Homerton University Hospital NHS Foundation Trust Quality Report; reporting period 2020/21

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 reporting period covered within this quality account report is for the 2020/21financial year.

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

Welcome to our 2020/21 Quality Account.

2020/21 was far from normal because of the COVID-19 pandemic. The year started a week after the first national lockdown and as the first wave reached its peak. It ended as the second and larger wave subsided, the vaccination programme reached full speed, and the country took its initial steps out of the third lockdown.

The pandemic had a dramatic impact on the range of services we were able to offer, the way we cared for patients, the way our operations were financed and the way we worked with the wider NHS and with other public services. Some of those changes, for example the shift of many outpatient appointments from clinic to phone or video, are likely to persist.

Initially we plunged into an emergency response to the unprecedented wave of illness and hospitalisations. 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. Across the NHS, 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. With many staff having to isolate themselves for a period to limit infection, many staff had to work outside their normal services. At the same time, we joined others in the NHS and universities in building a better understanding of the disease and in developing and testing new treatments for it.

From June, as the levels of infection and hospitalisation fell and the lockdown was lifted, the Trust resumed a full range of services and began to tackle the backlog of elective cases. But in the autumn infection levels rose again leading to renewed restrictions in the community and another surge in hospitalisations at Christmas and the New Year. North East London was one of the areas hardest hit in

this second wave and the numbers of COVID patients in Homerton were almost twice as high as in the first wave. Alongside dealing with the covid infection, the Trust played its part in the drive to vaccinate the adult population particularly by vaccinating our own staff and the staff of related organisations including the ambulance service, social care staff, and cleaners, drivers and other staff employed by our contractors.

Partly as a result of the lessons from the earlier surge we and our partners were able to maintain a wider range of services for other patients through the second surge but we know that many have had to wait longer for care or have been discouraged from seeking clinical help. The key priorities for the Homerton in the coming months are to do all we can in collaboration with our neighbouring Trusts, with primary care and with our local authorities to tackle this unmet need, to address the inequalities in health outcomes that the pandemic brought out so starkly and to build a more integrated care system for the people of City and Hackney.

We pay tribute again to staff throughout the Trust for their dedication to do the best for our patients and our communities despite the risks. The public spotlight was on the nurses and others caring directly for covid patients in acute wards and critical care. We applaud their work including the commitment of many staff from other parts of the Trust who switched to work in these most pressured areas. But we also applaud the work of others in the hospital and the community, in the frontline of care and in management or support roles, for their work and dedication which was also necessary to deal with the unprecedented demands. We also mourn again the deaths associated with the pandemic of many patients and of three members of our staff – Abdul Chowdhury, Michael Allieu and Sophie Fagan.

Although the pandemic reshaped our service and our year, we would note some other developments and achievements during the year.

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. Subject to the disruption during the two pandemic surges, we maintained low waiting times in our Emergency Department and for outpatients and for surgery. We maintained a good performance on infection control (including nosocomial infections of covid -19)

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 (CQC) which inspected the hospital services early in 2020. Their report, which was published last summer, revised up their rating for the Trust's acute services from "Good" to "Outstanding" which was a great tribute to the excellent work of all our staff. We have every expectation that the CQC will extend this to the whole Trust including the community services and Mary Seacole when they revise their wider ratings.

The Trust's objective is to build with our partners a truly integrated care and health system in City and Hackney while playing an effective and sustainable role in the provision of acute services across our wider region of north east London.

We saw progress in 2020/21 towards establishing an Integrated Care Partnership in City and Hackney to bring together the local authorities, primary care, community services and the acute services of

Homerton and the East London Foundation Trust (which provides mental health services). The boards combining providers and commissioners are expected to be launched in the summer. At executive level the Neighbourhood Health and Care Board will be led by our Chief Executive and will build on the experience of the Strategic Operational Command Group which was formed during the pandemic to ensure all the services pooled their information and collaborated effectively.

Closer collaboration in eight "neighbourhoods" is already leading to more integrated care pathways. One notable development has been the restructuring and strengthening of our adult community nursing service to work on the neighbourhood basis alongside the new Primary Care Networks and local authority services.

There have also been important developments in North East London more widely where an Integrated Care System (ICS, previously STP) has been established. In the crisis it has taken on a leadership role in coordinating the North East London (NEL) emergency response and now the recovery programme. It remains committed to integrating care and health across the region including through an Integrated Care Partnership for City and Hackney. At the end of the year, the seven NEL Clinical Commissioning Groups agreed to merge into a single Clinical Commissioning Group (CCG) for the whole of NEL in anticipation of becoming formally part of the ICS in 2022 following legislation which will also put the ICS and its partnership with local authorities on a statutory basis.

None of what we have achieved would have been possible without the commitment and quality of all our staff and the support of the organisations with which we work. We are both very conscious of and grateful for this.

Finally, in recognition of the importance of our community services and our work with partners to provide integrated care, the Board, Governors and Members agreed to change the Trust's name to Homerton Healthcare NHS Foundation Trust. This will come into effect in 2021.

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. Previously the Trust quality priorities would be agreed following a consultation with staff and stakeholders; including Governors, City and Hackney Clinical Commissioning Group and Hackney Healthwatch. However, the impact and the pressures of responding to Covid as meant that pace of implementing the priorities was slower than anticipated. As such the Trust has agreed to carry forward the priorities identified in 2020/21 into 2021/22 financial year.

Going forward the quality priorities will be monitored by the relevant oversight committees 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 2020/21;

Domain	Priority	Priority Title	Carried forward (2019/20)	New Priority (2020/21)	2020/21 Progress	Oversight Committee
Safe	1	To reduce the number of community and hospital attributed pressure ulcers	✓		↑	IPSC
	2	Improve the safe management of medicines within the organization		✓	↑	IPSC
	3	Reducing physical violence and aggression towards patients and staff	✓		↑	IPSC
	4	Improve falls management and individualised management plans of inpatients and the support given to both patients and staff post fall.		✓	↑	IPSC
Effective	5	Learning from complaints, incidents, claims and compliments	✓		↑	IPSC and ICEC
	6	Appropriate identification and management of deteriorating patients to support maternity and CSDO	✓		↑	ICEC
	7	Making Every Contact Count	✓		↑	ICEC and IPEC
Patient Experience	8	Improving the first impression and experience of the Trust for all patients and visitors	✓		↑	IPEC
	9	Improvements in staff health and wellbeing	✓		↑	IPEC
	10	Getting Patients Moving (End PJ Paralysis)	✓		★	IPEC

★**Target exceeded** ✓**Target fully achieved** ↑**Progress towards target achieved** *__Minimal (possible no) progress towards target achieved__

Table 1: Quality priorities for 2020-21

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 2020/21 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 2020/21 represents 100% of the total income generated from the provision of relevant health services by Homerton for 2020/21.

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 2020/21 and covered both account and community services.
During 2020/21, 53 national clinical audits and 3 national confidential enquiries covered relevant health services that Homerton provide.

Due to the delays in the publication of national audit reports and the redirection of services to support the Trust's Covid response the total number of national clinical audits that HUHFT participated is currently not available. However the Trust participated in 100% of eligible national confidential enquiries
National clinical audits and confidential enquiries that Homerton participated in, and for which data collection was completed during 2020/21, are listed in table 2 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.

Due to the pandemic HQIP specified that patient care was a priority and national audits were put on hold. The reporting for audits undertaken has also been delayed and at point of reporting not available for the quality accounts

National Audits reviewed 2020/2021

AUDIT TITLE	ELIGIBLE FOR PARTICIPATING	PARTICIPATED	PERCENTAGE OF CASES SUBMITTED
Antenatal and new-born national audit protocol 2019 to 2022	√	√	*TBC
Case Mix Programme (CMP);Intensive Care National Audit and Research Centre (ICNARC)	√	√	*TBC
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% - national report with leads
Elective Surgery - National PROMs; Programme NHS Digital	√	√	*Surgery suspended due to pandemic
Endocrine and Thyroid National Audit; British Association of Endocrine and Thyroid Surgeons (BAETS)	√	√	*Surgery suspended due to pandemic
Emergency Medicine QIPs - Fractured Neck of Femur (care in emergency departments)	Y	Y	*Audit delayed – data currently being collected
Emergency Medicine QIPs - Homelessness inclusion health (care in emergency departments)	Y	Y	*Audit delayed – data currently being collected
Emergency Medicine QIPs - Pain in Children (care in emergency departments)	Y	Y	*Audit delayed – data currently being collected
Falls and Fragility Fractures Audit programme (FFFAP); Royal College of Physicians (RCP)	√	√	*TBC
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	√	√	Check website
Learning Disabilities Mortality Review Programme (LeDeR)	√	√	100%
Major Trauma Audit; Trauma Audit Research Network (TARN)	√	√	100%
Mandatory Surveillance of bloodstream infections and clostridium difficile infection Public Health England (PHE)	√	√	*TBC

AUDIT TITLE	ELIGIBLE FOR PARTICIPATING	PARTICIPATED	PERCENTAGE OF CASES SUBMITTED
Maternal, New-born 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)- Physical Health in Mental Health Hospitals	√	√	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)	√	√	*Surgery suspended due to pandemic
National Audit of Cardiac Rehabilitation (NACR) University of York	√	√	*TBC
National Audit of Care at the End of Life (NACEL); NHS Benchmarking Network	√	√	100% - Report with leads
National Audit of Dementia (Care in general hospitals); Royal College of Psychiatrists (RCPsych)	√	√	100% - Report with leads
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)	√	√	*Surgery delayed due to the Pandemic
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 check
National Early Inflammatory Arthritis Audit (NEIAA); British Society for Rheumatology (BSR)	√	√	*TBC Services have resumed following Covid

AUDIT TITLE	ELIGIBLE FOR PARTICIPATING	PARTICIPATED	PERCENTAGE OF CASES SUBMITTED
National Emergency Laparotomy Audit (NELA) Royal College of Anaesthetists (RCOA)	√	√	100%
National Gastro-intestinal Cancer Programme; NHS Digital	√	√	*TBC
National Joint Registry (NJR);Healthcare Quality Improvement Partnership (HQIP)	√	√	* Surgery suspended due to pandemic
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)	√	√	*TBC
NHS provider interventions with suspected/confirmed carbpenease producing Gram negative colonisations / infections (PHE)	√	√	Suspended until 2021-22
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry	√	√	*TBC Ambulance Service audit
Sentinel Stroke National Audit programme (SSNAP); King's College London	√	√	*TBC
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)	√	√	*TBC
National Child Mortality Database	√	√	100%

Table 2: 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 2020/21, as the programmes were suspended due to the impact of Covid pandemic. We will continue to review our participation rates when the national audit reports are published (these are indicated by * in the table 2) and these will be reported to the Improving Clinical Effectiveness Committee.

There were 42 national clinical audits that were not applicable to the Trust, see table 3.

AUDIT TITLE	REASON
BAUS Urology Audit - Bladder Outflow Obstruction Audit	This is not carried out at Homerton
BAUS Urology Audits - BAUS Cytoreductive Radical Nephrectomy Audit	This is not carried out at Homerton

AUDIT TITLE	REASON
BAUS Urology Audits - Female Stress Urinary Incontinence Audit	This is not carried out at Homerton
BAUS Urology Audit – Radical Prostatectomy	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 –Renal Colic (BAUS)	This is not carried out at Homerton
BAUS Urology Audit - Urethroplasty	This is not carried out at Homerton
British Spine Registry	This is not carried out at Homerton
Child Health Outcome Review - Young People's Mental Health	This is related to Mental Health Trusts
Cleft Registration Audit Network (CRANE)	This is not carried out at Homerton
Falls and Fragility Fractures Audit programme (FFFAP) - Fracture Liaison Service Database / Vertebral Fracture Sprint Audit	This is not carried out at Homerton
Mental Health Clinical Outcome Review Programme 1 National Confidential Inquiry into Suicide by children and young people in England (CYP)	This is related to Mental Health Trusts
Mental Health Clinical Outcome Review Programme 1 National Confidential Inquiry into Suicide and Homicide	This is related to Mental Health Trusts
Mental Health Clinical Outcome Review Programme 1 The assessment of risk and safety in mental health services	This is related to Mental Health Trusts
Mental Health Clinical Outcome Review Programme – Suicide by middle aged men	This is related to Mental Health Trusts
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Asthma (Adult and paediatric) and COPD Primary care - Wales only	This relates to Primary Care and is for Wales only
National Audit of Pulmonary Hypertension (NAPH) NHS Digital	This is not carried out at Homerton
National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management (CRM)	This is not carried out at Homerton
National Cardiac Audit Programme (NCAP) - National Adult Cardiac Surgery Audit	This is not carried out at Homerton
National Cardiac Audit Programme (NCAP - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	This is not carried out at Homerton
National Cardiac Audit Programme (NCAP - National Congenital Heart Disease (CHD)	This is not carried out at Homerton
National Clinical Audit of Anxiety and Depression (NCAAD) - Core audit	This is related to Mental Health Trusts
National Clinical Audit of Anxiety and Depression (NCAAD) - Psychological Therapies Spotlight	This is related to Mental Health Trusts
National Clinical Audit of Psychosis - EIP audit 2019/2020	This is related to Mental Health Trusts

AUDIT TITLE	REASON
National Ophthalmology Audit (NOD) 1, 2 Royal College of Ophthalmologists (RCOphth) - Adult Cataract surgery	This is not carried out at Homerton
National Paediatric Diabetes Audit (NPDA) 1 Royal College of Paediatrics and Child Health (RCPCH)	This is not carried out at Homerton
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
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) - Monitoring of patients prescribed lithium	This is related to Mental Health Trusts
Prescribing Observatory for Mental Health (POMH-UK - Prescribing Clozapine	This is related to Mental Health Trusts
Prescribing Observatory for Mental Health (POMH-UK - Use of depot/LAI antipsychotics for relapse prevention	This is related to Mental Health Trusts
Prescribing Observatory for Mental Health (POMH-UK - Assessment of side effects of depot and LAI antipsychotic medication	This is related to Mental Health Trusts
Prescribing Observatory for Mental Health (POMH-UK) - Antipsychotic prescribing in people with a learning disability	This is related to Mental Health Trusts
Prescribing Observatory for Mental Health (POMH-UK) - Prescribing valproate	This is related to Mental Health Trusts
Prescribing Observatory for Mental Health (POMH-UK) - Prescribing for depression in adult mental health services	This is related to Mental Health Trusts
UK Cystic Fibrosis Registry Cystic Fibrosis Trust	This is not carried out at Homerton
UK Renal Registry National Acute Kidney Injury programme -UK Renal Registry	This is not carried out at Homerton

Table 3; National audits not applicable to the Trust – source internal Trust records

Implementation of actions implemented following the publication of the national audit 2020/21

Examples of actions that the Trust intends to take or has taken following the review of the 17 national audit reports published during the financial year 2020/21, there consists of 5 audits from 2018-19, 6 audits from 2019-20 and 6 audits from 2020-21. 4 reports have action plans assigned and these are summarized in table 4 below. 13 of these reports are currently being reviewed by the project lead at the time of reporting.

However, it should be noted that due to a reporting lag the data referenced in national clinical audit reports could have been collated during previous financial reporting years.

AUDIT TITLE	GOOD PRACTICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
National Emergency Laparotomy Audit (NELA)	• There has been improvement noted in Preoperative documented risk • Cases with clinical access to theatres within timescales • High risk cases with surgeon/anaesthetists in theatre • High risk cases admitted to critical care postoperatively • Risk adjusted 30 day mortality • Positive performance against Best Practice Tariff	• Reduced case ascertainment (both nationally and locally) from previous year and action put in place to improve case ascertainment rate. • Consultant review of CT scans prior to surgery above national average (71%), but below 80% target. Related to audit tool not including outsourced reviews as completed by a consultant. All NELA radiology data is reviewed and audited to identify any discrepancies between reports and operative findings.	• Cases audited have now risen as a result of actions put in place • Improvements in theatres times have also been made • Overall performance during COVID period has shown that despite the decrease in number of Laparotomies overall, the level of care provided to emergency laparotomy patients were mostly maintained .
National Early Inflammatory Arthritis Audit (NEIAA)	• Early arthritis clinics are available in 77% of departments • Annual review almost universal. Audit data not representative • Self-management encouraged. • Talks to GPs and GP trainees delivered. Education via advice and guidance service • Talks delivered to physiotherapists. • Dedicated psychology service • All referrals triaged by consultant • Close liaison with MSK services • Telephone clinics embedded • Urgent referrals vetted and prioritised.	• Consider expanding education material and introducing monitoring 'app' to improve patient experience. • Patient 'follow-up' capacity issues (one year remission rate) to be reassessed after COVID disruption • Annual review of patients almost universal; Audit data fully not representative due to collection methodology. • Consider the introduction of a proforma to standardise annual review data	• Provision of education and monitoring • Ensure that follow up cases are resumed following Covid • identify further data collection outside the parameters of national audit

AUDIT TITLE	GOOD PRACTICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
BTS Pneumonia National Audit	• Results show that the Trust has designated NIV area/s • Compliant in many recommendations	• Not all cases had smoking status recorded • Time between admission and first antibiotic in minutes not always recorded	• To explore the feasibility of the mandatory recording of smoking status • Education on staff of the importance of recording data timely
Learning Disability Mortality Review Programme (LeDeR) (COPD) Secondary Care	• Trust Lead is part of the Steering group which is led by CCG • Training sessions scheduled following an event around patient who died 2 years ago. • Trust working disability group; representative's includes service users, advocates. • Sharing of the learning; review A&E attendances and putting in place some support for the service users. • Active review of cases – audit progress notes to identify lapse in care and what went well so that we can share learning such as use of passport • Work with the community team but we refer people to the learning disability team if appropriate • Review DNRs and any other decisions are appropriate and that reasons are recorded • Training on the deterioration for patient with learning disabilities; including recognising pain and asking questions in a different way.	• Develop working with End of Life Care Team to identify appropriate and timely referrals	• Training available to identify the signs of patient approaching end of life.

AUDIT TITLE	GOOD PRACTICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
	• Care plan to be available on EPR which is currently being tested to assess pain and reasonable adjustments with service users. • NEWS scores -family and cares are included in the discussion so that staff what is known as 'normal'.		

Table 4; actions identified from national audit reports

Local Audits reviewed 2020/2021

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. There were 143 local audits registered during 2020-21. The reports of 80 local clinical audits were reviewed by us in 2020/2021 A selection of these audits is outlined in table 5 and the Trust intends to take the following actions to improve the quality of health care provided.

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
Service evaluation of Child protection medical examinations	CSDO/ Safeguarding	• Consideration of a trainee in the VCC to speed referrals being seen • To ensure awareness is raised • To ensure smooth transfer of services practice to inform specialty team of Senior doctors should ensure that all essential parts of the spider form is checked which will indicate completion of ED clerking, drug chart, senior review and specialty referral. • Only a senior doctor plus the NIC can make the decision to spider a patient to the ward. Both names should be indicated on the spider form. • The SOP should be updated before or during March 2020. • Ward nurses to contact specialty teams if the patient still has not been seen within the recommended timeframe	• Consideration of staffing in the VCC to improve speed of neglect referrals • Present findings to paediatric department – acute and community • Continue staffing levels to ensure physical abuse cases are assessed in a timely fashion • Review of pathways for very young children to ease transition between acute and community setting.

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
Audit on suitable milk provision on the Neonatal Unit (NNU)	CSDO/ Neonatal	• Increased incident reporting when error noted • Discussion with sister in charge how to communicate any errors found • Addition of milk to daily nursing check list • Presentation of findings at the Grand Round • Potential of new training sessions for experienced nurses • Additional reference materials on the NNU	• Official incident reporting of any babies on the wrong milk. Staff have been reminded of the need and importance of reporting and evidenced by incident reporting. • Identify appropriate method to communicate errors to staff • Discussion with practice development team about suitability/ development of phrases for the daily nursing check list • Planned presentation of audit findings in relation to the new Enteral feeding guidelines • Training days for band 5-7 staff • Share practice development nurses updated enteral feeding guidelines with appendix of updated flow chart for trolley showing SMA range • Previously developed information sheet to be displayed in the milk kitchen
Audit of the Camish operational guidance for information sharing for safeguarding young people U18	CSDO/ Camish	• Providers are able to evidence that safeguarding list/temporary record system (Brook) has been checked prior to patients being seen for consultation • The guidance is embedded in new staff inductions and safeguarding training updates in each organisation • Deputy arrangements are put in place during staff absences. • Safeguarding leads to review system and strengthen it where necessary	• Each provider reviews recording system to ensure it is fit for purpose • The audit results and recommendations are fed back to staff at network clinics by the safeguarding leads. • All staff are advised to familiarise themselves with the guidance, which is kept on each providers shared network drive along with their organisational safeguarding policies and procedures • All staff are reminded of their role and specific tasks in following the guidance and of accurate and timely documentation • The safeguarding leads review their deputy arrangements

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
			and agree a system with their deputies to help remind them to follow the process during their absence. • The safeguarding leads review their system and strengthen it where necessary.
Summary - Point Prevalence Audit of Antimicrobial Prescribing Hospital "	CSDO/ Pharmacy	• New review date after 48h evaluation of IV antibiotics not being documented on prescription • Documentation of antibiotic indication not documented well in the notes. • Documentation of oral antibiotic duration not documented well in the notes and incorrectly prescribed on the drug chart. When completing a course of antibiotics, the total duration is made up by both IV and oral administration of antibiotics and should not exceed number of days as recommended in the micro guide (unless clinically indicated). • Slight increase in the prescribing and Meropenem, may be explained by increase in amount of prescriptions than last audit. • Documentation of antibiotic indication not documented well in the notes. • Increased use of Meropenem	• Train staff to ensure correct documentation • Indications to be documented on both the drug chart and in the notes for all antibiotics. • Duration of antibiotics need to be documented on both the drug chart and in the notes for all antibiotics, particularly oral medication. • The total course length should not exceed the recommendation in microguide. This can be done through increasing prescriber awareness of amending review/stop dates of antibiotics on electronic drug charts and encourage pharmacists to highlight old dates to prescribers. • Continue to monitor usage of all antibiotics and work hard in reducing the amount of restricted and broad spectrum antibiotics prescribed. Encourage appropriate step down of antibiotics once causative organism is known. Increased inappropriate use does not benefit patients, elevating the risk of C. difficile and candida infections and encouraging the development of resistant bacteria. • Monitor use of Meropenem and encourage early review of iv antibiotics
Inequality for the high-risk Foot: The INFO clinical audit into foot	IMRS/ Podiatry	• Workshops on the implementation of RA foot management guidelines • Series of educational workshops for podiatrists in rheumatology foot	• Workshops to be developed • Specialist Workshops to be developed • Proforma to be developed

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
health management standards of rheumatoid arthritis compared to foot health management standards of diabetes mellitus in North-East London		health and its association with the high-risk foot. • Creation of a pro-forma to be used during initial assessment of people who present with a rheumatology (not RA specific) foot/ankle issue. • Creation of a specialist rheumatology podiatrist or lead podiatrist for people who present with a high-risk foot and have a rheumatology disorder to act as a liaison between podiatry and rheumatology.	• To create a specialist post for rheumatology podiatry
Radiographer Commenting And Preliminary Clinical Evaluation Audit	CSDO/ Radiology	• Staff should be made aware that use of the red dot and sticky note is not optional, but mandatory and the policy should be enforced more. This would help avoid missed abnormalities in the future. • Staff to be given extra training with image interpretation sessions at lunchtime or when the department is quiet. This would help staff improve their skills and knowledge and make them feel more involved with the patient's diagnosis rather than just producing the images.	• To present the findings to staff and ensure staff are guided to the policy • To provide training sessions on the red dot system
Management in the delivery room audit	CSDO/ Neonatal	• Transfer more babies on CPAP from the delivery room to the neonatal unit if the clinical condition allows. • Need to order consumables, train staff and implement Less Invasive Surfactant Administration technique at the Home	• Share audit with colleagues • To order more consumables • To train staff on CPAP and ensure competencies
Lyme's Disease	IMRS/ED	• Clinician education to update on Lyme disease diagnosis and when to select laboratory testing • Clearly accessible resource for choice of antibiotic, dosage and duration for clinicians • Clinicians to check for pregnancy in all women of child bearing age • SOP of the week final stage on process map of Lyme disease management to include giving patient education and information leaflet • Patient information leaflet added to EPR for printing on completing discharge summaries	• Reminder message on Microguide to indicate no testing required if has matching history with typical erythema migrans rash • New Microguide page (adults and paediatrics) for Lyme disease • Include section on pregnancy on Microguide

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
		• Distribute amongst ED, PUCC and microbiology staff email. • Clinicians to provide adequate education and information at point of patient discharge • Share the results of this audit	
COVID VTE Audit	IMRS/ Respiratory	• Presented a summary of the audit and key learning points at the Medical Mortality and Morbidity meeting (19/06/20). The medical unit was reminded of the new VTE guidelines with particular focus on ensuring that patients receive a D-dimer when deemed medically fit for discharge to allow complete assessment. • An email reminder of the guidelines was distributed • An additional checklist column was added to the weekend discharge list as a reminder to check the D-dimer on discharge for patients with COVID-19 (19/06/20). • Posters were put up in key areas such as ACU and wards designated for COVID admissions (20/06/20). At the time these were Lloyd / ECU South / Lamb / Edith Cavell / Thomas Audley	• Present findings to reminded staff of new guidelines • Email reminder to be sent to Staff • add additional column to weekend discharge list • Posters to be put up on wards
Outcomes of the X-PERT Diabetes Structured Education Program delivered at the Hackney Diabetes Centre	IMRS/ Diabetes	• Provide additional visual materials for X-PERT programs for different ethnic groups (Asian, Caribbean, African) adapted to their needs about dietary habits and meal ideas. • World Carbs & Cals book have the photos and portion sizes of the South Asian, African and Caribbean meals. • Involve the participants and adopt their visual materials (such as the food labels) which can be used for the X-PERT programs. • Re-design the post - program questionnaires to evaluate the relevance of the program for the minority ethnic groups and reflect their specific needs	• To tailor the teaching materials to the needs of the participants from the group. • There is a specific session in the X-PERT program about the food labels. Ask the participants to bring their own food labels which they are using on an everyday basis and discuss those labels with them; or arrange a grocery store tour with a couple of participants to gather some labels • Add to the existing questionnaire the questions about the food, to find out if the cultural diets/dietary habits of that specific group were covered at the session

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
Audit on Diagnosis of Chronic Heart Failure	IMRS/ Cardiology	• To ensure that correct procedures are followed such as: NT-proBNP levels should be measured in people with suspected heart failure, Patients with suspected heart failure and a NT-proBNP level above 2,000 ng/L to have a specialist assessment and transthoracic echocardiography within 2 weeks urgently, Patients with suspected heart failure and an NT-proBNP level between 400 and 2,000 ng/L should have a specialist assessment and transthoracic echocardiography within 6 weeks.	• To improve awareness of guidelines by sharing these results with colleagues and GPs; via audit presentation day and GP session • Improvement in record keeping by emphasizing the importance during the audit presentation • Possible mandatory entries of ECHO and NT-proBNP in the EPR – discussion to take place with EPR lead on feasibility • Improve the access for cardiac ECHO – discussion with lead on referral process and timeframes in line with guidance • Possible mandatory entries of ECHO and NT-proBNP in the EPR – discussion to take place with EPR lead on feasibility
Clinical Audit on the appropriateness of IV paracetamol use across surgical wards.	CSDO/ Pharmacy	• To document clearly the indication for the IV paracetamol in the medical notes/drug chart, as it should be reserved for those patients who are unable to tolerate oral intake. • All IV paracetamol prescriptions should be reviewed within 24 hours of initiation, and continued every 24 hours until patient is able to tolerate oral intake, with a view to switch to the oral route as soon as possible.	• Email to the surgical team leads, highlighting audit findings and recommendations and rational. • Ward pharmacists to proactively review all patients on IV paracetamol on their wards with a view to advising prescribers to step-down to oral as appropriate.
ANNUAL RPA AUDIT	CSDO/ Radiology	• The Trust's radiation protection policy should be reviewed as it is now overdue. Please ensure that references to IRMER2000 and IRR99 are updated with the new regulations in mind. • The staff declaration form should be signed by all relevant staff to evidence that they have read and understood the IRMER procedures that apply to them. • The list of clinicians who may refer patients identified in IRMER5 should include references to the GPs who are permitted to refer patients to the department. Whilst they need not be	• Update policies • Ensure staff are made aware of the guidelines • List of referrers to be updated • To incorporate guidance into procedures • To ensure training completed every two years • New format local rules are provided with this report. These should be reviewed upon receipt by the RPS and annually, thereafter. All previous versions should be removed from circulation.

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
		identified individually in the IRMER procedures, reference to the relevant electronic lists should be made. • The latest copy of the IRMER18 procedure for dealing with radiation incidents arising from medical exposure is available via the RPC dropbox. The new procedure includes the latest guidance and reporting thresholds issued by CQC earlier this year and should be incorporated into your framework of procedures • Please be aware that RPC provide online radiation protection update training for radiographers. This should be completed at least once every 2 years. Individual passwords required to access this training can be provided by RPC. • New format local rules are provided with this report. These should be reviewed upon receipt by the RPS and annually, thereafter. All previous versions should be removed from circulation. • IRR17 requires employers of staff who work with ionizing radiation at multiple sites to share personal dose information in order to ensure that dose limits are not exceeded. A pro-forma letter that can be edited locally and sent to the other employers of the gastro consultants is provided with this report. • The same principal should be applied to all staff who work at multiple employer sites including radiologists and any other staff groups	• To ensure that dose information is shared
The Cappuccini Test: An audit of supervision	SWSH/ Anaesthetics	• The name of the supervisory consultant anaesthetist should be observable on the anaesthetic rota	• The mentee needs to clearly document on the anaesthetic chart for each case the name and location of their mentoring consultant. - this was shared at the local CG meeting • On the day, the mentee should approach their

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
			assigned mentor to confirm they are being supervised and to highlight and potential issues on their list.- this was shared at the local CG meeting • Any omission of a NCG not being assigned a mentor should be highlighted at the earliest opportunity to the rota-coordinator such that this can be rectified on the anaesthetic rota as soon as possible - this was shared at the local CG meeting
Traceability Audit	SWSH/ Fertility	• For all IUI-H and D, template must be selected by the person preparing sperm sample • For all verification for patients, a template must be added • to check feasibility of moving traceability to RI	• Staff training • To arrange a session with RI
Morbidity and Mortality Documentation	SWSH/ General Surgery	• Medical Certificate of Cause of Death (MCCD) Note • Morbidity and Mortality Meeting Note	• Template has been devised and needs to be added to EPR • Present at M&M/governance meeting
What proportion of Semen Analysis (SA) results are still emailed, and why?	SWSH/ Fertility	• Proactive engagement of CIS/Pathology and GP electronic personnel • TPAs with errors that will expire soon • TPAs with errors that will not expire soon • TPAs not getting a lay perspective or a dedicated Quality perspective.	• Liaise with (CIS), (Pathology) • Highlighted on Q-pulse, will be addressed when renewed • Email contacts to amend TPA • All new and renewed TPA now go through both Lab Director and Quality Manager
Audit of suboptimal x-ray images	SWSH/ Radiology	• To identify whether the suboptimal images are performed in or out of hours. • Audit of Ankle, Knee and Facial Bones examinations. • Continually address individual image quality • Informal departmental CPD talks • More consistent use of Sticky Notes	• A new field on the suboptimal images folder to select in or out of hours. • Ankle audit currently being undertaken. Ask for volunteers for knee and facial bones audit • Currently being done on an on-going basis. • To be discussed – COVID-19 considerations allowing. • Audit recently completed, reminders communicated regularly.

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
Consent of emergency general surgery patients for COVID 19 risk during pandemic	SWSH/ General Surgery	• All patients undergoing emergency surgery need COVID risk documented on either standard yellow consent form or the new consent specific consent form. • Swab testing to be discussed at the time of team brief as per the suggestions from the audience • All patients going to theatre should be COVID tested either in AE or on ward	• Findings to be discussed with teams and emailed
Cholecystectomy in gallstone pancreatitis	SWSH/ General Surgery	• Patients admitted with Gallstone pancreatitis who do not have an index admission laparoscopic cholecystectomy with no further investigations pending should be booked for laparoscopic cholecystectomy on discharge and this should be booked urgently within the 6-8 week timeframe. Ideally they should get a date for their operation before going home • Any pending investigations as an outpatient (such as MRCP/repeat bloods) should be booked urgently with a timely follow up of results (e.g. paper clinic) and then, if appropriate, laparoscopic cholecystectomy booked urgently within the 6-8 week window from initial discharge • A further longer term project ideally should be initiated to work out feasible plan to increase laparoscopic cholecystectomy during index admission for gallstone pancreatitis (as well as “hot” laparoscopic cholecystectomy for cholecystitis) • Use Glasgow scoring as clinically appropriate, as well as ABG results, to guide discussion with critical care outreach and HDU/ITU teams.	• Team to book patients for urgent OP cholecystectomy at or before discharge • Team to book investigations as stated • Complex pathway which will need significant planning and implementation. • On call teams updated at the Audit meeting and to make clinical decisions as deemed appropriate
Covid patient experience of Home treatment	SWSH/HANS	• Improvement to Pathway • To update SOP	• Flow chart to be devised • Information on HANS website such as diagrams • Provide Peer support • Update SOP

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
Audit on VTE prophylaxis in lower limb injuries seen in out-patient clinics	IMRS/ED	• To standardise care • To ensure that all lower limb injured patients receive prophylaxis if appropriate • Documentation to be improved • To review/devise Protocol or highlight Sop with staff	• Flow chart to be completed and shared with staff • Posters on display in clinics • SOP for VTE in limb injuries to be followed, • risk assessment as per EPR VTE form • Autotexts in clinic letter template • SOP to be presented at departmental audit meeting
Review of practice: management of fever in 1-3 month old infants	CSDO/ Paediatrics	• Clarify with microbiology the choice of antibiotics for suspected sepsis in the Microguide • Discuss the findings with the General Paediatrics department and recap NICE guidelines for the management of fever in 1-3 month olds	• To check if guidelines at Homerton contain recent NICE guidance published 07/11/2019– if not this needs to be updated • Findings presented 03/09/2020 to 15 members of the department (grades: senior house officers, registrars, consultants and senior nurse)
COVID VTE Audit Cycle 2	IMRS/ED	• To raise awareness of standards • An order set of bloods can be created on admission for suspected COVID patients, which includes a D-dimer level. This ensures that this is done straightaway and may require liaising with the A+E department to ensure this is done.	• Presentation of the results of this audit at a suitable forum to create greater awareness on this topic. • Further teaching sessions on COVID VTE assessment and prescribing with junior doctors. This was something that was hard to implement during the pandemic due to stricter social distancing rules in the hospital. However, there appears to be many more established mediums, such as Microsoft Teams, which this could take place • Poster to be displayed on expectations • Liaison with the A&E Department on D-dimer level blood tests
An audit of VTE assessment/ prophylaxis	SWSH/ Maternity	• Educate midwifery staff on the need to complete VTE assessment at 26/40 • VTE assessment as part of SBAR during handovers/Accurate	• To be presented in a community midwife education session

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
		prescribing and documentation of VTE assessment and treatment plan on the discharge summary • Review of VTE assessment flowchart to remove ambiguity • Accurate prescribing and documentation of VTE assessment and treatment plan on the discharge summary	• Update of midwifery guidelines • Postgraduate midwifery training • Re-circulate this as the tip of the fortnight and ensure it is part of the induction process. • Liaise with EPR for mandatory filling to access records • To be considered during guideline review • To be part of SHO's induction training • Incorporate into the discharge package/documentation on EPR as a compulsory action to address the poor compliant and improve documentation.
Patient satisfaction survey - Outpatient hysteroscopic surgery (true clear)	SWSH/Gynae	• Improve communication • Post procedure leaflet • Pain relief during the procedure	• Email , text and letter about patient leaflet and pain relief. • Await BSGE video for patients – To overcome language barrier. • Review current leaflet and create a post procedure plan / give letter print out • Consistent with use of local anaesthesia , entonox, conscious sedation , PR Diclofena
What do we offer to women at their first attendance with urinary incontinence"? Do we meet the standards	SWSH/Obs and Gynae	• To amend practice • To raise awareness • New leaflet • Incorporate Urogynaecology Proforma on EPR	• Improve documentation, with the incorporation of the urogynaecology Proforma on EPR • Raise staff Awareness – present findings to staff • Design new leaflet
Saving Babies' Lives SGA/FGR Audit	SWSH/ Maternity	• SFH Chart education, audit and compliance • Documentation changes for identification of risk • Consideration of future scanning pathways	• Organise action plan • Educational support • On-going compliance monitoring • Changes to EPR to record risk factors and guide staff to care plan guidance. The creation of a MTD sheet outlining additional scan criteria.

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
			Consideration on strategies on how additional scans are booked • Ethnic background, social factors and language barriers – consideration of an offer of additional scanning with one or a combination of these factors. • Future consideration of universal offer
Clinical audit of currently existing reflex serum triglyceride testing in lipaemic blood samples	CSDO/ Pathology	• Reflex TG testing in lipaemic samples in A & E patient is useful and will continue • Clinical alignment with this policy of reflex TG testing in A & E patients with high LI ,by Bart's and Lewisham & Greenwich Hospital	• Clinical biochemistry IT specialist and co-auditor to complete the IT change form to remove reflex testing in GP and outpatients • Bart's Health and Lewisham & Greenwich Hospital to consider aligning with this protocol – to liaise with them around feasibility
The Safe Transfer of Women from Hospital to a Community Setting	SWSH/ Maternity	• Improve failsafe measures • Remind staff that missed/delayed visits should be datixed • Generalise failsafe measures for all areas of maternity • Re-evaluate how discharges are delegated and received by community teams at HUH. • Review discharge email addresses • Datix training	• Add a column in the discharge diary to be signed by the clerk when the failsafe has been completed. Write instruction at the top of each page indicating 'Please sign once correct hospital and email checked'. This will ensure the failsafe is followed when bank staff clerk in the ward. • Send all maternity staff an email and ensure they are aware that if they identify a missed visit this should be escalated appropriately and datixed to ensure appropriate analysis and audit can be undertaken in future. • Ensure when women are discharged from delivery suite/birth centre that they are written in the postnatal diary in Templar so that the failsafe can be performed. • For discussion with community clerks to review how they ensure all emails received from HUH discharge

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
			email are dealt with in a timely manner. • Review the list of outward postnatal discharges. Ensure that each area of maternity has an up to date summary of all surrounding hospitals community discharge emails. • Consider implementing some additional training surrounding incident reporting so that common themes can be easier identified in subsequent audits.
Shoulder dystocia re-audit 2019	SWSH/ Maternity	• Send e-mail to maternity staff to • address areas of improvement • (syntocinon infusion, all fours) and praise the team • SD training	• Tips of fortnight • Simulations and workshops on SD, to continue with monthly PROMPT teaching
Bereavement Care in Maternity Services:	SWSH/ Maternity	• Improve completion of the bereavement checklist. • Improve intrapartum documentation (e.g. birth plan discussion). • Improve communication between teams	• Bereavement midwives to continue to monitor completion and provide feedback to staff. Bereavement midwives to complete where possible • Meet with K2 midwife to develop 'Bereavement' section in 'notes' in K2. • To inform community teams/referring hospitals/GPs of any loss.
Covid Consent Audit	SWSH/ Fertility	• Simplifying form • Extending clinic times • Staff training	• Assess to see what information can be down sized; speak with doctors/admin etc. • Ensuring that scan times are no shorter than 15 minutes • Staff training to be organised after modification of forms

Table 5: 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] This remains particularly pertinent in light of today's pandemic and the health crisis the population is encountering.
The Trust is committed to this path, growing research capacity year on year. However, during this exceptional year most research activity was paused to concentrate resources to COVID 19, opening studies focusing on the treatment of patients infected with virus. Nevertheless, the target of 2000 recruits per year was missed by just 89.

Our vision remains 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.

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2020/21 that were recruited during that period to participate in research approved by a research ethics committee was 1909. This was out of a total of 2318 patients who were deemed eligible and were screened for inclusion. A total of 1229 of these were patients diagnosed with COVID19

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 Research & Innovation (R&I) 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. Additional approvals were sought during this pandemic from the Clinical Review Group to ensure a balance between gathering vital information and ensuring our patients continued to receive optimal clinical care.

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 professionals3.
The R&I team engaged in a number of high profile COVID 19 Urgent Public Health Studies 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), 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. The Clarity study is investigating the impact of biologic therapy on COVID 19, and MERMAIDS is a study designed to investigate why people react so differently to the virus.

As the year drew to a close the department once again refocused to reopening closed studies and sourcing new studies that would be relevant to the patients and staff of the trust.

[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

2.2.4 GOALS AGREED WITH COMMISSIONERS

As a result of the Covid pandemic the contractual arrangements for 2020/21 with NHS foundation trusts were modified to a block payments approach.

The block payments approach for arrangements between NHS commissioners and NHS providers in England will now remain in place for the first half of the 2021/22 financial year. Block payments to NHS providers are deemed to include CQUIN, and there will be no 2021/22 CQUIN scheme (either CCG or specialised) published at this stage.

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 2020/21.

We did not participate in any special reviews or investigation carried out by the CQC during 2021/21.

Homerton University Hospital was last inspected by the CQC in January 2020, covering three core services; older people's 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 rating remained unchanged in 2020/21. The figure below outlines the current CQC hospital rating against the five key lines of enquiry.

Overall rating for this hospital	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Good ●
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆

Figure 1: CQC ratings – overall summary; report published 2nd July 2020

Action plans have 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.

Mary Seacole Nursing Home has been identified for use as a designated care setting for people discharged from hospital with a positive Covid-19 status. To ensure that the service was compliant with infection control and prevention measures, the CQC undertook a focussed inspection at Mary Seacole Nursing Home in December 2020. The CQC is assured that the care home has safe infection control and prevention systems in place. The rating of the care home remains at '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 University Hospital NHS Foundation Trust submitted records during 2020/21 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 20 – Mar21**:

- which included the patient's valid NHS number was

SUS Dataset	Trust	London	National	Performance against London	Performance against National
Admitted Patient Care	99.1%	98.9%	99.5%		
Outpatients	99.7%	99.1%	99.7%		
A&E	98.0%	97.2%	98.6%		

Table 6: Valid 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	100.0%	99.9%	99.8%		
Outpatients	100.0%	99.9%	99.7%		
A&E	99.9%	99.7%	99.6%		

Table 7: Valid GMP code

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.

The Acute and Community Services Data Quality Committees continue to take place bi-monthly. During the height of the COVID pandemic the committees did not take place but they reconvened in August 2020.

Locally agreed core DQ Acute and Community indicators continue to be monitored and discussed during committee meetings. Figures from the Data Quality Maturity Index (a monthly publication intended to raise the profile and significance of data quality in the NHS) are also presented to the committees and the Trust's data quality performance is discussed. The DQMI mainly focuses on the completeness and validity of the data the Trust submits.

The committees are a vehicle for data quality improvement and awareness within the Trust. They continue to promote and maintain robust processes for creating and managing accurate information within the organisation and ensuring that information that leaves the organisation is of the highest quality.

The Data Quality department do carry out audits at agreed frequency to check the consistency of the key SUS data items for admitted patients and outpatients between SUS submitted data, Data warehouse tables and front end of EPR (Cerner Patient Administration System).

New data quality indicators will be monitored as and when identified and deemed necessary by the committees. They will be vehicle through which new issues are raised, analysed to identify cause, impact and manage resolution. This will continue to be the platform through which strategies, policies and standards are monitored to ensure they align with operational requirements.

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 (DSPT) 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 DSPT to 30.06.2021; the trust has decided to plan its submission for this date. So the current status of the Trust's DSPT remains 'Standards Not Fully Met (Plan Agreed) at least until the above date.

2.2.8 CLINICAL CODING

Homerton University Hospital NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2020/21 by the Audit Commission.
Homerton University Hospital NHS Foundation Trust will be taking the following actions to improve data quality:

- Maintain its internal clinical coding audit programme
- Commission external clinical coding audits where deemed necessary
- Monitor a range of data quality issues via its Data Quality Committee

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.

The Acute and Community Data Quality (DQ) Committees reconvened in August 2020 having stopped during the height of the COVID pandemic. The committees continue to provide a focused space 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 including the Data Quality Maturity Index which looks at the validity and completeness of the data the Trust submits. 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.

The Information team have regular meetings with Clinical Systems team to review and resolve the current technical and reporting issues within main clinical systems.

The Data Quality team has 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.

A Data Quality Bulletin is presented to the Informatics committee which provides a summary of the Trust's local indicators as well as the benchmarked data for key indicators against London and National figures.

Homerton University Hospital NHS Foundation Trust are taking the following additional actions to improve data quality:

- The Data Quality Team are currently working on the improvement of ethnicity data completeness. Using the ethnicity from the Discovery Data Service, the team are updating the ethnicity on EPR for patients with upcoming outpatient appointments. By taking this action we expect there will be an improvement in the Trust's ethnicity completeness submissions.

- The Data Quality Team are also currently working on the clean-up of potential duplicates on the Health Information Exchange. This is a critical piece of work ensuring that Homerton holds one record for every patient who can be viewed by other Trusts and organisation's to ensure safe and effective clinical care.

- Improve our completeness in the Data Quality Maturity Index by incorporating low performing completeness datasets into our Data Quality dashboards. By reviewing these data sets in the DQ committees we are developing a dialogue to push improvement forward. For the Community Services Data Set this will include Language code, Ethnic category and Consultant Medium. For the Acute data sets this will include Ethnic Category and Decided to admit date.

2.2.10 LEARNING FROM DEATHS

During 2020/21, 680 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 MDT reviews
Quarter 1	189	149
Quarter 2	76	73
Quarter 3	143	142
Quarter 4	271	247

*Table 8: 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)

Overall deaths numbers are higher than in previous years in keeping with an increased mortality from COVID.

From April 2020 – March 2021 a total of 680 adult deaths occurred.

Overall 379 deaths occurred with COVID recorded on the MCCD (Medical Certificate of cause of death) as part 1 or part **2** from April 2020 – March 2021.

- Quarter 1: 124 out of 189 deaths,
- Quarter 2: 5 deaths out of 76 deaths,
- Quarter 3: 47 out of 144 deaths,
- Quarter 4: 203 out of 271 deaths.

For comparison in the year 2018/19 a total of 387 patients died of **all causes**, 2019/20 a total of 421 deaths of **all causes**.

Background information:

- Counted are both COVID swab positive deaths (which make up >90% of all COVID deaths) and a small number of COVID swab negative deaths ("clinical COVID", e.g. based on clinical presentation, imaging, supportive blood tests, lack of a better alternative diagnosis). Note: these are not routinely followed up by Post mortem results.

- All deaths with positive and negative swabs are reported to CPNS (COVID 19 patient notification system) by the Trust. A change regarding reporting regulations happened on 24.04.20 regarding swab negative deaths, which means that these are now included in CPNS data. ONS (Office for National Statistics) data however is based on MCCD information only which used to cause two different total of COVID deaths numbers. The Trust has reported all COVID deaths including swab negative deaths to CPNS from the beginning and an audit and reconciliation exercise happened in May 2020 and all but 1 death were reported as per the regulations to CPNS.

Key achievements made in 2020/21:

1) **COVID specific arrangement for deaths reviews and learning:**

Despite the time pressures of the Pandemic, the well-established mortality review process continued as evidenced by ongoing very high numbers of Consultant and MDT reviews:

Quarter 1: Consultant review in 100% of cases, MDT discussion in 79% of cases documented (more took place but were not captured on the tool).

Quarter 2: Consultant review in 100% of cases, MDT discussion in 96% of cases.

Quarter 3: Consultant review in 99% of cases, MDT discussion in 99% of cases.

Quarter 4: Consultant review in 98%of cases, MDT discussion in 91% of cases (some still pending as there is usually a time lag between death and mortality discussion).

For both waves of the Pandemic there was enhanced focus on multidisciplinary assessment of cases with ITU and some other Medical Speciality cases being additionally independently reviewed by a body of General Medical Consultants who were not directly involved in care of the patient in addition to the parent team in order to strengthen the review process. This was felt to be beneficial on both accounts and helped share learning more widely.

Both the ACU as well as the ITU mortality meetings were used as fora for wider Trust relevant learning of significant cases that stimulated debate and shared learning.

In addition some teams have put on shared learning events like academic afternoons or hosted a Medical Unit Meeting with the express wish to facilitate wider system learning, e.g. with regards to Continuous Positive Airway Pressure (CPAP) on the wards and escalation planning.

This work has build on other work that was already being conducted like the establishment of CPAP daily meetings and new guidance on escalation pathways for COVID.

2) End of life care / palliative care:

One theme from MDT mortality discussions that has been flagged by different members of the multidisciplinary team on several occasions was concerns about when and how to conduct end of life discussions.

An end of life SIM has been established as an action from it with the aim to improve staff skills in recognising the dying phase of a terminal illness, manage symptoms in dying patients appropriately and manage end of life care conversations with patient and relatives.

The end of life facilitator has also done work with different staff groups and the Palliative care team has also in a pilot expanded its working hours to a 6 day on site service to help facilitate face to face reviews which was well perceived (additional Consultant Palliative Care input is available at all other times on the phone).

There was a small but noticeable increase in the number of patients from wave 1 to wave 2 who were correctly identified as approaching the end of life where palliative care were able to assist in addressing symptoms and provide support for patients, their families as well where appropriate for staff members.

3) Independent scrutiny:

The Medical Examiner System was introduced nationally as part of the Department of Health and Social Care's death certification reforms programme for England and Wales.

The aim of the system is to address 3 key questions:

- What did the person die from?
- Does the death need to be reported to a Coroner?
- Are there any clinical governance concerns?

The system is designed to provide bereaved families with greater transparency and opportunities to raise concerns.

3 Medical Examiners have scrutinised cases since July 2020 (in an incremental way in keeping with guidance from the National Medical Examiner), with a fourth Medical Examiner recently having joined the team.

The Medical Examiners are accountable to the Regional Medical Examiner.

4) Structured Judgement reviews:

The Royal College of Physicians' structured judgement review (SJR) methodology is part of a whole range of measures intended for review of deaths for specific adult inpatients.

The Structured Judgement review is a validated research methodology which blends traditional clinical judgement based review methods with a standard format. The benefit is that it provides a structured and replicable process to review deaths, which examines both interventions and holistic care.

This requires the reviewer to make safety and quality judgements over phases of care. This is done by making explicit written statements about care for each phase of the hospital admission and to score each phase. The aim is to look at strengths and weaknesses of the caring process, to obtain information about what can be learnt about systems where care goes well and identify gaps or problems in the care process.

The AHSN (Academic Health Science Network) "Implementing Structured Judgement Reviews for Improvement" based on The National Quality Board Guidance 2017 suggests that each Trust should have mechanisms to review deaths of people;

1. With a Learning Disability
2. With a Serious Mental Health Illness
3. Those aged under 18 years

A pilot has so far run and a Standard Operating Procedure has been developed which recommends for completed structured judgement reviews to be reviewed in the 2 monthly Mortality Leads meeting and at this point fed back to the parent team and it is suggested that this is then included in the local mortality review process and that the electronic mortality tool is updated as appropriate. If an overall care score of 1 or 2 (poor or very poor care) is reached then this is referred to the Trust Incident reviewing process. These cases are also fed into the departmental governance structure.

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

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

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%).

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.

This exercise has not been repeated since that time because of the COVID pandemic. There has been no expectation from NHS England that board level assurance has been needed in the form of these case reviews since the first wave of the pandemic.

We continue to provide twice daily consultant reviews as per patient need as set out in standard 8.

For standard 2 we ensured we retained the same level of consultant review by increasing consultant presence during covid with doubled up consultant rotas during the surges and additional weekend working especially in January 2021 to meet the needs of the expanded medical inpatient population with a significantly higher acuity than normal.

The Trust continues to meet standards 5 and 6.

Future Plans – Seven Day Services

We will be guided by the national ask in this area with regard to what audits and notes reviews we undertake. We will continue to review incident reports and root cause analyses where there is any suggestion that there was a delay in consultant review.

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; 'Our Homerton People'.
The Trust has two Freedom to Speak up Guardians in the Trust who have dedicated time to promote speaking up and support staff who speak up. In line with national regulations, the Trust has an executive lead (Director of People) and a named Non-Executive Director with responsibility for speaking up (Dr Michael Gill).

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. Following the Covid-19 pandemic and in line with national guidance, the Trust will submit data to the National Guardian Office on a quarterly basis, and will continue to present a six-monthly report to the Trust Board, is presented in person by the Freedom to Speak Up Guardians. This report includes details of live/closed formal cases that have occurred in the reporting period, actions taken and feedback received.

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 88% fill rate across medical and dental posts. 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 66 occasions. There has been an increase in recruitment activity due to during the last six months, which is likely attributed to a reduction in advertising during the peaks of the pandemic, and a "back log" created.

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

Data for 2020/2021 has been impacted by the Sars – CoV2- Pandemic. Additional caution needs to be taken when interpreting SHMI data.

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 Jan'20 to Dec'20. Our Trust SHMI score is 85.16 which equates to NHS Digital Band 3 (lower than expected deaths when compared to the national baseline).

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
(a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period	Oct 2016 – Sept 2017	Value: 0.87 Banding: 3	Value: 1.01	Value: 1.25 Banding: 1	Value: 0.73 Banding: 3
	Oct 2017 – Sept 2018	Value: 0.69 Banding: 3	Value: 1.00	Value: 1.27 Banding: 1	Value: 0.69 Banding: 3
	Jan 2018 – Dec 2018	Value: 0.76 Banding: 3	Value: 1.00	Value: 1.23 Banding: 1	Value: 0.699 Banding: 3
	Jan 2019 – Dec 2019	Value:0.77 Banding: 3	Value: 1.004	Value:1.1999 Banding: 1	Value: 0.6889 Banding: 3
	Jan 2020 – Dec 2020	Value:0.85 Banding: 3	Value: 1.0016	Value:1.1845 Banding: 1	Value: 0.7030 Banding: 3
(b) The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.	Oct 2016 – Sept 2017	45.40%	31.60%	11.50%	59.80%
	Oct 2017 – Sept 2018	43.60%	33.80%	14.30%	59.50%
	Jan 2018 – Dec 2018	46%	34%	15%	60%
	Jan 2019 – Dec 2019	48%	36%	10%	60%
	Mar 2019 – Feb 2020	51%	37%	10%	59%
	Jan 2020– Dec 2020	47%	37%	8%	61%

Table 9: SHMI scores since 2016 to 2020(NHS Digital)

Assurance Statements

Data for 2020/2021 has been impacted by the Sars – CoV2- Pandemic. Additional caution needs to be taken when interpreting SHMI data.

The data for SHMI has been sourced from HED, Trust benchmarking tool. The data period is January 2020 – December 2020 which includes wave 1 of the Sars CoV 2 Pandemic and in part wave 2 of the Pandemic. The SHMI is not designed for this type of Pandemic activity. Our Trust SHMI score is 0.85 and banding is a NHS Digital Band 3 (lower than expected deaths when compared to national baseline) which is a trend which has continued from previous years.

How is Homerton University Hospital NHS Foundation Trust doing?

1) The electronic mortality review tool has been in use since October 2018. It continues to have very high levels of engagement (for the year 2020/21 the following an MDT or second independent senior reviews of deaths took place for each Quarter: Quarter 1: 79%, Quarter 2: 96%, Quarter 3: 99%, Quarter 4: 93%. The high levels of ongoing engagement with the learning from death mortality review process pre Pandemic have continued throughout the Pandemic (with a short period during the height of each wave when reviews were delayed and then picked up again). New ways of supporting other teams have been established through a process

where an independent second Consultant Assessor from a different speciality has supported this process for certain areas with particularly high clinical workload which has added additional rigour to the process.

2) The Palliative Care team has worked in additional and close direct liaison with individual clinical teams during this period and has provided additional support for patients close to or at the end of life with individualised care plans and support. This has been possible through an expansion of the hours worked on site which has included additional weekend (Sunday) cover. Training on recognition of the End of life has been ongoing with different staff groups and a new SIM has been developed for recognition and communication of end of life scenarios to help build staff confidence.

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	April 2020-Mar 2021	**Not available at time of publication**			
	Apr 2019-Mar 2020	Insufficient records to calculate data (23 but 30 needed to report, n= 110 surgeries)			
	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

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
Total Knee Replacement Surgery	April 2020-Mar 2021	**Not available at time of publication**			
	Apr 2019-Mar 2020	Insufficient records to calculate data (24 but 30 needed to report, n=94 surgeries)			
	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	April 2020-Mar 2021	**Not available at time of publication**			
	Apr 2019-Mar 2020	Insufficient numbers to be included			
	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 10: 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.
- 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

Every acute Trust submits their admitted patient activity to Secondary Uses Services (SUS) as per the mandated timetable. Every month the submitted SUS data is cleansed by HES (Hospital Episodes Statistics). This dataset is provided to authorised organisations like HED.

The readmissions data is based on PbR (Payment By Results) logic.

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 11: 28 day readmission rates for patients aged 0 – 15 and aged 16 and over. Source is HED benchmarking tool.

Assurance statements

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

The Trust uses the 30 day readmission standard rather than 28 day readmission.

The Trust has a robust clinical coding and data quality assurance process, and 30 day readmission data is monitored through the Trust Management Board on a monthly basis. The Trust board readmission rates have agreed local exclusions applied over and above the PbR logic.

The Trust has the following to support regular monitoring and take actions as required

- Information team has developed an electronic readmissions report that enables local services to drill down seamlessly from Trust wide through divisional to local level and identify possible causes of the increased readmission rates.

- 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.

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.	2019/20	64.7	67.1	60.0	84.2
	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 12; 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.

The Trust intends to take the following actions to sustain and improve the patient satisfaction 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.
- The review of learning from the communications team developed through the pandemic to shape ongoing work on patient experience
- The training of staff in communicating in PPE
- The continued focus on first impressions and work to improve this area of experience
- The ongoing implementation 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	2020	**77.0**	74.3	49.6	91.7
	2019	**76.2**	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 13: 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 survey was conducted on behalf of the Trust by Picker Institute, an approved provider by NHS England. All full and part time staff employed by the organisation on the 1st September 2020 (with certain specific exclusions) had the opportunity to complete the survey electronically between October and November 2020. The Trust achieved a return rate of 47.6%, which represented decrease of 8.5% from 2019.
- We have performed above the national average for staff recommending friends and family as a place to be treated with the score improving by nearly 4% since 2020.

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:

- Implementing 'Our Homerton People' plan - The plans and projects that will deliver the improvement in our people's experience be made of the following key elements:
  - People matter at Homerton Healthcare
  - Achieving equality and inclusion for our people
  - Creating a values-led organisation for all our people
  - Supporting the health and wellbeing of our people
  - Developing our people's potential

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. It is estimated that as many as half of all cases of VTE are associated with hospitalization for medical illness or surgery. VTE is an international patient safety issue and its prevention has been recognized as a clinical priority for the NHS in England**.**

During the 2019/20 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 that 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 ensured 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.

Indicator	Reporting Period		Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	2020/21	Q1	**88.9**	N/A	N/A	N/A
		Q2	**86.3**	N/A	N/A	N/A
		Q3	**85.7**	N/A	N/A	N/A
		Q4	**88.5**	N/A	N/A	N/A
	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**	*	*	*
	2018/19	Q1	**95.5**	95.6	75.8	100
		Q2	**97**	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**	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	100

*Table 14: VTE risk assessment data (NHS Digital); *Q4 publication delayed due to Covid*

Following this change there was unfortunately a drop off in VTE performance. The new VTE process is clinically safer for patients who have it completed (because it links the VTE risk assessment directly to

the prescription of prophylaxis and has far more data relevant to decision making displayed within the form). However despite this improvement in quality of assessment there was a fall in % completion.

This was quickly picked up as an issue and is discussed on a monthly basis by the trust board.

The reasons for this fall in performance include:

1) Changes in the alert that a VTE risk was not completed- previously these forced a decision before all the relevant information was available but in response to the concerns described above these have been changed to regular reminder pop ups.

2) As activity has moved around the hospital there may be some issues with data quality especially in surgical specialties where some patients not admitted to hospital may have been counted in totals

3) The upsurges of covid and associated redeployment of staff

Assurance statements

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

There is a clear plan in each division to tackle the fall in VTE performance. The Associate Medical Directors in association with the Divisional Governance Leads review performance weekly and report to the Medical Director on their improvement plans.

In order to address this issue an icon flag has been added to the inpatient view on EPR which provides a pictorial summary for all alerts for all inpatients which clearly shows who has an outstanding VTE assessment.

The acute admitting wards; ACU and Lloyd, have appointed “VTE champions”-and weekly performance is feedback to the junior doctors; this has led to a real improvement in completion of forms for medical admissions with IMRS performance in March of > 90%.

The SWISH team are working with the Quality improvement team to understand both the data quality and clinical performance issues to develop a full range of interventions to improve performance for patients admitted under surgical specialties. We would expect this approach to lead to the same performance improvements seen in IMRS.

It was important to address the safety concerns we have identified in previous years. VTE risk assessment is a surrogate marker for a complex process of risk assessment and decision making that needs to be patient centred and seamless.

Whilst the challenge of reduced form completion rates is being taken very seriously and this package of interventions along with the safer redesigned form will lead to a higher quality process for each patient moving forward will be reviewed regularly going forward; performance will be reported within the Trust’s governance framework

7. Clostridium difficile rate - NHSI Quality Indicator 24

In the financial year 2020-2021, there were 10 Trust-attributable C.difficile toxin positive cases against Public Health England's very low target for the Trust of 12 cases. This was despite the extraordinary pressures put on the staff at the Trust by the COVID pandemic including the higher than usual use of broad spectrum antibiotics to cover for possible secondary bacterial chest infections in COVID patients. This demonstrates the educational work performed by the Antimicrobial Stewardship Team to ensure that inappropriate antibiotic use was minimised and the commitment by the ward teams to follow that advice closely in very pressurised circumstances and should be formally recognised.

Of the 10 Trust-attributable C.difficile toxin positive cases, 1 was defined as 'community onset healthcare associated' (COHA). COHA cases are those occurring in the community/within 2 days of admission when the patient has been an inpatient in the reporting Trust in the previous 4 weeks. The other 9 were defined as 'hospital onset healthcare associated' (HOHA). HOHA cases are those detected in the reporting Trust two or more days after admission. Although the formal 'Post Infection Review' root cause analyses are still in progress for a number of the cases due to the backlog of reports as a result of the pressures of the COVID pandemic, the 'lapse of care' findings on preliminary review are as follows:

Month	Lapse of care issues	Category of case
April-20	Delay in side room isolation	COHA
Nov 20	Delay in sending of stool sample & side room isolation	HOHA
Dec 20	Delay in consideration of C.diff infection/Delay in sending of stool sample & Side room isolation	HOHA
Dec 20	Delay in sending of stool sample & side room isolation	HOHA
Dec 20	Delay in sending of stool sample & side room isolation	HOHA
Jan 20	Delay in sending of stool sample & side room isolation	HOHA
Feb 20	Delay in side room isolation	HOHA
Feb 20	Delay in consideration of C.diff infection/Delay in sending of stool sample & Side room isolation	HOHA
Feb 20	Nil	HOHA
Mar 21	Delay in sending of stool sample & side room isolation	HOHA

Table 15: Lapses of care identified

Assurance statements

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

In the 10 Trust-attributable cases, there were no 'lapse of care' issues related to cross-transmission or inappropriate antibiotic use. Only 4 cases were in long-term inpatients and only 7 cases were in patients over 65 years of age, indicating good adherence to the Trust's antimicrobial policy. Two cases were admitted with diarrhoea and their C.difficile infection, from a clinical perspective, was community-onset. However, due to delay in recognition of the possible diagnosis and therefore sending of the stool sample, from the PHE perspective these were HOHA cases. The main theme form review of the cases was the delay in sending stool sample once the patient met the criteria for C.difficile testing and the delay in side room isolation. It is probable that this was, at least in part, due to the pressures of caring for a large number of patients with COVID and therefore a decrease in awareness of other infection issues.

The Trust remains committed to minimising the risk of any avoidable C.Difficile case and 'Post Infection Review' root cause analyses are performed on all trust-attributable cases where there are possible 'lapse of care' issues so that the learning from these reports can be shared across all stakeholder groups.

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	Oct 2019 – March 2020	**2502**		6502	1271	22,340
Rate of patient safety incidents (per 1000 bed days)		**56.65**		50.66	15.7	110.2
Number (%) of patient safety incidents resulting in severe harm or death		Severe	**3 (0.12%)**	14 (0.24%)	0 (0.0%)	91 (0.8%)
		Death	**0 (0%)**	5 (0.10%)	0 (0.0%)	22 (0.6)
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		**3151**		5449	1311	19897

Rate of patient safety incidents (per 1000 bed days)	Oct 2017 – March 2018	**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 16: 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 (October 2019 – March 2020) does not cover this reporting period (2020/21). For this period, Homerton was noted as a relatively high reporting Trust when compared nationally (see figure 2 below).

Figure 2: reporting to the NRLS October 2019 – March 2020

During this period, there were 56.65 incidents reported per 1000 bed days, a decrease from 64.82 incidents per 1000 bed days over the same period in 2018/19. It should be noted that these figures relate to when incidents are uploaded into the NRLS system rather than when they occur or are reported within the Trust. Work has been going on throughout 2020/21 to improve the internal incident approval process and thereby improve the timeliness of reporting to NRLS.

A number of broad areas of work will be prioritised during 2021/22, 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 2021/22. This will require a significant programme of work involving staff across the whole organisation. The Head of Patient Safety has been identified as the Trust's Patient Safety Specialist, and will be linking into a national network of people in the same role to ensure the Trust is linked into all relevant national programmes of work.

- Continuing the Datix improvement project,which during 2020/21 has focused on developing and improving the complaints, claims and risk register modules. During 2021/22, 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. A new Quality and Patient Safety Manager has been appointed to lead on this work.

- 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. This will link into the national patient safety syllabus which has been developed as part of the Patient Safety Strategy.

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 works hard to ensure 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.

During the pandemic the collection of Friends and Family data was suspended and so the trust is not able to report any data for the full year. Data collection has recommenced and this will be reported on a regular basis to the Board and in the 2021/22 Quality Account.

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

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 preventable financial pressures.
There is continued national focus on the need to reduce the number of pressure ulcers both hospital and community acquired. The new neighbourhoods model that will be operating in our community will aim to improve collaborative multi-agency work and reduce pressure ulcer incidence.

Metrics

- Number of preventable hospital acquired pressure ulcers category 3 and above
- Number of preventable community acquired pressure ulcers category 3and above
- Number of preventable hospital acquired pressure ulcers category 2
- Number of preventable community acquired pressure ulcers category 2

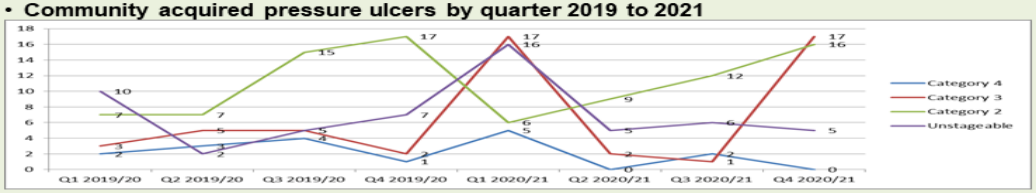
Updated:
June 2021

Position update

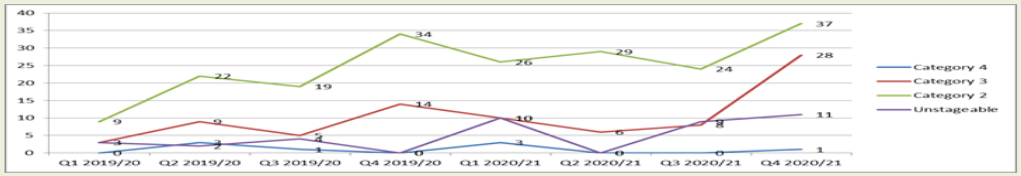
Aim of priority when originally launched

- Reduce the number of category 3 and above pressure ulcers by 10%
- Reduce the number of category 2 pressure ulcers by 5%

- Review methodology of reporting pressure ulcers
- The pressure Ulcer Scrutiny Committee (PUSC) continues to meet with Therapy and Dietetics now attending
- A Thematic analysis of all category 2 and above pressure ulcers HUH recorded from 1st April 2020 till 31st March 2021, identified the similar themes for the acute and community:
  - Skin inspection, Lapses in the implementation of PU prevention/management interventions and Lapses in documentation
- **Community acquired pressure ulcers by quarter 2019 to 2021**



- **Homerton Hospital acquired pressure ulcers by quarter 2019 to 2021**



- Worldwide there has been an increase in the incidence of the pressure ulcers in patients who are severely unwell with Covid 19 and this is likely due to the hypercoagulability, which affects the microcirculation, and subsequently leads to ischaemia (NPIAP, 2021). The pandemic has also led to an unprecedented bed occupancy/high turnover of patients, workforce challenges among others, which has had an impact in following all the actions that the Trust had initially planned for (for e.g. regular auditing, thorough skin inspection within 6h of admission etc.)
- Following the 1st Covid wave, a Covid 19 Contigency plan was developed and actioned during the 2nd Wave (Winter) which showed to be effective and led to a reduction of 19% of incidence of PUs in ITU setting.
- In the community setting, Wound Multidisciplinary Team meetings, including Foot Health, TVN and Community nurses have been taking place each month since September 2020.
- Pando app has been implemented, which allows staff to share photos of the wounds (with patients' consent) and get support from the TVN team as required
- Tissue Viability team participate in the Worldwide "Stop the Pressure Ulcer Day"

Actions to sustain

- Complete QIP
- Action plan to improve the assessment of patient's skin in accordance to national guidance, ensuring the assessment is correct and escalation is appropriate.
- Ward managers are already auditing pressure ulcer care as part of the Perfect Ward.
- Covid-19 contingency plan
- To continue with Wound MDT meetings in the community

Key risks going forward

- Mini-rcas not always being completed in a timely matter.
- Improvements to reports generated from Datix
- Replacement of the monthly national Safety Thermometer audit tool.
- Timely completion of root cause analysis

Outcome

Carried forward from 2018/19 on 2 year cycle.

Continued oversight to be provided by the Improving Patient Safety Committee

2. Improve the safe management of medicines within the organization

Back ground

New priority for 2020/21

Stakeholder survey identified a need to support and improve the safe and secure handling of medicines, learning from medication incidents and embedding best practice.

Missed/omitted doses can impact upon patient physical and mental wellbeing, delayed discharges, bed management and staff morale.

Metrics

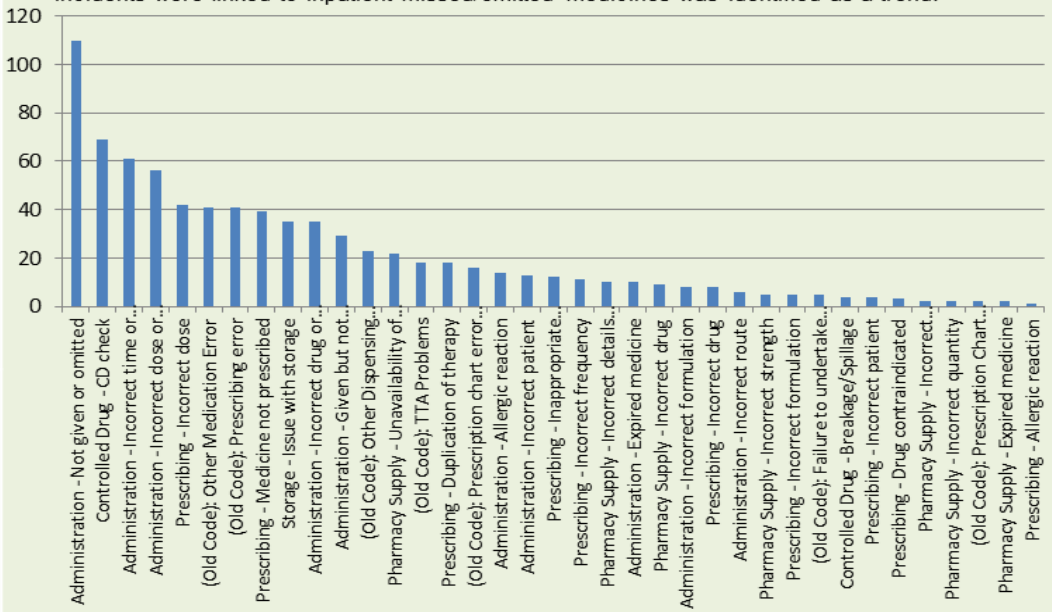
To be agreed by Working Group

- Number of missed/omitted doses for inpatient medication recorded on Datix
- Further metrics to be identified by T&F Group

Updated:
May 2021

Position update

- Established working group for quality priority
- Review of the medication incident data on Datix for 2019 identified 13% of all medication incidents were linked to inpatient missed/omitted medicines was identified as a trend.



- Omitted medicines audit completed March 2021,reviewed EPR records for 7476 omitted or delayed administration during November 2020;
  - 40% patient refusal, 21% reason not documented, 20% various clinical reasons, 9% medication unavailable, 6% incorrect route (NBM or no IV access)
  - Templar ward identified over 300 incidents of missed medication due to medications that was meant to be discontinued after delivery but was not discontinued on EPR; linked to non documentation for reason of non-administration
  - Common medications refused were analgesics and laxatives.
  - Prescription of STAT medications not communicated to nursing teams

Actions to sustain

- Implement action plan to reduce missed/omitted medication based on audit
- Link with NICU medication QIP
- Develop links to Medication Safety Strategy and relevant re-audits;
  - Develop local critical medicines list
  - Introduce regular missed medications report
  - Improve training of IV medication
  - Trust wide annual safe & secure handling of medicines audit
  - Medicine administration chart (MAR) audit on MSNH, HTNRU & community services

Key risks going forward

- Impact on resources of Covid-19.
- Launching new quality priority
- Nurse training for IV access
- Linking to NICU medication QIP

Comments

New priority 2021/22

Oversight to be provided by the Improving Patient Safety Committee

3. Reducing physical violence and aggression towards patients and staff

Back ground

Carried forward from 2018/19 and then into 2020/21

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.

Metrics

- Number of V&A incidents recorded on Datix
- Feedback following NHS Staff survey
- Number of Red/yellow cards issued to patient/visitors (28 yellow cards and 1 red card)
- Local implementation of the national strategy

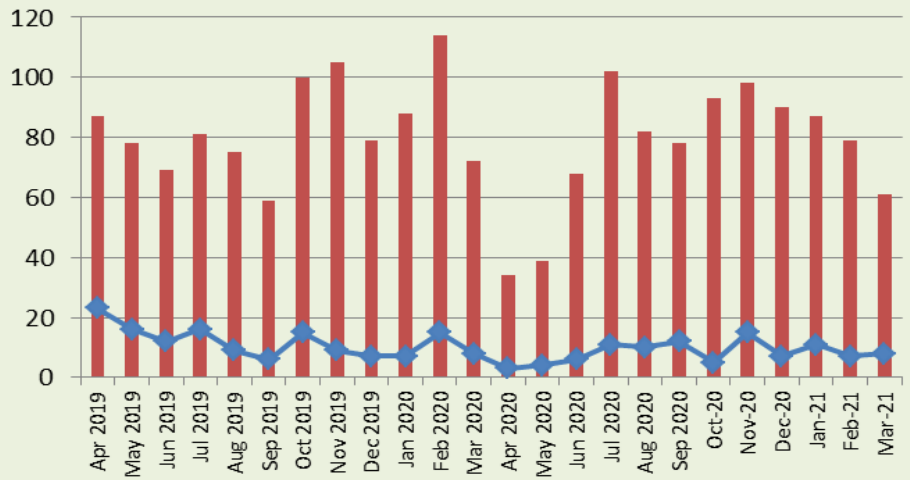
Updated:

May 2021

Position update

- Reduction of physical assaults on staff by 43% for 2019-2020 FY
- Reduction of physical assaults on staff by 31% in 2020-2021 FY
- Improved reporting of violence and aggression continues as the number of total violence and aggression increased each year but reduction in physical assault is a positive result.
- Increased number of yellow and red cards issued (31 yellow & 4 red)
- Continued partnership with Met Police on Operation Cavell, 4 police community protection notice issued (CPW).
- Increased number of reported crimes to police which shows staff are more confident in escalating incident with police as there is better support and result.
- Increased number of convictions and fines resulting from offenders being arrested by the police for V&A incidents.

Actual physical assaults (blue line) versus V&A incidents reported (red columns)on Datix



Actions to sustain

- Further reduce physical assaults on staff
- Restart the Enhanced Maybo Conflict Resolution Training for staff to give them better knowledge and skills to deal with violence and aggression and deescalate situations.
- Continue raising awareness and improve reporting on Datix
- V&A champions in each areas to support staff
- Staff not to tolerate violence and aggression and seek sanctions through yellow and red card
- Support community services with better police support from issuing CPW and support in joint risk assessments for high risk home visits
- Effective roll out of new lone worker device solution to support staff working alone.
- Quarterly review by Health & Safety Committee

Key risks going forward

- Raised awareness of the issue may result in an increase in the number of incidents reported by staff on Datix.
- Embedding the use lone worker devices
- Delivering Maybo training on-going

Outcome

Priority carried forward into 2021/22

Continued oversight to be provided by the Improving Patient Safety Committee

4. Improve multidisciplinary falls assessments and individualised management plans of inpatients and the support given to both patients and staff post fall

Back ground

New priority for 2020/21

CQC survey identified a need to Improve multidisciplinary falls assessments and individualised management plans of inpatients and the support given to both patients and staff post fall.

Metrics (Proposed)

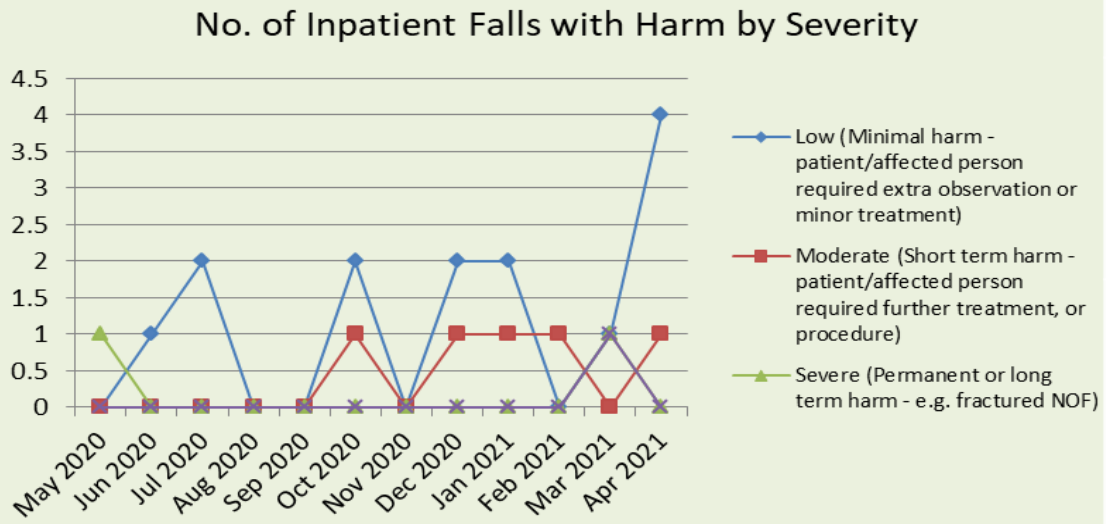
Metrics to agreed by working group.

- the number of patients with documented MDT individualised falls management plan
- Inpatient Falls Per 1000 Bed days
- Number of inpatient falls with harm

Update:
May 2021

Position update

- Quality priority to be progressed by Strategic Falls Group and the Falls Working Group
- Ward based training on personalised care planning for band 5 & 6 Nurse's completed in April. A 2 week mini audit and, spot check and micro teaching planned for every 2 weeks until the end of June.
- Started focused MDT project on ECU – progress limited due to wave 2
    - Project registered with QI team
    - Based on learning from Falls care plan audit
    - Audit of therapies manual handling assessments and use of mobility charts
    - Aiming to improve individualised falls care plan documented in nursing care plan
    - In planning stage of PDSA – will liaise with QI team for support
- Initial focus on ECU – then plan to share learning and consider what change ideas could have impact across the trust
- Post fall support for patients and staff will continue into 2021/22
- Continued audit of falls reported on Datix to identify themes and trends



Actions to sustain

- Integrate quality priority into Strategic Falls Group Action Plan Work Streams
- QI project on ECU
- Implement actions of Falls care plan audit
    - Improve completion of falls assessments
    - Improve completion of falls management plans
- Follow up on the Therapies manual handling and mobility chart audit
- Yearly falls awareness week to be held in October
- Yearly Audit of falls with Harm
- Staff feedback on managing patients who have fallen
- Review of priority progress and aims

Key risks going forward

- New quality priority
- Continuation of audits during Covid

Outcome

Continue priority for 2021/2022

Continued oversight to be provided by the Improving Patient Safety Committee

5. Learning from complaints, incidents, claims and compliments

Back ground

Carried forward from 2019/20

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..

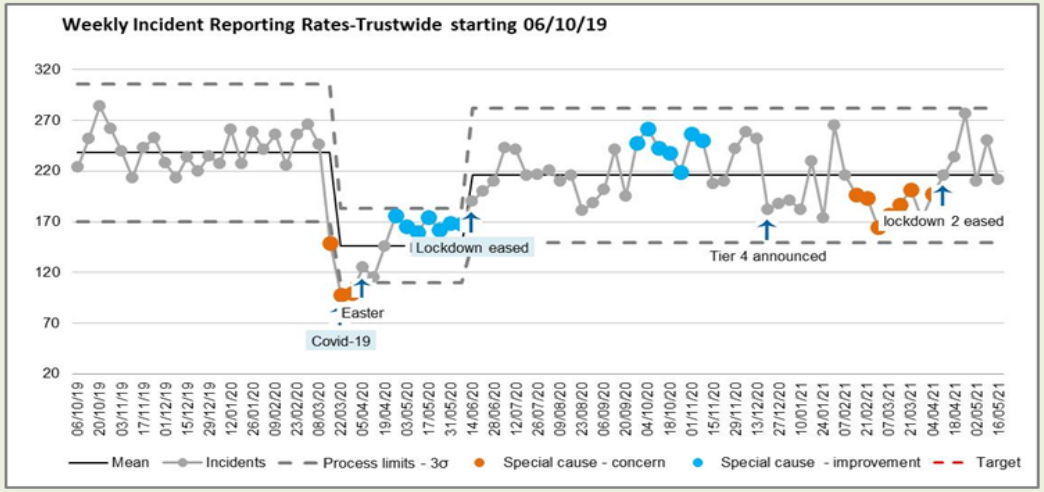
Metrics

- Evidence of sharing the learning from incidents with patients (Duty of Candour audits)
- Evidence of learning from Serious Incidents shared with staff
- The number of incidents reported on Datix
- Patient feedback from PALS and Complaints
- Number of incidents open beyond agreed timeframe (20 days)

Update:
May 2021

Position update

- Updated Datix incident categories and reporting forms, easier to extract themes and learning – resulted in increased reporting
- Resumed training to specific departments on claims, inquests and advisory work including department specific statistics on claims and also themes of claims.
- Migrated all claims and inquest management onto Datix web to ensure that data can be analysed efficiently and develop further links with the complaints and incidents work streams
- Establish closer links with the Patient Safety and Complaints team to review wording in SI/RCA's and complaint responses to ensure they adequately reflect the facts of the case and ensure that any claim related concerns are raised early.
- Ensure effective communication internally to ensure that once a claim or inquest has concluded, that all learning is shared and any actions are completed.
- Attending SIR meetings to identify areas of care that may require further investigation to enable a more rounded analysis and give an indication of weaknesses in a potential claim.
- Working closely with NHSR to improve the relationship with the Early Notification Scheme leaders and to learn from themes and trends in maternity care.
- Completed recruitment into Patient Experience team
- Completed recruitment of trust wide Q&PS Manager dedicated to developing actions plans and sharing the earning from SI's
- Statistical Process Control charts for incident data include in Governance reports.



Actions to sustain

- Finalise process to disseminate learning to staff outside of formal meetings (SI learning alert)
- Develop support from QI Team
- Introduciton 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.
- Support the timely closure of incidents based on agreed metrics
- Implement Patient Safety Strategy

Key risks going forward

- Further development of after action review process required
- Launch of post serious incident learning
- Covid-19
- Datix development

Outcome

Priority carried forward into 2021/22

Continued oversight to be provided by the Improving Patient Safety Committee and Improving Clinical Excellence Committee

6. Appropriate identification and management of deteriorating patients extended to maternity and neonates

Back ground

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

The DPG will continue to support the adult work stream.

This priority will be extended to initially include maternity and then neonates.

Metrics

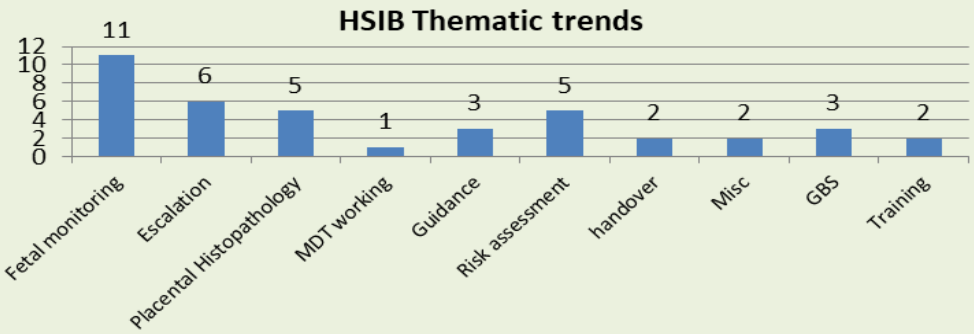
Metrics to be agreed by working group based upon:

- Appropriate escalation of Neonatal Early Warning Triggers(NEWTT) score
- Appropriate escalation of Cardiotocography (CTG)
- Audits of patient notes- recording escalations and actions taken

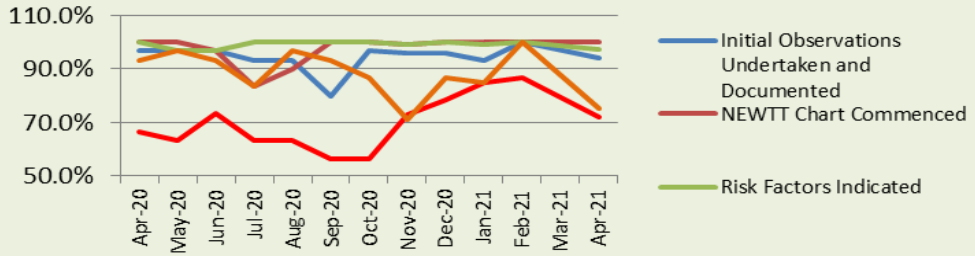
Update:
May 2021

Position update

- Identified key staff to patriciate in maternity style Deteriorating Patient Group
- Thematical analysis of the outcome of maternal investigations completed by the Healthcare Safety Investigation Branch (HSIB



- NEWTT refresher training on the principles of NEWTT scoring undertaken and training slides shared with staff
- Utilise staff working remotely to complete real-time reviews of NEWTT score
- Increase the number of computers to enable to timely recording of observations
- Exception reporting at MRMR meetings
- Audit monthly of NEWTT compliance and metrics identified, opportunities to improve identified



- Support from QI Team to identify approach to further embed progress
- Identified community based improvements for deteriorating children to include policies, review mechanisms, training of school based staff, reporting metrics and establish membership of T&F group.
- Explore outcome of nation pilot scheme to plan next steps for deteriorating children on the acute site

Actions to sustain

- Establish 'maternal deteriorating patient' Task and Finish group
- Categorise CTG's to establish normal, suspicious and pathological (when escalation is needed)
- Expand timeframe for continuing priority into 2021/22
- Continue NEWTT audit – introduce SPC analysis
- QI Team support to meet compliance targets
- Launch Maternity Oversight Group
- Develop service improvement plan with support from Deteriorating Patient Group
- Introduce priority into CSDO for appropriate paediatric work streams and metrics in the community and on the acute hospital site

Key risks going forward

New/extended quality priority

- Establishing Task & Finish group
- Impact of Covid-19
- Introduce priority into CSDO for deteriorating children on both community and acute settings

Outcome

Priority modified to support maternity and paediatric services during 2021/22.

DPG will support and advise working groups. Progress to be reported to the Improving Clinical Effectiveness Committee.

7. Making Every Contact Count (MECC)

Back ground

Carried forward form 2019/20

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.

Metrics

- Friends and Family Test
- NHS patient Survey
- PALS and complaints

Further metrics to be advised by task and finish group

Update:
May 2021

Position update

- Hackney council-funded MECC training delayed during 2020 due to Covid-19, but restarted in February 2021
  a) experiencing health and social inequalities
  b) training delivered virtually and added to Maternity Mandatory Training week - to be repeated annually. 95 midwives trained to date
  c) Discussions on-going to continue training after funding ends in August 2021

- MECC steering group

Members of the steering group 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.

- Triangulate learning from interactions implemented following the first Covid wave. After Action Reviews completed by QI team have been collated and reported to the Trust Management Board.
- Extend work stream beyond maternity, starting with therapies
  - Therapies MECC working party established during 2020.
  - Musculoskeletal Physios from the Locomotor service and Homerton MSK team attended a virtual MECC training in September 2020.
  - Online teaching session was recorded and remains available along with the slides for staff to view on the MSK MS Teams channel
  - Incorporate health promotion and signposting to the find support services on the Trust's internet web page, into the new online self-referral to Physiotherapy service
  - Therapies team supported the 'Getting Patient Moving' quality priority

- Oversight to be shared with Improving Clinical Effectiveness Committee from February 2021

Actions to sustain

- Training recommenced during February 2021
- Therapies MECC working party established
- Improved oversight - shared with ICEC
- Identify learning from Covid-19; for example
  - Patient admission lifestyle questionnaires – smoking
  - Nutrition support post Covid-19

Key risks going forward

- Availability of staff to complete training
- Covid-19
- Extending work steam to other clinical services
- Changes to divisional leadership team

Outcome

Priority carried forward into 2021/22

Oversight to be shared with Improving Clinical Effectiveness Committee and Improving Patient Experience Committee

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

Back ground

Carried forward from 2019/20

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.

Metrics

Currently begin refreshed due to changes in project leadership. Previously identified metrics were:

- Metrics from survey and client experience feedback
- Length of outpatient clinics
- Percentage of staff completing customer care training

Update:
January 2021

Position update

The First Impressions Group has 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 to be rolled out to the rest of the trust later in 2020/21 - 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…" yellow badges ordered for staff with several teams already wearing the badges.
- Uniforms provided to clearly identify admin/clerical and volunteers
- Reception signage when areas are temporarily unstaffed
- Hospital signage for areas not frequented by patients; e.g. blood clinics
- Signage and disability access monitored by Improving Patient Experience

Actions to sustain

- Update on progress to be reported to divisional governance meetings by the Associate Chief Nurse for CSDO
- Staff training programme to relaunch post Covid-19
- Review hospital and reception signage
- Review original action plans and evidence
- QI projects ongoing
  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 in 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 access requirements.
- Changes to CSDO Divisional leadership team
- Impact of Covid on patient feedback programme

Outcome

Priority carried forward into 2021/22

Continued oversight to be provided by the Improving Patient Experience Committee

9. Improvements in staff health and wellbeing

Back ground

Carried forward from 2019/20

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.

Metrics

Metrics to be based upon

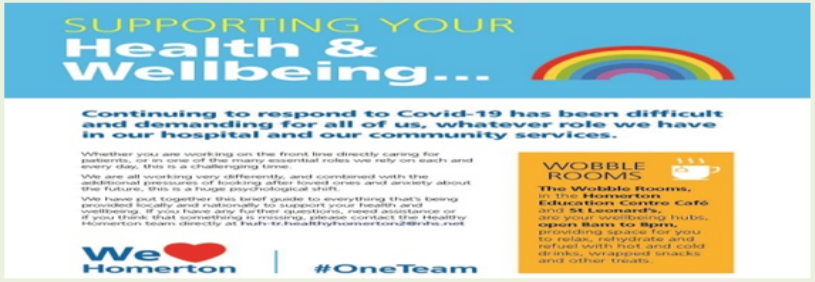
- "Health and wellbeing" theme (National Staff Survey)
- Recommendation as a place to work (National Staff Survey and Friends & Family Test)
- Long-term and short-term sickness (ESR)
- Turnover (ESR)

Update:
May 2021

Position update

Progress achieved to date:

- Improvement in "Health and Wellbeing" theme as measured through the National Staff Survey 2020; up from 5.5 to 5.8
- From September 2020, BollyX , Pilates, Yoga and Barr Fit were moved online
- Homerton Choir online
- Health Assured (Trust's Employee Assistance Programme) – offering online counselling, webinars
- Wobble Room, ran throughout both waves and investment for Community wobble rooms to be developed.
- Feel Good Trollies roll-out across the wards, to bring, information, support and welfare to ward based staff.
- Regular staff briefings, which always feature health and well-being, intranet pages update to date with all information for staff.
- Executive team webinars
- Going home check lists, support for shielding staff
- Various information sheets for staff e.g. sleep, diet, exercise
- Promotion of well-being apps and offers from NHSI/E (NHS People)
- Talk Changes Psychological support for staff
- Support for staff with children via First Steps, including dedicated email address, webinars and 1-1 support.
- General wellness offers around childcare support / parking/ travel/ accommodation/ cycle to work.
- Schwartz rounds offering a safe space to share stories
- Supporting Menopause Awareness day, holding HUH's first menopause café
- Improve communications around health and well-being, via weekly email newsletters.
- Visit from Dexter the Met Policies Therapy dog
- Project Wingman – Wellbeing bus visited for 2 weeks, offering staff first class lounge experience from Aircrew
- Memorial service for staff to reflect, remember and come together
- Throughout October 2020 over 5,000 breakfasts were given out to staff as a thank you
- Thank you cards for all staff from the Chief Executive
- Well-being day – additional annual leave day given to substantive staff as a thank you.



Actions to sustain

- Embed wellbeing support across the Trust, including ensuring sustainable psychological support and developing our leaders to support staff health and wellbeing
- Establish clear pathways and signposting for staff to access appropriate care
- Deliver refurbishment programme to update and upgrade staff areas; three areas identified and a further three being scoped
- Embed health and wellbeing in the wider Trust strategy
- Utilise funding from early 2020 to deliver Mindfulness and Mental Health first aiders
- Project Wingman revisiting in September 2021

Key risks going forward

- Staff engagement & NHS staff survey completion rates
- Impact of Covid

Outcome

Priority carried forward into 2021/22

Continued oversight to be provided by the Improving Patient Experience Committee and will link with new 'People and Culture Group'.

10. Getting Patients Moving (End PJ Paralysis) - CLOSED

Back ground

Carried forward from 2019/20

During hospital admission it has been widely publicised that patient can have a dramatic decrease in their functional ability which can lead to hospital acquired disabilities (HAD), prolonged hospital stays, increased dependency on discharge, poor patient experience, and subsequently increased cost.

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.*"

Anecdotally it is believed that patient activity while residing at HUH was limited and furthermore that the majority of their time was spent in bed in hospital gowns.

Trust priority was set in 2019/20 to get patients moving.

Update:
November 2020

Position update

The overall aim of the ~~whole~~ QI project; in order to meet the Trust priority, was to have a 20% increase of all eligible patients sitting out in a chair by midday across the acute inpatient wards.

Final position statement – October 2020

Results:

- GSU (baseline 36.4% up to 84.6%) = **48.2% improvement**
- ECU – (baseline 50% up to 71.3%) = **21.3% improvement**
- ITU – The mean (average) = **97% compliance.**
- ACU – (baseline 15% up to 48%) = **33% improvement**
  - On review ACU had not sustained this achievement. The unit showed a 6% sustained change of practice
- Cardiology – (baseline 34.6% up to 68%) = **33.4% improvement**
- Lamb – (baseline 30% up to 74%) = **44% improvement**
- Lloyd – (baseline 61% up to 81%) = **20% improvement**
- OMU – (baseline 39.1% up to 87.8%) = **48.7% improvement**
- TA – (baseline 46.1% up to 74.4%) = **28.3% improvement**
- Edith Cavell (baseline 24% up to 53%) = **29% improvement**
  - On review EC had not sustained this change and reverted back to a baseline mean (average) of 24%

Pre-project understanding

35% not heard of HADs

30% did not know what caused them or how to prevent them

Post-project understanding

100% understanding on both questions

Lessons & Limitations

- The importance of co-production in projects of this type and that better results can be achieved through collaborative working
- Including patients in the co-production phase
- Speaking with teams from similar hospitals, incorporated the data from a prior project within HUH and used the resources available from the #EndPJparalysis campaign – not to duplicate work or re-invent the wheel
- While the same QI methodology can be applied, change ideas might need to be adapted according to the needs of different wards and disciplines
- The time taken to understand the wards, the faculty roles, responsibilities, barriers and enablers
- During the co-production phase, it was important to face up to challenges as they arose
- Acknowledge that a proportion of patients, who, no matter how much positive persuasion were provided by staff, would simply refuse to get out of bed
- Many of the frailest patients in the sample also experienced incontinence may have had only one or few sets of clothes and there were limited washing facilities

Actions to sustain

1. Making early mobilisation of eligible patients a topic of conversation on a daily basis during all staff handover and whiteboards
2. There needs to be clear ownership and accountability, which really needs to be ward-driven
3. Advocates or champions could be allocated for each ward to continue the positive progress that has been made and keep it as a focus
4. Using the relevant questions on the 'Perfect Ward' and seeing them as important as the other elements
5. A relevant senior executive could be responsible for ensuring the senior leadership team is engaged with the initiative and provided with relevant information on progress

Key risks going forward

1. Impact of Covid-19 on ward staff and patients
2. Reverting to older practice during times of increased pressure
3. Failure to embed changes within daily practice and use the perfect ward app as a measurement tool
4. Engagement of patients and families to participate with "get up, get dressed, get moving".
5. Not agreeing on sustainability objective recommendations

Outcome

The QI project demonstrated that improvements can be achieved.

The focus should now be on embedding this practice across all inpatient wards.

FOR CLOSING

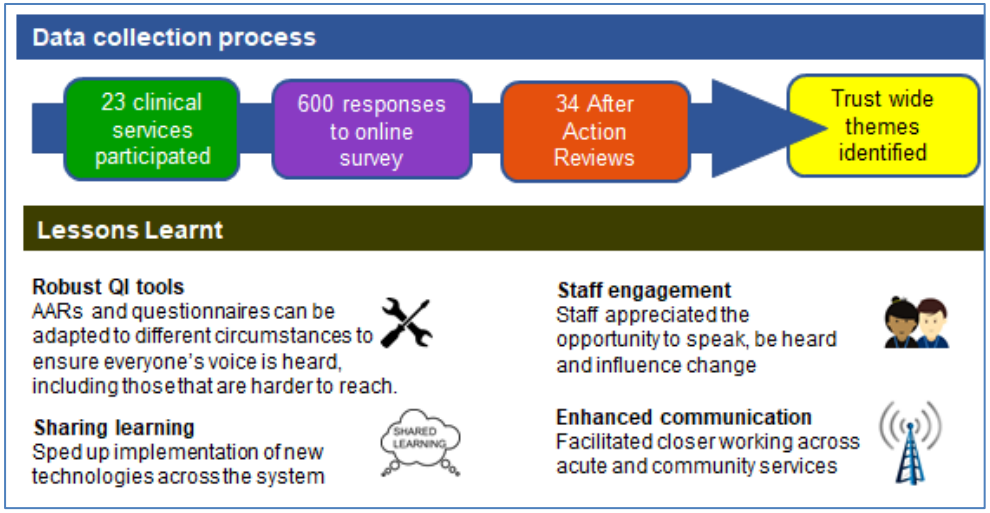
Final update presented to Improving Patient Experience Committee

3.2 Quality Improvement at the Homerton

The QI approach at Homerton aims to foster an improvement mindset in staff across all the Trust services. We recognise that ideas for improving services come from staff and our patients from the 'bottom up'. Our challenge is to give staff the permission, time and the tools to test out ideas for changes in service delivery and measure whether changes really are an improvement. The small central Homerton QI team deliver training and coaching to staff on QI methods, blending the IHI Model for Improvement with Kaizen Lean tools. Staff are encouraged to put this knowledge into practice by working on a QI project in their area. This 'learning by doing' approach means that over 50% of the staff undertaking QI training then register and work on a QI project. In 2020/2021, 125 staff completed basic QI training, despite the disruption to all services and teams (including the QI team) caused by COVID. 76 projects were registered - 11 of which were completed and 65 are ongoing.

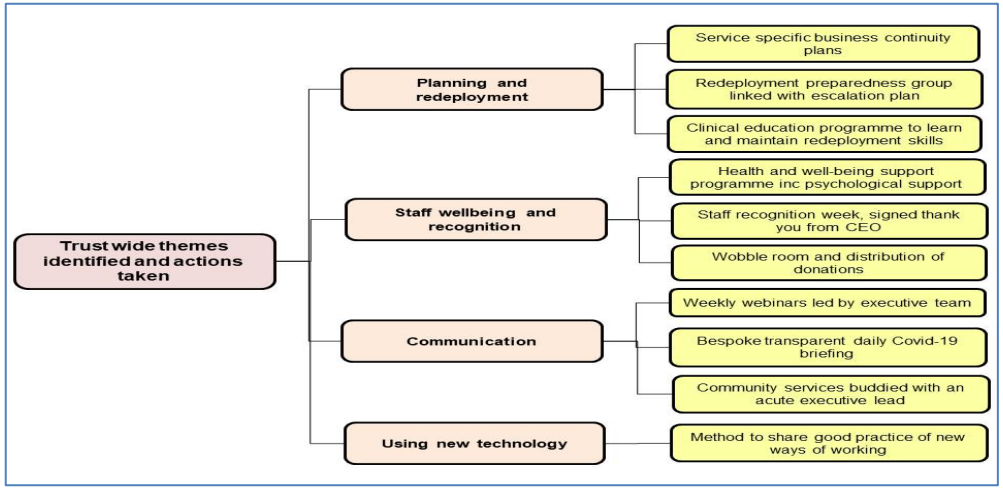
Capturing learning from COVID

A key focus of the Homerton QI team during 2020 was to devise and deliver a programme to capture learning from the first wave of Coronavirus-19 infections. We used techniques such as After Action Reviews (AAR) and anonymous online surveys to collect the views and experiences of a wide range of staff working in the hospital and community services. The diagrams below show the data collected, the themes identified and changes made as a result.



Showcasing innovations developed in responses to COVID

In October 2020 we showcased innovations developed in response to COVID – all of which used QI approaches:



- Acute Kidney Injury (AKI) in COVID Patients – 25% of COVID patients develop AKI. This project developed interventions to improve the awareness and confidence of Doctors in identifying and treating AKI in these patients.
- Improving the pathway of newborn babies being discharged home with a heart murmur – QI tools such as process mapping were used to streamline the pathway, reduce long waits for diagnosis and treatment, improving patient and staff experience.
- Improving discharge processes - The surge in COVID patients meant it was imperative that health, social care and voluntary services (third sector) work together ensuring that patients were discharged home in a safe, coordinated and efficient manner.
- Post COVID Recovery: Development of Patient Information Pack – This presentation detailed the development of an information pack for patients with 'Long-COVID'. The pack has been shared nationally and is a model of collaborative working.

- Developing Virtual Consultation and Digital Resources across Allied Health Professional (AHP) Services – Iterative development of virtual exercise classes in the 'Locomotor' service. Classes, live and pre-recorded, were developed for clients unable to attend group sessions due to social distancing requirements.
- Children's Therapies response to COVID – with schools, health and children's centres closed in the first wave of COVID, children's therapies services developed innovative ways to support children and their families. Examples included interactive virtual telehealth sessions. Hackney children's Speech and Language Therapy was featured on ITV news and Twitter, raising awareness and reaching over 4 million viewers.

What matters to you?
In the second wave of COVID, the 'Ward Communication Team' was set up and trained through joint working between a QI Lead in the Homerton QI team and the Lead Nurse for Cancer and Palliative Care. The team provided COVID patients with support to connect with their loved ones and the opportunity for a 'what matters to you' conversation. This work has elicited excellent patient and family feedback as well as improved staff experience.

This service wasn't available when I was in hospital last year and I felt very lost and lonely, and I didn't have things that I needed like my phone charger and toiletries. I think this service is so valuable to patients

The 'what matters to you' approach continues to grow with Homerton QI staff coaching Homerton staff as part of the North East London cancer collaborative and cancer services.

Quest network Improvement Science for Leaders
Homerton is proud to be a member of the Quest network – the first member convened network for NHS Trusts, who focus relentlessly on improving quality and safety. With support from the Homerton QI team, staff from the maternity service and the cancer programme continue to participate in the Improvement Science for Leaders course during 2020/21. The course provides rigorous training in improvement science. Graduates from the course have not only delivered improvements in care but will continue to bolster a network of QI advocates and champions at Homerton.

First Annual QI Awards - Spreading improvements and awareness of QI
In December 2020, we held our first QI Awards to celebrate the Homerton culture of QI. QI projects delivered sustained improvements in:

- End of life care
- Staff experience and wellbeing in the sexual health service
- Management of lacerations in children in the Emergency Department
- Oxygen therapies in medical inpatients
- Managing iron deficiency in patients undergoing major gynaecology surgery

As the Trust Chairman, Sir John Gieve, said *'This is one of my favourite afternoons of the year. Again today it has shown in a vivid way how staff, senior and junior, can take the initiative, work out how to improve Trust services and patients' lives'*

3.3 Performance against national indicators

During 2020/21, as a consequence of Covid, the Trust's actual performance against national operational standards suffered (along with the rest of the country). However, given the circumstances, the Trust delivered a comparably strong operation performance against the suite of core standards. It should be noted that due to the Covid pandemic.

The following table 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 monthly and/or quarterly.

Key Performance Indicators	2020/21 Target	2020/21 Performance	2019/20 Performance
A&E patients discharged < 4hrs	**95%**	**93.00%**	**93.75%**
Cancer			
2 Week Wait	**93%**	**96.16%**	**97.86%**
31 Day Target	**96%**	**98.43%**	**99.30%**
62 Day Target	**85%**	**84.60%**	**86.93%**
Infection Control			
MRSA	**0**	**5**	**1**
***Clostridium difficile* (*C.diff*)**	**12**	**10**	**8**
18 Week RTT Indicator			
Incomplete Pathways	**92%**	**74.08%**	**95.13%**
IAPT Indicators			
6 week target	**75%**	**98.02%**	**96.81%**
18 week target	**95%**	**99.68%**	**99.60%**

Table 17: 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. Details of performance against key quality indicators that were prioritised throughout 2020/21 are presented in the Quality Account which will be published later this year.

Annex

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

1.1 Commissioners Statement for Homerton University NHS Foundation Trust 2020/21 Quality Account

Commissioners Statement for Homerton University NHS Foundation Trust 2020/21 Quality Account

NHS North East London Clinical Commissioning Group is the lead commissioner responsible for commissioning health services from Homerton University Hospital NHS Foundation Trust on behalf of the population of east London.

Thank you for asking us to provide a statement on the Trust's 2020/21 Quality Account and priorities for 2021/22.

Last year we asked that the Quality Account provide greater emphasis on our City and Hackney plans for greater integration with our Local Authority and other partners and the development of our neighbourhood model. We are pleased to see this included and celebrated in this year's Quality Account.

We recognise the immense challenge the Trust faced during the year to respond to the SARS- CoV-2 pandemic. Locally we saw strong leadership from the Trust, mutual support and closer working with partners in City and Hackney and north east London to deliver services as safely and effectively as possible. The Quality Account provides a clear and compelling picture of the strengths of the Trust and its staff to maintain quality of services in such difficult circumstances and the selfless devotion to patient care that staff delivered. We are acutely aware of the sacrifices staff made and are deeply grateful.

Going forward we know there is much work to be done to meet the needs of our residents and to design clinical pathways so that these can be delivered remotely where it is safe, effective and patient-centered. We welcome the opportunity to work with colleague in developing neighbourhood teams and primary care networks, moving towards closer integration with primary care, mental health and social care partners in the City and Hackney Integrated Care Partnership. We anticipate a richer partnership with the voluntary sector, patients, carers and citizens so that we can co-produce local services that meet local needs.

Last year we congratulated the Trust on receiving an Outstanding rating by the CQC and we applaud the Trust for its journey to being Outstanding in every area of its work.
The Quality Account outlines a wide range of quality improvement projects and programmes and, as always, a strong focus on participating in national audits, research and quality improvement initiatives.

The Trust's quality priorities show progress and ambition and we welcome the two new priorities for 2021/22.

Of note is the impressive and comprehensive programme of work relating to learning from deaths in the Trust, the use of Consultant and multi-disciplinary review of cases and General Medical Consultants who were not directly involved in care of the patient. We think this work could be shared more widely and is exceptional. We also applaud the work and expansion of the end of life team and the learning from phase one of the pandemic that enabled the service to provide exceptional care throughout and for phase two.

We note the Trust is reporting medical staffing rota gaps and can see there have been considerable efforts made to advertise and fill these: we hope these will reduce over the coming year as the Trust has an impressive reputation for staff wellbeing and quality of care.

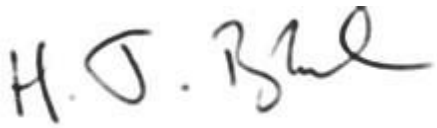
We are pleased to see unplanned readmissions being addressed directly by relevant teams. As always the Trust performs very well on staff feedback and we hope to see exceptional performance in relation to patient and carer feedback as services are restarted and staff are able to recover. We wish to offer all our support to initiatives that enable staff to reflect, recover and receive the support they need.

The "what matters to you" project is a brilliant example of how a new approach can deliver fundamental change for both staff and patients and carers; we hope this will be expanded beyond cancer services and be used in neighbourhood partnerships.

Patient safety data is reassuring and we agree that the Trust's data shows a good reporting culture. The new Patient Safety strategy will be a challenge to implement for the NHS and we offer our support to embedding the various elements over the next few years including changes to the serious incident process and Medical Examiner's role.

We confirm that we have reviewed the information contained within the Account, and checked this against data sources where these are available to us and we have no concerns about accuracy or completeness whilst recognising that the publication of several national audit reports has been delayed as programs were suspended due to the impact of Covid.

Overall we are welcome the 2020/21 quality account, we offer our deepest thanks to the Trust and staff during the past year for their devotion to high quality and compassionate services and we look forward to another year working together to improve the quality of services for the population we serve.



Henry Black

Acting Accountable Officer, NHS North East London CCG

1.2 Healthwatch Hackney Statement for Homerton University NHS Foundation Trust 2020/21 Quality Account

Catherine Pelley

Chief Nurse

Homerton University Hospital Foundation Trust

Homerton Row,

E9 6SR

25th June 2021

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 and its aftermath, which places the NHS under considerable on-going pressure. We know this has been a very difficult time and that Homerton staff have risen to this challenge admirably. We express our deep sorrow at the loss of patients and staff in this pandemic. It is important there is local public recognition of these losses and contribution of health (and social care) staff to support and treat people during the pandemic. We further welcome the Homerton's work developing a Long COVID clinic, this is a very important initiative given that the extent of Long COVID is now unfolding.

We note the tighter timescale to produce this QA. Ironically, this undermines the intention to demonstrate quality and a commitment to it. We appreciate the Homerton's efforts to produce a QA are the result of decisions by the Dept. of Health and Social Care and NHS England; their approach risks focusing on the appearance of quality rather than a commitment to effectively resource quality outcomes.

We know from our research the Homerton is a locally respected institution and recognised for the quality of its services. We believe the Homerton demonstrates a clear ability to respond to local need. In this context we welcome the moves by the Homerton to actively seek control of the St Leonards Hospital site, from NHS Property Services Limited, and work 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 will actively support this with the development of the People's Plan for St Leonard's, which we are coproducing with residents and our partner in this work, Healthwatch City of London.

We note within the Northeast London Integrated Care System, the closer working of acute providers, BART's Health and Barking, Havering and Redbridge University Trust. We are concerned this could impact on the independence of the Homerton and has the potential, with the planned Government health legislation, to focus on developing one acute hospital for all of Northeast London. This would make acute services more distant from those they serve and undermine the approach in Hackney (and the City of London) of services being locally based.

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) It is a long and complex document and as recommended for the last QA, a short form should be produced for Homerton members, patients and staff. The short form should demonstrate how patients have influenced the QA.

2) HUH has done outstanding work in vaccinating its own staff and staff in primary care, e.g. dentists, GPs, pharmacists and opticians.

3) We welcome the increased focus on the HUH's community services, which have like the acute services been exemplary during the pandemic.

4) The number of patients and staff (including contracted staff) who were infected and died at the Homerton from Covid are recorded in the report and the HUH should create a public memorial for those who died. It would be useful for the HUH to record where the deaths occurred, e.g. are deaths included where the patient was receiving NHS CHC from Homerton community staff?

5) The ethnicity of patients and staff (including contracted staff) who were infected, and those who have died of covid, should be published by the HUH to enhance knowledge of the impact of ethnicity on infection, morbidity and mortality.

6) The Homerton should publish details of the number of infected people transferred to care homes, the outcomes, e.g. in relation to deaths, and the learning from these very difficult situations.

7) Priorities for Improvement: Page 4 summary table and detailed support section 3.1. The progress set out in the table is unclear and gives an impression of sustained progress with this symbol:  . However, it is difficult to assess progress as there is no clear baseline set out in the supporting section 3.1. For example, in section 9 'Improvements in staff health and well-being' under the 'progress achieved to date' section states bullets point Dermatology Clinic and Gynaecology Clinic. It is unclear what the progress is here. Across section 3.1 it is difficult to assess the meaning of the symbol  on page 4 and the level of improvement set out in section 3.1.

8) The Patient Safety Committee and the Assurance Committee continue to carry out outstanding work and continue improve year on year. However, the HUH should share with patients/carers the outcome of serious incident and complaints investigations to demonstrate how these investigations enhance the quality and safety of patient care. The quality of this work was maintained during the pandemic.

9) HUH has stopped communicating with it's members on a regular basis and has stopped active recruitment. Pandemics are times to develop a shared understanding of the pressure that the Homerton and people in the community are under, not to shut down. Our research in 2020 on the impact on the pandemic on residents told us there is increasing public mistrust of their national *and local* institutions. In this context we strongly urge the Homerton to improve its communications with its members and continues to promote membership

10) We are very pleased that the Homerton achieved outstanding from the CQC. We are disappointed that community services and Mary Seacole House have not been similarly acclaimed. The Action Plans should be published so that HW can better monitor HUH progress with achieving goals set by the CQC.

11) In relation to Mary Seacole House we would like to see evidence that all staff and visiting staff (GPs, social workers etc) are regularly training in the implementation of DOLS.

12) Whilst the objective of creating a truly integrated health and care system is highly valued, we believe that the objectives for this aspiration need to be clearly laid out in terms of service redevelopment and specific benefits for patients.

13) The establishment of an integrated care partnership and Neighbourhood Health and Care Board are high level attempts to better integrate service for the benefit of patients. But to patients the aspirations are obscure and should be clearly explained. Will they benefit patients or just create a more powerful and distant bureaucracy?

14) People in the local community are mostly not aware of the existence of PCNs and Neighbourhood and their benefits in relation to joint work with the HUH should be explained.

15) Change of Name: We hope that the change of name of the HUH will lead to 'parity of esteem' between community and acute services and between the needs of patients using both sectors.

16) Participation in Local and Nationals Surveys: There has been a very impressive level of participation, but we are not sure in some cases whether there is evidence of consequent service improvement. E.g.
    - Telephone Clinics have been embedded in the system, but we don't know if they have or will improve or worsen services for patients. Neither do we know if patients have a choice whether they will receive care face to face or by phone.
    - Learning Disabilities Mortality Review – it is not clear whether the actions have been implemented or are proposed actions.

17) Patient Verification- details of the process to prevent patients receiving the wrong treatment or wrong diagnostic tests should be published in the QA.

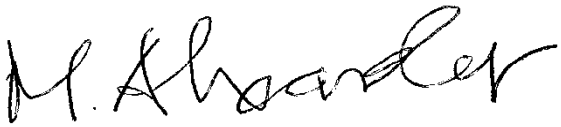
18) Learning from deaths: we found this section confusing. Does it refer to all patients or only to CESDI – stillbirths and deaths in infancy?

19) Independent scrutiny of deaths: We would like to see more information about the HUH's learning from deaths and the outcomes of recommendations made to the HUH by Coroners, including feedback from bereaved families.

20) Freedom to Speak Up Guardians: We would like the QA to give assurance that all staff have easy access to the guardians including front line staff contracted by the HUH.

21) We were disappointed to see the results of the 'Responsiveness to personal needs of patients – NHSI Quality Indicator 20 which suggests that the HUH is performing below the national average and is showing little improvement over recent years. We would strongly recommend joint work with Healthwatch Hackney to ensure that the patients and carers voice is heard more loudly and has real impact on service improvement. This also connects to the need for the Trust to listen to HUH members ideas and proposals and demonstrate how they follow through patient led recommendation for quality and safety.

Yours sincerely,



Malcolm Alexander
Chair, Healthwatch Hackney

Healthwatch Hackney announcement of its key recommendations for the Homerton Hospital Quality Account 2021/22

Healthwatch Hackney - KEY RECOMMENDATIONS

1. We strongly **RECOMMEND** the Homerton to continue to actively seek control of the St Leonard's Hospital site, from NHS Property Services Limited. We are pleased with the positive role the HUH has taken to work with local health and care leaders, to shape the services at St Leonard's hospital to meet local needs, and to co-produce future developments at St Leonard's 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. Evidence of improvement needs to be set out clearly so the public can understand were the Homerton has achieved improvements, the extent of those improvements and where there is need for work to be done.

3. 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 patients have knowledge of the process that allows them to both compliment and criticize medical practice. Despite several requests to the HUH, they have been unable to explain how they meet their statutory duty to enable patients to contribute to doctor's revalidation.

4. We **RECOMMEND** 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.

5. We **RECOMMEND** 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.

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

7. We **RECOMMEND** HUH works with Healthwatch Hackney to ensure effective use of patient feedback to improve patient experience. This would involve (a) Healthwatch establishing a patient group to review and making recommendations to improve the HUH Complaints, PALS and Compliments services, and (b) Homerton and Healthwatch agree feedback areas where Healthwatch can provide the Homerton with patient feedback through its enhanced online feedback centre to be launched in the autumn.

1.3 Overview & Scrutiny Statement for Homerton University NHS Foundation Trust 2020/21 Quality Account

Overview & Scrutiny

Health in Hackney Scrutiny Commission
Hackney Council
Town Hall
Mare St,
London E8 1EA
Reply to: jarlath.oconnell@hackney.gov.uk

28 June 2021

Ms. Catherine Pelley MBE
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 2020/21

Thank you for inviting us to submit comments on the Draft Quality Account for your Trust for 2020/21. We are writing to provide our insights arising from the scrutiny of the Trust's services over the past year at the Commission.

The impact of the Covid-19 pandemic continues to be deeply felt by all the local health and care providers. We note that last year because of the unprecedented pressures on the NHS this process was completed in Sept and you attended our Oct meeting and responded in further detail in November. This letter therefore will pick up on issues since then and we note that this year's report is more truncated than usual.

We've been grateful to your Chief Executive for her engagement with our work especially now in her new role as Integrated Care Partnership (ICP) Lead for City and Hackney. In Sept she took part in a discussion panel on the plans for the ICS, in Nov in another panel on Covid-19 and Care Homes and in January she participated in an item on the vaccinations programme roll-out. In March she presented the new governance structure for the City and Hackney ICP.

We do appreciate the Quality Account exercise 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. The Commission Members take a great interest in the performance of our key local acute trust and we're pleased to learn about some of your key achievements over the past year.

We commend the Trust for the role it played during the pandemic and in particular for the drive to vaccinate the adult population particularly staff of other local health and care providers (ambulance service, social care staff, cleaners, drivers etc). On a personal note, congratulations on your much deserved MBE.

We note that the usual reporting of your performance on many national audits has been delayed as patient care was given priority over such exercises during the pandemic. We also note that as a result of the pandemic the contractual arrangements for 2020/21 with NHS foundation trusts were modified to a block payments approach (as opposed to PBR) which will remain in place for the first half of 21/22. This also means there is also no reporting on CQINs which usually gives us an indicator of overall performance. We also note that during this exceptional year most clinical research activity (which HUHFT normally excels at) was paused to concentrate resources on the pandemic, although you still managed to engage a significant number of patients with Covid in important clinical studies.

We are pleased that despite the pandemic you delivered a comparably strong performance against the suite of core national standards (p.62) when performances of Trusts nationally have deteriorated because of Covid.

With respect to page 30 please can you outline what measures you have taken to improve the shortcomings around the completeness of ethnicity data recording, considering that patients from ethnic minority groups often have poorer outcomes and are disproportionately affected by Covid.

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

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.* No specific guidance was issued for 20/21.

• 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 2020 to March2021

– papers relating to quality reported to the board over the period April 2020 to March 2021

– feedback from commissioners emailed on 22nd June 2021

– feedback from governors following meeting on 17th June 2021

– feedback from local Healthwatch organisations dated

– feedback from overview and scrutiny committee dated

– the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 29/07/2020 (20/21 report not yet finalised)

– the latest national patient survey completed during July 2019 (2020 survey delayed due to Covid)

– the latest national staff survey published March 2021

– the Head of Internal Audit's annual opinion of the trust's control environment dated 24/05/2021

– 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