Royal Free London NHS
NHS Foundation Trust

Update from the Quality Account 2016/17

This report presents an update to Barnet Health Overview and Scrutiny Committee (HOSC) on areas outlined in the quality account 2016/17. The report is divided into two sections:

- Part one: feedback on the points raised by Barnet HOSC (May 2016)
- Part two: update on progress to meet the quality account priorities identified in 2016/17

Part One: Feedback from points raised by Barnet HOSC

In 2016/17, the Barnet Health Overview and Scrutiny Committee (HOSC) reviewed the draft quality account 2016-17 and following comments were recorded. A response from RFL is as follows:

Comment from Barnet HOSC	Response from Royal Free London
The Committee was pleased that the Trust had been rated 'Good' in most areas by the CQC	Thank you for this comment.
The Committee complimented the Trust on their continuing progress on its Dementia Strategy in particular the introduction of a Passport for Carers	Thank you for this comment. Dementia care remains a priority for the trust and several initiatives have been undertaken to support this. As a result of our participation in the national audit of dementia, the audit lead and the dementia nurse have been invited to attend the National Audit of Dementia Event which takes place in London in Dec 2017. This has created the opportunity for staff to discuss the role of the dementia champions and the support they provide at Barnet Hospital. (Further initiatives are outlined on page 7)
The Committee congratulated the Trust on the list of its key achievements over the year.	Thank you for this comment.
The Committee noted the Trust's participation in national clinical audits which it found most informative. Whilst this is prestigious, it is recognised that there is considerable additional work for practitioners. However, the Committee was pleased that the results of the audit are being used to improve local practice	The trust also recognises that participation in national audits is additional work for practitioners and clinicians and their teams are thanked for their hard work, commitment and dedication. Additionally, through our Clinical Pathway Groups (CPGs), the results from national clinical audits are integrated to support the reduction of unwarranted variation in clinical care. (Further information on our CPGs are outlined on page 8)
The Committee acknowledged the efforts made by the Trust to make the data clearer in this year's	Thank you for this comment.

report and found the statistics suggested that the Trust was doing well when its performance is compared with the national average	
The Committee commented that lower levels of diabetes were reported at Chase Farm than expected and queried the reasons behind this. The Trust said there had been an improvement in in-patient foot surveillance, in addition to projects on improved interventions in order to alert staff to dangerous changes in glucose levels. The Trust explained that at any one time up to 20% of patients at the Royal Free can be diabetic and it is a great challenge for the diabetic team to manage all of these.	Through various clinical initiatives, there remains a continued focus on diabetes care across the trust. On particular, the patient safety work stream includes two areas of focus on diabetes. 1. To reduce serious incidents related to uncontrolled glycaemic episodes, hyper and hypo, across all pilots. 2. To increase the percentage of patients who have appropriate blood sugar time to control to 95% on the pilot wards.
The Trust explained they were looking into an alerting system for pre-diabetics and this would be the focus for the next few years. The Committee requested that the Trust bring an update on this back to a future meeting.	The trust has chosen to focus on an app (stream device) for renal patients before other potential uses. The AKI app is discussed on page 9 and 10 of this report.

The Committee noted that the number of reported incidents at the Trust had risen since last year. The Trust explained this was viewed as a positive sign that members of staff were reporting more incidents and the number of serious incidents resulting in harm had actually gone down.	The trust continues to monitor the number of reported incidents and this is reported to our Clinical Performance and Patient Safety Committee. Full details on our performance will be reported in the quality account 2017/18
The Committee queried the accuracy of the figures on Sepsis. The Committee suggested these figures be investigated before the final version of the report is published. The Committee also queried whether a Sepsis intervention programme was currently in place in order to educate all staff about the signs and seriousness of Sepsis. The Committee were assured that all staff were trained to look for signs of Sepsis, especially at the triage stage of care	The final data on sepsis was reviewed prior to the final publication and changes were made accordingly. Our current performance on sepsis is outlined on page 14.
The Committee noted that the c.diff key performance indicator on page 85 of the Royal Free report did not make sense, as it appeared that the Trust was performing better than the highest national performing trust. The Committee suggested these figures were also checked. The Chairman commented that she found last year's table easier to understand. The Committee commented that the c.diff figure	The final data on c.diff was also reviewed and changes made in the overall presentation.

was not clear, making it difficult to understand if the Trust was doing well when compared with its own previous year's figures as well as other hospitals. The Committee asked that the table be made clearer and the figures checked.	It is anticipated that the data would be presented more clearly in the 2017/18 quality account.
The Committee felt that being ranked 23rd out of 25 hospitals for c.diff indicated this was an issue the Trust should look into further. The Trust explained that c.diff is measured in a number of ways and cannot be avoided in all cases, however the aim was to get the number as close to zero as possible. The Trust stated that they needed to do some work comparing its numbers of c.diff cases with other hospitals with similar complex cases.	The trust continues to prioritise work around managing infection control which includes c.diff. Our performance is reported at various forums across the trust which includes the Clinical Governance and Patient Safety Committee (CPPSC) which is attended by our Director for Infection Prevention and Control (DIPC) and chaired by the medical director at Barnet Hospital. Further information will be presented in our quality account (2017/18).
The Committee acknowledged that A&E had experienced a challenging winter which had been affected by social care provision issues, not necessarily caused by the five NCL Boroughs but often by Hertfordshire, which had led to difficulties with discharging patients. The Committee asked whether there appeared to be a trend whereby patients preferred to seek treatment from A&E rather than via other methods of accessing urgent care. The Trust said it was not able to comment on what was causing the trend but there had definitely been an increase in the number of patients attending A&E. The Trust suggested it could be due to the increasing and changing demographics in the population. The Trust explained it was working closely with colleagues in Primary Care and the CCG, as well as local councils, to try to co-ordinate responses across the system in order to ensure patients do not have to wait more than four hours when possible. The Trust also stated work was needed to encourage patients to go to the most appropriate place for care, but did not anticipate this being an easy issue to resolve.	Thank you for this comment.
The Committee questioned the number of 'Never Events' and how these were being managed to prevent reoccurrence. The Trust explained these were mainly incidents in surgery and one was currently under review to establish whether it met the criteria to be classified as a never event. The Committee did however acknowledge there had been a big reduction in these events over the year and encouraged the Trust to ensure these numbers	Details on our surgical safety program are presented on page 10 of this report.

remained as low as possible. The Committee were pleased to hear a surgical safety programme would be continuing and patient safety meetings were due to be held throughout the year.	
The Committee commented that no section had been included in regard to any compliments or complaints. The Committee suggested that a number of these are included in the final report.	Detailed information on our complaints and compliments was presented in our annual report 2016/17. Therefore to avoid duplication it was not repeated in the quality account. It is anticipated that the 2017/18 quality account may include a brief overview on compliments/complaints.
The Committee wished to put on record again their concern regarding the insufficient amount of parking at Barnet Hospital for both patients, visitors and staff. The Committee had mentioned this issue at last year's Quality Account meeting and were disappointed that the Trust had done nothing to improve matters since then. The Committee also expressed its concern that a quarter of the visitor/patient car park had been re-designated as staff parking and that a portacabin was also taking up 18 patient/visitor spaces	A separate report has been sent to Barnet HOSC covering the issue of parking.
The Committee asked specifically about whether the hospital had received complaints in regard to the lack of parking. The Committee explained that at previous Health Overview and Scrutiny meetings suggestions had been made to extend the current car park on the east side of the hospital. The Trust said it would have to look into this. The Committee also suggested the Trust look into the possibility of installing a camera at the exit of the car park which would inform the driver whether they had paid for their parking or not. This would give the person the opportunity to return to the car park and pay for their parking rather than being fined	A separate report has been sent to Barnet HOSC covering the issue of parking.

The Committee asked about whether there was a strategy for parking at the Royal Free Hospital, whilst acknowledging that the site was very restricted for space.	A separate report has been sent to Barnet HOSC covering the issue of parking.

The Trust told the Committee that no viruses had infected the Royal Free computer system. Over the weekend, the Trust had closed down some of its systems that were not key as a precaution, but these were now all back up and running and in-patient services had remained unaffected. The Royal Free said that had also provided support to other Trusts that had been affected. The Trust explained that they constantly reviewed and enforced cyber protection with a number of different anti-virus and encryption tools which were updated regularly. The Trust also ensured that staff were educated on the issue and sent out regular communications on the importance of cyber safety and security. The Trust also explained that it had contingency plans in place in the event of an attack.	No further comment on relation to cyber safety and security.

Part Two: Update of quality account priorities- 2016/17

Following consultation with key stakeholders in January and February 2017, the quality account priorities were agreed. The chosen priorities remain within the three domains of quality; namely patient experience, clinical effectiveness and patient safety and continue to have a designated lead and associated committee where progress is monitored and assurance provided.

Quality domain	Designated trust lead	Associated committees (Group level)
Patient experience	Deputy director for patient experience	Clinical Standards and Innovation Committee (CSI)
Clinical effectiveness/quality improvement	Clinical Pathway Group Director and Director of quality	Quality Improvement and Leadership Committee
Patient safety	Deputy director for patient safety	Clinical Standards and Innovation Committee (CSI)

During the reporting period, the trust has made progress in achieving the quality account priorities. The following information outlines our progress to date and the overall status is defined as 'progress on track' or 'change in methodology'.

Key:

⬆	Progress on track
⬆	Change in methodology

Priority 1: Improving patient experience: delivering world class experience

The patient experience priorities were chosen as they are linked to specific strands of ongoing work which are a part of the patient experience strategy (2015-19). The strategy outlined the trust's vision of being strong leaders of positive patient experience so we can effectively serve our communities.

Our quality priorities for 2017/18 are:

Priorities for 2017/18	Progress	Status
To achieve trust certification for the 'Information Standard' by 2018.	• Following creation of the patient information policy 2016, we now have over 100 patient information resources approved in line with the policy. We also have over 250 leaflets which have been submitted for review and are at various stages of the processes outlined in the policy. • Work is in progress with the radiotherapy, imaging and ophthalmology departments to embed the practice of evidence based information production, a key requirement of The Information Standard. • We are in the process of updating our patient information policy based on feedback from staff and to incorporate changes and new requirements of The Information Standard in readiness for an application in late 2017/early 2018 – this date is pending executive committee approval.	
To improve how patients, carers and families can provide feedback to the trust. Each service must have at least three ways of allowing feedback about a person's experience.	The trust has identified three ways of gaining feedback from our patients regarding their experience. These include: • **The National Department of Health funded approaches -** The uptake of patients using NHS Choices has increased and is regularly used as an engagement tool. • **Social Media** - the trust frequently uses Twitter and Facebook as ways of allowing patients to feed back on their experience of care. • **Patient Advice Liaison Service (PALS) –** the trust is seeking to move from a static PALS approach to one of flexibility around patients and increased response times for email and phone queries.	
To systematically analyse the experience of bereaved families and friends.	The trust chose to explore how the experience of bereaved families and friends could be improved. A bereavement survey is given to all persons who collect a Medical Certificate Cause of Death from the hospital. It is recognised that there may not be an easy time to ask for feedback as the return rates on the survey have been low. Therefore a web based survey is being launched which may be easier for providing feedback.	
To further enhance and support dementia care	During 2016/17, the trust has continued to focus on improving the experience for our patients with dementia and their carers.	

initiatives across the trust through the delivery of the dementia strategy by 2018.	Through the dementia strategy (2017-2019) several key initiatives have been identified and steady progress has been made. This has been monitored through the Dementia Implementation Group (DIG) These include: • **Flexible visiting times for carers in line with the principle of John's Campaign**. In 2016/17 71% of our in-patients wards were compliant. To date, all our in-patients wards (100%) are now compliant with John's Campaign. • **Improving the environment**- Dementia-friendly refurbishment of 10N (in-patient ward) commenced in September 2017. • **Joint working-** The DIG is partnering with associated Clinical Practice Group (CPG) to produce a world class dementia care pathway across organisation (currently in process-mapping phase)	
To recruit 30 Patient and Family Experience Partners	The trust has defined a 'partner' to be a person who: • Wants to help enhance the quality of our hospitals care for all patients and family members. • Gives advice to the hospital based on his or her own experience as a patent or family member • Partners with hospital staff on how to improve the patient and family experience through short and/or long-term projects and volunteers his or her time. Recruitment is underway and Camden Clinical Commissioning Group (CCG) who have advertised the role through their patient communications. Posters have been produced and wider recruitment will commence.	

The trust has a process in place where progress to achieve the set priorities are discussed at our three hospital units committees. Additionally, overall performance and assurance continues to be monitored at our:

- Group executive committee
- Clinical innovations and standards committee
- Quality improvement and leadership committee
- Clinical performance and patient safety committee

Priority 2: Improving Clinical Effectiveness: achieving excellent outcomes

The clinical effectiveness priorities were chosen because they directly align with trust wide plans to focus on the reduction of unwarranted clinical variation, which will strengthen and support the delivery of significant improvements in the quality of patient care.

In July/August 2017, the trust commenced the deployment of a trust-wide methodology to manage unwarranted variation in clinical care, through the creation of Clinical Practice Groups

(CPGs). They led by senior clinicians and are fully embedded into day to day operations and the aim is to develop standardised guidelines for key clinical pathways.

In addition, to support this approach, the trust is implementing a unified approach to Quality Improvement (QI) which will equip and empower local teams to address opportunities to improve the quality of care they deliver both within and outside the scope of CPGs.

Our quality priorities for 2017/18 are:

Priorities for 2017/18	Progress	Status
To have at least 20 key clinical pathways identified with standardised guidelines developed	The trust has made progress in developing the 20 clinical pathways. The CPGs will be further developed through a series of workshops over the next nine months. Topics included in the workshops are: • Governance • global digital excellence • pathway design and planning	
To have at least 50 QI projects in place. (The projects are required to have core features which includes a clear aim, change logic, ongoing PDSA and measurement linked to learning).	Work is underway to develop a Quality Improvement (QI) initiative tracker tool to provide real-time intelligence on status of QI projects across the trust. Additionally, the trust continues to work in partnership with the Institute for Health improvement (IHI) as QI partner: 29 teams, each with a QI project as central to their work and the Improvement practitioner training commenced at the end of September 2017.	

The trust has a process in place where progress to achieve the set priorities are discussed at our three hospital units committees.

Additionally, overall performance and assurance will be monitored at:

- Group executive committee
- Clinical innovations and standards committee
- Quality improvement and leadership committee

Priority 3: Improving patient safety: listening, learning, acting.

Our quality priorities for 2017/18 are:

Falls

- To decrease by 25% the rate of falls incidents per 1000 occupied bed days**.**
- To reduce by 20% the proportion of patients that experience moderate harm or above

Milestones for 2017/18

1. We will evaluate phase 1 of 24/7 Falls Free Care.
2. We will initiate phase 2 of the programme by recruiting 6-7 wards.
3. Implementation and spread of new falls prevention plan and bedrail assessment tool across the trust.
4. Harmonise bedrail policy

Progress to date (August 2017)	Status
During 2016/17, ten wards participated in phase 1 including: Adelaide, Edgware Neuro Rehab Centre, Beech, MSSU, Juniper, 7East A, 7West, 8West, 8East and 10East. Subsequently, Adelaide ward withdrew due to organisational changes and 8East withdrew due to leadership changes. We identified 11 falls with harm in 2015/16 in the pilot wards; in comparison 4 falls resulting in harm in 2016/17; giving a reduction of 63%. During the evaluation phase we identified the successful ingredients for the programme as: • MDT buy-in, especially from the clinical leads • MDT Falls Champions • Allocated time (an hour per week) • Regular feedback of ward data, with display and discussion of data • Looking at local trends and themes, and having a patient story within team meetings During the learning sessions of phase 1 (2016/17) frontline multi-disciplinary staff completed the safety culture survey and over time results of the first three surveys showed that: • Staff feel more involved in safety briefings where falls are discussed • Staff receive a detailed handover of falls risk for patients in their care. • As a team, they discuss learning from falls incidents This learning has now been incorporated in phase 2 of the programme and has included sharing and learning the falls related incident data with divisional teams. Following this, nine new wards will be participating in phase 2: Barnet ED, Canterbury, Damson, 5East B, 7East B, 10South, 10 North, 12South, 12West. These clinical areas have committed to using a 'buddying system' to join two to three wards together with a view to increase collaborative working, and to make it easier to disseminate and share learning among neighboring wards or same divisions.	

Acute kidney injury (AKI)

- To increase by 25% the survival for in-patients.
- To increase by 25% the proportion of patients who recover renal function.
- To reduce by 25% the length of in-patient stay.
- To measure and improve patient experience and wellness scores.

Milestones for 2017/18

1. Through testing of new AKI app at RF site, we will develop an implementation plan for trust.
2. Through PDSAs cycles, we will co-designing AKI proforma to support the local clinical teams to deliver interventions specific to AKI pathology.
3. Identify high prevalence areas and co-design educational package to increase recognition and treatment of AKI.
4. Develop methods for patient involvement into the programme:
    a) To develop and test patients experience survey.
    b) To develop and test AKI patient information leaflet.

Progress to date (August 2017)	Status
Significant further development of the AKI app (stream device) has evolved from incorporating user feedback and troubleshooting technical issues. In this quarter, there has been 2nd update on the streams device following discussions with the RFH renal consultants. Monthly improvement meetings with Google Deepmind Health continue so that technical issues, user issues, clinical responses, alert patterns, workload, patient and local ward team feedback on the device can be raised and addressed. **AKI Clinical proforma:** Additionally in this quarter, further changes to the AKI proforma were made based on the learning from our continual PDSAs cycles. We are currently on version 9 of the AKI proforma which is a printed in sticker form as an aid to provide written handover to the local clinical team. Along with the AKI proforma, we have tested and implemented the new AKI treatment sticker that is placed in the nurses notes (version 4) to help support therapy following an acute AKI renal intervention. An AKI training pack and posters has been developed and delivered to all multi-disciplinary teams on the four wards: 8North, 8West, 8East and 7West on our Royal Free hospital site.	↑

Safer Surgery

- To improve compliance to 95% with each of the five steps to safer surgery
- To reduce by at least 50% the number of surgical never events from 9 to 4

Milestones for 2017/18

1. Spread and Implementation of tested methods to deliver robust processes of care at steps 1 & 5 (brief & debrief)
2. by scaling up our plan-do-study-act (PDSA) cycles, we will develop locally driven methods to robustly embed the quality of step 4(counting swabs, needles and instruments)
3. We will help co-ordinate the development of theatre team human factors skills and knowledge. This will include a framework for theatre etiquette and WCC behaviours.

Progress to date (August 2017)	Status
In quarter 1 a total of 10 theatres have tested the running debrief tool; accumulatively now this has been used >1880 times, currently tested on version 17. Data captured through the running debrief include: - Brief (step1) achieves all team 'buy in' on average 91% of the time - Debrief (step 5) achieves all team 'buy in' on average 47% of the time. Due to the re-design of the debrief data collection tool, measurement of 'buy in' has been less robust.	↑

The running debrief PDSA output includes locally designed 'escalation ladders'; which have enabled theatre teams to feel better empowered to recognise and action a variety of issues in more timely manner; with clarity on who to ask for assistance depending on the issue. The RFH maternity team have continued to test and re-designed a transfer sticker used for invasive procedures and transfer of mothers on labour ward. Data have been captured to scope the scale and opportunities within labour ward that mums may require when transferred and at risk of retained objects (e.g. massive haemorrhage or post-partum haemorrhage) incidents. These occur on average 15 times per month; although the use of invasive objects is very rare (only 1-2 times per month). In April 2017, the team undertook a snap shot retrospective look back on cases that required transfer to theatre within the maternity setting and required a procedure. 21 cases were reviewed and the team found accurate documentation 91% of the time. Current observational data of procedural 1st, mid and final count is captured from a random sample of 10 procedures from each site and was found to be achieved in RFH Theatres 75%; RFH Maternity 92%; BH 99%; and CFH 100% of the time. In Q1 scoping with the workforce team has begun to build a 'Theatre Etiquette Framework'. This framework will describe agreed World Class Care behaviours for the crucial points of the surgical checklist as recommended by NHSE National Standard for Invasive procedures (NatSSIP).	

Deteriorating patient

- To reduce the number of cardiac arrests from 1.17 at Barnet Hospital (Apr15-Mar16) and 2.4 at Royal Free Hospital (Apr14-Dec14), to less than 1 per 1,000 admissions (as measured for ICNARC) at both Barnet and Royal Free Hospitals by 31 March 2018

Milestones for 2017/18

1. We will use one primary pilot ward to test continual PDSA cycles to improve processes & mechanisms to enhance timely communication within and between teams through the use of SBAR handover tools & enhanced ward rounds, board rounds and safety huddles
2. We will use ward-based metrics such as cardiac arrest rates, PARRT referral and numbers of Multidisciplinary team meetings triggered to track progress
3. We will develop the 'champion' role further in this pilot area to enable long term sustainability
4. Implementation and spread of tested communication mechanisms and processes to other areas in the organisation

Progress to date (August 2017)	**Status**
Collaborative weekly meetings with 10W team and PARRT continue to iteratively learn from PDSA cycles of the co-designing the new 'white board' communications board. These board round tool triggers the discussion of "bigger complex decisions" for complex patients. The PARRT team have been working closely with the cardiology team to review current processes, patterns in data and re-establish a common purpose for the MDT board rounds. Thematic analysis of cases presented at Palliative Care/PARRT team co-lead MDT have been shared for learning with clinical teams and departmental audit days. These themes have influenced the development of a bundle of interventions to support this work: **'SURe Bundle'** *Supporting Uncertain Recovery for everyone (staff, Patients and families/friends)* • A regular place for MDT to talk	

○ including other teams about patients they are looking after – e.g. weekly MDT or similar • Communication/human factors education ○ Non-technical skills training • Patient/family/staff information ○ Pre-emptive expectation management - written & verbal • Decision making support framework ○ Planning implementation of *'Deciding Right' App* • Creation of 'Difficult conversations Support' faculty ○ clinicians made available to support clinicians with difficult EoL conversations with patients and their families • Local testing of implementation of 'Respect' document ○ Support the documentation of treatment escalation plans for establishing appropriate and safe ceilings of care Due to the complex nature of implementation of the different elements of this bundle of interventions, they have been tackled separately. The weekly 10W Palliative Care/PARRT MDT thematic analysis triggered the initiation of a case note review of all patients who have had more than two cardiac arrests on 10W/CCU over the past 12 months to explore themes to draw into this improvement work. The PARRT team have developed a Non-technical skills training day. The first official session will be delivered in Q2. An evaluation will be shared on completion for the purpose of iterative improvement of content design and delivery. The *Deciding Right'* App is being tested on a small scale with the 10W/CCU MDT meetings to understand if this is appropriate for scaled implementation within the Trust to support complex clinical decision making.	

Deteriorating unborn baby

- To reduce by 50%, the number of claims relating to deterioration of the unborn baby from a mean of 2 per year to a mean of 1 per year.

Initiate planning phase following thematic analysis of (1) Unexpected admission of term babies to Neonatal unit and (2) Unexpected intrauterine death: Reducing smoking in pregnancy- The milestones include:

Milestones for 2017/18

1. Scope current processes around Elective caesarean sections performed before 39 weeks gestation and identify areas that could be improved to reduce preventable C Sections
2. Improve team communications of potential expected admission to NICU – through adopting PDSA cycles to implement team huddles, SBAR handovers
3. Undertake staff confidence survey associated with CTG interpretation; using this information to Co-design teaching and skills package to improve CTG confidence in staff
4. Using PDSA cycles we will plan methods of standardising the administration of Oxytocin infusion

Progress to date (August 2017)	Status
The Maternity team are participating in the NHS Improvement collaborative, which aligns well with Patient Safety deteriorating unborn baby improvement work, and the Clinical Pathway Group (CPG) discussions. The work will also involve adopting a validated Safety Culture data tool to collect data across the 120 participating organisations Peer review from consultants occurs across both sites has been harmonised and an agreement	

that elective caesarean sections will be booked after 39 weeks unless clinical indication for them to be undertaken earlier. Elective caesarean section rates are monitored as part of monthly dashboard at both divisional and directorate board.

Using the results from the thematic analysis of unexpected admission of term babies to Neonatal Intensive Care Unit (NICU), the clinical pathway group team have started mapping and designing reliable pathways of care for the 'normal expected' birth, this will help identify unwarranted variation in the system. In Q1 the team have started to capture baseline data on trust-wide rate of unexpected NICU admissions per 100 births. We plan to use this baseline data along with some external benchmarking to ascertain a 'SMART' aim for reducing unexpected admissions.

To introduce remote integrated team working; planning and rapid 'Plan-do-study-act' testing cycles have been undertaken within maternity & neonatal services to:

- Enhance team communications;
- Optimise a culture of collaboration cross site and cross speciality;
- Build a sense of community & feeling connected to each other -allies working towards a common goal;
- Promote feelings of increased accountability & empower teams to speak up - encouraging culture of collaboration

Huddles

The 10 minute huddle starts at 11am each week day with a structured format and required MDT attendance. During June & July there have been 31 opportunities to conduct huddles; and this has been achieved 100% of the time.

Information discussed at the huddle includes:

- Identified high risk babies e.g. small for gestational age; abnormal scans
- Identified high risk mothers e.g. complex medical conditions, other pathology.
- Safety critical information

CTG Capability

During Q1, The National Institute for Clinical Excellence published the agreed national recommendation for fetal monitoring. This has been reviewed by our local maternity team and aligned with information from previous local 'CTG confidence survey' undertaken, in Q4 2016/17.

A 'CTG working group' has been established to agree the final version of our local guidance that will influence the design of *a 'CTG capability package'* that will address:

- Identifying normal or suspicious and pathological readings.
- Rationale for starting/stopping CTG monitoring
- Standardisation of language
- Planning of CTG workshops -that will include theory of baby physiology in wider context of expecting mothers' physiology
- Identify gaps in current system and innovate with clinical teams ideas to be tested through rapid PDSA learning cycles
- Identify and measure in real-time if changes should be adapted, abandoned or adopted into the system.
- Design of a CTG pathway decision tool/sticker

The oxytocin guideline has been harmonised across both units. CTG Teaching is undertaken on a weekly basis where administration of oxytocin is also discussed and management options reviewed by the Consultant Obstetrician.

Sepsis

- To reduce by 50% severe sepsis-related serious incidents across all sites from 1 in 2014/15 to zero in 2017/18
- To increase survival by 50% for those patients on the sepsis bundle across all sites from a mean of 83% (2014/15) to a mean of 91% (2017/18).

Milestones for 2017/18

1. We will be further consolidating sustained improvement in existing pilot areas
2. We will be planning and implementing a sepsis workstream plan of spread across the organisation with all key stakeholders, including establishing mechanisms to continue monitoring progress beyond the formal life of the workstream
3. We will be sharing the learning from the 10 pilot sites in the workstream with everyone involved and impacted by this spread, including further expansion of the 'champion' role to support long term sustainability

Progress to date (August 2017)	**Status**
The sepsis improvement work is in the following pilot areas: • RFH: ED, Paediatric ED, 10S, 10E, 8N, 6E, 7W, Labour ward and • BH: ED and Labour ward During Q1 we have engaged with teams from the following areas for the next pilots: • BH & RFH Paediatric Emergency Departments • Urgent Care Centre (UCC) at CFH • BH & RFH PARRT teams These teams will co-design and develop local sepsis pathways to test through PDSA cycles. This work has included mobilising of teams, building will, recruiting improvement champions, sharing learning and local data and co-designing implementation plans. Sepsis capability is also currently being developed through E-learning packages and tools appropriate to each clinical area. The package is currently in draft format; planning to be disseminated in quarter 2. BH emergency department improvement champions and their teams have identified that the practical capacity to collect data has become a huge challenge. The significant clinical demands of the department and the current data collection methods are being reviewed to find a more sustainable and synchronised way of sampling e.g. electronic tools at triage.