delivery of a skills-based MECC training programme for City and Hackney's frontline staff

4. Communications and engagement strategy
a) Contact made with nine teams across the UK that have implemented MECC on a scale similar to City and Hackney's vision.
b) Draft strategy developed collaboratively with residents, frontline staff, and other key stakeholders.

5. Held the second MECC steering group
a) Members are from key partners across Hackney and the City and will act as MECC champions, coordinating actions on behalf of their organisation and help to unblock operational and strategic barriers to implementation.

6. Completed quality improvement projects
a) Maternity smoking cessation
b) Wider determinants of health in a musculoskeletal outpatient setting

Actions to sustain

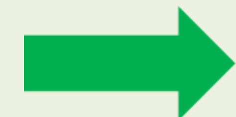
- Implement recommendations from the scoping phase
- Finalise scoping report, models and evaluation framework
- Finalise logic Mobilisation of training contract
- Present programme update to the Prevention Core Leadership Group, Accountable Officers Group and Integrated Commissioning Board.
- Plans for MSK and Maternity services on hold due to Covid-19

Key risks going forward

- Slow implementation due to self-assessment and system wide stakeholder approach
- Relaunch programme post Covid-19

Outcome

Priority to be carried forward into 2020/21



Continued Oversight to be transferred to the Improving Patient Experience Committee

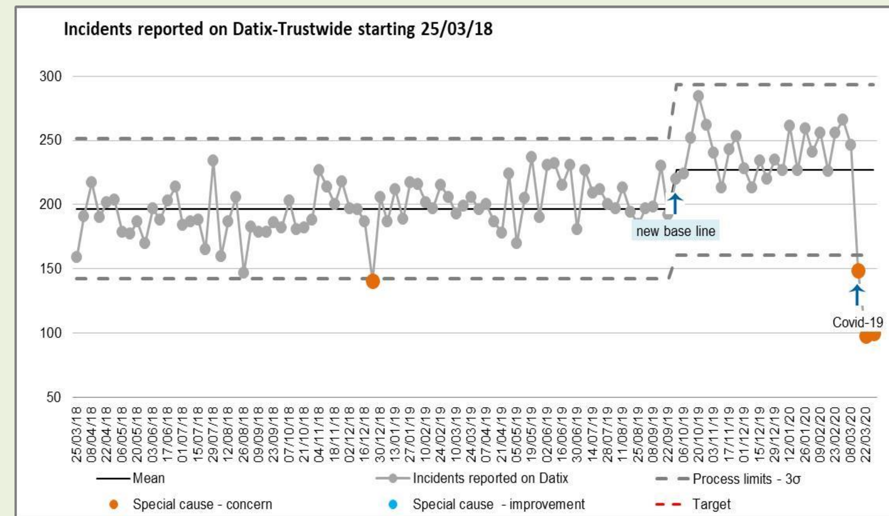
6. Learning from complaints, incidents, claims and compliments

Back ground

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 feedback to staff and shared across the organisation and practice is changed to prevent recurrence..

Final position statement – April 2020

- Updated Datix incident categories and reporting forms, easier to extract themes and learning – resulted in increased reporting



- Introduced Datix “auto feedback” to reporters
- Quarterly DoC audits of evidence attached to Datix (100% Q1 2019/20)
- Improved incident data presentation in TMB reports using SPC charts
- Exec briefing includes summary (SI's, Never events, open incidents, Complaints, PALS, Claims, inquests and safeguarding concerns)
- Strengthened divisional governance meetings
- Patient Safety Event held November 2019, covered human factors, trends, patient safety systems, mortality.
- HSIB reports for maternity shared with the patient and relatives
- Using simulation teams for post incident learning exercises
- Learning shared via staff newsletters (for example QTc)

Actions to sustain

- Finalise process to disseminate learning to staff outside of formal meetings (SI learning alert)
- Development of Datix dashboards for incidents, complaints and claims
- Review of Datix modules for claims and complaints
- Scoping exercise with Patient Experience and Claims Robust mortality review process.

Key risks going forward

- Further development of after action review process required
- Launch of post serious incident learning
- Interim Leads in place of Patient Experience team

Outcome

Priority to be carried forward into 2020/21

Continued oversight to be provided by the Improving Patient Safety Committee

Homerton Quality & Patient Safety

NHS Homerton University Hospital NHS Foundation Trust

7. Improving the first impression and experience of the Trust for all patients and visitors

Back ground

The First Impressions project aims to create a culture where patients, visitors and staff experience a positive and helpful first impression(s) when they visit our services.

Final position statement – April 2020

The First Impressions Group had continued to prior to the pandemic, nominating two governors as members. There is a work plan and agreed standards which was piloted in CSDO with a view to transfer the approach throughout the Trust.

- Posters to ensure that the patients and visitors were aware of our standards, to be produced post Covid-19 pandemic.
- At the end of the financial year 100% of the CSDO administrative staff members had undertaken Customer Care Training. Training was to rolled out to the rest of the trust later in 2020 has been delayed due to Covid-19.
- Training sessions to be rebooked once it is safe to do so, as the course dates were nearly at capacity following recommendations from colleagues.
- The course has received high praise and staff have fed-back that they feel more confident when dealing with patients who are angry or frustrated, understand when they should escalate issues and to whom.
- “Hello My Name is…” badges would be ordered for staff and several teams have ordered the badges already.
- Agree uniform to provide clear identity for reception staff and volunteers
- Reception signage when areas are temporarily unstaffed
- Hospital signage for areas not frequented by patients; e.g. blood clinics

Actions to sustain

- Staff training programme to relaunch post Covid-10
- Review hospital and reception signage
- Consider 6 C’s approach
- QI projects started;
  1. To improve the number of completed client experience feedback collected by 10% within the next 3 months, at all contacts.
  2. To reduce the average time clinics outpatients overrun from 1hr 30 mins to 45 mins by November 2019.

Key risks going forward

- Roll out of associated staff training programme
- Consider disability requirements. Awaiting further work Trust-wide

Outcome

Priority to be carried forward into 2020/21

Continued oversight to be provided by the Improving Patient Experience Committee

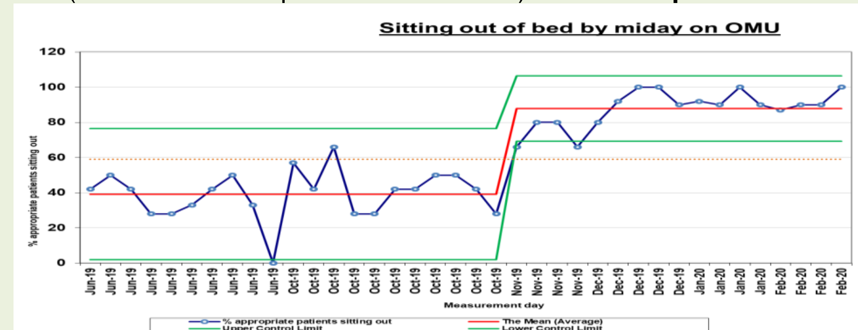
8. Getting Patients Moving (End PJ Paralysis)

Back ground

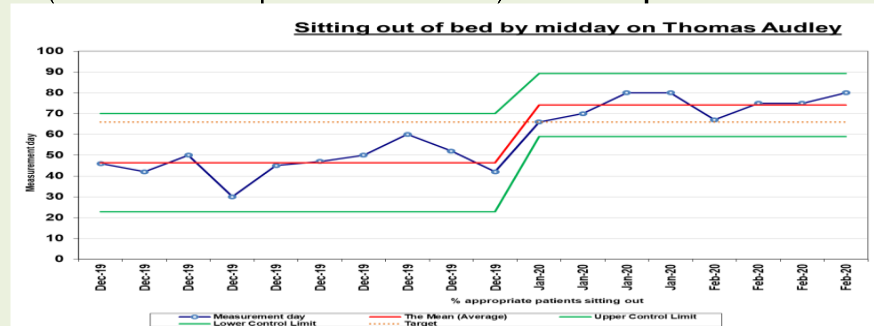
EndPJParalysis is a global social movement embraced by nurses, therapists, and medical colleagues. It's aim: to value patients' time and help more people to live the richest, fullest lives possible by reducing immobility, muscle deconditioning, and dependency at the same time as protecting cognitive function, social interaction and dignity. Getting patients up and moving can:
Reduce falls within an organisation, reduce pressure ulcers, and complaints,
Reduce length of stay by up to 1.5 days.
Reduce the development of hospital acquired disabilities (HADs).

Final position statement – April 2020
A review of the patient DTOC Action Plan and with key stakeholders identified 1 key priority:

- Increase the number of patients getting up and moving by midday across 2 wards by 20%
- QIP data from July – November 2019 period – GSU and ECU
- GSU (baseline 36.4% up to 84.6% in Nov) = **48.2% improvement**
- ECU – (baseline 50% up to 71.3% in Nov) = **21.3% improvement**
- QIP project continues on OMU and Tomas Audley (TA) to increase the number of patients sat out of bed by midday.
- QIP data from December 2019 – March 2020 period
- OMU – (baseline 39.1% up to 87.8% in March) = **48.7% improvement**



- TA – (baseline 46.1% up to 74.4% in March) =**28.3% improvement**



Actions to sustain

- Expanding quality improvement projects to other wards – EC and ITU
- Establishing a hospital wide working group with representation from each ward
- Continued communications – newsletter, Twitter, bi-monthly reports
- Intra and internet pages
- Band 5 and 6 on-going nurse training
- Engaging experts by experience coproduction group.
- Design how we will get people into their own clothes

Key risks going forward

- Impact of Covid-19 on wards and staff
- Limited engagement with staff
- Failure to embed changes within daily practice
- Engagement of patients and families to participate with "get up, get dressed, get moving".
- Action plan in place to mitigate risks as part of project design framework

Outcome

Priority to be carried forward into 2020/21

Continued oversight to be provided by the Improving Patient Experience Committee

9. Improvements in staff health and wellbeing

Back ground

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.

Final position statement – April 2020

- Actions implemented 2019/20:
- Healthy Living Ambassadors established, monthly emails / quarterly emails to them are all well established
- Part of a London wide NHS employers sub group for sharing of health and wellbeing ideas, meetings are quarterly.
- Homerton 2020 Step challenge on hold due to Covid 19
- Bollywood X classes now established, unable to start Circuit training due to lack of interest.
- Funding was secured for both Mindfulness and Mental Health first aiders but due to the Covid-19 situation we have not been able to progress them any further so currently on hold.
- In response to the Covid-19 pandemic the Trust has established various initiatives to assist and support staff's health and well-being during this time.
- Promotion of Health Assured the Trust's Employee Assistance Programme
- Establishment of a 'Wobble Room' where staff can relax and unwind and pick up some treats
- Facilities team distributing 'goodies' to staff across the organisation on a daily basis
- Daily all staff briefings, which always feature health and well-being, intranet pages update to date with all information for staff
- Executive team webinars so staff can speak to and ask questions
- Going home check lists
- Various information sheets for staff e.g. sleep, diet, etc.
- Promotion of well-being apps and offers
- Talk Changes Psychological support for staff
- NHS People support line
- Additional support for staff who may need some additional support around gynaecology and dermatology services for staff have been established.
- General wellness offers around childcare support / parking/ travel/ accommodation have all been promoted across the organisation

Actions to sustain

- Relaunch the initiatives that we put on hold due to Covid-19

Key risks going forward

- Staff engagement & NHS staff survey completion rates
- Working with the LBH and CCG has not been occurring due to change of staffing within those departments.

Outcome

Priority to be carried forward into 2020/21

Continued oversight to be provided by the Improving Patient Experience Committee

NHS
Homerton
University Hospital
NHS Foundation Trust

3.1.1 Quality Improvement at the Homerton

'Quality Improvement' (QI) can be defined as an approach to problem solving and improving service quality, efficiency and morale simultaneously, using improvement science. Homerton's QI activities are supported by a small central team which helps to foster an 'improvement mindset' in staff across all Trust services. This year the team sought to build QI skills through 'learning by doing' – ensuring that staff put QI training into practice by carrying out QI Projects. During 2019/2020 over half of the 216 staff who completed training registered a QI Project. Over a third of registered projects were completed within 120 days.

An innovative feature of QI at Homerton is the development of a blended approach to QI methodologies with the creation of a Homerton QI Toolkit featuring IHI Model for Improvement and Lean tools. Next year we will focus on building a network of QI advocates and champions able to support their colleagues in delivering improvements in care that is linked to the service and Trust quality priorities.

QI Projects were showcased at the monthly QI Forum, which is open to all staff. This year we have made efforts to align the QI Forum topics with the Trust Quality Accounts. The forums provide an opportunity to showcase the numerous QI projects that assist supporting the delivery of the priorities, as shown in the table 19 below.

Priority 1. To reduce the number of community and hospital attributed pressure ulcers	**Priority 2.** Appropriate identification and management of deteriorating patients	**Priority 3.** Reducing physical violence and aggression towards patients and staff	**Priority 4.** Improving management of end of life patients for adults	**Priority 5.** Making Every Contact Count (MECC)	**Priority 6.** Learning from complaints, incidents, claims and compliments	**Priority 7.** Improving the first impression and experience of the Trust for all patients and visitors	**Priority 8.** Getting Patients Moving	**Priority 9.** Improvements in staff health and wellbeing
February 2020 Getting the most from national and regional collaboratives NHSI Pressure Ulcers	**May 2019** Treatment escalation planning on ECU	**October 2019** Reducing violence and aggression at ELFT: using a QI approach to tackle complex issues	**July 2019** Equality, diversity and inclusion in palliative and end of life care	**January 2020** Making Every Contact Count In Maternity and also in AHP services	**April 2019** Using Datix to monitor patient safety Improving discharge safety in the maternity service	Not applicable – no QI projects registered or completed.	**February 2019** Move, Groove and Improve on ECU and GSU	**June 2019** Improving enjoyment and wellbeing at work – a QI approach in Children's Speech & Language Therapy (Shortlisted for NHS Elect Award 2019)

Table 19: Quality Improvement projects supporting quality priorities.

3.3 Performance against national indicators

The Trust performed strongly during 2019/20 and delivered the majority of the national operational standards during this period. For the standards that the Trust did not meet, it should be noted that in relation to the A&E waiting time standard, the Trust performed comparatively well compared to the majority of its London-peers, as well as nationally. With regard to MRSA, it is important to note that the target was missed due to one hospital-acquired case.

The table 19, below, sets out performance against the key indicators contained within the Risk Assessment Framework. The performance has been presented on a cumulative basis for the year, although we, as with all NHS trusts, were required to report to NHS on a range of measures quarterly

Key Performance Indicators	2019/20 Target	2019/20 Performance
A&E patients discharged < 4hrs	**95%**	**93.75%**
Cancer		
2 Week Wait	**93%**	**97.86%**
31 Day Target	**96%**	**99.30%**
62 Day Target	**85%**	**86.93%**
Infection Control		
MRSA	**0**	**1**
***Clostridium difficile* (*C.diff*)**	**12**	**8**
18 Week RTT Indicator		
Incomplete Pathways	**92%**	**95.13%**
IAPT Indicators		
6 week target	**75%**	**96.81%**
18 week target	**95%**	**99.60%**

Table 20: national indicators

Monitoring quality and performance

Performance against key metrics is monitored and reviewed by the executive directors at senior team meetings. The Trust Board considers detailed performance and quality information each month.

Annex

1.0 Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

1.1 Healthwatch Hackney

Catherine Pelley
Chief Nurse
Homerton University Hospital Foundation Trust
Homerton Row, E9 6SR

3rd September 2020

Dear Catherine,

Draft Quality Account

Thank you for sending us the draft Quality Account (QA) for review and comment. We very much appreciate Homerton Hospital seeking views on its QA given the challenges of the coronavirus pandemic. We know this has been a very difficult time and that Homerton staff have risen to this challenge admirably.

We congratulate the Homerton on achieving an Outstanding rating from the Care Quality Commission. We are pleased at the work the Homerton is doing to ensure BAME staff are supported and risk assessed. We further welcome Homerton's decision to ensure ISS contracted staff have the same sick leave conditions as salaried staff.

We know from our research the Homerton is a locally respected institution. We believe the Homerton demonstrates a clear ability to respond to local need. In this context we strongly **RECOMMEND** the Homerton to actively seek control of the St Leonards Hospital site, from NHS Property Services Limited, and works with local health and care leaders, to shape the services at the hospital to meet local need and to co-produce future developments at St Leonards together with local people.

We found the Quality Account interesting and informative. There are some areas where we feel clarification is required and where we have made suggestions and recommendations.

1) **RECOMMENDATION:** We would like a short form of the QA to be to be available for the Annual Trust Board meeting and for HUH Members and the public. This would aid the public appreciation of the Homerton and its work.
2) **P2-3** Outcomes. We are surprised that only 2 of 9 Quality Account priorities have been achieved. We would like to understand more about the impact on patients of this delay in achieving the QA priority objectives. Not achieving the majority of QA priorities would seem to undermine the purpose of these QA objectives. We are particularly concerned that the following objectives carried over from 2018/2019 have not been met.
    - **1) To reduce the number of community and hospital attributed pressure ulcers**
    - **7) Improving the first impression and experience of the Trust for all patients and visitors**

3) **P5/6** – We would like to see how to access the full outcomes of all Clinical Audits carried out by the HUH and the impact on the care you provide. Appendix A is not attached but Table Six does provide a very useful summary of outcomes of some Clinical Audits. We would for example like to see the outcome of the 'Mental Health - Care in Emergency Departments Royal College of Emergency Medicine (RCEM) audit'. We have concerns, that we have shared with HUH in the past, about patients in a mental health crisis, experiencing long waits before being transferred to an appropriate service.

4) **P9** -The role of the Quality Improvement (QI) team should be explained in relation to both QA priorities and Clinical Audits.

   Has progress has been made in relation to the finding that:

   "*Globally, many measures of patient experience are scored low at the Homerton Hospital, ranging from choice of suitable meals, through to staff being definitely, or to some extent, able to answer patients' diabetes related questions*"

   And how successful the HUH has been in: "*Addressing spiritual, social and cultural needs"* in relation end-of-life care.

   Regarding the National Diabetes Audit – Action completed bullet 3. This is a very important point about how health inequalities drive this condition and impact on patient experience. At the end it says the:

   "*Trust continues to monitor the results for opportunities where these can be made".*

   Please explain what this means. Also, how HUH is raising this as a concern locally, e.g. through the Health and Well-being board and Integrated Commissioning?

   With respect to the: "*National Emergency Laparotomy Audit (NELA)"* can you confirm that you have sufficient surgical resources for emergency laparotomies 24/7.

5) **P12-16 Local Audits reviewed 2019/2020**
   We were very impressed by the range, depth and outcomes of the Local Audits carried out by the HUH.

6) **P17 – 2.2.3**
   Sally Davies is not CMO. She retired from the job in 2019 and is now the UK Special Envoy on Antimicrobial Resistance.

   In para two and three we are not sure what is meant by (*in italics*):

   "Much of the care that we deliver at the moment is based on uncertainties of experience but not on evidence".

   "We aim to ensure that staff, patients and families understand the importance of research and research is seen and a benefit and not a compromise to NHS clinical activity.

   In paragraph five, what steps are you taking to ensure that research will resume in 20/21?

7) P18 – 2.2.4

Please provide examples of CQUIN goals and outcomes.

2.2.5 REPETITON IN CQC SECTION

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

Homerton University Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The text in CQC section is a little confusing to the non-specialist, because whilst HUH had no special reviews or investigations, you did have a focused inspection of maternity, end of life and medical care, and had both a finding of Outstanding and a notice regarding maternity of "Requires Improvement". There was also the CQC Inspection of Mary Seacole Nursing Home.

Perhaps this section could be rewritten in a more accessible way?

2.2.6 and 2.2.9

Text needs clarifying regarding the establishment of acute and community Data Quality Committees. Some parts of the text are contradictory and repetitious.

P20 2.2.7 the DSPTK - Data Security and Protection Toolkit

Please clarify why HUH is non-compliant.

P20 2.2.8 CLINICAL CODING ERROR RATE

It is not clear what is meant by the 'error rate'.
Why does the section only refer to coding for 'diagnosis and operations?

P21 2.2.10 LEARNING FROM DEATHS

Can this paragraph explain the rise in deaths in Q 3 & 4, and the relevance of the star?

Reporting quarter 2019/20	Number of deaths	Number of completed reviews
Quarter 1	84	72
Quarter 2	82	77
Quarter 3	108	101
Quarter 4	147*	128

Table 8: mortality reviews completed per quarter -includes Covid-19 deaths

- Please explain what is meant by: Design of an ICD deactivation flowchart.

We RECOMMEND that:

a) Details of all recommendations made by Coroner's to the HUH (Coroner's Regulations 28 (Prevention of Future Death Reports) are placed in this QA.

b) Action taken by the HUH in response to Coroner's recommendations and evidence of implementation should also be placed in the QA.

P22/23 2.2.10 CMC – Coordinate My Care
It is not clear what the purpose of the SOP&GP is.

The purpose of CMC is explained clearly.

The acronyms SHO, ICD, NEWS, MDT should be explained

RECOMMENDATION: Patients should be advised about the purpose and content of their CMC plan. They should also be advised how to initiate a CMC if they believe this would be useful for themselves or family members during a medical emergency. We can provide a draft leaflet for the HUH on this matter.

P24 2.2.11
It is of great concern that only 87% of patients received a Consultant review within 14hrs of admission. Is there any evidence of harm to those patients not seen within 14hours? Is a raised NEWS the only risk factor for patients who are not seen by a Consultant who is specialist in their condition, within 14 hours?

P24 2.2.12 SPEAK UP SAFELY
We congratulate the HUH on agreeing to provide access for ISS workers to the Freedom to Speak Up Guardians.

This is a very good and important section - it should be more highly profiled in the report (and mentioned in the Executive Summary) to demonstrate Homerton's commitment to an open culture. The QA, would benefit from an example where this worked successfully for HUH staff.

P27 2.3 Reviewing mental health and learning disabilities (LD) deaths

Please clarify if there were any deaths of patients with mental health problems. How are MH problems for this section defined?

We note there were six death in the period covered by the report for patients with LDs. Please include the consequent improvements for health and social care services for people with learning disabilities as a result of your learning from these deaths.

Who is the HUH lead for LDs?

P27-28 2.3 PROMS - PATIENT REPORTED OUTCOME MEASURES

Table 10 is incomprehensible to us.

Please clarify whether all patients having the operations described below are invited to participate in the survey and whether some are excluded because of communication

issues, e.g. language or learning disability. What percentage of patients who have these operations at the HUH return the questionnaires.

- Hip replacements (primary and revisions)
- Knee replacements (primary and revisions)
- Groin hernia

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.

P29 28-day emergency readmission rate

How meaningful is the data, bearing in mind that it only includes patients returning to the HUH? Surely, it should include patients who go or are taken to the other hospitals e.g. the Royal London and UCH.

P29/30 Responsiveness to personal needs of patients–NHSI Quality Indicator 20

We note there is no current data for 2018/19 and 2019/20.
We look forward to receiving data and working with the HUH to develop better responsiveness to the personal needs of patients, using co-design between patients and colleagues from the HUH.

We note that the Trust acknowledges that sometimes it may not be as responsive as it would like to be, especially when the system is under pressure. It would be useful if the Trust could explain this finding in more detail and explain the following statement:

Service specific user engagements guarantee patients have the opportunity to discuss their views and concerns on what really matters to them to/with the right people.

Please explain the meaning of the SWAN scheme in relation to enhanced care for patients who are at the end-of-life.

P30 - Rate of admissions assessed for VTE - NHSI Quality Indicator 23

Are VTE blood tests to be continued onsite at the Homerton, if not, will this impact on the effectiveness of the redesigned VTE risk assessment?

P32 - Clostridium difficile rate - NHSI Quality Indicator 24

We welcome the positive work in this area and Homerton's low rates of infection, backed up by comprehensive actions, which seek to reduce the rate further. We have concerns that the move of pathology might slow down the time taken to access reports on C. difficile infection.

We welcome the 8 recommendations to further reduce the incidence of C. difficile infection, especially bullet seven which should reduce the incidence of multiple antibiotic use.
- Daily antimicrobial stewardship reviews of antimicrobial prescribing.

We would like to see the programme for implementation of these 8 recommendations.

P34 – Apparent misplaced paragraph?

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.

P35/37 - Patient Safety Indicators – NHSI Quality Indicator 25
8.0 Patient Safety Indicators – NHSI Quality Indicator 25- Incident Reporting

It is difficult to draw conclusions from the data provided because the number of incidents for each Trust depends on the size on the Trust, so comparisons based on the number of incidents are of no use. The 1000 bed day data is also difficult to interpret because higher reporting can suggest more incidents as well as more active reporting.
Therefore, the actual performance of the HUH is not clear from table 16. The data on severe harm and death has no comparator at the moment so we cannot assess performance.

It would be useful if this section explained the role of the Assurance Committee and Patient Safety Committee, and the assessment role of the CCG for all SIs.

We welcome further strengthening of the ways in which the HUH learns from incidents, investigations, root cause analysis, complaints, legal cases and matters referred to the PALS team. This learning should include recommendations by Coroners from inquests. HWH can also contribute data collected from patients, families and carers.

The quality of SI investigation and root cause analysis reports has improved substantially over the past year. The process is observed by two HW Board Members, who have access to all documentation and are free to raise issues and concerns at all Assurance and Patient Safety Meetings, and frequently do so. We have not observed the process for investigation of complaints but hope to do so in the future. The key issue for all investigations is the production, where appropriate, of recommendations for service improvement, and consequent evidence of enduring enhancement of service access, safety and quality.

We welcome the decision of HUH to: "*Undertake a review of the way in which patients and their families are involved in the investigation process, including looking at the Duty of Candour process and the ways in which investigation reports are shared with the family".* Our observations suggest that in a small percentage of cases that there is no evidence that the Duty of Candour has been properly implemented, or that it is not implemented fully in terms of the inclusion of the patient and/or family.

In relation to the final two bullets on page 37, we **RECOMMEND** that advances made in learning from incidents and investigations, are publicised more widely to patients using services at the HUH and their families.

P37 9. Patient Experience: Friends and Family Test

We welcome the improvement in results but note the low response rate. As the Quality Account notes, low response rates increase the risk of bias. It is also delivered by NHS staff/volunteers raising patients' concerns about giving honest feedback. Healthwatch is developing its Public Feedback Centre and could run an independent Friends and Family test on behalf of the Trust. This could help improve responses rates.

P46 - Learning from complaints, incidents, claims and compliments

In the spirit of the **Hackney Complaints Charter,** which we feel as the Homerton is a signatory should be highlighted in the Quality Account, Healthwatch Hackney would like to work with the Homerton to ensure it continues to be able to effectively use patient feedback to improve patient experience. This would involve Healthwatch setting up a patient group to review and making recommendations to improve the Homerton Complaints, PALS and Compliments service.

Patients Involvement in the Revalidation of Doctors.

We **RECOMMEND** publication by the Trust of ways in which patients can contribute to their doctor's annual appraisal for Revalidation. The GMC guidance makes it clear that every doctor's annual appraisal should include patient comments, but we have been unable to obtain from the HUH any evidence that this process is active. It is possible that data is collected generically, but patients should still have knowledge of the process that allows them to both compliment and criticise medical practice. HW did agree a public information leaflet on this issue some years ago with the HUH but the leaflet is not now being made available to patients.

P47 - Improving the first impression and experience of the Trust for all patients and visitors
To support this important work, Healthwatch Hackney proposes collaboration with HUH to review patients' experience through a 'mystery shopper' project.

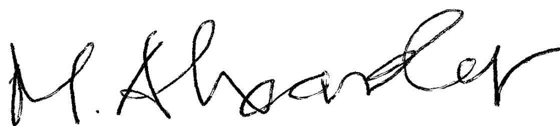
P49 – Improvements in staff health and wellbeing

We welcome this initiative. Could the Homerton confirm this initiative is open to all staff including contracted staff. Given the possible continuation of the coronavirus into 2021 what actions will the Homerton put in place to support staff health and wellbeing.

P51 - Performance against national indicators

We welcome the high performance against national indicators.

Yours sincerely,



Malcolm Alexander
Chair, Healthwatch Hackney

OUR KEY RECOMMENDATIONS

1) We strongly **RECOMMEND** the Homerton to actively seek control of the St Leonards Hospital site, from NHS Property Services Limited, and works with local health and care leaders, to shape the services at the hospital to meet local need, and to co-produce future developments at St Leonards together with local people.

2) We **RECOMMEND** that a short form of the QA be made available for the Annual Trust Board meeting and for HUH Members and the public. This would aid the public appreciation of the Homerton and its work.

3) We **RECOMMEND** that details of all recommendations made by Coroners to the HUH (Coroner's Regulations 28 (Prevention of Future Death Reports)) for the relevant period are placed in this QA, and that actions taken by the HUH in response to Coroner's recommendations, and evidence of implementation are also be placed in the QA.

4) We **RECOMMEND** that patients should be advised about the purpose and content of their Coordinate My Care (CMC) plan. They should also be advised how to initiate a CMC if they believe this would be useful for themselves or family members during a medical emergency.

5) We **RECOMMEND** that evidence of enduring improvement of access, safety and quality of services, and advances made in learning from incidents and investigations, are publicised more widely to patients using services at the HUH and their families.

6) We **RECOMMEND** that HUH works with Healthwatch Hackney to ensure effective use of patient feedback to improve patient experience. This would involve Healthwatch establishing a patient group to review and making recommendations to improve the HUH Complaints, PALS and Compliments services.

7) We **RECOMMEND** publication by the Trust of ways in which patients can contribute to their doctor's annual appraisal for Revalidation in line with GMC guidance, so that patients have knowledge of the process that allows them to both compliment and criticise medical practice.

Overview & Scrutiny

1.2 Health in Hackney Scrutiny Commission

Health in Hackney Scrutiny Commission

Hackney Council Room 118,
Town Hall Mare St, E8 1EA

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

4 September 2020

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 Homerton University Hospital NHS Foundation Trust's draft Quality Account for 2019/20

Thank you for inviting us to submit comments on the Quality Account for your Trust for 2019-20. We are writing to provide our insights arising from the scrutiny of the Trust's services over the past year at the Commission.

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 senior executives to attend our Commission meetings. We thank you for this engagement and being prepared to open yourself up to scrutiny and to be held accountable.

The Commission Members take a great interest in the performance of our key local acute trust and were very pleased to learn about some of your key achievements over the past year. We would like to congratulate you on receiving a rare ''Outstanding" rating from CQC following a January inspection of your Acute Services. We were also pleased that your Mary Seacole Nursing Home was also rated 'Good' following a February inspection. We are further immensely grateful for the work of staff at the Homerton during the Covid-19 pandemic.

We note that this year's report is being submitted later than usual and in a more truncated form due the pandemic. We appreciate the exercise however as it allows us also to step back from individual issues we raise with you over the course of the year and take an overview of the quality of your services.

Your Chief Executive attended our June and January meetings where we discussed the development of the

new Pathology Partnership with Barts Health and Lewisham & Greenwich Trusts as well as the progress of the Unplanned Care Workstream which she chairs. We also discussed the Secretary of State's response to our letter regarding your implementation of the 'Overseas Visitor Charging Regulations' and we welcomed your commitment to work more closely with Hackney Migrant Centre on mitigating the impact of these on vulnerable, non-documented, migrants.

In January we discussed again the issues around your contract with ISS for 'soft services' which has been the subject of an industrial dispute. In July you attended an urgent meeting of our Commission in response to concerns about the sudden 5-year extension of that contract. We are grateful for the steps you have taken to ensure better sick pay for workers on the ISS contract but, as has been discussed, wish to keep a dialogue ongoing with you on this and in particular encourage you to move towards in- sourcing options in the medium term. We would welcome sight of any options appraisals you produce on this as soon as it can be debated.

We are pleased to note the ongoing improvement across so many of the Quality Indicators and the level of benchmarking you report. We wish to make the following comments, noting that the report we've had sight of is a rough draft with some key data still missing:

a) Re 2.2.9 on p.21: How is data quality going to be improved in the new contract for 'community services,' now called "Neighbourhood Health and Care". We note that a "*decision was taken to have two Data Quality Committees: one for Acute services and the other for Community services, so that both acute and community services have focussed space and time to review and discuss the DQ issues and steps to improve them"*.

b) Re p.24 why is 'Coordinate My Care' (the shared urgent care plan) still being discussed as a work in progress? We understood after our own 'End of Life Care' review two years ago that it was already operational. What are the delays?

c) Re. 2.2.12 p.25 you detail both the policies and structures you've put in place to support Whistleblowers, which are admirable, but how many actual reports have there been? We note that the content and or gravity of incidents might vary considerably but seeing a total number of incidents would demonstrate to us that "Speak up safely" is working.

d) Re item 3 on p.43 why was there a spike in violent and aggressive incidents in late Feb and was just this down to improved reporting?

The Chair further recalls from his time on the Council of Governors that there was a long term issue with respect to not all staff receiving annual appraisals – has this improved in the last year and what percentage of staff received their annual appraisal?

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 Christopher Kennedy, Cabinet Member for Health, Social Care and Leisure Dr Sandra Husbands, Director of Public Health, City and Hackney

Jon Williams, Director, Healthwatch Hackney

1.3 NHS City and Hackney Clinical Commissioning Group (CCG)

NHS
City and Hackney
Clinical Commissioning Group

Commissioners Statement for Homerton University Hospital NHS Foundation Trust 2019/20 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 2019/20 draft Quality Account and priorities for 2020/21.

During December to March 2020 the Trust was radically changing the care it provided to respond to the global pandemic caused by SARS-CoV-2. Words seem inadequate to convey our gratitude on behalf of City and Hackney residents to all Homerton staff who selflessly provided the highest possible standards of care to their patients, and sometimes their colleagues, in such difficult circumstances. We would like to express our sincere and deep held sympathy to the families and loved ones of staff and patients who lost their lives. We are working with local partners to support people who have experienced trauma, illness and bereavement in City and Hackney during the pandemic and to better understand and address the health inequalities that caused our residents in Hackney to be so severely and disproportionately affected.

We are pleased that once again the Trust held a wide consultation to determine the 2020/21 priorities.

The Trust set itself nine quality priorities for 2019/20. We are pleased to see two of these have been achieved and that all are showing progress despite the impact of the pandemic. We would like to suggest that future priorities might include specific dimensions relating to inequalities.

The Trust has increased its focus on ensuring patients get the most effective, and efficient care and how local and national clinical audits can be used to improve patient outcomes. We congratulate the Trust in taking part in world class research studies such as the RECOVERY and REMAP-CAP studies that provided clear evidence that use of dexamethasone for COVID 19 patients would save lives.

The Trust's recent CQC inspection of its hospital services which were judged to be "Outstanding" overall highlighted how committed the Trust is to continuous quality improvement and the range of outstanding care provided to local residents. Last year we congratulated the Trust on their journey to move from Good to Outstanding and this year we are delighted to see additional progress. The Trust received one requirement notice that relates to the safety domain for maternity services and we are assured the Trust will be focusing on this going forward. We also congratulate the Trust on achieving an overall rating of "Good", once again for the Mary Seacole Nursing Home.

Whilst data is missing from the national patient experience scores we hope to see continuing improvement to these scores in line with previous years. We note the positive scores for the national Friends and Family scores at the Trust but these do have a very low response rate compared to other London Trusts. Other ways of measuring patient experience over time could and should be developed.

We are pleased to see improvement in staff fill rates across medical and dental specialties. The Trust receives good feedback from junior doctors about their experiences at the Trust and support from Consultants and this is an important measure of how well the Trust engages and supports key staff.

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 for working at the Trust. We also note the work the Trust is doing to improve scores relating to the NHS Workforce Race Equality Standard and we support the work taking place to ensure black and minority ethnic staff feel they belong, contribute, and can thrive in their chosen career.

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 would, again, welcome more focus on wider system work throughout the document and are keen to see these developments progress further over 2020/21. The new City and Hackney Neighbourhood Alliance, bringing together Homerton community health services, primary care and mental health services will be crucial to enable local health and care services to provide integrated care and support social care in City and Hackney. There is considerable scope to use the Alliance to keep people well at home, both in terms of physical and mental health care; to improve quality of care and prevent hospital admissions.

We confirm that we have reviewed the information contained within the Account, and checked this against data sources where these are available to us. There are some data gaps, due to late publication caused by the pandemic, which we expect the Trust to rectify before publication.

Overall we welcome the 2019/20 quality account, congratulate the Trust on their improved CQC ratings and again look forward to developing outstanding 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

2.0 Statement of directors' responsibilities for the quality report

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 2019/20* and supporting guidance *Detailed requirements for quality reports 2019/20*

• 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 2019 to September 2020

– papers relating to quality reported to the board over the period April 2019 to September 2020

– feedback from commissioners dated 14/09/2020

– feedback from governors; none received.

– feedback from local Healthwatch organisations dated 03/09/2020

– feedback from overview and scrutiny committee dated 04/09/2020

– the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 29/07/2020

– the [latest] national patient survey completed during July 2019

– the [latest] national staff survey published 01/09/2019

– the Head of Internal Audit's annual opinion of the trust's control environment dated 04/06/2020

– CQC inspection report dated 02/07/2020

• 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

.............................Date...Chairman

.............................Date...Chief Executive