Homerton Healthcare NHS Foundation Trust
Quality Account Report
for the 2025/26 financial year

Introduction

All NHS providers are required, under the Health Act 2009 and subsequent NHS England guidance, to publish an annual Quality Account. The purpose of this report is to provide a transparent and balanced overview of the quality of services delivered, including progress made in improving patient safety, clinical effectiveness and patient experience, alongside areas where further improvement is required.

This Quality Account presents the Trust's performance over the reporting period 1 April 2025 to 31 March 2025. It sets out how the Trust has assessed and improved the quality of care, how priorities for improvement have been identified, and how patients, staff and partners have been engaged in shaping these priorities.
The report is structured in line with national requirements and reflects the three key dimensions of quality:

- **Patient Safety** – ensuring care is delivered in a safe environment and risks of harm are minimised
- **Clinical Effectiveness** – ensuring care is evidence-based and achieves the best possible outcomes
- **Patient Experience** – ensuring care is responsive, compassionate and centred on the needs of patients and their families

The Trust remains committed to continual quality improvement and to learning from performance data, patient feedback, incidents and national benchmarking. This Quality Account provides assurance that robust governance arrangements are in place to support quality improvement, whilst also identifying areas where further action is required.

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

I am pleased to present the Quality Account for 2025/26, providing a transparent and balanced assessment of the quality of care delivered across the Trust. It sets out clearly where we are performing well and where we know we need to go further.

This has been a demanding year. Despite sustained operational and workforce pressures, our teams have continued to maintain high standards of care and to improve services for our patients. I want to recognise that, and thank colleagues across the organisation for their professionalism, commitment, and resilience.

We have built on our strong partnerships across City and Hackney, including with Hackney Council, primary care and the voluntary sector, recognising that improving outcomes for our population depends on working together.

Throughout 2025/26, we have maintained focus on the three domains of quality: patient safety, clinical effectiveness, and patient experience. These remain at the core of how we plan, deliver, and improve care. We remain committed to learning, continuous improvement, and fostering a culture of excellence across all services.

We continue to foster a strong safety culture, reflected in high levels of incident reporting and a commitment to learning. The embedding of the Patient Safety Incident Response Framework (PSIRF) has strengthened our approach to understanding incidents, moving us further towards a more learning-focused and compassionate approach that supports patients, families and staff.

A significant milestone this year has been the launch of our Trust Strategy to 2031. Our vision is that everyone we serve will experience high-quality, equitable, and connected care. Our three priorities are:

- Integrated care – joining up services across home, hospital and community
- Better value: better care – making the best use of our people and resources
- Innovation – using digital and new approaches to improve care and experience

These priorities give us a clear and consistent framework for decision-making and focusing on what will make the biggest difference to patients and the communities we serve.

Some of our key achievements over 2025/26:

- Operational performance remained strong, with our Emergency Department performance continuing to be among the best nationally, achieving 81.74% against a 78% standard, alongside a very low numbers of patients waiting over 12 hours (0.73%) and continued improvements in patient flow and experience.
- We have also seen significant improvement in elective care performance, reaching 76.56% by March 2026, exceeding our trajectory and improving on last year's position.
- Cancer Performance has remained strong with a 62-day wait performance exceeding 82% and continued improvement against the Faster Diagnosis Standard, positioning the Trust as a high performer nationally.
- We have delivered a high volume of elective procedures, including over 13,400 procedures in main theatres alongside the opening of the New Elective Centre, which is improving capacity, productivity and resilience. We have also introduced robotic surgery capability, supporting more advanced and less invasive treatment options.
- Our focus on patient safety has continued to strengthen. The full implementation of PSIRF has supported a more strategic, learning-based approach. Increased levels of incident reporting reflect ongoing work to develop a transparent and psychologically safe culture, and we have expanded the Patient Safety Partner roles to strengthen the patient voice in safety and improvement work. In addition to this, over 150 staff have completion PSIRF human factors training.
- We have also continued to invest in our people. Staff survey results show improvements in staff experience and engagement, with over 74% of staff recommending the Trust as a place to receive care. We recognise there is more to do, particularly on wellbeing, development and inclusion, and this remains a core focus.
- Our approach to clinical effectiveness and quality assurance remains robust with sustained participation in national audits and mortality outcomes remained within or better than expected ranges, with continued improvement in infection prevention This provides assurance that we are delivering safe and effective care, while continuing to identify areas for improvement.

- We have strengthened our data quality governance and digital capabilities, supporting better insight, decision making, and service improvement. We have also continued to publish our Trust wide patient safety newsletter 'Spotlight on Learning', supporting organisational learning and best practice.
- We have also continued to work closely with system partners across City and Hackney to address health inequalities and improve population health outcomes, recognising that this is a shared responsibility across our local system.

While there have been many achievements, we are clear that there are areas where we need to improve. These include documentation quality, multidisciplinary communication, and workforce capacity. These challenges are well understood and are being addressed through focused improvement programmes.

We remain committed to embedding continuous quality improvement across the organisation and translating learning from audit, incidents and patient feedback into measurable improvements in care.

Overall, this report reflects a Trust that is performing well in a challenging environment, but that is also clear about where it needs to go further.

In my opinion, the information presented in this Quality Account is accurate and presents a fair and balanced view of the quality of care provided by Homerton Healthcare NHS Foundation Trust during 2025/26.

I want to thank our staff, patients, partners, and stakeholders for everything they have contributed over the past year. It is their continued commitment that underpins both our performance now and our confidence in what we can achieve next.

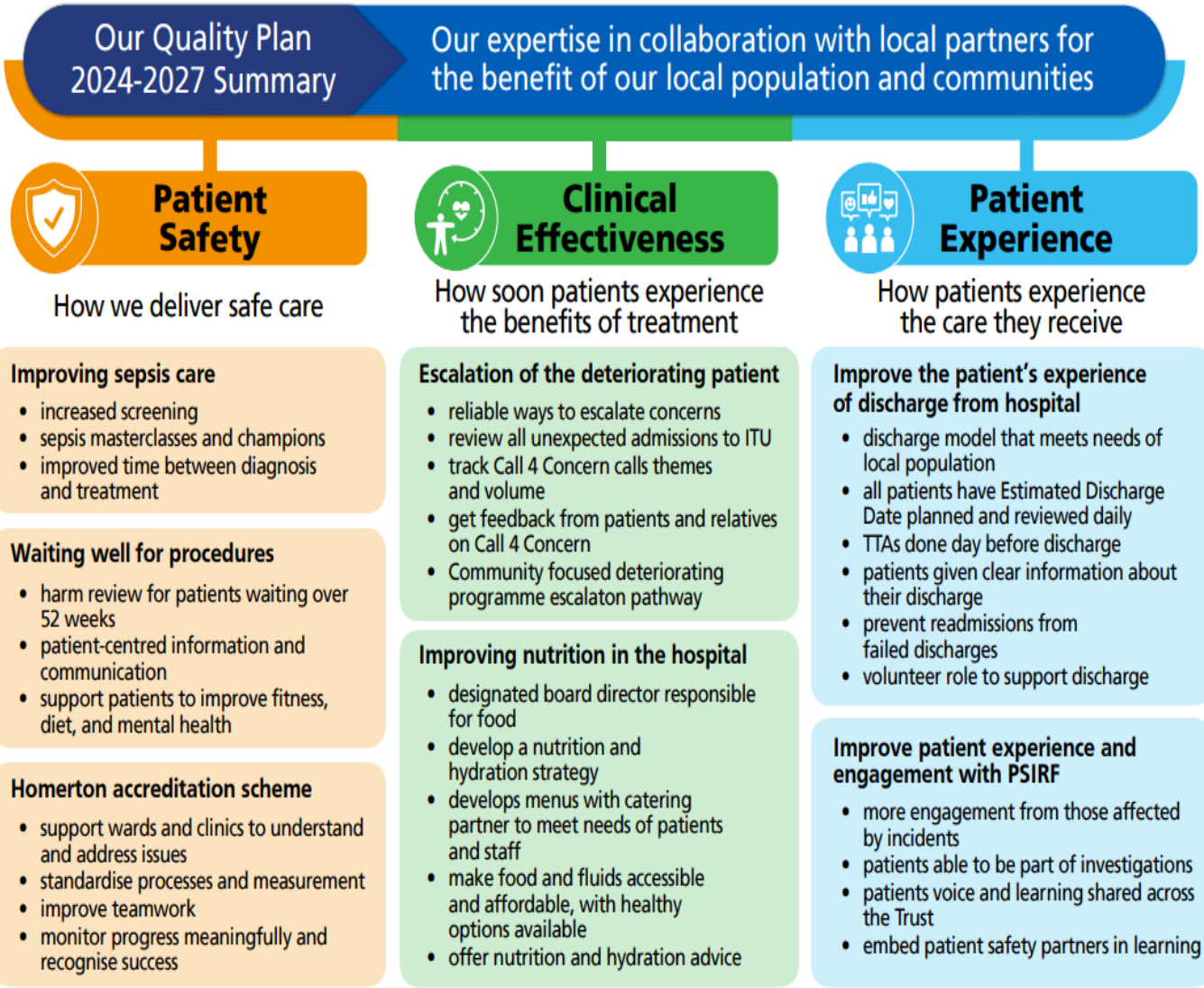
Basirat Sadiq, Chief Executive Officer and Place Based Leader

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

2.1 PRIORITIES FOR IMPROVEMENT

Our quality ambitions program for 2024-27 is based on bringing our expertise to bear in collaboration with local partners and designed for the benefit of our local population and communities.

Our quality ambitions for 2024 to 2027 are:



Progress during 2025/26 of the 3-year quality ambition programme can be found in section 4 of this report.

2.2 STATEMENTS OF ASSURANCE FROM THE BOARD

NHS foundation trusts are required, under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010, to include formally approved statements of assurance from the Board of Directors within their Quality Account. These statements are mandated nationally to provide transparent and accessible information to the public on the quality of services delivered. Accordingly, the content and structure of this report have been developed to comply with the requirements set out in Department of Health and Social Care and NHS England guidance.

2.2.1 REVIEW OF SERVICES

During 2025/26 Homerton Healthcare NHS Foundation Trust provided and/or sub-contracted 68 relevant health services.
The trust has reviewed all the data available on the quality of care in all these relevant health services.
The income generated by the relevant health services reviewed in 2025/26 represents 100% of the total income generated from the provision of relevant health services by Homerton for 2025/26.

2.2.2 NATIONAL AND LOCAL CLINICAL AUDIT

National Clinical Audits are commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of the Department of Health and Social Care as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). While participation in individual audits is not mandated, NHS organisations are strongly expected to take part in those relevant to the services they provide. Trusts are, however, required to report their level of participation within their annual Quality Account.

During 2025/26, the Trust demonstrated high levels of participation in national clinical audits, engaging in 63 of 69 eligible programmes, alongside a comprehensive programme of local clinical audit. Audit findings indicate strong performance in several key areas, with identified opportunities for improvement supported by clear action plans.

Of the 69 national clinical audits applicable to the Trust, participation was confirmed in 63 (91%). The majority of programmes involve continuous data submission, with findings routinely reported through governance structures including ICEC. Key areas of strength include high data completeness in national audits such as NCAA and blood transfusion, with targeted improvement actions identified where variation is noted.

Robust governance arrangements are in place to ensure that audit findings are systematically reviewed and translated into measurable improvements in patient care. National clinical audits and confidential enquiries open during 2025/2026 are listed in table 1 of the appendix (section 7).

Non-participation in a small number of audits is primarily attributable to service configuration or resource constraints (e.g. specialist services not provided or infrastructure limitations) and

this position is reported within internal governance frameworks.

A number of national clinical audits were not applicable to the Trust during 2025/26, primarily reflecting the scope of services provided and established referral pathways to specialist centres. See table 2 of the Appendix (section 7).

Summary of national audit outcomes

Participation in national and local audit programmes demonstrates that the Trust continues to deliver safe and effective care across a broad range of services, with multiple areas of good practice aligned to national guidance. Audits have also identified targeted opportunities for improvement, primarily relating to documentation, standardisation of practice, and optimisation of multidisciplinary communication. Action plans are in place and progress is being monitored through governance structures**.** See table 3 of the appendix (section 7) for examples of learning from national and local audits.

Key Areas of Good Practice identified

Across audit programmes, several consistent strengths were identified:

- Strong adherence to clinical guidelines and protocols, particularly in:
  - Medication prescribing (e.g., bariatric PPI prophylaxis)
  - VTE risk assessment standards within maternity services
- High-quality patient care and experience, including:
  - Positive patient-reported outcomes and confidence (e.g., stoma care, MSK services)
  - High-quality assessments in vulnerable groups (e.g., Looked After Children)
- Effective multidisciplinary working, notably:
  - Pharmacy involvement improving safety and discharge processes
  - Collaboration between clinical teams and diagnostics (e.g., radiology)
- Efficient service delivery models, including:
  - Radiographer-led vetting of imaging requests
  - Effective use of home-based care pathways (e.g., allergy services)
- Clear communication in discharge and transfer processes in some areas, reducing duplication and medication errors

Actions and Improvements Implemented

The Trust has already taken forward a number of actions in response to audit findings:

- Implementation of new clinical tools and pathways, including:
  - Post-falls assessment frameworks aligned with Royal College guidance
  - MRI selection criteria and imaging governance improvements
- Strengthening education and training, including:
  - Simulation-based learning (e.g., VTE risk assessment)
  - Inclusion of audit themes in mandatory and foundation training programmes
- Policy and guideline development, including:
  - Updates to falls policy and CT vetting guidance
  - Development of standardised documentation templates (in progress)
- Enhanced patient support initiatives, including:
  - Improved education and self-management support
  - Better signposting to community and voluntary sector resources
- Service improvement initiatives, including:
  - Review of diagnostic access and clinic capacity
  - Exploration of new care models (e.g., trusted assessor pathways, community treatment options)

Local audits 2025/2026

Local clinical audit is a key component of improving the quality, safety, and effectiveness of clinical care, ensuring that services are evidence-based and aligned with agreed professional standards. All staff are encouraged to undertake clinical audit and related activity to monitor performance and drive continuous service improvement.

During 2025/26, a total of 172 local clinical audits were registered within the Trust. Of these, 64 audit reports were formally reviewed during the reporting period.

Local clinical audit activity during 2025/26 demonstrates active engagement across clinical services, with findings informing service-level improvements in areas including medicines optimisation, diagnostic decision-making, and patient experience.

Audit outputs are routinely reviewed through governance structures to ensure actions are implemented and sustained. Examples of local audits completed are listed in table 3 (section 6).

Overall, the Trust's audit programmes provide robust assurance of care quality, with evidence of continuous improvement and responsiveness to audit findings. While no widespread systemic concerns were identified, targeted improvements are required to ensure consistency in documentation, prescribing, and care coordination.

The Trust is actively addressing these areas through structured action plans, policy updates, and workforce development, ensuring ongoing alignment with national standards and best practice.

2.2.3 PARTICIPATION IN CLINICAL RESEARCH

Clinical research remains a priority for both the Government and the Trust, supported by funding from the Regional Research Delivery Network (RRDN) and commercial research. The Research & Innovation (R&I) team, working with the RRDN, is committed to expanding and delivering high-quality research across NHS and community settings.
Since the Care Quality Commission (CQC) incorporated clinical research into its Well-Led Framework in 2018, research has been recognised as a core component of high-quality patient care rather than an optional activity. Clinical research is now viewed as integral to improving outcomes and should be embedded alongside standard care. This commitment is further reflected in the Government's continued support for the National Institute for Health and Care Research (NIHR).

We aim to open studies that are particularly relevant and a benefit to the patients who are treated and cared for at Homerton Hospital and the wider population. We confirm with potential Principal Investigators that the 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; that we recruit patients who are eligible for the trial; That we collect and maintain necessary data, accurately record the data; review the funding stream for the project to asses that financial impact, and finally confirm secure archiving of all necessary trial related documentation at the end of the study.

Research and Innovation is committed to growing capacity year on year and Innovation continues to be a key focus and R&I are keen to collaborate and look at ways in which we can spotlight more focus on innovation and create ideas to expand with Innovation.

R&I's vision remains to ensure that research and innovation is an integral key function on of

the Trust agenda, working with staff and patients to improve the health and wealth of our community. We aim to ensure that staff, patients and families understand the importance of research, have clear and easy access to research and innovation opportunities, and that it is seen as a benefit and not a compromise to NHS clinical activity. We value those involved in research by offering support and training.

The R&I team continue to be engaged in several high-profile studies that reflect our population particularly within the Neonatal and Reproductive Health portfolio. Through the CRDC and as part of the contractual agreements HUH are tasked to increase the commercial portfolio by 25% in 2026.

We continue to excel in commercial research within the sexual health portfolio. We are developing and supporting specialities who in the past have not participated much in commercial studies, including both Dermatology and Respiratory. R&I has recently opened a commercial Dermatology Study and has just been selected for a commercial Respiratory study.

In September 2025 R&I were successful in a strategic funding bid to receive funds for a Parkinson's Disease Research Nurse. The post is funded for 12 months and at the 6-month impact report has shown positive improvement in patient care, uptake in participant recruitment and collaborations with our community and the public.

R&I continue to support the highly successful VERBO project. To ensure continuous evolvement and accessibility of verbo, R&I have submitted Two grants for additional funding and are awaiting the outcomes:

- NIHR i4i – AI Parent Explanations for Multilingual Engagement in Early Speech and Language Support

- NIHR RfPB – Feasibility of multilingual (Bengali/Turkish) parent-facing SLCN support within Verbo

Financial management in 2025/26 was steady with R&I maintaining a self-funded workforce through commercial income, grant income and RRDN yearly allocation funding.

In 2025-26 R&I continued to encounter challenges with lab capacity and capability. Although we are hoping the new lab space will be live in the next quarter.

Another challenge 2025-26 was still the infrastructure and space to conduct research investigations. R&I have no dedicated facility to see patients once they have been identified and deemed eligible to participate in a trial. The lack of infrastructure and capability has resulted in the Trust declining worthwhile research and missing out on crucial commercial funding.

The CRDC (Commercial Research Delivery Centre) has been live since 1.4.25 after Barts were awarded the full proposal of £4.7m. This 7-year programme has a vision to create a clinical research environment for commercial research that is more efficient, more effective, and more resilient, with research delivery embedded across the NHS and in the community. Over the past year the project has gained momentum and allowed collaborations and working relationships with other Trusts and commercial sponsors to flourish to have the opportunity to grow the commercial portfolio and appetite for commercial research. Although the impact of the CRDC has been positive in some areas, recent data has shown slow uptake from clinicians at HUH for participation in commercial studies. Since April 25 HUH has been offered 197 commercial studies so the data proves there is a wide range of

commercial research that HUH could access. Data also shows that 37 studies were available to HUH between Jan-26 and Feb-26, with 31 of those declined due to PI capacity or no response from the researchers

An ongoing goal is the access underserved communities have to research. Our local population is ethnically diverse with approximately 50% identifying as Black, Asian or Minority Ethnic against a national 20%. Languages spoken within the Trust were last recorded as in excess of 100. To understand the barriers to engagement in research, R&I have looked in to how we make research more available to these communities and have successfully held a series of focus groups/workshops to include representatives of our multiethnic and multi faith communities to get their input and opinions on the barriers and reasons they may be hesitant to participate in research. We record ethnicity and religion as standard within our data attributes on the local Trust system EDGE, to try and understand the areas of low uptake in research and ways we can improve this.

2025-26 R&I screened over 1900 patients, and over 1650 patients have consented to participate in research.

In summary, 2025–26 has been a productive year for Research & Innovation, with continued growth in research activity, strong performance in participant recruitment, expansion of the commercial portfolio, and successful investment in new research capacity. Despite ongoing challenges relating to infrastructure, clinical capacity, and laboratory facilities, we remain committed to embedding research and innovation at the heart of patient care. Through collaboration with clinical teams, partners, and our diverse local communities, we will continue to increase opportunities for patients to participate in research and support the delivery of high-quality, impactful studies that improve health outcomes for our population.

2.2.4 GOALS AGREED WITH COMMISSIONERS

The Commissioning for Quality and Innovation (CQUIN) framework has historically provided a national mechanism for incentivising quality improvement by linking a proportion of provider income to the achievement of agreed quality goals.

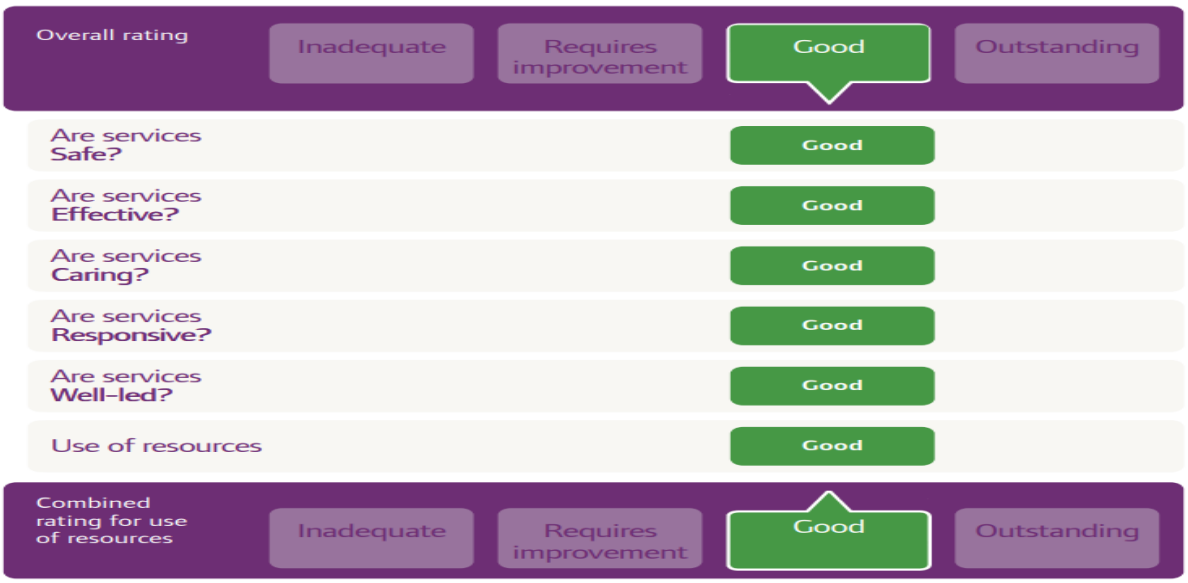
Since 2023/24, NHS England has paused the nationally mandated CQUIN scheme, and this position remains in place for the 2025/26 reporting period. As a result, there are no national CQUIN indicators or financial incentives applied to provider contracts during this period.

2.2.5 WHAT OTHERS SAY ABOUT THE HOMERTON

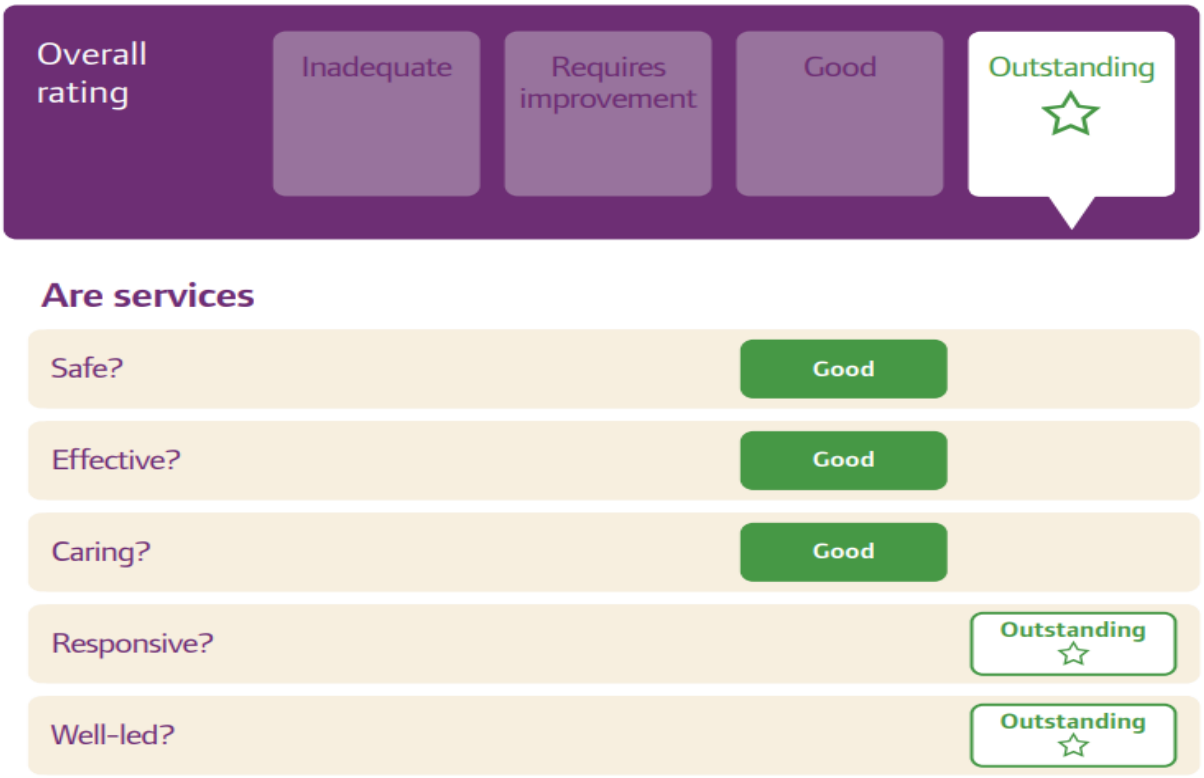
Homerton Healthcare NHS Foundation Trust is required to be registered with the Care Quality Commission (CQC) under Section 10 of the Health and Social Care Act 2008 and remains registered at the end of the reporting period. The Trust is registered to provide a range of regulated activities across its registered locations, covering acute, community and adult social care services.

During 2025/26, the Trust's overall CQC rating remains 'Good', with ratings for Homerton University Hospital, community services, and Mary Seacole Nursing Home unchanged. It should be noted that no enforcement action was taken by the Care Quality Commission against Homerton Healthcare NHS Foundation Trust.

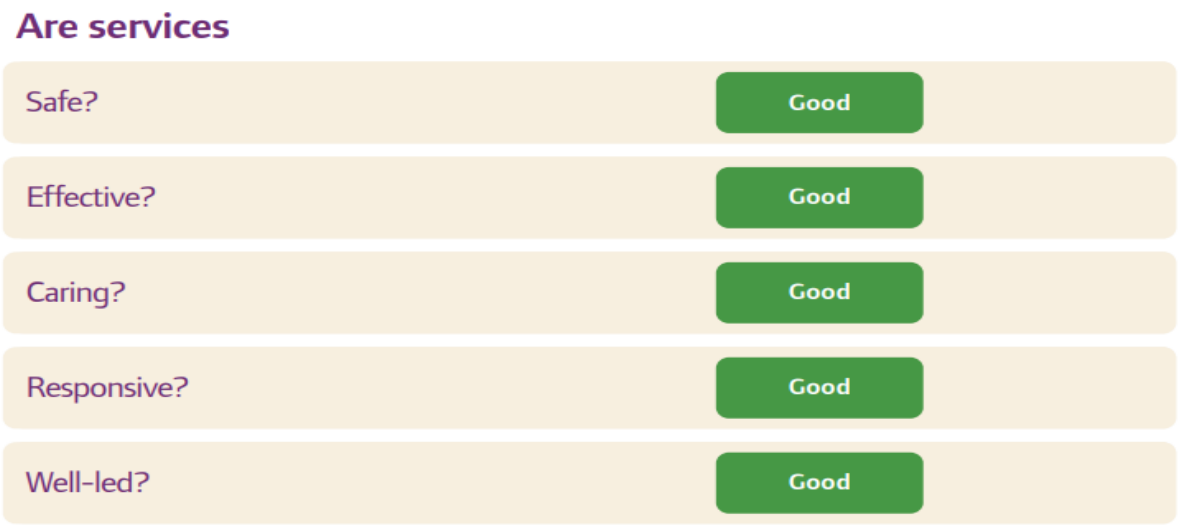
Homerton Healthcare NHS Foundation Trust CQC rating



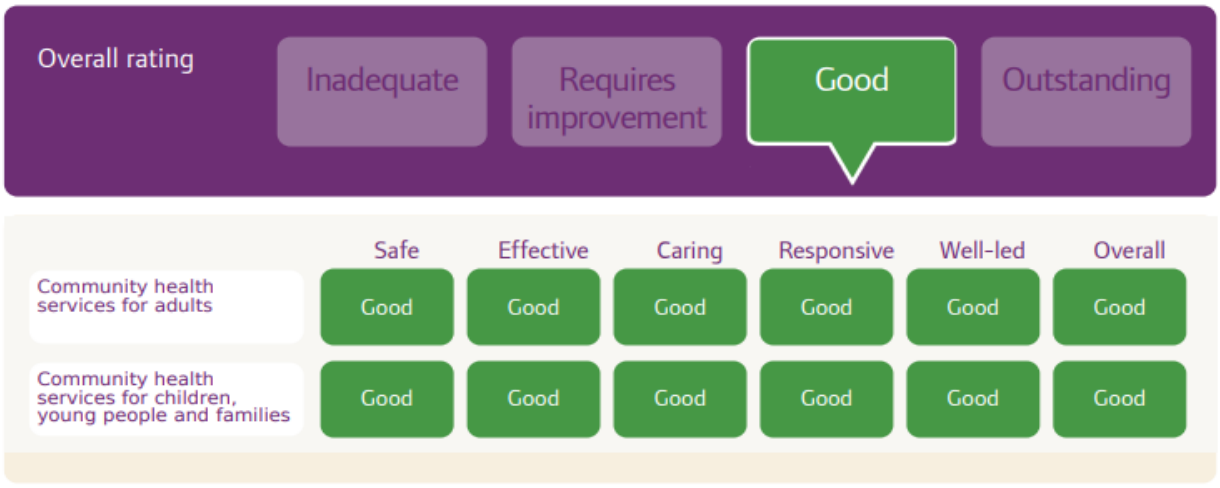
Homerton Hospital site CQC rating:



Mary Seacole Nursing Home CQC rating:



Homerton Community Services



There are no conditions attached to the Trust's registration for these regulated activities delivered at Homerton University Hospital and Community Services.

One condition remains attached to the Trust's registration in relation to Mary Seacole Nursing Home:

The registered provider must only accommodate a maximum of 43 service users at Mary Seacole Nursing Home.

This condition applies solely to Mary Seacole Nursing Home and does not apply to services delivered at Homerton Hospital or within community services. All regulated activities are managed in line with CQC requirements, including the appointment of registered managers where applicable.

The most recent CQC inspection undertaken by the Trust was of maternity services at Homerton University Hospital. This inspection took place in June 2023 as part of the national maternity inspection programme, with the final report published on 14 September 2023. Maternity services were rated Good overall, with two 'Must Do' actions and eleven 'Should Do' actions identified. Progress against the 'Must Do' and 'Should Do' actions continues to be monitored through local maternity governance structures and the Trust's Quality Committee.

Maternity Perinatal Incentive Scheme and Service Improvement
In March 2026, the Trust has self-declared compliance with the NHS Resolution Year 7 Maternity Perinatal Incentive Scheme, having met all 10 Safety Actions based on achieving the standards of the scheme. There are three Safety Actions that have documented mitigations, with action plans that have been approved by the Trust Board and North East London Local Maternity and Neonatal Systems.

In line with actions from previous inspection reports, and as part of ongoing quality improvement within maternity services, BadgerNet was successfully implemented in March 2025. This system provides a comprehensive end-to-end electronic maternity record and integrates with existing Trust electronic patient record systems.

2.2.6 NHS NUMBER AND GMC PRACTICE CODE VALIDITY

The NHS number is a critical component in the integration of clinical systems, enabling effective and efficient information sharing between health and social care organisations. Inaccurate or duplicate NHS numbers can result in shared records becoming inaccessible to users, which may adversely affect the delivery of clinical care.

The NHS number and the patient's Registered GP practice remain essential in enabling patients to access their online medical records through NHS-supported applications such as the NHS App, Patient Access, Patient Knows Best, and DrDoctor. These identifiers play a critical role in allowing patients to manage their medical conditions, medications, and appointments. The accurate recording of a patient's Registered GP practice is vital to ensure the correct and timely transfer of clinical information from the Trust to the patient's General Practitioner (GP).

The Trust submitted records during 2025/26 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 25 – Mar 26 which included the patient's valid NHS number was:

SUS Dataset	Trust	London	National	Performance against London	Performance against National
Admitted Patient Care	99.6%	99.1%	99.7%		
Outpatients	99.9%	99.4%	99.8%		

% >= National % | % <= 0.5% below National % | Invalid > 0; % > 0.5% below National %

which included the patient's valid Registered medical practice was:

SUS Dataset	Trust	London	National	Performance against London	Performance against National
Admitted Patient Care	99.3%	99.8%	99.8%		
Outpatients	99.6%	99.8%	99.6%		

% >= National % | % <= 0.5% below National % | Invalid > 0; % > 0.5% below National %

The percentage of records in the Emergency Care Data Set published data for Financial Year 2025 -2026
which included the patient's valid NHS number and valid Registered GP Practice was

ECDS DQ Dashboard	Trust	London	National	Performance against National
NHS number	98.2%	97.9%	99.0%	
Registered GP Practice	92.3%	99.6%	99.7%	

% >= 95% | % >= 70% AND < 95% | % < 70%

The Trust continues to prioritise the improvement of NHS number and Registered GP data across all clinical patient systems. Ensuring that this information is accurate, complete, and up to date is essential for delivering safe, efficient patient care and for supporting high-quality data submissions.

The Acute and Community Services Data Quality Committees meet bi-monthly to review locally agreed core indicators. These include NHS number and GP completeness, along with other key data sets submitted to the Secondary Uses Service (SUS) and the Community Services Data Set (CSDS). Figures from the Data Quality Maturity Index (DQMI)—a monthly publication designed to highlight the importance of data quality across the NHS—are presented at these meetings, and the Trust's performance is reviewed. The DQMI focuses specifically on the completeness and validity of submitted data.

The Data Quality Team continue to undertake quarterly acute and community data audits to assess the consistency and accuracy of information recorded on the Trust's clinical systems and submitted nationally.

There continues to be regular quarterly EPR uploads of Organisation Data Service (ODS) data to ensure that GP information held within the EPR remains accurate and up to date. Following each upload, the Clinical Information Service (CIS) team notifies the Data Quality Team of any GP practices that have closed or changed address, as well as any GPs who have left a practice. Patient lists associated with these practices or GPs are then extracted, and the corresponding records are updated with the correct GP or practice details. All demographic information is validated against the National Care Records Service (NCRS). The Data Quality Team are responsible for managing and maintaining data quality on the Master Patient Index (MPI) for the East London Patient Record Health Information Exchange (ELPR HIE). They act as the key point of contact when clinicians are unable to access HIE

information, reviewing and correcting demographic issues on the MPI to restore access to shared records.

A range of Data Quality reports are regularly distributed to services to support improvements in data completeness across clinical systems. Ongoing checks, updates, and staff training are carried out whenever new issues or errors are identified.
The Data Quality Team continues to focus on specific areas to improve the Trust's NHS number and GP completeness. These activities include:

- **Mini Spine Dashboard**
  Identifying records that have failed batch tracing due to discrepancies in NHS number, date of birth, GP details, or address. The team investigates these cases, verifies the correct demographics using the National Care Records Service (NCRS), and updates the EPR accordingly.
- **Keystone**
  Highlighting correspondence where no Registered GP or an unknown GP is recorded. The team searches for the correct GP details and, where identified, ensures that correspondence is issued via hybrid mail.
- **NHS Number and GP Clean-Up Reports**
  Patient demographic data relating to past, current, and future activity is submitted for batch tracing against the Spine. Where a match is identified, the team updates the data on the EPR system using NCRS for validation.
- **IAPT NHS Number Tracing**
  Identifying and completing missing NHS numbers to support accurate and complete Improving Access to Psychological Therapies (IAPT) data submissions.

2.2.7 INFORMATION GOVERNANCE ASSESSMENT REPORT

The Data Security and Protection Toolkit (CAFv8) is June 30th 2026 by NHSE.
The status of the HHFT DSPT publication remains designated as 'Approaching Standards' until re-assigned in July 2026 by NHSE.

2.2.8 CLIINICAL CODING

Homerton Healthcare NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2025/26 by the National Audit Office.
Homerton Healthcare NHS Foundation Trust will be taking the following actions to improve data quality:

On-going internal audit of clinical coding standards led by the Trust's Clinical Coding Auditor to identify areas where coding is not in line with national guidance
Independent external audit of clinical coding standards to assess the overall quality of the Trust's clinical coding and to ensure any actions/recommendations are implemented appropriately.

- Implementation of AI supported clinical coding for Endoscopy and Well Babies.
- Implementation of a quality control audit tool to better identify areas where coding is not compliant with national standards.

2.2.9 ACTIONS TO IMPROVE DATA QUALITY

The six dimensions of data quality—completeness, consistency, accuracy, timeliness,

uniqueness, and validity—are monitored on a regular basis to provide intelligence that supports clinical and strategic decision-making. The Trust is committed to ensuring that high-quality information is available to support the delivery of safe, effective, and efficient clinical services, as well as accurate and complete data submissions.

Data Quality Committee's

The Trust continues to operate a monthly Data Quality Committee. The Committee alternates between Acute and Community services, during which both local and national data quality indicators are reviewed and monitored. These Committees act as a key mechanism for driving data quality improvement and raising awareness across the Trust. They promote and maintain robust processes for the creation and management of accurate information, ensuring that all outbound data is of the highest quality. New data quality indicators are introduced and monitored as they are identified and approved by the Committees. This forum will continue to serve as the primary platform for monitoring strategies, policies, and standards, ensuring alignment with operational requirements

Data Quality Reporting

Regular daily, weekly and monthly processes are in place to monitor key areas such as;

- the accurate recording of patient demographics
- ethnicity and language capture
- checking out and outcoming of appointments
- the timely production of discharge summaries and validation of notes
- accurate recording of length of stay (A&E and admitted activity)
- the correct recording and coding of clinical events
- Caseload accuracy by monitoring the number of open referrals for community services
- SUS data quality improvement
- DQMI data set improvement
- Death status on the Trusts clinical systems
- Duplicate RTT encounters
- Invalid admission and discharge data fields

Prechecks for Secondary Uses Service (SUS) data submissions

The Data Quality team continues to monitor admissions and attendances with Data Quality issues before data is submitted to the Secondary Uses Service (SUS). There continues to be a focus on the clean-up of GP, NHS numbers and main specialty.

London Discovery Data

In 2025/26, the Data Quality Team continued to utilise Discovery data to improve the completeness and accuracy of information held within both EPR and RiO systems. Discovery is a live data source that stores and processes data from approximately 39 million linked patient records across UK organisations. By comparing the Trust's internal demographic data with Discovery demographic data, the team has been able to identify gaps within local records and update them accordingly, resulting in improved data completeness and overall data quality.

EPR Ethnicity

Ethnicity data is important to understand health inequalities in the Trust's cohort of patients.

The Data Quality Team have continued to focus on updating patient's records who have a missing ethnicity or unknown ethnicity for future outpatient appointments using the discovery data. By doing this proactive work ethnicity data has been recorded at the time of activity, and there has been an improvement in the Trust's ethnicity completeness from 97.1% (Feb 25) to 98.0% (Feb 26)
(Data from Commissioning data sets (CDS) Data Quality Dashboard as of 05/05/26)

RIO Ethnicity and language

This work continues for ethnicity and language completeness within RiO. All patient records with a future community appointment that have missing ethnicity or language data are updated using Discovery data. Language is a particularly important dataset for understanding advocacy and communication requirements within community services. Although there is a three-month delay in the publication of DQMI completeness data, an upward trend in these datasets has been observed and is expected to continue.

Data Quality Maturity Index	Jan-25		Jan-26	
Data Item	Trust	National	Trust	National
Language Code	52.2%	33.0%	53.8%	36.1%
Ethnic Category	87.3%	70.5%	88.1%	71.4%

Data from Data Quality Maturity Index as of 05/05/26

Mobile Number

There has been a Trust-wide focus on capturing mobile telephone numbers to help reduce DNA rates by ensuring accurate details are available for text message reminders. The Data Quality Team has used Discovery data to update mobile telephone numbers within the EPR system

HIE Master Patient Index

The Data Quality Team continues to manage and maintain the Master Patient Index (MPI) for the East London Patient Record (eLPR). This is a critical function that ensures the Trust holds a single, accurate record for each patient, which can be accessed by other trusts and partner organisations to support safe and effective clinical care.
The Data Quality Team acts as the key point of contact when HIE information is inaccessible to clinicians. They are responsible for reviewing and resolving demographic issues and correcting records on the MPI, enabling clinicians to access shared patient information. The team has maintained excellent data quality standards, placing the Trust in a strong position for the future Oracle Health Information Network (OHIN) upgrade.

Mortality Data Review Data Provision Notice

The Date Quality Team continue to ensure compliance with Mortality Data Review Data Provision Notice. This mandates that all Acute trusts should update date of death on Spine services within 24 hours of the deaths which occurred in hospital (either in ward, theatre, A&E or outpatients).

DQ Awareness training

All clinical and non-clinical staff are responsible for data quality and are accountable for the

data they collect and process as part of their roles. To support this understanding, Data Quality Awareness training modules for acute administrative staff and community services are now available on ESR.

The Trust is actively encouraging uptake of this training by engaging services directly, contacting new starters to promote early completion, and including data quality awareness as a standing agenda item within Data Quality Committees. This work will continue to be promoted across the organisation. In addition, work is underway to finalise the acute data quality awareness training for clinicians and make this available on ESR.

Audits

Quarterly audits are carried out in line with Data Security and Protection Toolkit guidance to ensure the validity and completeness of data submitted to Secondary Uses Service. Community audits will continue to be undertaken alongside Acute audits each quarter.

Homerton Healthcare NHS Foundation Trust will be taking the following additional actions to improve data quality:

- Continue to improve completeness in the Data Quality Maturity Index and Secondary Uses Service Dashboards by incorporating low performing completeness datasets into our Data Quality dashboards and reporting. By reviewing these data sets in the Date Quality committees, we are developing a dialogue to push improvement forward.
- Continue to work collaboratively with services to improve data accuracy and completeness
- Improve uptake of Data Quality awareness training through proactive engagement with services across the Trust.

2.2.10 LEARNING FROM DEATHS

During 2025/26 411 inpatients at Homerton Healthcare NHS Foundation Trust died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

Reporting quarter 2025/26	Number of deaths	Number of completed reviews
Quarter 1	93	92
Quarter 2	104	102
Quarter 3	107	105
Quarter 4	107	74

mortality reviews completed per quarter – reviews for Q3 and Q4 are ongoing

Part of the mortality review process includes assigning a likelihood that there were issues with care that may have affected the outcome. These scores are allocated 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, in one case the death during the reporting period) was judged to be more likely than not to due to problems in the care provided to the patient (CESDI 2) after MDT review and additional review following the existing governance processes.

If a CESDI score of 1 or above is obtained the case will be discussed in a multidisciplinary forum or by a second independent reviewer. The process particularly focuses on identifying areas of good practice as well as opportunities for improvement. Themes are extracted and presented to the Quality Committee and discussed in the Mortality Leads meetings and where appropriate actions are attached and completed.

Additionally, all cases in 2025/26 were also scrutinized at the point of death certification by one of the Medical Examiners.

All reviews scored as CESDI 2s and above are investigated via the Trust's Patient Safety Incident response framework process (note there were no cases scored a CESDI 3).

Summary of learning from case record reviews over the period 2025/26:

Areas of good practice:

- These are often noted on multiple occasions in the mortality review tool and include:
- Team went to great effort to arrange for ICD deactivation.
- Good liaison with specialist team at a neighbouring hospital.
- A very vulnerable NOK was supported by the MDT.
- Involvement of the learning disabilities and autism team throughout a long admission.
- Tripartite decision making to strengthen the decision process.
- An unnecessary transfer elsewhere was avoided which would have made the patient uncomfortable.

Areas for improvement:

- These are often a single incident. Action taken listed in brackets.
- Fall in last hours of life due to agitation (Action: Datix submitted, discussed in mortality meeting with relevant parties present).
- Too much focus on the presenting pathology which meant that the slow but ongoing deterioration took time to be picked up (Action: mortality meeting MDT discussion).
- Non invasive ventilation used outside of licensed indication (Action: ongoing theme under observation by the AMD and featured in the mortality newsletter for trust wide learning).
- NOK was attempting to influence the treatment being given (Action: discussed in the mortality meeting with multidisciplinary attendance).

Summary of the key achievements during 2025/26:

- **Learning from PSIRF (Patient Incident Response Framework)**

  Departmental mortality leads are encouraged to score all cases on mortality review initially if in doubt higher and ensure that they are flagged via Datix for further governance review. The Mortality Lead in liaison with the Patient Safety Lead ensure that this is process adhered to in all relevant cases. Themes that may link with mortality are kept under review and updates given to the Mortality review group as appropriate.
  Additionally, feedback pathways have been established with the Medical Examiner team for individual cases that require additional scrutiny or discussion. The patient voice feeds into this process by feedback from patients being flagged to the Medical Examiners where appropriate.
- **Comparison with comparable local Trusts**

  Homerton Healthcare has established mortality reviews for all inpatients which

provides rich information on areas for improvement and examples of exemplary care whereas many other Trusts review a selection of cases flagged which makes like for like comparison difficult.
One helpful way is by looking at the Summary hospital level mortality indicator (SHMI). Homerton healthcare has been having lower than expected or expected SHMI and this is better or the same as other trusts it compares itself with.
Please also see the section “indicator 12 – SHMI”.

- **Review of inequality data**

  Work has progressed on interrogating available inequality data. Data is easily accessible on ethnicity however it is acknowledged that this is only one factor that may influence the likelihood of people experiencing health inequalities. Many other protected characteristics are less well recorded in an easily searchable format. Good information across the life course exists on patient with a learning disability and or autism diagnosis from the national Learning from lives and deaths – people with a learning disability and autistic people (LeDeR) programme and particular focus has been this year on close liaison with the learning disabilities and autism team to establish key takeaway messages including a renewed focus on the mandatory Oliver McGowan training for staff.

  Additionally, ethnicity data has now been broken down further into comparing the total number of those admitted as inpatients with the total number of deaths by ethnicity with trends being closely monitored.

- **Work on establishing communication / language barriers**

  In a manual review of EPR notes for 100 consecutive patients who later died the question was asked about barriers in communication for patients but also their NOK with a particular focus on language barriers and the actions taken to overcome those barriers. In 38 cases no barrier was found, the rest of cases, the patient was either medically too unwell to communicate during the entire hospital stay, or they had longstanding communication barriers i.e. Dementia, prior stroke diagnosis or were known to have other barriers like visual or hearing impairment. Examples of how these barriers were overcome were looked at and included a “this is me” booklet, use of translation services, support by the learning disabilities and autism practitioner, support by associate healthcare professionals including for families for signposting.

- **Trust wide dissemination of key findings through the mortality newsletter**

  The “Let’s talk about death” trust wide newsletter is published on the Intranet every 3 months and aims to highlight cases (heavily anonymised) to learn from as well as provoke thinking often along a theme (e.g. recently it featured a theme on breathlessness towards the end of life). This newsletter is meant for all staff, not just clinical staff, so is not always focused on clinical scenarios but often highlights or wishes to provoke thoughts about what makes for good holistic care and support for patients, their loved ones and what matters to staff caring for patients in the final stages of life.
  This process is collaborated by the palliative care team who help co-produce it.

- **Multiprofessional / multidisciplinary working focus with teams supporting and complementing each other**

Recently a very useful exercise has started whereby some additional input has been obtained from a number of consultants to support a team that has had long term absence which has strengthened cross team / multiprofessional working and has highlighted how reviews benefit from bringing together different people with their individual professional background to highlight learning that can be derived from death reviews.

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. The focus was to ensure parity of care across the weekday and weekend. Four of the 10 clinical standards were identified as priorities based on 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

There has been no change to consultant on call structure since the initial audit was completed 2019 (as reported in previous Quality Account Report). Consultants continue to work within the same working patterns, which allows for twice daily reviews when needed. It is therefore not anticipated that our compliance with the seven-day services standards will change.

Reviews of reported clinical incidences over the 2024/2025 period have not identified any concerns with regards to a delay in consultant review with no reported patient incidences associated.

We will be guided by national directives to determine what audits and note reviews need to be undertaken. Since 2020 there has not been an expectation from NHS England that regular case reviews are required. No further audits have therefore been completed.
No change to the on-call framework is currently predicted which would negatively impact current performance. The Seven Day Services initiate was designed to provide care standards for all patients admitted to hospital. The expansion of same day emergency care (SDEC) to a 7-day service will increase access to consultant (ED trained) directed interventions within the emergency department. Whilst this will not impact on the clinical standards outlined in the 7-day services framework, it may increase access to consultant-directed interventions for those being managed in the ambulatory care setting.

In November 2025 the Same Day Emergency Care (SDEC) Service has increased to a Seven Day Service. This fits with the original Ten clinical standards for seven-day services 2013 and the NHS England directive for management of Same day Emergency Care standards

2.2.12 SPEAK UP SAFELY

Freedom to Speak Up (FTSU) is now an established provision in Homerton and a vital part

of both Patient and Staff Safety that is evidenced in our 2025 staff survey.

Homerton has been able to grow our Speak Up culture by working across the organisation with departments such as the Culture Team the People Team and with the support of the Guardian and our FTSU Champions. We also gather both quantitative and qualitative (anonymised) data that is regularly presented to the CEO and our board members.
Following the Dash Review in July 2025 one of the recommendations was that the responsibilities of the NGO (National Guardians Office) should be incorporated into the Trust, but other support functions would be aligned with functions in NHS England.
The review emphasised that ensuring these functions happen would be a core function of CQC as the independent regulator. The Trust has started to incorporate some of these changes with the imminent closure of the NGO in June 2026.

2.2.13 ROTA GAPS

During the reporting year, the Trust continued to experience rota gaps in some areas. These were mainly due to vacancies, sickness absence, and complex rota arrangements, particularly in services with a high proportion of less than full-time working.
The Trust has kept a strong focus on identifying rota gaps as early as possible. This is supported by clearer escalation and approval processes for temporary cover, strengthened governance with Divisions, and enhanced oversight through the Trust Leadership Team (TLT) and Quality Committee. Regular Medical Workforce led meetings with services continue to support a coordinated response to emerging gaps.

Vacancies remain a contributing factor in some services, including posts that are historically hard to recruit to. Targeted recruitment activity is underway to fill these vacancies and reduce reliance on temporary staffing, alongside ongoing review of establishment.

Whilst Less Than Full Time (LTFT) working supports staff wellbeing, retention and equality, higher concentrations of LTFT roles can increase rota complexity and create gaps if not carefully planned. Work is underway to better understand these patterns and to mitigate their impact through improved rota design, clearer forward planning, and alignment of recruitment and job planning approaches.

We have recognised that relying on manual rota management can delay the identification of LTFT gaps. To address this, the Trust has continued work to improve medical rostering systems and governance. Electronic rostering pilots have been introduced in selected services, improving real-time visibility of gaps, supporting better management of leave, and reducing the need for late escalation to arrange cover. There are plans to procure an electronic rostering platform across the Trust managed by rota co-ordinators who will have the access to review for future gaps and address these accordingly.

Robust medical bank and agency review arrangements remain in place to ensure that any temporary staffing is clinically appropriate, well governed and represents good value for the organisation, with patient safety remaining the top priority.

Alongside these system improvements, clearer ownership of rota design and changes has been embedded. This is supported by defined escalation routes, routine review of gaps and fill rates, and closer working between clinical teams, workforce and finance colleagues. Together, this helps improve forward planning and reduces the operational and financial impact of last-minute rota gaps.

Oversight has also been strengthened through the resident doctor exception reporting process. Exception reports provide valuable insight into workload pressures, missed breaks and potential unsafe working patterns linked to rota gaps or unexpected service pressures.

Reports are reviewed locally and escalated where needed, allowing timely action and learning to help prevent repeat issues.

The Guardian of Safe Working (GOSW) provides independent assurance that rota gaps and temporary staffing arrangements do not compromise safe working hours or patient care. The GOSW reviews exception reporting trends, considers fines and educational outcomes where appropriate, and provides assurance to the Trust Board on compliance with safe working standards.

The Trust recognises that addressing rota gaps requires ongoing effort. Work continues to review the outcomes of rostering pilots, standardise good practice across services and strengthen internal medical bank capacity. This forms part of a wider programme to build a more resilient workforce, support staff experience, and ensure the consistent delivery of safe, high-quality care.

3.0 REPORTING AGAINST CORE INDICATORS

3.1 Summary Hospital-level Mortality Indicator (SHMI) and patient deaths with palliative care (Quality indicator ref 12)

The SHMI reports on mortality at trust level across the NHS in England. SHMI is the ratio between the number of patients that die following hospitalisation, and the number of patients expected to die based on the national average and on the particular characteristics such as comorbidities of our patients. It reports on all deaths of patients who were admitted to hospital and either died whilst in hospital or within 30 days of discharge.

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 (band 1) 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 (band 3).

The data in table below describes the SHMI has been sourced from NHSE Digital.

Indicator	Reporting period	Homerton performance	National average	Lowest performing Trust	Highest performing Trust
SHMI value and banding	Dec 2024 to Nov 2025	Value:0,7675 (banding 3)	Value: 0,999	Value: 1,3183 (banding 1)	Value: 0.7194 (banding 3)
	Jan 2024 to Dec 2024	Value: 0.7960 (banding 3)	Value: 0.999	Value: 1.323 (banding 1)	Value: 0.9661 (banding 3)
	Jan 2023 to Dec 2023	Value: 0.88 (banding 2)	Value: 0.999	Value: 1.2548	0.7202 (banding 3)

				(banding 1)	
% deaths with palliative care coded at either diagnosis or speciality level	Dec 2024 to Nov 2025	47%	44%	17%	69%
	Jan 2024 to Dec 2024	53%	44%	17%	66%
	Jan 2023 to Dec 2023	48%	42%	16%	67%

SHMI scores and % of deaths coded as palliative since 2023

The latest data period for which information exists is from December 2024 to November 2025. Currently no information is available from December 2025 onwards.

Our Trust SHMI score is 0.7675 which equates to NHS Digital Band 3 (lower than expected SHMI when compared to the national baseline, falls between the upper and lower control limit).
The SHMI is the ratio between the observed number of patients who die following hospitalization at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients. It includes patients up to 30 days of discharge.

How is the Trust doing?
Our SHMI score remains below 100 and has been for the previous years. Care is however needed when interpreting the SHMI score in isolation. It is best viewed alongside other metrics.

3.2 Patient Reported Outcome Measures (PROMS) (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 two clinical procedures:

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

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.

It should be noted that during the reporting year NHS Digital updated the operational processes of the PROMS data collection impacting upon the linkage methodology causing a subsequent delay in the timeliness of the PROMS publication series.

However, due to the low response rate of the second part of the questionnaire there is insufficient data for the Trust's figures to be included in the annual NHS Digital report.

Assurance statements

The Trust considers the data described for the following reasons:

- The PROM two-part questionnaire process consists of pre-operative (Q1) and postoperative (Q2) questionnaires. Patients are asked to complete the Q1 form and post it back to a third party to complete submission to NHS Digital. Where fewer than 30 modelled records are received, the adjusted health gain cannot be calculated* and is displayed as No Data in the above table.
- The pre and post-operative responses are reviewed by the PROMS Lead when the provisional data published by NHSE for both hip and knee replacements.

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

- Trust to consider introducing local process for the collection / analysis of PROMS on Amplitude data analytics platform rather than using paper forms that are returned to a third party.
- Reviewing PROMs data and responses when available and discussing these within relevant departments.
- Reviewing PROMS data on a regular basis through the Improving Clinical Effectiveness Committee.

3.3 28-day emergency readmission rate (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 submitted to authorised benchmarking suppliers like HED.

The readmissions data collated by NHS Digital can be seen in the table below:

Indicator	Reporting Period	Homerton Performance	London Average
% of patients readmitted within 28 days of being discharged (0 - 15 years of age)	Feb'25 - Jan'26	6.42%	7.65%
	2024-25	5.08%	7.36%
	2023-24	5.86%	7.64%
% of patients readmitted within 28 days of being discharged (16 years and over)	Feb'25 - Jan'26	7.84%	6.55%
	2024-25	7.34%	6.47%
	2023-24	8.17%	7.01%

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

Assurance statements

There is an increase in the 28 day readmission rate for the latest period in the table above for both 0-15 years and 16 years and over.

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

- The Trust uses the 30-day readmission standard reported by NHS digital.
- The Trust has a robust clinical coding and data quality assurance process, and 30-day readmission data is monitored monthly with agreed local exclusions.

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

- The 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.

- It has been agreed by the Trust's Improving Clinical Effectiveness Committee that utilisation of the readmission report will be overseen the Divisional Leadership teams will support the specialties in the real time review of outliers and identify urgent interventions to reduce readmission.

During 2026/27 part of Flow workstream, there is a focus to further reduce the readmission rate.

3.4 Responsiveness to personal needs of patients (Quality Indicator ref 20)

The trust uses several avenues to assess the responsiveness to the personal need of patients. The main three ways are via national Picker surveys (although these are limited to those who have received a service and only to particular areas of care such as end of life care / children and young people / inpatients etc), FFT questionnaires and complaints and pals.

Standard of care from FFT questionnaire	Percentage
Good	92%
Poor	5%
Breakdown	
Very good	74%
Good	17%
Neither good nor poor	3%
Poor	2%
Very poor	3%
Don't Know	0%

FFT overall results for the Trust 24/25

Year	Complaints	PALS
2021-2022	546	2200
2022-2023	633	2006
2023-2024	712	2907
2024-2025	771	2982

Overall complaints and pals received over the last few years and including 24/25

Assurance statements

With the increasing demands on our services, delays due to industrial actions and the attention to the backlog of both long waiters and others, and the challenging financial position across the NHS, the Trust continues to report a high number of patient feedback both through FFT and through PALS and complaints.

Despite the obvious challenges, the Trust's FFT data indicates high scores and most of the time above the national benchmark. The patient experience team is working hard with the divisions to ensure that as many places have more than one option to provide FFT feedback and these include via text message, QR code and via paper feedback forms.

As can be seen by Figure 2 above, the number of complaints continues to rise year on year. These are distributed fairly equally across the divisions and one of the main themes always coming up is bookings and appointments and cancellations. This rise in complaints has also meant that the trust's ability to respond to all complaints within the time frame that is considered best practice also very challenging. (This time frame is dependent on the complaint. For those that are simple the time frame is 30 working days, 60 working days for those that are more complex and cover more than 1 service and national guidance that complaint responses are received within 6 months.) The Trust acknowledges that on occasions it may not be as responsive as it would like or expect to be, especially when the system is under extreme pressure.

- The Trust's assessment, accreditation and recognition programme is well established and continues to be rolled out across the trust. This includes a focus on quality improvement in care delivery and the impact that has on patients. As part of this programme each visit is attended by one of the Trust's patient safety partners – who focus only on the patient experience during each visit. This is fed back directly to the ward / area to attempt to resolve any concerns and to highlight areas of work that need addressing.
- The Trust was one of the pilot sites to introduce Martha's rule. Call 4 Concern is the service that has been established for over a year now and is delivered by the Critical Care Outreach Team (CCOT). This service is delivered 24/7 and is slowly being rolled out to include all areas across the acute site. Currently this covers the inpatient wards and the main hospital and paediatrics and is looking to expand across all acute services. It is delivered 24 hours per day, seven days a week and is a key service where patients can raise their concerns directly with clinicians.
- The Trust introduced PSIRF (Patient Safety Incident Response Framework) which helps the Trust focus on the patient experience as well as the incident. The trust has – in year 24/25 – begun to involve patients and their families in our investigation processes to ensure there is open and transparent communication with those affected by incidents.
- Inpatient ward leadership teams have worked on welcome leaflets to help patients and families know how to escalate concerns but also to ensure that patients are aware of the running of the ward and what they can expect.
- Our wishes – your wishes booklet for maternity was launched and well received by both patients and staff. This continued to be used throughout the year.
- The patient experience team went through a consultation process to improve their ability to engage with both the patient engagement within the trust as well as responding to feedback received by patients. This was completed in 24 / 25 and implementation was during 25 / 26.
- Civility training was rolled out across the acute site – acknowledging the impact incivility has on patient care. This is something that is available to all staff through the normal training route.

3.5 Staff recommending the Trust as a place to work or receive treatment to Family and Friends. (Quality indicator ref 21)

People Promise Elements	Question	2022	2023	2024	2025	% Change	Change from 2024 - 2025
Compassionate Culture	Care of patients / service users is my organisation's top priority.	82.50%	81.34%	81.38%	82.41%	1.27%	improvement
Advocacy	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	70.57%	71.98%	72.16%	73.96%	2.49%	improvement

Table X; F&F data

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 1 September 2025 (with certain specific exclusions) had the opportunity to complete the survey electronically between October and November 2025. The Trust achieved a return rate of 48% which represented an increase from previous years

- The Trust's 2022 results showed a reduction of 4% in recommendation as a place to receive care for their friends and family. In 2023 it improved to 72% and has been maintained with approximately 2000 staff responding to these questions. In the 2025 survey we have made further improvements to 74.4%

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:

1. Continuing to implement '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:
2. Achieving equality and inclusion for our people – focusing on workplace culture and inclusion
3. Staff health and sickness - Targeted work to reduce sickness absence and improve wellbeing at work
4. Learning and development - Implementing the recently developed inclusive talent management & succession planning framework, aligned to the forthcoming national Management and Leadership Framework.

3.6 Rate of admissions risk assessed for VTE – (Quality Indicator ref 23)

Recent NHS England guidelines on VTE prophylaxis have resulted in changes to the reporting structure. An interim board report has therefore been produced which summarises

recent changes to NHS England requirements for venous thromboembolism (VTE) risk assessment reporting and sets out the likely implications for Homerton Hospital.
It focuses particularly on the impact of these changes on patient flow, admission pathways, and the need for reliable cohorting of patients who require VTE risk assessment and timely prophylaxis.

Summary of national changes
NHS England continues to require all providers of NHS-funded acute hospital care to submit mandatory VTE risk assessment data, with an operational standard of 95% of acute hospital admissions aged 16 and over being risk assessed each month. Historically, the collection measured whether patients were risk assessed within 24 (and more recently 14) hours of admission. Updated national guidance now shifts the focus to completion of risk assessment within 14 hours of decision to admit, aligning reporting more closely with the relevant NICE guidance and the intended timing of thromboprophylaxis. NHS England has also signalled that patients remaining in A&E for 12 hours or more should be risk assessed under the updated NICE framework, although these patients are not yet fully incorporated into the formal data return during the transition period.

In practice, this is more than a technical reporting amendment. The change brings the clock for assessment and prophylaxis earlier in the patient journey and increases the importance of identifying the point at which a patient becomes an acute admission. It also places greater emphasis on pathways where patients may wait in the emergency department, such as Observation Medical Unit (OMU).

Implications for Homerton Hospital
As part of this process NHS England has reviewed data submissions from several trusts, including the Homerton. It has highlighted that previously excluded areas, such as the Medical Day Unit and Day Surgery unit, will now need to be included in our data collection. This has caused reported compliance to fall.
It should be noted that a ‘cohort approach’ to risk assessment using a national VTE risk assessment tool may be considered locally. This is considered appropriate for certain cohorts of patients undergoing certain procedures where the cohort of patients share similar characteristics and are not at risk of VTE according to the NICE guideline NG89. Any such local protocols must be agreed with the chief medical officer and included in local VTE governance policy and audits.

Review of current exclusions
Patients/ locations which have been previously excluded have been reviewed at AMD level. Previously excluded patients have been divided into 3 groups:

- Low Risk Groups that can be cohorted
- Patients undergoing emergency assessment and therefore not requiring VTE prophylaxis
- Patients undergoing higher risk procedures that need individualised risk assessments.

Next Steps

- Discussion and sign off Cohorting process at Improving Clinical Effectiveness Committee
- Confirmation with informatics team about changes to data collection process, including cohorting process.
- Understand the implications of above changes on overall performance and need for additional processes to meet 95% target.

Whilst this work is ongoing, please note; no serious incidences have been identified over the

reporting period and, overall, the incidence of VTE in the hospital has not increased over the last few years.

3.7 Clostridium difficile rate – (Quality Indicator ref 24)

Clostridioides difficile infection (CDI) remains an unpleasant and potentially severe infection, particularly affecting older adults and those with underlying health conditions or recent antibiotic exposure.

All cases of C. difficile, including inpatient and community (GP) samples, and all toxin-positive results are reported to the UK Health Security Agency (UKHSA) in line with national requirements. Consistent with national definitions, both hospital-onset healthcare-associated (HOHA) and community-onset healthcare-associated (COHA) cases are considered 'Trust-attributable'.

The NHS England threshold for 2025/26 remained at 17 cases for Homerton Healthcare. During the reporting period, the Trust reported:

- 12 Trust-attributable CDI cases, remaining below the annual threshold
- Of these, 8 were hospital-onset healthcare-associated (HOHA) and 4 were community-onset healthcare-associated (COHA)

This represents an improvement compared to 2024/25, where higher numbers of Trust-attributable cases were reported.

Assurance statements

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

- Data is sourced from the UKHSA Data Capture System and validated locally
- All Trust-attributable CDI cases are reported as incidents and reviewed through the Infection Control Response (ICR) process, aligned to the Patient Safety Incident Response Framework (PSIRF)
- Cases are subject to multidisciplinary review to identify learning and opportunities for improvement
- Ongoing surveillance is undertaken to identify trends, clusters, or potential transmission events at an early stage

The majority of CDI cases during 2025/26 were associated with recognised risk factors, including advanced age, comorbidities, prolonged hospital stay, and antibiotic exposure. There was no evidence of sustained transmission or outbreaks, with cases either unrelated or not linked microbiologically.

Where cases were temporally associated, further investigation including ribotyping did not demonstrate clustering, providing assurance that cross-transmission was not a significant contributory factor.

Actions and improvement

The Trust continues to focus on reducing CDI through established infection prevention and antimicrobial stewardship practices, including:

- Prompt identification and isolation of suspected cases
- Timely diagnostic testing and treatment
- Ongoing antimicrobial stewardship in collaboration with microbiology and pharmacy teams
- Routine surveillance and review of all cases to identify learning

Learning from case reviews during 2025/26 has highlighted:

- Opportunities to improve timeliness of specimen collection and patient isolation
- The importance of accurate and consistent clinical documentation, including stool chart completion
- Continued reinforcement of hand hygiene and standard infection prevention practices

The Trust will continue to build on these areas, with a focus on improving reliability of practice and documentation to support sustained reduction in CDI rates

3.8 Patient Safety Indicators – (Quality Indicator ref 25)

Homerton actively encourages its staff to report all incidents that have affected patients and staff, both those that have or have the potential to cause harm, and those that have not caused harm. 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.'

During 2025/26, 15,523 incidents occurred across Homerton Healthcare, of which 12,251 were patient related. This is slightly higher than reporting numbers from last year, which represents an ongoing trend of increased incident reporting year-on-year. Of the 15,523 incidents that were reported in 2025/26, 6092 (39%) caused no harm to patients or staff.

Homerton records harm as experienced by the patient, irrespective of whether that harm is attributable to the organisation, and so on our incident reporting system, reporters can select whether the harm caused by a patient safety incident is attributable to the trust or non-attributable. The table below shows the number of attributable harm incidents that occurred in the trust in 2025/26.

Level of attributable harm	Number of incidents
Low	3684
Moderate	360
Severe	26
Death (incident related)	2

The 26 incidents recorded as causing severe harm that was attributable to Homerton Healthcare were all reviewed and investigated via our incident review process. There were 80 deaths recorded that were not caused by a safety incident, and two deaths recorded as having been caused by a safety incident. Both of these were still under review at the time of writing.

Assurance statements

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

- We submit all eligible incidents to the national “Learning From Patient Safety Events” (LFPSE) system. Benchmarking data demonstrated that the Trust was in the top quarter of Trusts in terms of number of incidents reported per 1000 bed days.
- We continued to work with staff to ensure incidents were appropriately reported, investigated and actions taken where necessary to improve patient safety. Learning from investigations and learning responses is shared across the organisation.
- The Patient Safety Team provide a range of training, via trust and junior doctor induction, ward development days, the nurse preceptorship scheme and many other forums to ensure staff feel supported in reporting incidents and receive feedback on actions taken and improvement identified.
- The Trust transitioned from the Serious Incident Framework to the Patient Safety Incident Response Framework in February 2024, and during 2025/26 embedded and strengthened the new systems and processes introduced to support the Framework, along with rolling out a comprehensive programme of training and support for our staff.

4.0 Overview of the progress with the Trust's 2024 to 2027 quality priorities

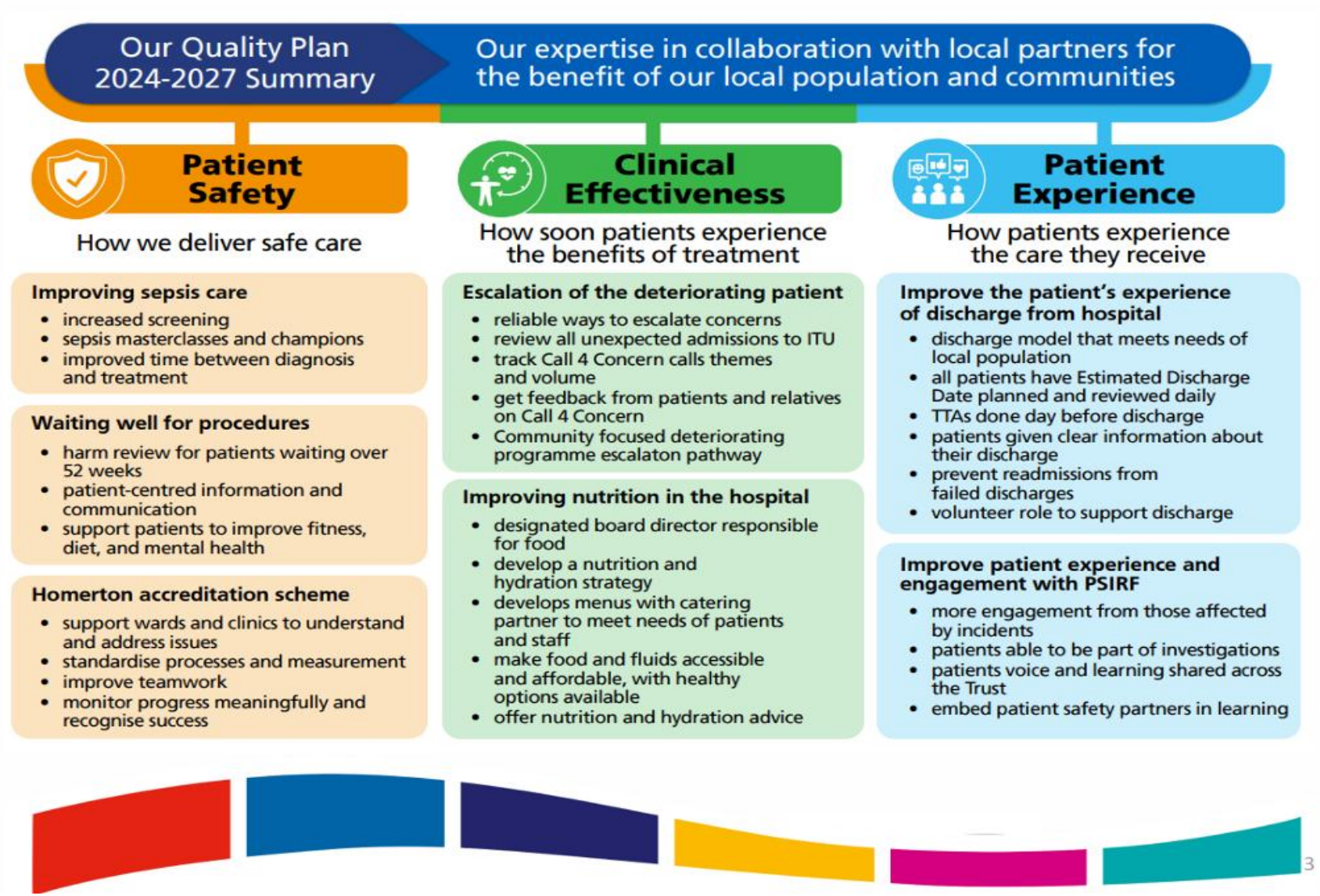
Forward

We strongly believe that the care of those who need us most starts with compassion and care from within. We continue to provide services that are clinically effective, safe, well-led, and responsive to patient needs, ensuring a positive patient experience. I am proud to be a leader in a Trust where staff dedicate themselves to continually improving the quality of care for patients. We have improved against almost every priority we set; we have either done what we set out to do or made meaningful progress towards it. This is all thanks to the commitment, adaptability and professionalism shown by staff across the trust.

Breeda McManus
Chief Nurse

Our relationships with our health and care partners and our communities will be key to maintaining high quality care throughout 2024 - 2027. We are more effective in making a positive difference for the people we serve when we work together and harness our collective knowledge, skills, and experience.

Our Quality Plan based on bringing our expertise to bear in collaboration with local partners, is designed for the benefit of our local population and communities.


Our Quality Plan 2024-2027 Summary
Our expertise in collaboration with local partners for the benefit of our local population and communities
Patient Safety
How we deliver safe care
Improving sepsis care
increased screening
sepsis masterclasses and champions
improved time between diagnosis and treatment
Waiting well for procedures
harm review for patients waiting over 52 weeks
patient-centred information and communication
support patients to improve fitness, diet, and mental health
Homerton accreditation scheme
support wards and clinics to understand and address issues
standardise processes and measurement
improve teamwork
monitor progress meaningfully and recognise success
Clinical Effectiveness
How soon patients experience the benefits of treatment
Escalation of the deteriorating patient
reliable ways to escalate concerns
review all unexpected admissions to ITU
track Call 4 Concern calls themes and volume
get feedback from patients and relatives on Call 4 Concern
Community focused deteriorating programme escalaton pathway
Improving nutrition in the hospital
designated board director responsible for food
develop a nutrition and hydration strategy
develops menus with catering partner to meet needs of patients and staff
make food and fluids accessible and affordable, with healthy options available
offer nutrition and hydration advice
Patient Experience
How patients experience the care they receive
Improve the patient's experience of discharge from hospital
discharge model that meets needs of local population
all patients have Estimated Discharge Date planned and reviewed daily
TTAs done day before discharge
patients given clear information about their discharge
prevent readmissions from failed discharges
volunteer role to support discharge
Improve patient experience and engagement with PSIRF
more engagement from those affected by incidents
patients able to be part of investigations
patients voice and learning shared across the Trust
embed patient safety partners in learning
3

Quality Plan – Patient Safety

Improving sepsis care

Sepsis is recognised as a common cause of serious illness and death. It is estimated that there are 123,000 cases in England each year and 46,000 deaths. Sepsis also has long term impacts on patient morbidity and quality of life. Sepsis is associated with high healthcare costs; the UK Sepsis Trust estimates that improved care could lead to savings to the NHS of £170 million. Timely identification and appropriate antimicrobial therapy has been shown to be effective in reducing transition to septic shock and therefore reducing mortality.

What we aim to achieve

- Improve screening of sepsis in our emergency departments and inpatient settings so that at least 90% patients who meet the relevant criteria are screened.
- Report Sepsis Data to Patient Safety Committee quarterly
- Develop and deliver Sepsis masterclasses
- Develop Sepsis champions on the wards
- Improve the timely commencement of appropriate antimicrobial therapy for patients found to have sepsis so that at least 90% of receive IV antibiotics within 1 hour.

Quality Plan – Patient Safety

Improving Sepsis care

Progress update 2025/26

- **Opportunities to improve**
  - Explore an ED NEWS score update via EPR change board
  - Time of escalation not completely documented
  - Improving the checking of lactate levels (68%) and prescribing oxygen (40%)
  - Administration of antibiotics within 1 hour (40%, audit of 10 patients)
  - Improve triangulation across ED, inpatient, community and neonatal services
  - Reduce unwarranted variation in antibiotic delivery
- **Next steps for 2026/27**
  - Education & training in clinical areas with highest numbers of patients at high risk of severe sepsis – ACU & Lamb
  - Steps to improve checking of lactate – value of checking lactate (theme from ICU work also)
  - Steps to improve time to antibiotics in neonatal services
  - Embed EPR-based alerts/RAG rating for NEWS2 ≥5
  - Expand datasets for neonatal, children's services, maternity and ICU admissions where feasible
  - Continue next cycles of QI projects

Quality Plan – Patient Safety

Improving Sepsis care

Progress update 2025/26

- **Actions completed**
  - ✓ Established regular data collection has begun Utilising CQUIN7 dataset (unplanned ICU admissions) of patients with sepsis to assess performance against NICE Sepsis guideline.
  - ✓ Development of Sepsis training resources, including NEWS2 and SIM training covering the extremely rapid deterioration of meningococcal sepsis patients
  - ✓ Updated Trust policy to reflect NICE sepsis guidelines
  - ✓ Introduced an ED/Acute medicine sepsis working group
  - ✓ Creation/Purchase of sepsis trollies in ED to bring sepsis care to patient's bedside promptly
  - ✓ Quality improvement projects presented at departmental meetings and RCEM annual conference (April 2026)
- **Areas of good practice**
  - ✓ Improved antibiotic compliance for sepsis within 1 hour (28% to 48%)
  - ✓ Blood draw (including lactate and blood cultures for severe risk of death from sepsis) between 90% to 100%,
  - ✓ 89% of patients had a senior clinical review within 1 hour
  - ✓ 100% reviewed by Critical Care Outreach Team (CCOT)
  - ✓ 94% patients had a follow up review (mostly by CCOT and DP SHO)
  - ✓ 100% documented ceiling of care

Quality Plan – Patient Safety

2. Waiting well for procedures

Evidence shows that some simple steps before surgery or treatment to improve fitness, diet and mental health, helps patients make a better and quicker recovery. It also reduces the risk of their treatment being cancelled because of them not being well or fit enough to have the operation.

What we aim to achieve

- Understand the importance of improving the experience of waiting
- Undertake Harm reviews for patients waiting in excess of 52 weeks
- Invest in the development of patient-centred information and communication.
- Offer advice for staying well mentally
- Support people while they wait through healthier eating, stop smoking, finding appropriate exercise and support to help with anxiety and sleep
- Give guidance on current waiting times
- Help prepare patient for the procedure itself

Quality Plan – Patient Safety

Waiting well

Progress update 2025/26

- **Actions completed**
  - ✓ Outpatient Transformation Team implemented Advice & Refer (A&R) – outpatient services more efficient.
  - ✓ Reducing missed outpatient appointments supporting better patient outcomes, reduces waiting times and improved RTT position
  - ✓ Elective Single Point of Access (SPOA) technical guidance released, focussing on SPOA implementation
  - ✓ DrDoctor launched to manage appointments
  - ✓ Opening of New Elective Centre
  - ✓ Patient initiated follow-up (PIFU)

- **Areas of good practice**
  - ✓ Improved missed appointment rate (5118 missed appts Sept 2024 – 3906 March 2026)
  - ✓ Reduction in waiting times following introduction in A&R,
    - ➢ neurology reduced from 19 weeks to 7 weeks (30% reduction)
    - ➢ Rheumatology reduced from 12 weeks to 3 weeks (29% reduction)
  - ✓ PIFU rates (Homerton 7%, nationally 5%) second best in London

8

Our Values: Personal, Respectful, Safe, Responsible, Inclusive

Homerton Healthcare
NHS Foundation Trust

Quality Plan – Patient Safety

Waiting well

Progress update 2025/26

- **Opportunities to improve**
  - ✓ Trust DNA rate remains high – 9.3% (8% target)
  - ✓ Surgical optimisation workstream and delays to surgical lists
  - ✓ Improve diagnostic turn around times (e.g. Histology)

- **Next steps for 2026/27**
  - ➢ Missed Appointment reduction plan for 2026-27
  - ➢ Implement a process where patients on the ward appointments are accordingly rescheduled and are not marked as DNA
  - ➢ Develop best practice referral guidelines for C&H GPs
  - ➢ Develop pre-op diabetes and anaemia pathways
  - ➢ Improve theatre readiness and flow (emergency list starts, CEPOD access)
  - ➢ Harm reviews to be undertaken for 62-day breaches

Quality Plan – Patient Safety

Homerton accreditation scheme

We will embed safe and effective care in every ward and clinic by introducing a Trust wide assessment and accreditation framework.

The Homerton Accreditation, Assessment, and Recognition Programme (HARRP) scheme will support wards, clinics and managers to understand and address issues where they find them and measure the success of their improvements in a standardised way.

What we aim to achieve

We want to make sure that all wards and clinics have the same standards, processes and approaches to caring for our patients. Making sure that all our wards are delivering safe, high quality, compassionate care is central to this work.

By scrutinising ward data closely, the HAARP framework will improve the ward environment by:

- setting standards
- providing meaningful information for ward teams to monitor their progress
- creating constructive conversations to enhance the teamwork around improvement
- recognising and rewarding success

Quality Plan – Patient Safety

Homerton Accreditation scheme

Progress update 2025/26

- **Actions completed**
  - 18 HAARP visits completed during 2025 in Starlight, ITU, NICU, all Adult Community Nursing Neighbourhood Teams and Main Theatres and Recovery and the Emergency Department
  - 7 visits between January and May 2026 in adult inpatients wards, ED Injuries/PUCC, Children's Outpatients and the main Outpatient Department

- **Areas of good practice**
  - All adult inpatient areas showed improvement within their scoring following the second HAARP visits.
  - HAARP visits now feed into the Divisional Governance - Clinical Effectiveness meetings to feed back on local action plans for improvement

Quality Plan – Patient Safety

Homerton Accreditation scheme

Progress update 2025/26

- **Opportunities to improve**
  - ECU developed a newsletter to share learning
  - ECU focus on discharge planning
  - ECU MCA & DoLs project
  - ED Injuries/PUCC expansion of ENP scope of practice – training, competency framework and support
  - ED/Injuries supporting and improving Injuries nurse assessment skills

- **Next steps for 2026/27**
  - CQC style audit questions added to the Tendable app with the long-term plan to combine the HAARP and CQC Peer review programme.
  - Reviewed consistency of scoring provide a strong focus on patient safety and regulatory compliance,
  - The Corporate team will continue to do the initial HAARP visit.
  - The divisions have agreed to complete follow up inspections for areas within their division. This is just being finalised.
  - Plan for new area HAARP visits agreed into 2026/27

Quality Plan – Clinical Effectiveness

Escalation of the deteriorating patient

Continue supporting the work of the deteriorating patient pathway, including the introduction of Martha's rule and the NEWS2 community escalation pathway.

Call 4 Concern is a patient safety service enabling patients and families to call for immediate help and advice when they feel concerned that the health care team has not recognised their own or their loved one's changing condition. Once Martha's rule is fully implemented, patients, families, carers and staff will have round-the-clock access to a rapid review from a separate care team if they are worried about a person's condition

What we aim to achieve

- To develop, test, implement and evaluate reliable methods for patients (or their families/carers) to escalate worries and concerns about acute illness and deterioration when standard care is not meeting their needs.
- Hold focus groups to understand the staff experience of implementing Call 4 Concern
- Measure and case review of all unexpected admission to ITU from inpatients Wards
- Collate themes, volume, appropriateness and outcomes from Call 4 Concern contacts
- Survey patients and relatives feedback understanding the benefits / improvements required
- Develop Community Focused Deteriorating Programme – Escalation Pathway

13

Quality Plan – Clinical Effectiveness

Escalation of the deteriorating patient

Progress update for 2025/26

- **Actions completed**

- Implementation of structured governance arrangements across all services, including Deteriorating Patient Group (DPG) and community-specific oversight groups with regular reporting into DPOG
- Rollout and embedding of NEWS2 training and escalation pathways, including mandatory training for AHPs and nursing staff
- Delivery of simulation-based training programmes across community, ED and neonatal services to improve recognition and response to deterioration
- Establishment of sepsis improvement programmes and QIPs, including ED sepsis pathway, SOPs, and inpatient baseline data collection aligned to NICE guidance
- Implementation of Martha's Rule / Call for Concern, including pilot participation and extension to ED and inpatient settings
- Introduction of data-driven monitoring approaches, including CQUIN07 metrics, audit cycles, SPC charts and Datix thematic reviews
- Deployment of new clinical tools and interventions (e.g. videolaryngoscopy, transcutaneous CO_2 monitoring, sepsis trolleys) to support earlier detection and management

Quality Plan – Clinical Effectiveness

Escalation of the deteriorating patient

Progress update for 2025/26

- **Areas of good practice**
  - Strong compliance with NEWS2 recording and clinical response standards in adult inpatients, with consistently high performance across most domains
  - Demonstrable improvement in sepsis management, particularly increased antibiotic delivery within target timeframes following QIP interventions
  - Established culture of multidisciplinary learning, including simulation, mortality & morbidity reviews, and cross-team case discussions
  - High training compliance in critical areas, including neonatal life support and mandatory deterioration training programmes
  - Proactive incident review and learning systems, with Datix used effectively to identify themes and drive improvement across services
  - Effective cross-system collaboration, including ED–ITU joint learning, NEL improvement networks, and perinatal optimisation pathways
  - Appropriate escalation behaviours, evidenced by high medical emergency call rates alongside low cardiac arrest rates, suggesting early recognition

15

Quality Plan – Clinical Effectiveness

Escalation of the deteriorating patient

Progress update for 2025/26

- **Opportunities to improve**
  - Variation in timely escalation and senior clinical review, particularly out-of-hours and in high-acuity settings
  - Inconsistent achievement of sepsis treatment targets, with antibiotic delivery and IV fluid
  - Workforce and capacity pressures impacting response, including ED overcrowding, neonatal staffing challenges, and CCOT workload/burnout risks
  - Data and metric limitations, particularly in community services and small sample sizes for inpatient sepsis review
  - Equipment and infrastructure gaps, including access to monitoring equipment and impact on blood culture collection or escalation processes
  - Rising Medical Emergency Team (MET) activity, requiring further understanding of drivers, timing and resource implications
  - Variation in culture and team working, including civility concerns and cross-team pressures in some

Quality Plan – Clinical Effectiveness

Escalation of the deteriorating patient

Progress update for 2025/26

- **Next steps for 2026/27**
  - Strengthen data maturity and assurance, including agreed Trust-wide metrics, improved digital solutions, and triangulation with incidents and outcomes
  - Embed and scale sepsis improvement work, with a continued focus on achieving NICE-compliant treatment times and sustaining QIP gains
  - Optimise escalation systems, including NEWS2 digital integration, RAG rating, and enhanced tracking of senior clinical review
  - Further develop Martha's Rule / Call for Concern, ensuring consistent implementation and evaluation of impact across all care settings
  - Target workforce capability and resilience, including sustained training programmes, simulation expansion, and addressing staffing gaps (particularly senior decision-makers)
  - Complete and act on MET call analysis, introducing targeted interventions to improve responsiveness and workload management
  - Expand community pathway maturity, including NEWS2 compliance monitoring, sepsis awareness and access to appropriate equipment
  - Continue innovation and evaluation of new clinical interventions and pathways, ensuring measurable impact on patient outcomes

Quality Plan – Clinical Effectiveness

Improving nutrition in the hospital

Offering patients good nutrition and hydration in hospital has the potential to reduce recovery times, improve patient outcomes and reduce costs to the NHS.

What we aim to achieve

- Designate a board director responsible for food
- Develop a Nutrition and Hydration Strategy
- Work with catering partner ISS to develop menus that meet the diverse needs of our patients and staff providing essential nutrients to maintain health and prevent nutrition-related health problems
- Update trust wide policies and guidelines to make sure evidence-based practice is maintained
- Timely access for specialist advice across all specialist areas
- Make food and fluids accessible and affordable with healthy options available to staff and visitors and provide advice and education on good nutrition and hydration

Quality Plan – Clinical Effectiveness

Improving nutrition in the hospital

Progress update for 2025/26

- Actions completed
  - Establishment of robust governance through the Nutrition Steering Committee, overseeing policy, incidents and MDT engagement across acute and community services
  - Implementation of Food Focus Group (FFG) to strengthen ward-level engagement between catering, dietetics, nursing and SaLT, with introduction of patient feedback mechanisms
  - Delivery of nutrition-related QI initiatives, including nasal bridle project, NG tube audits and development of catch-up feeding protocol to mitigate feed delays
  - Launch of Nutrition and Hydration Study Days to improve staff capability and awareness, with positive feedback and planned ongoing programme
  - Recruitment and embedding of a Nutrition Clinical Nurse Specialist role, supporting enteral feeding management, outpatient clinics and admission avoidance
  - Development and update of key policies and guidelines, including enteral/parenteral nutrition policies, refeeding guideline, and eating disorders SOP
  - Progression of ONS prescribing optimisation programme aligned to NEL guidance and NHSE productivity requirements Implementation action plan, including audit of food charts and development of training and governance processes

Quality Plan – Clinical Effectiveness

Improving nutrition in the hospital

Progress update for 2025/26

- **Areas of good practice**
  - Strong multidisciplinary working across dietetics, nursing, SaLT and catering, particularly through the FFG and training programmes
  - Demonstrable responsiveness to patient feedback, with improvements in menu access and first-choice meal provision following escalation
  - Proactive management of safety risks, including rapid response to field safety notice for nasogastric tubes and inclusion on risk register
  - Improved incident learning and governance, with Datix themes driving training, protocol changes and system improvements (e.g. feeding delays, gastrostomy care)
  - Innovative service developments, including CNS-led outpatient support for feeding tubes and admission avoidance pathways
  - Evidence of improving process measures, including increased menu availability and improved MUST performance compared to prior periods
  - Alignment to national and system priorities, including malnutrition standards, IDDSI compliance and regional prescribing guidance

Quality Plan – Clinical Effectiveness

Improving nutrition in the hospital

Progress update for 2025/26

- **Opportunities to improve**
  - Catering provision and patient experience limitations, including restricted menu choice, lack of pictorial menus and inconsistent availability of snacks and drinks
  - Inconsistent nutrition processes at ward level, particularly food record chart completion, MUST scoring accuracy and documentation reliability
  - Workforce and capacity constraints, impacting audit completion, outpatient dietetic services and delivery of improvements
  - System interface risks with ELFT mental health services, including lack of dietetic provision leading to delayed discharges and avoidable admissions with malnutrition
  - Equipment and pathway issues, including NG tube safety concerns and delays in diagnostics impacting feeding delivery
  - Challenges delivering financial and productivity targets

Quality Plan – Clinical Effectiveness

Improving nutrition in the hospital

Progress update for 2025/26

- **Next steps for 2026/27**
  - Finalise Nutrition and Hydration Strategy
  - Support catering transformation and procurement, including defining nutrition KPIs, improving cultural appropriateness and addressing patient choice and accessibility issues
  - Enhance data maturity and assurance, including improved audit frameworks, consistent metrics and strengthened Datix reporting culture
  - Address workforce gaps, including business cases for dietetic capacity (e.g. gastroenterology, mental health interface) to reduce admissions and delays
  - Advance safety improvements in enteral feeding, including review of NG tube devices, training and protocol standardisation
  - Expand education and training offer, including regular study days and targeted ward-based interventions
  - Strengthen system collaboration, particularly with ELFT and community partners, to improve continuity of nutrition care pathways
  - Continue QI programme delivery, including monitoring impact of interventions (e.g. FFG, CNS role, prescribing optimisation)

Quality Plan – Patient Experience

Improve the patient's experience of discharge from hospital

Hospital discharge is the final stage in an individual's journey through hospital following the completion of their acute medical care, when they leave an acute setting and move to an environment best suited to meet any ongoing health and care needs they may have.

What we aim to achieve

- We will develop and implement a discharge model that best meets the needs of our local population
- Each patient with have an Estimated Discharge Date (EDD) planned and reviewed daily
- Ensure To Take Away (TTA) medicines completed day before discharge
- We will ensure Patients are provided with clear information about their discharge plans
- Agreed process and actions if a patient refuses to be discharged
- Prevent readmissions from failed discharges
- Develop Volunteering role to support hospital discharges

Quality Plan – Patient Experience

Improve the patient's experience of discharge from hospital

Progress update for 2025/26

- Review of discharge planning processes, ranging;
  - from a review of whiteboard processes,
  - discharge management from admission to discharge
- Streamlining of discharge processes as Trust wide flow improvement workstream head by the Medical Director focused on;
  - improving the LOS,
  - reducing stranded patients
  - improving workflows for staff members

Quality Plan – Patient Experience

Improve the patient's experience of discharge from hospital

Progress update for 2025/26

- **Actions completed**

- Established discharge improvement as a Trust quality priority, supported by analysis of incidents and complaints.
- Created a multidisciplinary discharge steering group with oversight of improvement activity and governance arrangements.
- Implemented a structured improvement programme focusing on communication, early discharge planning, and optimisation of medicines and transport processes.
- Developed and introduced patient-facing discharge information materials and ward-level patient experience measures
- Designed and operationalised the Transfer of Care Hub (ToCH) as a central coordination model for discharge pathways.
- Delivered 2025/26 ToCH progress, including:
  - Core team recruitment and operational model establishment
  - Review of discharge processes
  - Strengthened integrated working across system partners
  - Deployment of a real-time dashboard to support oversight of discharge activity

25

Quality Plan – Patient Experience

Improve patient experience and engagement with PSIRF

Progress update for 2025/26

- **Areas of good practice**

- Clear strategic alignment and Board-level prioritisation of discharge experience improvement, supported by triangulated evidence.
- Use of data-driven improvement, including thematic analysis of incidents, complaints, and real-time discharge dashboards.
- Establishment of integrated, system-wide working through the Transfer of Care Hub, linking acute, community, and social care teams.
- Proactive identification and escalation of delays and system blockages impacting patient flow and experience.
- Introduction of patient-centred interventions, including improved communication of discharge plans and expected discharge dates.

Quality Plan – Patient Experience

Improve the patient's experience of discharge from hospital

Progress update for 2025/26

- **Opportunities to improve**
  - Persistent delays in discharge processes (transport, pharmacy, documentation) continuing to impact patient experience.
  - Ongoing communication gaps with patients and families, particularly regarding discharge planning and readiness.
  - Incomplete or inconsistent discharge documentation, affecting continuity of care across interfaces.
  - Interface risks between hospital and community services, including coordination and information transfer.
  - Need to further embed and utilise data insights from dashboards and audits to drive sustained improvement

- **Next steps for 2026/27**
  - Launch and fully implement the Transfer of Care Hub model (planned July/August).
  - Deliver full discharge model implementation, embedding consistent processes across pathways.
  - Strengthen admission avoidance pathways to reduce unnecessary admissions and improve patient flow
  - Expand dashboard functionality and reporting, improving visibility of performance and patient experience metrics.
  - Develop volunteer support models, including potential post-discharge follow-up.
  - Establish a new audit and quality improvement cycle to sustain assurance and continuous improvement.

Quality Plan – Patient Experience

Improve patient experience and engagement with PSIRF

The Patient Safety Incident Response Framework (PSIRF) integrates four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approaches to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning

What we aim to achieve:

- Greater engagement with those affected by an incident, including patients, families and staff.
- Grow our work on the National Patient Safety Strategy and in particular the implementation of the Patient Safety Incident Response Framework (PSIRF)
- Ensure patients are treated with compassion and able to be part of any investigations
- Ensure the patient's voice and learning is shared as part of the wider learning shared across the organisation
- Continue to embed patient safety partners in learning outcomes

28

Quality Plan – Patient Experience

Improve patient experience and engagement with PSIRF

End of year update 2025/26

- **Actions completed**
  - ✓ *Increased patient engagement of patients and families in PSIIs and roundtables*
  - ✓ *Increased staff involvement and Patient Safety Partner review of learning responses*
  - ✓ *Updated our local priorities for learning responses, irrespective of harm*
  - ✓ *Developing approach to consider the impact of health inequalities on the outcomes to patients*
  - ✓ *Developed feedback survey for patients / families involved in PSIIs*
  - ✓ *Strengthened DoC compliance and agreed as Trust KPI.*
  - ✓ *Developed bespoke training and delivered simulation training for human factors, PSIRF and facilitating SWARM huddles*
  - ✓ SharePoint created as a source of DoC information and letter templates to support DOC

- **Areas of good practice**
  - ✓ *Updated Datix data panels for DoC and PSIRF so that data can be collected from July 2026)*
  - ✓ *PSII patient engagement survey feedback*

Quality Plan – Patient Experience

Improve patient experience and engagement with PSIRF

End of year update 2025/26

- **Opportunities to improve**
  - ✓ Increased patient/ family involvement with learning responses
  - ✓ Review and update the DoC process
  - ✓ Consistently filling in Datix fields re patient/ family engagement to monitor progress
  - ✓ Continue developing the process for including patients/ families in roundtables
  - ✓ Further updates planned to Datix DoC fields to go live July 2026
  - ✓ SharePoint live/ sending out DoC letter templates to staff to support DOC
  - ✓ Survey and leaflet for patients/ families involved in learning responses (excluding PSIIs)

- **Audit recommendations**
  - ✓ Datix audit of PSIRF patient/ family engagement questions on panel 19
  - ✓ Datix audit of updated Duty of Candour fields
  - ✓ Review of qualitative feedback survey of patients/ families following an investigation

Quality Assurance and Governance

Quality improvement will be supported through the Homerton's governance framework to maximise assurance, engagement and feedback across all areas.

Progress reports on each of the quality ambitions will provide a communication and escalation pathway between the leads, exec sponsors, divisional teams and summary updates to the Trust Board.

Title	Working Group and Oversight committee
Improving sepsis care	Critical Care Committee Improving Clinical Effectiveness Committee
Waiting well for procedures	Improving Patient Safety Committee.
Homerton accreditation scheme (HAARP)	Improving Patient Experience Committee Trust Quality Committee
Escalation of the deteriorating patient, (including the implementation of Matha's rule)	Deteriorating Patient Oversight Group Improving Clinical Effectiveness Committee
Improving nutrition in the hospital	Nutrition Steering Group Improving Patient Safety Committee
Improve the patient's experience of discharge from hospital	Improving Patient Experience Committee
Improve patient experience and engagement with the Patient Safety Incident Response Framework (PSIRF)	Improving Patient Safety Committee. Improving Patient Experience Committee

5.0 Performance against national indicators

The table below shows the Trust's performance against the National NHS Oversight Framework operational performance targets 2025/26:

Indicator	Target	Performance - Year	Performance - March 2026
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	73% by March 2026	n/a	76.6%
Percentage of patients waiting over 52 weeks for elective treatment	<1% by March 2026	n/a	0.7%
Percentage of patients waiting over 52 weeks for community services	<1% by March 2026	n/a	0.1%
Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral	80%	82.7%	81.9%
Percentage of patients treated for cancer within 62 days of referral	75%	86.1%	85.1%
Percentage of emergency department attendances admitted, transferred or discharged within four hours	78%	81.7%	85.1%
Percentage of emergency department attendances spending over 12 hours in the department (quarter)	0%	0.7%	0.6%

Monitoring quality and performance

Performance against key metrics is monitored and reviewed by the executive directors at senior team meetings including monthly Performance Trust Leadership Team meetings, monthly Divisional Performance review meetings and the monthly Finance and Performance Committee (Board sub-committee). The Trust Board considers detailed performance and quality information each month.

6.0 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 2020/21* and supporting guidance *Detailed requirements for quality reports 2019/20.* No specific guidance was issued for 2025/26
- 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 2025 to March 2026
- papers relating to quality reported to the board over the period April 2025 to March 2026

- feedback from commissioners dated June 2026
- feedback from local Healthwatch organisations dated June 2026
- feedback from overview and scrutiny committee dated June 2026
- the latest national patient survey completed September 2025
- the latest national staff survey published November 2025
- CQC inspection report dated June 2023

➢ 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 England'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

Mary Elford	Basirat Sadiq
Chair of the Board of Directors	Chief Executive
XX July 2026	XX July 2026

Annex

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

1.1 Healthwatch Hackney

1.2 Overview and Scrutiny Committee

1.3 Commissioners Statement

7.0 Appendix

7.1 National audits programme

National programme name	Workstream name	Eligible	Participated	Quality Account Comments
acute PAncreatitis National auDit of pRActice (PANDORA)		✓	✓	Not a Quality Account
Adolescent Mental Health (AMH)	RCEM	✓	✓	2026 - Year 1. (Audit Period 2026-2028)
Care of Older People (COP)	RCEM	✓	✓	2025 – Year 3: Participated 2026 - Year 4 (Audit Period 2023-2026)
Time Critical Medications (TCM)	RCEM	✓	✓	2025 - Year 2: Participated 2026 – Year 3. Audit Period (2023-2027)
Mental Health (Self Harm)	RCEM	✓	✓	2025 - Year 3 (Audit Period 2022-2025). 100% Data Submitted
BAUS Data & Audit Programme	British audit Of the investigatiOn and referral of woMen with rEcurrent uRinary trAct infectioN using recent Guidance (BOOMERANG)	✓	TBC	Participation pending confirmation
BAUS Data & Audit Programme	Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	✓	TBC	Participation pending confirmation
Breast and Cosmetic Implant Registry		✓	✓	Participated - Data submitted for 2025/2026.

				Continuous Data Submission
British Hernia Society Registry		✓	TBC	Participation pending confirmation
Case Mix Programme (CMP)	intensive care national audit & research centre (icnarc)	✓	✓	Participated - Data feedback reported / presented to ICEC every six months Continuous Data Submission to ICEC every six months Continuous Data Submission
Child Health Clinical Outcome Review Programme	NCEPOD Stabilisation of the critically ill child	✓	✓	Data & notes submitted, Clinical and Organisational Questionnaires completed. NCEPOD Report Publication Date December 2026.
Elective Surgery (National PROMs Programme)		✓	✓	Participated - Data feedback reported / presented to ICEC every six months Continuous Data Submission
Exploring the Role, Challenges, and Impact of Non-Medical Prescribers Across the UK: A Cross-Sectional Survey		✓	✓	Not a Quality Account
Improving Quality in Crohn's and Colitis (IQICC) [Note: previously named Inflammatory Bowel Disease (IBD) Audit]		✓	✘	Inflammatory Bowel Disease has become National Inflammatory Bowel Disease Register (NIBDR) under NHSE. Started in January 2026. Unable able to participate due to resourcing and additional cost of IBD interface.

LeDeR - Learning from Lives and Deaths of People with a Learning Disability and Autistic People		✓	✓	Continuous Data Submission.
Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal morbidity confidential enquiry - annual topic based serious maternal morbidity	✓	✓	Continuous Data Submission
	Maternal mortality confidential enquiries	✓	✓	Continuous Data Submission
	Maternal mortality surveillance	✓	✓	Continuous Data Submission
	Perinatal mortality and serious morbidity confidential enquiry	✓	✓	Continuous Data Submission
	Perinatal Mortality Surveillance	✓	✓	Continuous Data Submission
Medical and Surgical Clinical Outcome Review Programme	NCEPOD Acute Limb Ischaemia	✓	✓	Participated as Spoke NCEPOD report published November 2025
	NCEPOD Managing acute illness people with learning disability	✓	✓	100% Data Submitted. Clinical and Organisational Questionnaires completed. Awaiting NCEPOD report.
	NCEPOD Pleural Procedures	✓	✓	
	NCEPOD Rib Fractures	✓	✓	
National Audit of Cardiac Rehabilitation (NACR)		✓	✓	
National Audit of Care at the End of Life (NACEL)		✓	✓	Participated – Data feedback reported / presented to ICEC every six months

National Audit of Dementia		✓	✓	No active data submission was required in 2025. Registered for 2026 Participation. Audit consists of mini-spot audits which have been scheduled.
National Bariatric Surgery Registry (NBSR)		✓	✓	Continuous Data Submission
National Cancer Audit Collaborating Centre (NATCAN)	Breast Cancer, Primary (NAoPri)	✓	✓	NATCAN use nationally mandated flows of data submitted from hospitals to the National Disease Registration Service (NDRS) in NHSE for cancer audits. Continuous Data Submission.
	National Bowel Cancer Audit (NBOCA)	✓	✓	
	National Lung Cancer Audit (NLCA)	✓	✓	
	National Oesophagogastric Cancer Audit (NOGCA)	✓	✓	
	National Prostate Cancer Audit (NPCA)	✓	✓	
	Non-Hodgkin Lymphoma (NNHLA)	✓	✓	
	Ovarian Cancer (NOCA)	✓	✓	
	Pancreatic Cancer (NPaCA)	✓	✓	
National Cardiac Arrest Audit (NCAA)		✓	✓	Continuous Data Submission. Data presented to EMRS Governance and ICEC according to reporting schedule.
National Cardiac Audit Programme (NCAP)	Myocardial Ischaemia National Audit Programme (MINAP)	✓	✓	Participated 100% data Submitted. Continuous Data Submission

	National Heart Failure Audit (NHFA)	✓	✓	Participated 100% data Submitted. Continuous Data Submission
National Child Mortality Database (NCMD)		✓	✓	Continuous Data Submission
National Clinical Audit of Seizures and Epilepsies for Children and Young People		✓	✓	Continuous Data Submission
National clinical audit on virtual skin lesion referral pathways 2025		✓	✓	Not a Quality Account - 100% Data Submitted
National clinical audit on virtual skin lesion referral pathways 2025: Individual Audit		✓	✓	Not a Quality Account - 100% Data Submitted
National Comparative Audit of Blood Transfusion	2025 Major Haemorrhage Audit	✓	✓	100% Data Submitted – Findings published Feb 2026.
	Audit of NICE Quality Standard QS138	✓	✓	100% Data Submitted. Data presented to PSC according to reporting schedule.
National Diabetes Audit (adults)	National Core Diabetes Audit	✓	✓	Continuous Data Submission
	National Diabetes Foot Care Audit (NDFA)	✓	✓	Continuous Data Submission
	National Diabetes Inpatient Safety Audit (NDISA)	✓	✓	Continuous Data Submission
	National Gestational Diabetes Audit [see May 2025 update to 'Supporting information' (Col BJ)].	✓	✓	Continuous Data Submission. Data is routinely collected for maternity services nationally via the Maternity Services Data Set (MSDS)
	National Pregnancy in Diabetes Audit (NPID)	✓	✓	Continuous Data Submission

	NDA Integrated Specialist Survey	✓	✓	Continuous Data Submission
National Early Inflammatory Arthritis Audit (NEIAA)		✓	✓	Continuous Data Submission. Identified as outlier along with other trust on one parameter. NHSE contacted for further information.
National Emergency Laparotomy Audit (NELA)	Laparotomy (Lap)	✓	✓	Participated - Data Continuous Data Submission
	No Laparotomy (NoLap)	✓	✓	Participated - Continuous Data Submission
National Falls & Fragility Fracture Audit Programme	National Audit of Inpatient Falls (NAIF)	✓	✓	Participated - Continuous Data Submission. Data presented to PSC according to reporting schedule.
	National Hip Fracture Database	✓	✓	Participated - Continuous Data Submission. Data presented to ICEC according to reporting schedule.
National Joint Registry		✓	✓	Continuous Data Submission.
National Major Trauma Registry (NMTR) Network [Note: Previously The Trauma Audit & Research Network (TARN)]		✓	✓	Continuous Data Submission. Data presented to ICEC according to reporting schedule.
National Maternity and Perinatal Audit (NMPA)		✓	✓	Continuous Data Submission.
National Neonatal Audit Programme (NNAP)		✓	✓	Continuous Data Submission.
National Obesity Audit		✓	✓	Continuous Data Submission.
National Perinatal Mortality Review Tool (PMRT)		✓	✓	Continuous Data Submission.
National Respiratory Audit Programme (NRAP) (was	Asthma Secondary Care	✓	✓	Continuous Data Submission.

National Asthma and COPD Audit Programme)	Children and Young People Asthma	✓	✓	Participated - Continuous Data Submission.
	COPD Secondary Care	✓	✓	Participated - Data submitted for 2025/2026. Continuous Data Submission.
	Pulmonary Rehabilitation	✓	✓	Continuous Data Submission.
Perioperative Quality Improvement Programme (PQIP)		✓	✗	Did not Participate for 2025/2026 service - standards specified for staffing is beyond the capability the trust's funding capabilities.
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS)	Non-melanoma skin cancers	✓	TBC	Participation pending confirmation
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS)	Oral and Dentoalveolar surgery	✓	TBC	Participation pending confirmation
RAFT-5 SECURE		✓	✓	Not a Quality Account
Sentinel Stroke National Audit Programme (SSNAP)		✓	✓	Participated - Continuous Data Submission.
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme		✓	✓	Continuous Data Submission.
Society for Acute Medicine Benchmarking Audit (SAMBA)		✓	✓	Audit to start in on 18/06/2026
UK National Flap Registry (UKNFR)		✓	✓	Continuous data submission started in June 2025 following start of procedure at trust.
UK Parkinson's Audit		✓	✓	Continuous data submission.

Table 1: national clinical audits 2025/26

7.2 Audits not relevant to the Homerton Healthcare NHS Foundation Trust

National programme name	Workstream name	Quality Account Comments
BAUS Data & Audit Programme	Environmental Lessons Learned and Applied (ELLA) to the Bladder Cancer Care Pathway	N/A - Service not provided at HHFT
BAUS Data & Audit Programme	Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard Care Practices (I-DUNC)	N/A - Service not provided at HHFT
BAUS Data & Audit Programme	Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	N/A - Service not provided at HHFT
BAUS Data & Audit Programme	Nephrostomy Audit	N/A - Service not provided at HHFT
BAUS Data & Audit Programme	Penile Fracture (SNAP) Audit	N/A - Patients are referred to UCLH
British Spine Registry		N/A - Procedure not done at HHFT.
BTS UK Interstitial Lung Disease (ILD) Registry		N/A - Service not provided at HHFT. UCLH is the prescribing service for HUH. Usually done by Tertiary referral services.
Cleft Registry and Audit NEtwork (CRANE) Database		N/A - Cases referred to GOSH
Mental Health Clinical Outcome Review Programme	Real-time data collection of probable suicide deaths by mental health in-patients and patients who died within 14 days of discharge	N/A - Service not provided at HUH
Mental Health Clinical Outcome Review Programme	Suicide (& homicide) by people under mental health care	N/A - Service not provided at HUH

Mental Health Clinical Outcome Review Programme	Suicide by people in contact with drug and alcohol services: a national study 2021 to 2022	N/A - Service not provided at HUH
National Acute Kidney Injury Audit		N/A - Service not provided at HUH. Nephrology patients are referred to RLH.
National Audit of Cardiovascular Disease Prevention in Primary Care	CVD Prevent Workstream 3	N/A – Primary Care Audit
National Audit of Eating Disorders		N/A - Service not provided at HUH
National Audit of Headache Disorders (NAHD)	National Audit of Migraine	N/A - Service not provided at HUH.HUH do not have a specialist headache service nor a neurologist with a primary headache specialisation
National Audit of Pulmonary Hypertension (NAPH)		N/A - Service not provided at HUH
National Cancer Audit Collaborating Centre (NATCAN)	Breast Cancer, Metastatic (NAoMe)	N/A - Service not provided at HUH. HUH Metastatic Patients are treated at Barts Health.
	Kidney Cancer (NKCA)	N/A - Service not provided at HUH. HUH does not have a Nephrology Service.
National Cardiac Audit Programme	Left Atrial Appendage Occlusion (LAAO)	N/A - Procedure not done at HUH.
National Cardiac Audit Programme	National Adult Cardiac Surgery Audit (NACSA)	N/A - Procedure not done at HUH
National Cardiac Audit Programme	National Audit of Cardiac Rhythm Management (NACRM)	N/A - Service not provided at HUH.

National Cardiac Audit Programme	National Audit of Percutaneous Coronary Interventions (NAPCI)	N/A - Service not provided at HUH.
National Cardiac Audit Programme	National Congenital Heart Disease Audit (NCHDA)	N/A - Service not provided at HUH.
National Cardiac Audit Programme	Percutaneous Foramen Ovale Closure (PFOC)	N/A - Procedure not done at HUH
National Cardiac Audit Programme	Transcatheter Aortic Valve Implantation (TAVI)	N/A - Procedure not done at HUH. Patients referred to Barts Health
National Cardiac Audit Programme	Transcatheter Mitral and Tricuspid Valve Procedure (TMTV)	N/A - Procedure not done at HUH. Patients referred to Barts Health
National Clinical Audit of Psychosis		N/A - Service not provided at HUH
National Diabetes Audit (adults)	Diabetes Prevention Programme (DPP) Audit	N/A - Primary Care Audit
National Diabetes Audit (adults)	Transition (Adolescents and Young Adults) and Young Type 2 Audit	N/A - Service not provided at HUH
National Falls & Fragility Fracture Audit Programme	Fracture Liaison Service Database	N/A - HUH not meet criteria for participation.
National Head and Neck Cancer Audit (HANA)		Audit was suspended in due to insufficient funding in 2016. Audit has Not resumed.
National Neurosurgical Audit Programme		N/A - Procedure not done at HUH.
National Ophthalmology Database (NOD) Audit	Age-related Macular Degeneration (AMD) Audit	N/A - Service not provided at HUH.
National Ophthalmology Database (NOD) Audit	Cataract Audit	N/A - Service not provided at HUH.
National Paediatric Diabetes Audit		N/A - Service not provided at HUH. Patients referred to RLH.

National Respiratory Audit Programme (NRAP) (was National Asthma and COPD Audit Programme)	Asthma and COPD Primary Care	N/A – Primary Care Audit for Wales
National Respiratory Support Audit		N/A
National Vascular Registry		N/A
Out of Hospital Cardiac Arrest Outcomes (OHCAO)		N/A
Paediatric Intensive Care Audit Network (PICANet)		N/A - Service not provided at HUH
Prescribing Observatory for Mental Health (POMH)	Improving the quality of valproate prescribing in adult mental health services	N/A – Mental Health service not provided at HUH.
	Opioid medications in inpatient mental health services	
	Rapid Tranquillisation in the context of the pharmacological management of acutely disturbed behaviour	
	The use of clozapine	
	The use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services	
	The use of melatonin	
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS)	Oncology & Reconstruction	N/A - Procedure not done at HUH. Patients referred to UCLH.
	Orthognathic Surgery	N/A - Service not provided at HUH.
	Trauma	N/A - Service not provided at HUH.
UK Cystic Fibrosis Registry	-	N/A - Service not provided at HUH.

UK Renal Registry Chronic Kidney Disease Audit	-	N/A - Service not provided at HUH. Patients referred to RLH

Table 3: clinical audits not applicable to Homerton

7.3 Examples of learning from audits

a. Learning from national audits

National Audit Care of End of Life (NACEL)
GOOD PRACTICE
• Homerton Hospital performs well in most areas, with results comparable to peer and national averages. • Recognition of dying is broadly comparable with peers, with timely documentation and reasonable intervals between recognition and death, suggesting appropriate clinical judgement once deterioration is identified. • Symptom management (pain, agitation/delirium, dyspnoea) is generally strong, with high levels of documented review and implementation of actions, often matching or exceeding peer performance. • Anticipatory prescribing and evidence of active clinical decision-making are well embedded, with most patients receiving appropriate, individualised interventions. • Access to specialist palliative care and escalation processes are in place and comparable to peers, indicating effective coordination when needs exceed ward capability. • Care planning and communication processes (including personalised care plans, advance care planning discussions, and communication about dying) show stable performance year on year and are broadly aligned with national expectations.
OPPORTUNITY TO IMPROVE

• Early recognition remains a challenge, particularly for Category 2 deaths (where death was not initially expected), limiting opportunities for earlier planning and optimal end-of-life care.
  - Reduce the time between recognition of dying and death to align with best practices.
• Holistic assessments (emotional/psychological, spiritual/cultural, and social/practical needs) are frequently completed, but full documentation that needs were addressed lags behind peers, especially for those important to the patient.
  - To Continue monitoring and improving personalized care and support planning to ensure all patients receive tailored care.
• Communication quality shows variability, particularly around hydration discussions and documentation of comprehensive conversations with patients and families.
• Consistency of documentation is a recurring issue: care may be delivered, but evidence in the record does not always fully demonstrate this, affecting audit outcomes.
  - To focus on improving documentation of needs assessments and interventions.
• Bereavement and family support measures show more variable results, highlighting an opportunity to strengthen support for those important to the dying person.

- To Enhance efforts to address emotional, spiritual, and social needs comprehensively.

- Early recognition remains a challenge, particularly for Category 2 deaths (where death was not initially expected), limiting opportunities for earlier planning and optimal end-of-life care.
  - Reduce the time between recognition of dying and death to align with best practices.
- Holistic assessments (emotional/psychological, spiritual/cultural, and social/practical needs) are frequently completed, but full documentation that needs were addressed lags behind peers, especially for those important to the patient.
  - To Continue monitoring and improving personalized care and support planning to ensure all patients receive tailored care.
- Communication quality shows variability, particularly around hydration discussions and documentation of comprehensive conversations with patients and families.
- Consistency of documentation is a recurring issue: care may be delivered, but evidence in the record does not always fully demonstrate this, affecting audit outcomes.
  - To focus on improving documentation of needs assessments and interventions.
- Bereavement and family support measures show more variable results, highlighting an opportunity to strengthen support for those important to the dying person.
  - To Enhance efforts to address emotional, spiritual, and social needs comprehensively.

National Cardiac Arrest Audit (NCAA)

GOOD PRACTICE

- The Trust consistently remains among the lowest NCAA participants for in-hospital cardiac arrests per 1,000 admissions, including periods where it was the lowest of 208 participating hospitals.
- Return of Spontaneous Circulation (ROSC >20 mins) and Survival to Discharge for ward-based arrests are:
  - Favourable compared to national peers (September 2025) and
  - Equivalent to national average (March 2026), indicating sustained performance despite service pressures.
- Case reviews of patients achieving ROSC demonstrate generally good neurological outcomes, providing qualitative assurance beyond headline metrics.

OPPORTUNITY TO IMPROVE

- **Arrest Volume Monitoring** - A slight increase in overall cardiac arrests was noted in March 2026, though figures remain below the Trust's historic mean and within strong comparative NCAA performance.

- **Governance & Data Scope** NCAA inclusion criteria are complex (e.g. ROSC >20 minutes, exclusion of pre-hospital arrests), requiring continued vigilance to ensure accurate and consistent data capture.

ACTIONS COMPLETED

- **Case reviews** of ward-based arrests achieving ROSC introduced to provide assurance regarding neurological outcomes and care quality.
- Close monitoring of trends through ward-only NCAA data, reducing dilution from ED attendances arriving in arrest.

The National Falls & Fragility Fracture Audit Programme (FFFAP) –

National Audit of Inpatient Falls (NAIF)

GOOD PRACTICE

- **Improving compliance with key falls assessments**: Compared with 2024, 2025 NAIF-related data shows improvements across all six components of the comprehensive falls assessment, including notable gains in lying–standing BP (+21%), continence (+22%), vision (+19%), medication review (+14%) and delirium assessment (+12%).
- **Better post-fall care and retrieval**: Live audit data shows 50% of patients with moderate/severe harm are now retrieved using flat lifting equipment, demonstrating improved on-the-floor assessments and injury recognition.
- **Strong governance and learning structures**: Robust processes are in place through the Strategic Falls Group, bi-weekly Falls Review Meetings, AARs, and alignment with PSIRF principles, ensuring NAIF findings are actively reviewed and translated into improvement actions.
- **Alignment with NAIF "Don't Stop Moving" recommendations**: Key recommendations—such as maintaining patient mobility, improving delirium screening, strengthening post-fall checks, and timely analgesia after injurious falls—have clear local action plans and are embedded into training, documentation updates, and QI work.
- **Proactive, trust-wide approach beyond NAIF**: To address limitations of national reporting, the Trust has implemented a **local live audit of all moderate and severe harm falls across all ages** since January 2024, enabling real-time monitoring and targeted improvement.

OPPORTUNITY TO IMPROVE

- **Timeliness and scope of NAIF data**: NAIF reporting is limited by a significant time lag (annual reporting, currently using 2023 clinical data) and historically restricted to patients aged 65+, reducing its usefulness for real-time operational decision-making.
- **Persistent gaps in specific assessment areas**: Despite improvement, **lying–standing BP, delirium (4AT), and vision assessments** remain the weakest components compared with others and below national benchmarks in earlier audit cycles.
- **Reliance on historical benchmarking**: Current national comparisons reflect past performance rather than recent improvements, making it difficult to demonstrate progress externally despite local gains.
- **Resource intensity of data collection**: Comprehensive data capture for frailty, acuity, and contributory factors is not routinely available in Datix, adding workload and limiting routine analysis.
- **Expanding audit requirements**: The NAIF expansion to include all injuries in over-65s increases reporting demands and will require sustained oversight to maintain data quality.

ACTIONS COMPLETED

Strategic Falls Group Priorities for 25/26 which are:

- To review MASA Documentation (inpatients) [Ongoing from 2024/205]
  - Review Falls documentation across Electronic Patient Record (EPR)to streamline
  - Improving compliance with and effectiveness of assessments.
  - Focus on six key MASA Components
- Swarm Huddle implementation
  - Establish a routine use of swarm huddle across the trust to help capture immediate learning from falls incidences
- Falls Policy Update
  - To review and update the trust falls policy including both inpatients and community fallers across children and adults
- Inpatient post falls response
  - Retrieval from the floor remains a concerns across the trust. With appropriate equipment (e.g. hoverjack) still not routinely utilised in the majority of falls. To continue to develop staff confident with utilising appropriate lifting equipment, learn from positive use and it hasn't been utilised, and monitor compliance

National Comparative Audit (NICE QS138) – Blood Transfusion

GOOD PRACTICE

- **Strong performance maintained** in key patient blood management standards, with 100% compliance achieved in:
  - Pre-operative iron supplementation for iron-deficiency anaemia (2024 & 2025).
  - Post-transfusion clinical reassessment and haemoglobin checks (improved from 80% in 2024 to 100% in 2025).
  - Use of restrictive haemoglobin thresholds (newly reported in 2025 at 100%).

OPPORTUNITY TO IMPROVE

- **Decline in compliance noted** in two peri-operative standards between 2024 and 2025:
  - Use of tranexamic acid in moderate blood-loss surgery fell from 70% to 50%.
  - Provision of verbal and written transfusion information to patients also reduced from 70% to 50%.
- **Patient Communication -** Patient information provision showed room for improvement, although above the national benchmark.
- Implement the QS138 Quality Insights Tool for quarterly audits and continuous monitoring.
- To use tranexamic acid in Surgery - Embed tranexamic acid protocols into perioperative electronic checklists/ education around its use.

ACTIONS COMPLETED

- Post-Transfusion Monitoring - Enforce a single-unit transfusion policy with mandatory post-transfusion symptom and Haemoglobin (Hb) reassessment.
- Utilised NHSBT resources and monitor leaflet dissemination.
- Restrictive Hb Thresholds
- On-going - Conduct regular audits of high-threshold transfusions and review outcomes in governance forums.

Table 3a: learning from national national audits

b. Learning from local audits

Audit Title: Falls
Directorate / Service: EMRS / Elderly Care Medicine
OPPORTUNITIES TO IMPROVE (1) Identifying polypharmacy and the use of pharmacists to provide structured medication reviews (2) Communication between multi professional teams – particularly around medication recommendations when managing complex individuals
ACTIONS TAKEN Extensive work has been completed and is ongoing in respect to on the floor assessments with new post falls flowcharts which include the Royal College of Physicians look, feel, move assessment being completed for inpatient, community and MSNH. These are in the final stage of being signed off and will be included in the updated falls policy this year. This has been rolled out during ward development days and has been included as a scenario in the foundation SIM training delivered to FY1 and FY2 doctors.

Audit Title: Proton Pump Inhibitors Prescription After Bariatric Surgery
Directorate / Service: SWNS/ Bariatric Service
GOOD PRACTICE • Our Audit confirmed that we are currently adhering to local guidance regarding PPI prophylaxis after surgery. • All of our patients received PPI as inpatients • All of our patients were prescribed PPI upon discharge with clear instruction • 39/40 reported good adherence with the medications • 2/40 has proven ulcers even though they were on PPI
OPPORTUNITIES TO IMPROVE • We will continue to emphasize on the importance of that to our patients upon discharge and on follow up • We will close the loops after 6 months.

Audit Title	**Prescription of MRI Scans for Patients with Temporomandibular disorder (TMD) Audit**
Directorate / Service: EMRS / Radiology	

GOOD PRACTICE

- Increased Use of Wilkes Classification - Improved collaboration between radiology and clinicians
- Reduction in Offering MRI at First Appointment - Reflects a more cautious, criteria-based approach to imaging and suggests greater alignment with national/local selection guidelines.
- Improvement in MRI Selection Criteria Adherence - Shows progress towards the standard, reducing inappropriate or unnecessary imaging.
- Demonstrates a more holistic, function-oriented approach to patient assessment

OPPORTUNITIES TO IMPROVE

- Improve Adherence to MRI Selection Criteria - Consistent in applying the selection criteria for MRI requests.
- Introduce Mandatory Documentation of Selection Criteria Before MRI Request.
- Expand Use of Functional Assessment Tools.

ACTIONS COMPLETED

- Discussion at local departmental meeting
- Creation of MRI selection criteria
- Expand Use of Functional Assessment Tools

Audit Title	**Review of anti platelet documentation on the stroke ward, with a focus on transfer documentation from RLH**

Directorate / Service: EMRS / Stroke

GOOD PRACTICE

- Patients who are on MDS (Monitored Dosage System) are usually screened by RLH pharmacist before transfer to HUH. Antiplatelets duration and start date are usually appropriately endorsed by the pharmacist. Moreover, by screening the discharge summary, it avoids pharmacists calling their community pharmacy on multiple occasions for drug histories, improving efficiency by avoiding task duplications. Additionally, it reduces potential medication error during transfer in this patient group.
- 100% HUH discharge summaries include pharmacy endorsements (whether medication is newly initiated/ drug history; whether any dose changes; any medications that are intentionally stopped/ held; etc.). This is especially significant in GSU patient as they tend to have prolonged stay, with multiple mediation changes. This helps improving clarity when community team (GP, community pharmacy) reads it.

OPPORTUNITIES TO IMPROVE

- This audit highlights significant variation in the prescribing and documentation of antiplatelet therapy in stroke patients. Although some patients were managed in line with national guidelines, others received suboptimal treatment—particularly with regard to the initiation and documentation of dual antiplatelet therapy.
- Documentation gaps, inconsistent prescribing practices, and interdepartmental communication issues were key contributors to this variation. These findings suggest a pressing need for standardization, enhanced education, and system-level changes to ensure best practice and improve patient safety.
- To address issues discussed above, we recommend:
  - Ensure 100% of RLH transfer summaries include a start/stop date for antiplatelets by August 2025.
  - For RLH to consider implementation of pharmacist verification for discharge summaries within 24 hours of patient transfer to improve efficiency and accuracy in transfer of care, planned completion by end of Dec 2025.
  - Introduce a standardized template for antiplatelet documentation in HUH discharge summaries by end of 2025.

ACTIONS COMPLETED

- Present to Barts Health Stroke Ward to feedback findings
- Lead pharmacist was reminded to emphasize the importance of clear pharmacy documentation in handovers, discharge summaries to the new GSU rotational pharmacist.

Audit Title: Non urgent CT radiographer vetting policy and audit

Directorate / Service: EMRS / Radiology

GOOD PRACTICE

- Radiographer-led vetting ensures a large quantity of GP and outpatient CTs are protocolled in a timely fashion at Homerton Hospital.
- CT studies are appropriately protocolled and authorised by vetting radiographers.

OPPORTUNITIES TO IMPROVE

- Project also identified problematic areas regarding radiographer user ID and documentation on existing RIS software.
- New iterations of authorisation guidelines will need to account for scale and complexity of CT referrals

ACTIONS COMPLETED

- Identified and summarised the more common scan indications and CT body parts, which we hope will be a useful starting point when editing trust policy document v3.0.

Audit Title: Did the Adult allergy service meet our criteria for offering home challenge?

Directorate / Service: EMRS / Allergy Service
GOOD PRACTICE • Only 3% did not meet the criteria for the home challenges • Adult allergy services are selecting patients on the set criteria. • Home challenges help save face-to-face appointments and help to decrease our food challenge waiting list.
OPPORTUNITIES TO IMPROVE • Flagging and documenting patients not meeting criteria and discussion with consultant. • Every patient assessed before discharge (aim for 100%). Can be integrated into home challenge protocol or final checklist. • The flagging and documentation process can be easily incorporated into existing discharge procedures without requiring additional resources or significant extra time. Can be one before patient leaves hospital, so immediate and clear.
ACTIONS COMPLETED • Discussed at MDT Meeting • Continue to follow the criteria for offering home food challenges.

Audit Title: Review Health Assessment Audit - nurse led audit
Directorate / Service: CCS / Health Looked After Children (HLAC)
GOOD PRACTICE • The quality of the initial health assessments for Looked After Children in City of London continue to be completed to a high standard. • The quality of the initial health assessments for Looked After Children in Hackney continue to be completed to a high standard. • (3) Voice of the child was captured in all assessments and children and young people voiced their aspirations.

OPPORTUNITIES TO IMPROVE

- Social worker training around consent processes, social care chronology and provision of forms M, B (<5 years) and PH (all ages, not Unaccompanied asylum seeking children (UASC))
- Social worker and Foster Carer training to include GP registration, vision and dental
- Foster Carer training around attendance at and contribution to Initial Health Assessment (IHA)
- Looked after child admin and Looked after child health to consider systems to ensure appropriate consent is signed ahead of IHA, ways to track that relevant associated referral letters are received, disseminated and uploaded and methods to tighten timeliness of report dissemination.
- All specialist nurses completing RHA's including Bank nurses to access L3 Looked after children specialist training to support their Continuous Professional Development (RCN and RCPCH 2020)
- Include more unaccompanied children (UASC) in the next audit cycle to fully understand the health and emotional needs/appropriate screening for this group of children.
- Ensure care health care plans are SMART (Specific, Measurable, Achievable, Realistic, and Timely, dates could be clearer, not evidenced in 2 of the completed Review Health Assessments reports audited.
- Ensure scores of all completed Strengths and Difficulties Questionnaires (SDQ's) are made available to the provider health team so that the score informs the health assessment ideally one month before the health review is due to support referrals to appropriate services (DfE and DH 2015).
- (9) Explore in more detail relationships and harm outside the home that affect vulnerable children and young people/those with complex needs-child sexual exploitation (CSE), Adverse childhood experiences (ACES), drugs and alcohol, substance misuse and sexual health and signpost as appropriate.

Audit Title: OA knee Class Service Evaluation

Directorate / Service: CCS / Locomotor

GOOD PRACTICE

- Patients find the class beneficial in PREMS and MSK-HQ but more data is needed.
- DNA protocol is now to discharge after 2 DNA.

OPPORTUNITIES TO IMPROVE

- DNA rates and completion were poor. Seems to have improved in the first instance of rolling.
- Underutilised by Band 5s and 6s
- Too many individualised conditions for a generic circuit class.

ACTIONS COMPLETED

- Establish long term benefit of rolling class in MSK-HQ and PREMS
- Recognise if objective of 'self management' aim is being fulfilled – less follow up rates, patients are more confident to manage in PREMs.
- Utilise better across 5s and 6s
- Improve completion rates in summer 2025 compared to 2024

Audit Title: VTE Assessment in Maternity Services
Directorate / Service: SWNS / Maternity
GOOD PRACTICE • Maternity VTE Guideline – Page 4 (Next Review date 2027) • The maternity guideline does state – VTE to be completed at any admission and repeated in every 24-hour interval.
OPPORTUNITIES TO IMPROVE • Improve staff knowledge and confidence in completing accurate and timely VTE assessments • Improve visibility and trend analysis of VTE compliance across maternity services • Enhance clinical decision-making and confidence in VTE assessment through hands-on learning Via Simulation - The simulation should incorporate SBAR communication and VTE risk assessment processes, aligning with our learning theme of translating knowledge into practice.
ACTIONS COMPLETED • Midwifery Mandatory training from April 2025 included Thrombosis and Embolism in pregnancy and puerperium • Metric for VTE assessment in inpatient services added on Maternity dashboard - Maternity Dashboards and standards are from NHS England. Compliance target of 95% set from National VTE Prevention Programme

Audit Title: Life with a Stoma: Patient Confidence, Care Experience, and Quality of Life
Directorate / Service: SWNS / Colorectal
GOOD PRACTICE • High patient confidence in self-management: • Most patients reported strong confidence in key aspects of stoma care, particularly pouch management (88%) and knowing who to contact for support (92%). • Positive care experience: Patients consistently reported being treated with dignity and respect, with clear information and good access to specialist nursing support. • Timely access to services: The majority of patients felt they could access help quickly when needed and that support met their needs. • Effective specialist nursing input: Specialist stoma nurses were frequently highlighted in qualitative responses as a key source of support and a major contributor to patient confidence and adaptation. • Efficient supply processes: Most patients (93%) reported that ordering and receiving stoma supplies was easy or very easy.

OPPORTUNITIES TO IMPROVE

- Support with self-management outside the home: Confidence was lowest in managing the stoma in social or community settings, indicating a need for more practical, real-world self-management support.
- Psychosocial and emotional support: Despite good overall care experience, 78% of patients reported some emotional impact, highlighting the need for more structured psychological and emotional support.
- Awareness of support services: Awareness of local support groups and charities was relatively low, suggesting a gap in signposting and community engagement.
- Ongoing follow-up and continuity of care: Patients identified a need for enhanced long-term follow-up and continued access to support beyond the immediate postoperative period.
- Education and patient understanding: A small number of patients were unsure of their stoma type, indicating potential gaps in patient education.
- Supply and prescription processes: Some patients reported delays related to prescription authorisation and communication between services.

ACTIONS COMPLETED

- Enhanced patient education: Reinforced education during clinic contacts, with a focus on practical self-management in real-life settings (e.g. travel, social situations).
- Improved signposting to support services: Increased promotion of local support groups, charities, and available community resources.
- Focus on holistic care: Greater emphasis on emotional wellbeing during consultations, with consideration of onward referral where appropriate.
- Review of follow-up pathways: Ongoing work to strengthen structured follow-up and ensure patients feel supported long-term.
- Liaison with primary care and suppliers: Addressing reported issues in prescription and delivery processes through improved communication with GP practices and supply services.

Audit Title: Homerton Hospital Same Day Emergency Care (SDEC) Case Mix Audit

Directorate / Service:

GOOD PRACTICE

- The majority of patients seen were new (93%) compared to follow-ups (7%) however 9 patients (31%) were given a follow up appointment following this attendance.

OPPORTUNITIES TO IMPROVE

- Extending opening hours over weekends in line with the National standard of 12 hours a day, 7 days a week will allow a larger number of patients to be seen in SDEC on the same day and avoid a number of
- follow-up appointments.
- Consider introducing ringfenced and bookable slots for diagnostics that aren't time specific and can be used throughout the day, in particular Doppler ultrasounds, to prevent patients from having to attend follow-up appointments for diagnostics alone. The trust reported that access to these scans is difficult in the afternoon.
- Opportunities for more work to be done with primary care to encourage GPs to call SDEC directly to refer patients. Where this hasn't been done and the patient has been sent to ED with a 'Dear Doctor' letter, the trust should send the appropriate patients direct to SDEC.
- Consider reviewing specialist clinic activity within the unit so that slots are reserved for true SDEC patients, in particular Cardiology, to ensure patients with a need for specialist input can be seen on the same day.
- Opportunities for more work to be done with services in the community where appropriate for administering IV antibiotics to prevent patients from having to attend follow-up appointments for this alone.
- Recommendation that the SDEC aims to take higher acuity patients and place a greater focus on admission avoidance. Only 1 patient (3%) on this day was admitted to an inpatient ward from SDEC. The
- region's recommendation is to aim for an admission rate of 10-15%.
- Consider introducing the trusted assessor model with LAS so that ambulances are able to convey directly to SDEC

Table 3a: learning from local audits

8.0 Acronyms and abbreviations

Acronym	Full Term	Description (Plain English)	Context in Report
A&E	Accident and Emergency	Hospital department for urgent care	Patient flow
CESDI	Confidential Enquiry into Stillbirths and Deaths in Infancy	Mortality review methodology	Mortality reviews
CQC	Care Quality Commission	Regulator of health and social care	External oversight
CQUIN	Commissioning for Quality and Innovation	Quality-linked funding framework	Commissioning
DQMI	Data Quality Maturity Index	Measure of data completeness/quality	Data quality monitoring

DSPT	Data Security and Protection Toolkit	Framework for data security compliance	Information governance
EPR	Electronic Patient Record	Digital clinical record system	Clinical systems
ICEC	Improving Clinical Effectiveness Committee	Trust governance committee for clinical effectiveness	Governance
LFPSE	Learn from Patient Safety Events	National incident reporting system	Patient safety
LTFT	Less Than Full Time	Flexible workforce working pattern	Workforce
MDT	Multidisciplinary Team	Group of professionals delivering care	Care delivery
PROMs	Patient Reported Outcome Measures	Patient-reported outcomes on care	Outcomes
PSIRF	Patient Safety Incident Response Framework	Framework for incident investigation	Patient safety
SDEC	Same Day Emergency Care	Same-day urgent care model	Patient flow
SHMI	Summary Hospital-level Mortality Indicator	Measure comparing deaths vs expected	Mortality
SUS	Secondary Uses Service	National healthcare data submission system	Data reporting
VTE	Venous Thromboembolism	Condition involving blood clots	Safety indicator

Table 4: acronyms and abbreviations