Quality Account 2015- 2016

Please note.

The content and illustrations used in this report may change in the final version.

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Part One: Delivering on quality

Statement on quality from the chief executive

As one of the UK's first hospital offering treatment free at the point of need, the Royal Free London NHS Foundation Trust is committed to providing exceptional patient care, leading-edge research, excellence in teaching and a positive patient experience. Since our foundation in 1828, we have made significant contributions to the development of new and better therapies, to advances in medical procedures and to medical education. We are justifiably proud of our heritage, but we are also committed to the relentless improvement of our services.

It is therefore my great pleasure to once again introduce our annual Quality Report. The aim of this is to assure our local population, our patients and our commissioners that we provide high-quality clinical care to our patients. It also shows where we could perform better and what we are doing to improve.

Each year we set a number of high-level quality objectives for the upcoming 12 months. Part three of this report provides details of how we performed against last year's objectives. Personally I have been extremely impressed by the work of our Patient Safety Programme, whose work underpinned some of those objectives. One of the highlights of the year was a visit to the trust by Dr Don Berwick, founder of the Institute of Health Improvement (IHI), during which we presented some of the improvements achieved by this programme. Over the years the IHI has made a huge contribution to patient safety, initially in the USA but now internationally. Don met with members of our patient safety team and staff of ward 10N who presented their work on diabetes improvement. It was obvious that Don was extremely impressed by their work and that our staff were thrilled, and proud, to be able to showcase their improvements.

I am always aware that in addition to our overall quality objectives, a great deal of other improvement work goes on within the trust. This year, as part of the preparation for this report, I asked each of our four clinical divisions to highlight the quality achievements they are most proud of. Those achievements are listed immediately following this introductory statement together with some examples of the comments patients have made about using our services.

The last year has been our second year as an enlarged organisation following the acquisition of Barnet and Chase Farm Hospitals NHS Trust in July 2014. We have continued to make improvements across all our hospital sites, but I would particularly like to highlight the rebuilding of Chase Farm Hospital. Previously, I reported that we were busy developing plans for the new hospital. This year I am pleased to report that the funding for the new hospital has been fully approved, planning consent granted, and work is well underway on the foundations of the new hospital. Once completed in 2018, this will provide a state-of-the art healthcare facility which will deliver clinical services of the highest quality.

In December 2015 our board approved a new quality strategy. The aim of this is to introduce large numbers of staff to methods of continuous improvement - in other words provide them with the skills they need to make things better. Components of this project are included in our objectives for the upcoming year, described in part two, and I will be particularly excited to see these come to fruition.

Finally, I should note that the trust underwent a major inspection by the Care Quality Commission at the beginning of February this year. This was part of the CQCs revised inspection programme introduced three years ago, and is the first time the trust has been inspected using this new methodology. Although we have not yet received the outcome of the inspection, including our ratings, I was so very proud of the welcome our staff gave to the inspection team. It was uplifting to witness just how many were keen to show the CQC what they do – in fact there was a real sense of disappointment in areas which the CQC were unable to visit. As chief executive, I could not have asked for a better response to the inspection and I am profoundly grateful to all our staff for this.

I hope you enjoy reading the rest of the report which I believe demonstrates our continuing commitment to providing high quality care.

I confirm to the best of my knowledge the information provided in this document is accurate.

David Sloman
Chief Executive

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Quality achievements made during 2015-16

This section of the report outlines some of the quality achievements that we have made during 2015-16 and a list of positive comments that we have received from our patients.

We have remained committed to provide patients with world class expertise and local care. Underpinned by our five governing objectives- Our four clinical divisions have made several key achievements of which we are proud and which supports our commitment to provide quality services to improve the experience and outcomes for our patients.

Our four clinical divisions are:

Name of division	Examples of services covered within each division
Surgery and Associated Services (SAS)	• Trauma and orthopaedics, ophthalmology, general, emergency and specialised surgery, pain management, therapy services, audiology, orthodontics.
Transplant and Specialist Services (TaSS)	• Nephrology, urology, diabetes and endocrine, haematology, oncology, liver transplant, hepatology, infection and immunity, gastronenerology, pathology, outpatient services.
Urgent Care (UC)	• Cardiology, pharmacy, acute respiratory, neurology and stroke, critical care, emergency department, North London Breast Screening Services (NLBSS).
Women's, Children's and Imaging (WCI)	• Children's services which includes paediatrics and neonatology, women services, imaging

Examples from our Surgery and Associated Services (SAS) division

Improvements made within our plastic surgery service

Our plastic trauma service is one of the specialized trauma centres in London. The service recognised that improvements could be made through the patients' pathway to reduce time from referral/injury to treatment and the length of stay for our patients.

what did we do?

- Appointed a locum to see patients who had been waiting a long time to been seen.
- Reallocated the threatre list if a consultant was away on leave.
- Appointed a trauma co-ordinator to manage the flow of patients through the plastics trauma clinic
- Moved the service to a dedicated ward (5NA) which has input from specialised medical and nursing teams to treat our patients.
- Our consultants currently work a six day routinue pattern with two elective operating lists on Saturdays.

what were the outcomes?

- Patients are waiting less time for their treatment.
- There is a dedicated registrar on the ward every day of the week and the nursing staff are specially trained to care for our patients.
- Our patients have a wider choice for their surgery dates , which also improves our 18 weeks target

Improving our pain services

The pain team is a part of the Surgery and Associated Services (SAS) division and during 2015/16. The service has made significant improvements in the management of pain for our patients. This supports our aim to deliver better experiences and outcomes for our patients.

what did we do?

- Reviewed the triage and referral system for pain management physiotherapy, streamlining the process.
- Introduction of group work in pain physiotherapy and set up a physio led short intensity pain management programme
- Ran a 8 week programme and several workshops for staff on 'mindfulness' (stress reduction)

what were the outcomes?

- Achieved a reduction in waiting times for pain management physiotherapy from 6 months to 4 weeks.
- A reduction in waiting list also released additional time for our physiotherapist to undertake more one-to-one sessions.
- Improved outcomes for some complex patients as a result of the peer support gained from being treated in a group setting.
- Introduced a greater variety of treatment options for pain management physiotherapy
- Supported staff, helping them to be able to deal with stress in their work and home lives.

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Examples from our Transplant and Specialist Services (TaSS) division

A new endoscopy unit

We built a new £2 million endoscopy unit which opened in December 2015 at Chase Farm Hospital. Our patients are offered a choice to use either our services at the Royal Free or Chase Farm hospitals. Our Barnet hospital site will continue to provide in-patient and emergency endoscopy services only.

what did we do?

- We built a dedicated building which has greater capacity than the previous unit
- The unit is the first in the country to use a tracking system.
- Provided twice as many treatment rooms as well as private recovery rooms each with en-suite facilities.

what were the outcomes?

- Provided an improved service to patients at Chase Farm Hospital
- Staff are able to monitor patients more closely with the tracking system
- shorter waiting times for our patients
- Increased privacy and dignity for our patients.

I am delighted that we have opened this new unit, which means we can offer a better service to our patients. We have more capacity, which means waiting times will be cut and we will also offer patients private recovery rooms. The new unit will have all the latest equipment and technology and will be more spacious and pleasant environment for our patients and staff.

Doug Thorburn, clinical director

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Examples from our Urgent Care (UC) division

Improving our dementia services

In 2015, we successfully appointment a dementia lead and have undertaken various initiatives to support dementia care across the trust. This has included the launch of our dementia strategy and our staff-led project on Larch ward at our Barnet hospital site.

what did we do?

- We transformed Larch Ward into a dementia friendly ward, helping to give patients a sense of place and creating a ward environment that is easier to navigate.
- The £330K project was inspired by an initial charitable donation from the Mayor of Barnet, who selected Barnet Hospital dementia care as one of his chosen charities.

what has improved for Larch ward?

- Each bed bay has its own theme to ensure patients have a sense of place within the bay and ensure they are able to easily locate their bay.
- The ward has enhanced lighting and signage, clearly visible calendars and clocks and positioned grab rails.
- New wood flooring enables patients to navigate around the ward with more independence.

"These changes will make a real difference to patients on Larch ward. Not all of our patients have dementia, but many of them do. We are making changes that research has shown will help patients feel less agitated, which will help their recovery and means they can return sooner."

Kate Hennessey, ward sister

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Examples from our Women's, Children's and Imaging (WCI) division

Innovative approach to lung biopsy for early detection of lung cancer

The trust won an award from the NHS Innovation Challenge Prize for Cancer Care. The initiative aimed to improve patient experience and outcomes by eliminating delays in lung cancer diagnosis, whilst reducing time spent in hospital, and costing 90% less.

what did we do?

- Recognised that radiology-led management of lung biopsy could offer a solution, without the need for hospital beds.
- Created an innovative lung biopsy service in 2011 to reduce delay in diagnosis for our patients

what were the outcomes?

- Lung biopsies are performed using an early discharge protocol, without pre-emptively booking hospital beds.
- It has also enabled us to perform lung biopsies in patients declined elsewhere.
- The cost of an uncomplicated biopsy is significantly lower as the patient simply goes home after 30-60 minutes.

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Improving the safety culture on our children's ward

The quality improvement project was led by Dr. Jane Runnacles and our multidisciplinary SAFE team. The project was built on the background that children in the United Kingdom experience higher morbidity and mortality than those in comparable health systems.

Twice daily multidisciplinary ward safety huddles

what did we do?

- We implemented the Cincinatti children's "huddle" technique, a ten minute open exchange of information between all staff, to encourage information sharing and equip professionals with the skills to identify children at risk of deterioration.
- Using the model for improvement we designed and tested a safety huddle proforma to be completed by the nurse in charge during the huddle. In October 2014 we tested morning huddles and adapted the process before implementing evening huddles 6 weeks later.
- Since October 2014, morning ward safety huddles occur 100% of the time, and since January 2015, evening huddles also occur 100% of the time.

what did we do?

- We designed a "MONTY the penguin" acronym (inspired by a Christmas TV advert) to motivate the staff with credit card size reminders of our criteria.
- Our nurse champion re-designed our patient board for the ward with "watchers" highlighted.
- Monthly safety crosses are completed and entered onto the Institute for Health Improvement (IHI) extranet to produce run charts of cardiorespiratory arrests, transfers to High Dependency and transfers to Intensive Care

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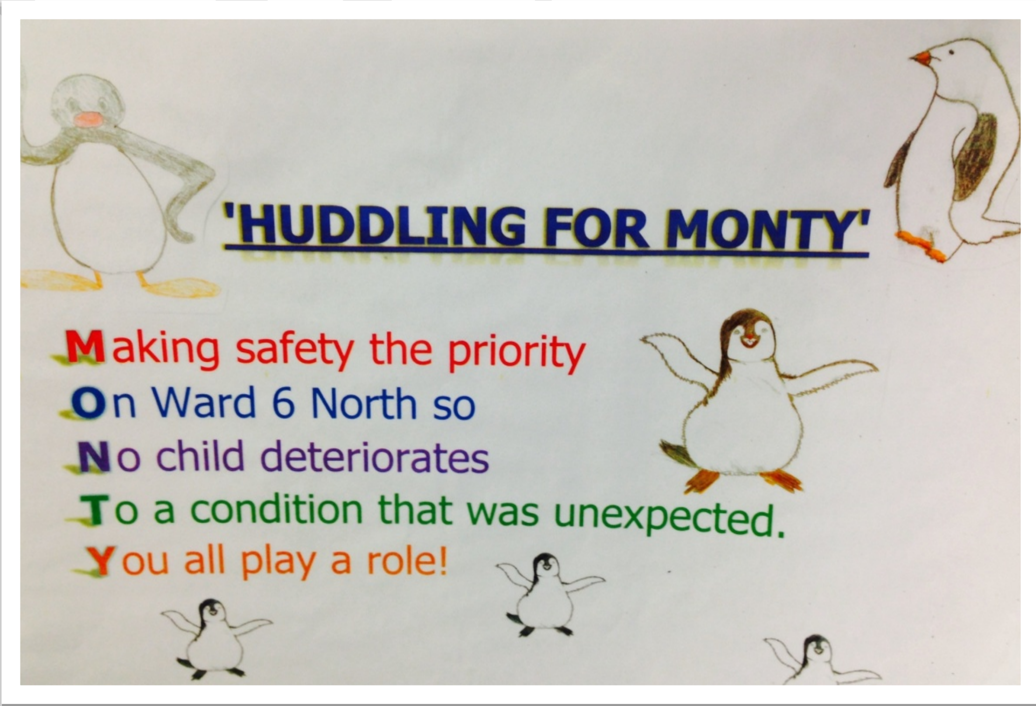
what were the outcomes?

- A survey of staff showed 100% found the huddle process useful, comments: 'improved knowledge of patients on the ward', 'real sense of support', 'pre-empt problems', 'highlighting patients at risk'. Qualitative case studies have demonstrated the impact of our huddles (e.g. highlighting a safeguarding concern the medical team were not aware of).
- We review all cases of deterioration monthly using the Rapid Evaluation of cardiorespiratory arrests with Lessons for Learning (RECALL) tool and cross- reference to our safety huddle records.

what were the outcomes?

- The ward safety huddles have improved situational awareness and empowered all staff, however junior, to raise concerns.
- Having the sfety huddles has also improved team working with the opportunity to learn about each other, consistent with published findings that huddles lead to empowerment and sense of community, creating a culture of collaboration and enhanced capacity for eliminating harm.

'MONTY'. Our Team metaphor



Other measures that we have taken on 6N (our paediatric ward) includes the following:

what did we do?

- Quality Improvement (QI) champions to improve PEWs (Paediatric Early Warning Score) chart compliance

what were the outcomes?

- 6N ward has used PEWs charts since 2010 to help recognize the deteriorating child and escalate concerns
- A junior charge nurse on the ward has been a PEWs “champion” since January 2015, reviewing 20 charts/month as part of the SAFE project
- PEWs chart compliance has increased from 70% to 100% by engaging all nurses on the ward and training student nurses

what did we do?

- Since May 2015 bedside whiteboards have been introduced to improve communication with parents

what were the outcomes?

- A daily plan is agreed with patients and/or parents and listed on the whiteboard during the morning ward round (for example times of medication/tests and parent’s schedules)
- The play specialists have engaged patients in the design of these boards and are champions for the daily plan boards on the ward

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what did we do?

- Engaging parents in ward safety culture, through leaflets and noticeboard specially designed for our parents.

what were the outcomes?

- Collaborative project with play specialists and patients to design a safety noticeboard for parents
- Information about the SAFE programme including data are displayed
- A "safety checklist" leaflet has been co-designed by a junior doctor with parents to educate them on recognising deterioration and empowering them to speak up if they are concerned

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what did we do?

- Learning from deterioration and disseminating to the team

what were the outcomes?

- Multidisciplinary notes of all patients who have required high dependency care or transfer to intensive care are analysed on a monthly basis using the RECALL tool.
- A junior doctor champion spreads learning via a new quarterly risk newsletter to all paediatric staff.

Innovation to reduce the risk of 3rd and 4th degree tears – OASIS

Background:

Between 2000 and 2012 there has been a threefold increase from 1.8% to 5.9% in the incidence in Obstetric Anal Sphincter Injuries (OASIS) in England and associated morbidity. This has led to an increased focus on possible preventative strategies.

Therefore, our project aimed to explore how we could achieve a slow delivery of the baby's head and shoulders through effective support, communication and perineal protection and therefore reduce the risk of 3rd and 4th degree tears.

what did we do?

- A multidisciplinary group comprising senior midwives, obstetricians, educationalists was convened to review current evidence, local practices and to formulate a strategy to address any issues identified.
-
- The rates are monitored monthly on the Barnet Hospital and Royal Free Hospital sites via the North Central London Maternity Dashboard.

what did we find?

- Antenatal perineal massage was not being routinely promoted
- Interventions that have significantly been shown to be associated with a reduced rate of OASIS including antenatal perineal massage, use of warm compress, hands on technique, slow delivery of the baby head, and correct technique of performing an episiotomy.
- Lack of consistency between midwives and doctors as to what they understood and practiced in relation to both "Hand's on" and "Hand's off".
- Midwives and doctors were poor in determining the correct angle for episiotomy.
- With exception of those birthing in our birth centres active pushing was been encouraged during the delivery of the head and shoulders.

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Innovations

Education	Mandatory workshop for all Midwives and Obstetricians
Practice changes	Antenatal perianal massage
	Use of warm compress in second stage
	Controlled delivery of the head and shoulders
	Introduction of epi-*scissors to facilitate accurate mediolateral episiotomy*
Supervision	Obstetricians Consultant supervision of Instrumental delivery between 08.00-23.00.
	Band 7 Supervision of Normal births against set audit tool
Audit	Instrumental delivery
	On-going OASIS
Information to women/training	Information for women on antenatal perineal massage and warm compress

Mandatory Workshops

A key component of the programme was staff education and all staff were mandated to attend a 3-4 hour workshop led by senior midwives and obstetrician's with respect to current trends in OASIS and preventative strategies.

Aim	**To promote evidence practice with respect to the delivery of the baby in an attempt to minimise the risk of severe perineal trauma**
Objectives	To share local and nation trends and practices. To review current evidence in relation to reducing risk of OASIS o Place of birth o Antenatal perineal massage o Perineal support (Hands on-Hands off) o Warm compresses o Position o Communication o Directed versus non-directed pushing o The use of episiotomy To provide a forum to undertake "practical hands on" support with a training model. To present future management at RFH in light of the current evidence and trends. To provide training and guidance for all staff on the use of Episcissors.

Results

To date approximately 90% of staff across the organisation have attended the mandatory programme. Feedback on the training has been extremely positive with staff proactively embracing and welcoming any practice changes that might help reduce OASIS rates. The rates of third and fourth degree tears among primiparous and multiparous women as reported on the dashboard and there have been significant improvements in the rates. This is monitored as part of our Maternity action plan.

Positive comments from our patients

During 2015/16 we received positive feedback from our patients which supports our values. Through our values we aim to ensure that we are welcoming, respectful, reassuring and communicative. Our values were chosen by our patients and staff and underpin all we do. The comments have been themed according to our values and were taken from our friends and family test and national inpatient survey.

positively welcoming actively respectful clearly communicating visibly reassuring

Positively welcoming

- The nurses involved were very nice, caring and supportive, making me feel comfortable.
- The medical care from the doctors was exceptional.
- I'm happy. The doctors and staff are good to me. I'm happy with them. They look after me well, thank you very much.
- From the time I went in for my operation until I went home they were very caring and they also looked after my husband while he was waiting for me. The nursing staff was great!
- Had an accident and received very swift treatment, with the operation taking place the following day.
- I was much impressed by the high level of care I received from both them medical and domestic staff on my ward, it turned a stressful experience into a relaxed time.
- I was extremely well cared for by doctors and consultants. These services were world class and excellent.
- The care I received was the best. That includes nurses and doctors they were all wonderfully caring.

Actively respectful

- Nothing was ever too much trouble for the nurses. Didn't matter what time of the day or night you needed them, they were always there for you.
- Pleasant and helpful staff seemed to be very busy and in demand, but they appeared to cope well.
- Greatly impressed by the thorough and prompt attention.
- Nurses were very good, emotional support was given and they paid great attention to me. Doctors were reliable and trustworthy.
- I watched three nurses come to help a fellow patient who knocked the water jug over in the middle of the night. They didn't shout, just politely told her that they were there to help and told her not to worry when she got distressed.
- There was one nurse that was really nice and made all us patients laugh. Laughter is definitely good for the soul.

Clearly communicating

- The staff and doctors were excellent. They answered all my questions.
- Everyone was very kind, even cleaners found time to say a few words and always had a smile.
- The surgeon was friendly and made me comfortable. All staff were polite, approachable and provided a good service of care.
- All staff: medical, nursing, catering and cleaning were polite, helpful and friendly. Most always had a smile on their face and asked "how I was".
- The kindness and understanding of the nursing staff was exceptional. They work such long hours with such responsibility – all praise and thanks to them.
- Nurses could answer the bell quicker, but this isn't a criticism – I know they are busy.

Visibly reassuring

- I'd had this type of operation before, so I knew what to expect, but was still kept informed about all aspects throughout my stay in hospital.
- The consultants took more care this time and communication with consultant in charge of care was fantastic.
- All information was fully explained and I was well looked after
- My surgery was fully explained to me by the surgeon, who was reassuring, kind and efficient. Equally, the anaesthetist introduced himself and after that I was totally unaware of anything and woke up on the ward.
- I attended a 'joint clinic; a few weeks before my surgery where I received information on exactly what would happen. There was plenty of time to ask questions too so I felt well prepared.
- I do not feel that I could have received better treatment anywhere else. From the consultant, to the nurses on the ward, everyone was very knowledgeable and knew exactly what to do to get me home as quickly as possible.
- During my stay I was treated both personally and medically with a very high degree of excellence.
- I am lucky to have such an amazing surgeon that I can put all of my faith into. I choose to have treatment at this particular hospital and am so glad I made this choice.
- The care, dedication and professionalism of the staff at every level cannot be praised too highly.

Comments taken from our friends and family test and national inpatient survey.

Part Two: Priorities for improvement and statements of assurance from the board

In this section of the quality report, we present a review of our performance and progress made during 2015/16 against the key areas that were identified for improvement in 2014/15 and how we have monitored and reported on the progress made.

We also provide data relating to our performance on specifically defined measures as presented within the section titled '*statements of assurance from the board'*.

2015/16 quality improvement priorities

In 2014/15, following consultation with our key stakeholders we agreed to focus on three key priorities for 2015/16. Progress was monitored and reported at our board level committees for patient safety, patient experience and clinical effectiveness.

Quality domain	Relevant committee	Chosen priorities for 2015/16
Patient experience	Patient and Staff Experience Committee (PSEC)	Priority one: Delivering world-class experience
Clinical effectiveness	Clinical Performance Committee (CPC)	Priority two: Improving in-patient diabetes
Patient safety	Patient Safety Committee (PSC)	Priority three: Improving our focus for safety

Table 1. Quality domains, associated committees and chosen priorities.

Priority one: Delivering world class experience

Our overall aim is to provide an excellent experience for our patients, which is intrinsically linked with our culture, the way we engage our patients, carers and staff and the improvements we prioritise. In autumn 2015, we published our four year patient experience strategy which focused on making improvements for those who use our services, their carers and families.

Specific areas identified were:

1. Improving the experience of those with a diagnosis of dementia.
2. Identifying and improving the experience of carers.
3. Enhancing the experience of people diagnosed with cancer.

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What was our aim during 2015/16?	What did we achieve in 2015/16?
To appoint four patient experience champions from amongst our consultant surgeons and physicians.	We submitted a report to the Medical Director regarding the implementation of 'Patient Experience Champions from amongst consultant surgeons and physicians, and we are in the process of identifying champions.
To ensure that 100% of inpatient and day care wards respond to their patient experience data with publically displayed responses from staff	Each ward and department display 'you said, we did' responses to patient experience feedback which are updated each quarter.
To provide each inpatient and day care ward with improvement targets mapped to feedback from patients and carers	Each ward and department has a target for response rate and recommendation rate.
To develop and publish a list of patient experience never events (things that should never happen)	Discussions were held with staff and patients regarding 'never events' and 'always events' (This would differentiate from the safety never events and allow greater integration with our world class care values). We will continue to develop and publish the list during 2016/17 and this work will be done in partnership with NHS England
To train staff in advanced facilitation and feedback interpretation for patient and carer focus groups	This training is currently being evaluated
To achieve the Macmillan Quality Environment Mark ® across all our hospital sites.	We successfully appointed a patient information manager to support the information standard certification assessment
To establish a patient reference group for those with a cancer diagnosis; ensuring that service improvements are important to them and informed by their input.	A variety of support and reference groups were held in 2015/16 (These included renal cancer and prostate cancer groups); These provided a forum for patient support between service users and health care professionals as well as feedback for service improvement.
To produce and implement a specifically designed carers' point of information display at each hospital site.	Discussions were held with carer organisations and carers regarding the type of information that would be useful if displayed within each hospital. A carers card is being developed, this will help identify carers and will be coupled with training for staff. We will continue to develop this further during 2016/17

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During 2015/16 we also chose to focus on other key areas to support our aim to provide an excellent experience for our patients. These included:

Additional areas of focus:	What did we achieve?
Consulting with carers on whether and how they would wish to receive training on safeguarding adults.	Discussions were held with carer organisations and carers regarding what learning materials would be useful to support their awareness on safeguarding, deprivation of liberty and mental capacity.
Ensuring that 20% of our inpatient wards will have undertaken the Triangle of Care self-assessment.	We are designing a new protocol carers and people with dementia which includes access to professionals and appropriate information.
Producing a care and compassion film for staff as a training aide filmed from the perspective of a carer.	The film has been produced and is now being used in training for multidisciplinary staff groups.
Increasing the number of dementia awareness trainers.	We have introduced a new clinical teaching programme that equips frontline members of staff in role modelling and dementia clinical skills. The teaching programme is a move away from traditional classroom teaching towards training delivered in the relevant clinical areas.
In partnership with the Picker Institute develop and conduct surveys for carers of people with dementia.	The Picker Institute facilitated focus groups with carers to be enabled to design a survey to be delivered in May 2016.
Undertaking the eligibility and readiness assessment for the Information Standard Certification and set a timeframe for achieving certification	We successfully appointed a patient information manager to support the information standard certification assessment

What are our next steps?

- We will continue our work to deliver world class experience for our patients and have agreed priorities for improvement for 2016/7 which are outlined in the relevant section of this report.

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Other measures undertaken to support dementia care.

Over 25% of all acute hospital beds across the NHS are occupied by a person living with dementia. These patients face unique and specific challenges when admitted into hospital, with statistics showing that they are more likely to stay in hospital longer, fall, die, develop delirium and frequently require residential care placements as a consequence of these factors.

Given the gravity and the complexity of the problem, any meaningful strategy required the following components; a comprehensive approach to reviewing and improving care structures, time-limited, achievable goals / milestones and a proactive group of professionals forming the Dementia Implementation Group who commit to work outside of the group to achieve goals with the support of the executive team.

This year a new 12 month strategy for dementia care was launched by the Dementia Implementation Group in December 2015. The new strategy comprises of 3 workstreams each focussed on one of the main stakeholders in world class dementia care; the patients and their carers, the staff and the organisation.

Among the achievements thus far:

Patients and carers

- We have launched John's campaign (the rights for carers of people with dementia to be welcomed onto wards outside of ward visiting hours) across our care of the elderly wards at Royal Free and Barnet sites.

- The development of a carer passport that entitles carers of people with dementia to staff reduction in the canteen, reduced parking costs, free massages and companionship by our dementia volunteers.

- We held the first of 3 "Living with dementia" events which took place at Royal Free Hospital in February. The event was designed as a drop in evening for carers with talks from the Chief Executive David Sloman, nurses and the dementia lead. Colleagues from various community groups including Alzheimer's Society, Age UK, Camden and Barnet Carers and advocacy services as well as hospital staff ran advice stalls and provided information to those in attendance. Further events are planned next year.

- We are building ever closer links with community dementia advisers in Camden and Barnet to establish a more integrated support system for carers to aid the transition from hospital to home and vice versa.

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Future actions;

- Development of a carer protocol for those caring for people with dementia in view of the specific challenges these carers face including information packs for carers
- Extending John's campaign to Chase Farm and additional wards outside of care of the elderly wards
- Designing and launching a "Carers Welcome" campaign across the trust to raise awareness of how valuable carers can be to us as an organisation, increasing empathy and improving the care delivered to carers when they visit

Staff

- Subsequent to the successful Dementia Discharge OT pilot (SHINE) and the permanent establishment of that service by the Trust, the Health Foundation awarded a grant to the project lead Danielle Wilde to disseminate and embed key learning points form the project
- Having reflected on the clinical experiences and analysing the data associated with the 18 month pilot, Danielle designed a protocol for replicating world class dementia care, "the CAPER toolkit", which stands for collateral, assessment, partnership, enablement and risk-positivity
- Owing to a surfeit of "Champion" schemes across the health sector, we decided upon the name "Anchor", the idea being that if there are enough "anchors" trained to allow one per shift, they will be the consistently high-quality dementia care on the ward
- The Anchor scheme identifies key frontline staff groups, many of whom have high levels of patient contact and low levels of training opportunity (domestics, nursing assistants and ward clerks) and provides them with a bespoke 6 week programme of training around dementia. This training is a departure from traditional classroom training in that it is delivered in clinical areas and focusses on the use of practical tools and strategies.
- In one example, a domestic assistant on one of our wards was able to correctly spot that a patient had developed delirium – something that the medics and nursing team had not picked up on.
- A key component of the Anchor training is the development of role-modelling skills. This organic method of spreading good practice has been found to be a more effective and sustainable way of affecting cultural change within clinical environments compared to classroom teaching and fosters a sense of achievement, pride and expertise in the Anchors, many of whom have never received any specialist training.
- We run a programme of drop-in teaching sessions across our wards in which our dementia lead runs a 15 minute teaching session 4 or 5 times over the course of an afternoon. This approach allows ward staff to cover each other for 15 minutes and therein have access to learning that rotas and staffing levels can sometimes make difficult
- The process and practice of "specialling" patients is being completely redesigned by a working party led one of our deputy directors of nursing. This piece of work seeks

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to improve the experience of complex patients by driving up quality and redesigning the process to avoid unnecessary interventions

- A group of staff visited De Hogeweyk in Amsterdam which is the world's first dementia village. This trip was organised by the team at Chase Farm hospital looking for inspiration for their dementia garden. The team were struck by the success and relative inexpense of a "social approach" to care and now thinking how we can adapt this model to the hospital environment
- Training of our staff continues

Dementia training figures (tier 1 and 2) January 1st 2015 - April 1st 2016 – **842 people**

Future actions

- We will extend the Anchor training scheme across all our sites with 60 Anchors due to be trained at a special one off event at Chase Farm hospital in April
- Various Dementia awareness events organised across sites to celebrate Dementia Awareness Week 15 – 17 May

Organisational

- We are now able to flag that a patient has dementia on our electronic patient administration system and this is currently being piloted at front of house (TREAT, HOT clinics) and on two care of the elderly wards. As well as making sure that staff know a patient has dementia it will also allow us to collect more accurate and robust data
- A review of coding has been undertaken and the many-hundred-long coding list has now been distilled into a favourites list of 20 – alongside a doctor led review of codes disseminated to junior doctors which should also help improve the quality of our data
- The Forget-me-not scheme (a scheme in which staff are alerted to the specific needs of a person with dementia by the depiction of a forget me not by their name on the ward board) now fully operational across all elderly care wards and extensively throughout Barnet hospital and Chase Farm hospital
- We have designed an electronic system to translate the dementia flag from Cerner into a forget-me-not on the nursing handover sheets which will allow nurses to identify people with dementia on their wards and meet their needs better

Further actions

- Design and launch of a delirium pathway for use across all sites
- This work will involve a delirium awareness-raising campaign, a new protocol for the prevention, detection and treatment of delirium and a new MDT care bundle for those presenting with a suspected delirium

Priority Two: Improving in-patient diabetes

Most patients with diabetes in our hospitals are admitted for reasons other than their diabetes. However, we made a commitment that every in- patient with diabetes should have a good *experience* of *safe*, *effective* diabetes care.

In 2014/15 we chose to continue with our diabetes improvement programme. We expanded the programme to include further elements of diabetes care and extended it to our three hospital sites.

<table>
<tr><th>What was our aim during 2015/16?</th><th>What did we achieve?</th></tr>
<tr><td>Reduce prescription errors by 20%</td><td>We were concerned that the incidence of prescription errors at our Royal Free site was high relative to other English hospitals. Compared to 2013, we have reduced prescription errors at the Royal Free Hospital site by 28%, and therefore achieved our aim.

Compared nationally, our performance at the Royal Free site no longer lies in the lowest quartile. Barnet Hospital has fewer prescription errors than average.

<table>
<tr><th>Prescription errors (Eng 22.0%)</th><th>2015</th><th>2013</th><th>Change</th></tr>
<tr><td>Royal Free Hospital</td><td>24.3%</td><td>33.8%</td><td>-28.1%</td></tr>
<tr><td>Barnet Hospital</td><td>15.6%</td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>Reduce severe hypoglycaemia episodes by 20%</td><td>We were concerned that the incidence of severe hypoglycaemia events at our Royal Free site was high relative to other English hospitals.
Compared to 2013, we have reduced the incidence of severe hypoglycaemia events at the Royal Free Hospital site by 55.2%, and have therefore achieved our aim. This improvement means that the Royal Free Hospital was in the group of best-performing hospitals in the recent audit.

The incidence of severe hypoglycaemia events at Barnet Hospital was 20%.

<table>
<tr><th>Severe hypoglycaemia events (Eng 9.9%)</th><th>2015</th><th>2013</th><th>Change</th></tr>
<tr><td>Royal Free Hospital</td><td>6.5%</td><td>14.5%</td><td>-55.2%</td></tr>
<tr><td>Barnet Hospital</td><td>20%</td><td></td><td></td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td>Achieving 30% foot assessments within 24hrs of admission</td><td>We were concerned that we did not perform timely foot assessments at our Royal Free site as well as other English hospitals. We aimed to improve to match the national average (2013).

We currently undertake foot assessments in 40% of in-patients with diabetes within 24 hours of admission to our Royal Free site. At our Barnet site, our performance on the same measure is 23%. Both sites perform above average for English hospitals.

<table>
<tr><th>Foot assessment on admission (Eng 28.7%)</th><th>2015</th><th>2013</th><th>Change</th></tr>
<tr><td>Royal Free Hospital</td><td>40%</td><td>6.5%</td><td>+515%</td></tr>
<tr><td>Barnet Hospital</td><td>23.1%</td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>Reduce hospital-acquired foot ulcers by 10%</td><td>Information to follow</td></tr>
<tr><td>Improve patient satisfaction scores by 10%</td><td>We were concerned that patient satisfaction at our Royal Free site falls below that of other English hospitals.

We are disappointed that the work we have done to improve diabetes care has not led to an improvement in reported patient satisfaction at the Royal Free site.

Satisfaction with our service at Barnet has improved by 17% compared to 2012.

We will undertake further work to understand the causes in order to inform further efforts (eg ability to take control of diabetes, meals and mealtimes, staff knowledge of diabetes). We will learn from the improvements made at Barnet.

<table>
<tr><th>Patient satisfaction (Eng 84.3%)</th><th>2015</th><th>2013</th><th>Change</th></tr>
<tr><td>Royal Free Hospital</td><td>73.1%</td><td>76.2%</td><td>-4%</td></tr>
<tr><td>Barnet Hospital</td><td>83.2%</td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>To participate in the National Diabetes Inpatient Audit on all eligible sites</td><td>The trust successfully participated in a snap shot audit on the 21 – 25 September 2015. Collectively 154 cases were submitted from Barnet and Royal Free hospital sites to the National Diabetes Inpatient Audit. (Chase Farm hospital site did not participate in the audit as they did not meet the specified criteria for participation).</td></tr>
</table>

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Improving Diabetes: A quality improvement project

As part of our patient safety programme (PSP), diabetes care is a key work stream and high priority for the Royal Free London. The 10 West diabetes improvement pilot began a year ago, following a serious incident on the ward.

Using a collaborative approach with improvement methodology, staff was empowered to help make changes to their clinical area. Recommendations were then made to address issues from the serious incident including improved recognition and escalation treatment of hyperglycaemia (high blood sugars levels).

We have developed a hyperglycaemia management pathway which was tested using improvement science methodology plan, do, study, act (PDSA), and small tests of change on the ward. As part of the pathway, clearer guidance around increasing diabetes medications, including insulin, was created. A separate pathway focusing on recognition and treatment of low blood sugars (hypoglycaemia) was tested in a similar format. Other key improvements from the pilot include:

- testing of a hypoglycaemia box
- new dosing guidance for increasing diabetes medication
- new insulin table guidance
- new colour coded blood sugar charts
- a new diabetes in-patient booklet
- new simplified alerts from glucometers to help staff recognise and escalate patients for early review.

Data so far has demonstrated that there is increasing compliance with using both pathways and patients are having more timely control with abnormal blood sugars. The next phase of work is reviewing the impact of the pathways on patient outcomes such as length of stay reduction, and also capturing patient feedback on their experience. With ward data now being collected by the diabetes nurse champions, instant feedback is being used to plan further changes.

The multi-disciplinary approach has shown earlier identification of high risk patients, better recognition, escalation and management by ward staff and improved diabetes awareness and safety on 10 West

What are our next steps?

- We will continue to work towards providing every patient with safe and effective diabetes care; however we have chosen to change this priority for improvement for 2016/17. These have been agreed and are outlined in the relevant section of this report.

Priority Three: Improving our focus for safety

In response to the national patient safety initiative we have set out the actions that we will undertake in response to the five Sign up to Safety pledges and have created our local Safety Improvement Plan to enable us to deliver our Patient Safety Programme over the next three years.

Safer Surgery

Our goal is to improve compliance with all aspects of the 'five steps to safer surgery'* guidance to 95% by 31/03/16 *(this is explained in our glossary of definitions and terminology).

What was our aim during 2015/16?	What did we achieve?
We aimed to achieve this by delivering the following milestones: • Identification of process issues to enable surgeons to attend the first and fifth step • Identification of clinical leaders in all our hospital sites • Review of solutions to staff flow and challenges • Consolidate the World Health Organisation (WHO) policy across all our hospital sites • Review and Refresh workshop to use successes and failures to identify how to move to 95% compliance in all five steps	During 2015/16, we identified that compliance to safer surgery was only measured consistently for steps 2, 3 and 4 and that data for steps 1 and 5 were poor and unreliable. So in order to take this work stream forward we have developed ways to measure and improve compliance with all 5 steps, and so we have amended our timeframe to allow these developments to embed. Unfortunately, we have reported 7 never events during 2015/16, 5 of which relate to surgery. Therefore, our new goal is to improve compliance with the 5 steps to safer surgery to 95% and to reduce the number of surgical never events by 31 March 2018. In September 2015, new guidance on National Safety Standards for Invasive Procedures (NatSSIPs) was published, to help trusts implement safer surgery checklists in non-surgical areas. We are therefore intending to include this within our approach as we develop our Safer Surgery improvement plan over the next 2 years.

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Falls

Our goal is to reduce falls by 25%, as measured by incidents reported on Datix (our electronic database) by 31 March 2018.

Our key objectives will be:

- To fully embed the existing improvement programmes for falls prevention across all wards.
- To assess new methods and technology (e.g. electronic patient sensors) to reduce falls risk.

What was our aim during 2015/16?	What did we achieve?
We aimed to achieve this by delivering the following milestones: • Set-up trust-wide Falls Working Group - to carry out root cause analysis of incidents, identify risk factors and areas for improvement • Identify Falls Champions in each clinical service line across all sites • Introduction of Falls Screening Tool (based on NSPA's STRATIFY) and Falls Prevention Plan (care bundle approach) by Division across all sites. • Continue staff education and development on falls prevention • Create sharing process to enable learning from falls incidents, especially serious incidents • Consolidate updated falls-related policies and post falls protocol across all sites • Set-up Falls Awareness Events and training with trust-wide Multi-Disciplinary Team (MDT) falls study day • Initiate falls podiatry assessment pathway	We have achieved all our 2015/16 milestones. Following the publication of the 2015 National Audit Falls (England and Wales) audit, there are now data on both the rate of falls and the rate adjusted measure of harm from falls. We have used this information for comparison which shows the RFL rate of falls per 1000 bed days (8.4) compared to combined national rate for acute trusts, where the mean is 6.63/1000 bed days. We are worse than the average, so there is room for improvement. During 2015, we updated our goal to reflect the amended the Royal college of Physicians national falls measurement. Therefore, we have reset the goal to a 20% reduction of falls per 1000 bed days, as measured by incidents reported on Datix, by 31 March 2018.

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Acute Kidney Injury (AKI)

Our goal is to increase the number of patients who recover from AKI within 72 hours of admission by 25% by 31 March 2018 and target:

- 25% reduction in AKI mortality
- 25% reduction in length of stay
- 25% reduction in stage 1 AKI that progresses to AKI stage 2 or 3

What was our aim during 2015/16?	What did we achieve?
We aimed to achieve this by delivering the following milestones: • Education of staff by App, website and e-learning • Identification of access to baseline informatics in pilot areas • Identification of AKI clinical leaders in pilot areas • Process mapping in pilot areas to understand patient flow and challenges • Introduction of STOP AKI diagnostic and care bundle in pilot areas • Introduction of outreach system for moderate AKI using PARRT as well as telemedicine senior renal support in pilot areas • Monitoring of AKI data, review of progress and continual PDSA cycles for improvement • Review and Refresh workshop to use successes and failures to identify how to move to 95% compliance	During 2015/16, the initial quality improvement work with AKI has focused on setting up the learning sets with trust wide participation and engaging with an analytical provider to start to review and analyse the data needed to identify the patients.

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Patient Deterioration

Our goal is to reduce the number of cardiac arrests to less than 1 per 1000 admissions by 31 March 2018.

What was our aim during 2015/16?	What did we achieve?
We aimed to achieve this by delivering the following milestones: • Initiate case note review of selected 2222 calls and deaths, and feedback lessons learnt to staff • Identify baseline data required at ward level and create process to feedback to staff in a timely manner • Provide staff training on SBAR and EWS monitoring • Identify pilot areas • Identify ward-based champions in pilot areas • Educate staff to undertake ward-based case note review • Review education programmes for clinical staff to further identify current courses that can include SBAR and EWS training • Monitor implementation of SBAR and EWS and use process mapping to consider where interventions are best placed for improvement	The measurement of the number of cardiac arrests has been an integral part of the Royal Free Hospital data submission to the National audit ICNARC; however, this data collection was only initiated at the Barnet Hospital from the first quarter of 2015/16 and is only available to the trust retrospectively once analysed by ICNARC, so only partial data are currently available for the year. The data indicates that RFH has significantly higher cardiac arrest rates than other trusts (about 2.5/1000 in comparison to 1.5/1000 nationally). The higher figure is in part due to the reporting of cardiac arrests in A&E, ICU and Theatres, which are not commonly reported as part of this audit in other trusts. However, we still have some significant work to do to decrease our rate. Therefore, the deteriorating patient work stream has been subject to a review in the last six months and its milestones have been significantly amended. A new innovative IHI Improvement Collaborative approach is now being implemented by using the IHI Break through series collaborative model.

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Unborn baby deterioration

Our goal is to reduce the number of claims relating to deterioration of the unborn baby to two claims per year, between January 2015 and March 2018.

We have introduced the "Risky Business" newsletter within our maternity department that shares lessons learnt from incidents across both hospital sites.

What was our aim during 2015/16?	What did we achieve?
We aimed to achieve this by delivering the following milestones:	
Identify baseline data required at ward level and create process to feedback to staff in a timely manner	Our work to identify baseline data required at ward level and create process to feedback to staff in a timely manner remains in progress
Determine CTG interpretation skills baseline by staff survey	We have also increased our K2 training for midwives, so that this is now an integral part of skills training across both sites and includes CTG interpretation skills. However, we have not yet clarified all the key drivers for change within this work stream and so this will be part of our on-going work throughout 2016.
Identify champions	We are also in the process of identifying champions to support this initiative

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Sepsis

Our goal is to reduce severe sepsis-related serious incidents by 50% across all sites (A&E and Maternity) by 31 March 2018.

What was our aim during 2015/16?	What did we achieve?
We aimed to achieve this by delivering the following milestones: • Staff training in sepsis recognition in Maternity and Barnet ED • Testing of improvement tools: sepsis trolley, sepsis safety cross, sepsis grab bag, sepsis checklist sticker. • Introduction of sepsis improvement tools: Severe sepsis 6 protocol • Monitoring of data and PDSA cycle improvements • Review of improvement to attain 95% compliance	We have achieved all our 2015/16 milestones. During 2015/16, we joined the UCLP Patient Safety Sepsis Collaborative to share ideas and provide opportunities for further learning. Staff training in sepsis recognition was undertaken in maternity and the emergency department at Barnet Hospital, and the sepsis improvement tools introduced in May and August 2015 respectively. The compliance data show significant improvements.

What are our next steps?

- Our quality improvement priorities are supported by the Patient Safety Programme team. The team was fully recruited from December 2015 and it is expected that significant improvements within all the work streams will occur during 2016/17. We have agreed priorities for improvement for 2016/7 which are part of our three year plan and are outlined in the relevant section of this report

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Priorities for improvement 2016/17

In order to provide the best possible care to our patients, each year we set three quality improvement priorities for the year ahead which will be reported and monitored at our board level committees and our trust board throughout 2016/17. The priorities fall within the three quality domains, patient experience, clinical effectiveness and patient safety was drawn from our intelligence, performance and discussions.

Building on the progress that we have made during 2015/16, our priorities for improvement for 2016/17 will continue to support the values, governing objectives and our underpinning quality strategy.

Our consultation process

As part of our consultation process, external stakeholders, the council of governors, patients and staff were invited to share their views on our proposed priorities and were also given the opportunity to indicate if there were any other priorities that the trust should consider for 2016/17. (We did not include any new proposal for patient safety as we set out in our last accounts our safety priority over a three year period).

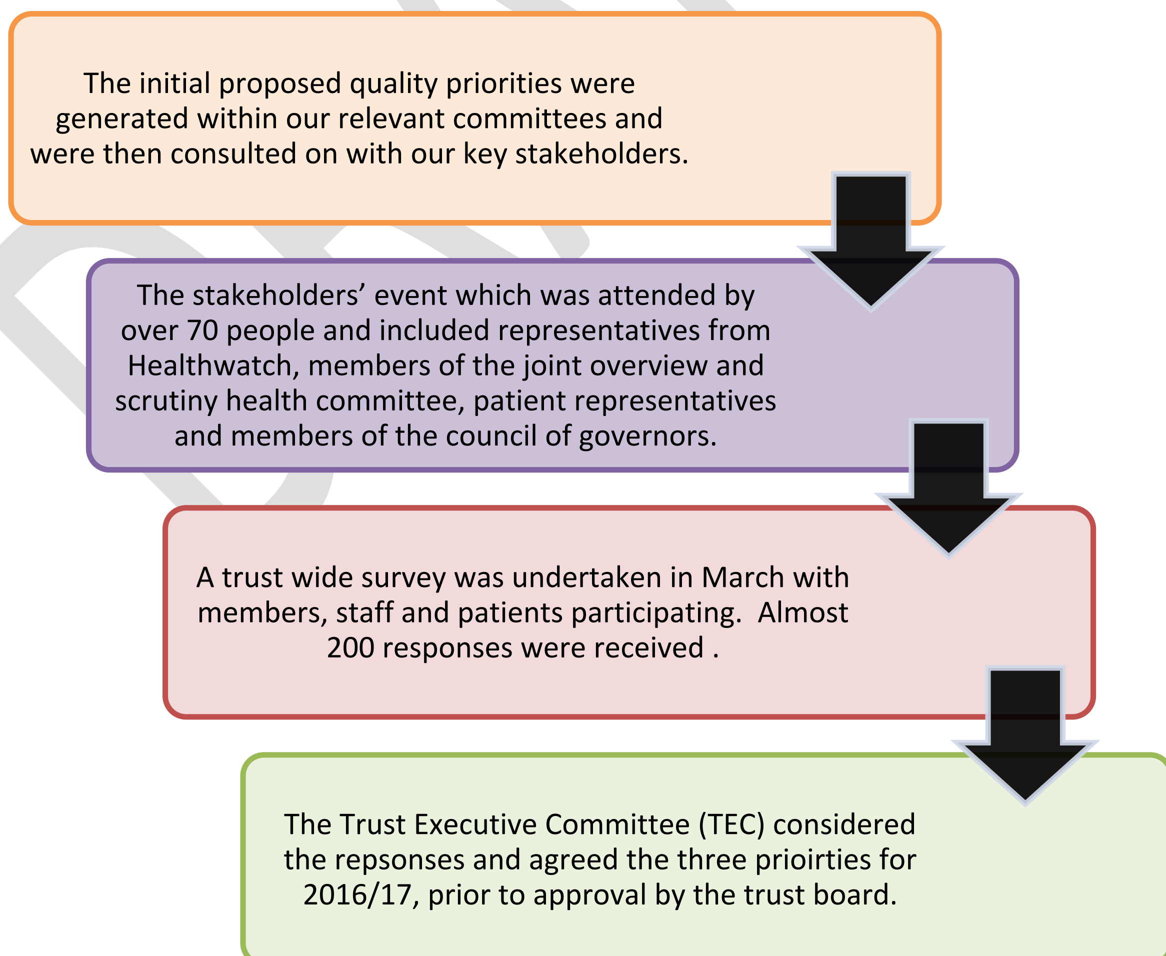

Figure1: Overview of our consultation process

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Our quality strategy

Our new quality strategy was approved by the trust board in November 2015 and spans all three domains of quality: patient experience, clinical effectiveness and patient safety. This year we are therefore including priorities spanning all three domains focused on key initial steps for implementation of the quality strategy itself (See Appendix A- Our quality strategy).

The strategy centres on equipping large numbers of staff with the capabilities they require to make continuous improvement core to their daily work, and to ensure the organisation supports them in their improvement efforts. This will ensure the trust's improvement work energises staff and has maximum impact for patients and families:

Our overarching chosen priorities for 2016/17 are:

- For the Trust board and senior leadership to work on their collective development, enabling them to provide effective leadership for improvement across the Trust.
- To develop and use a diagnostic which enables us to understand the readiness for implementing an improvement-focused approach across the Trust as a whole and for different parts of the organisation, helping us prioritise and target our work.
- To begin to build our trust-wide improvement team and faculty whose job is to support quality improvement work at the front-line across the trust.

Priority one: Patient experience priorities for improvement 2016/17

During 2016/17 we will continue to deliver on our mission and principles as outlined within our Patient Experience strategy and to support this we have agreed on a number of initiatives.

Through our Patient and Staff Experience Committee (PSEC) we will monitor and report progress.

Our chosen priorities for 2016/17 are:

- To publish an annual report; to include statement of dementia care on progress against the Trust Dementia Strategy and Fixed Dementia Care (Alzheimer's Society report) metrics.
- To allow flexible visiting times for carers of people living with dementia on 100% of inpatient wards.

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- To achieve trust certification for 'The Information Standard' by 2018.
- To ensure that 95% of patients (identified as end of life) have an end of life care bundle in place.

Priority two: Clinical effectiveness priorities for improvement 2016/17

Improving clinical effectiveness – outcomes for patients – is core to the Trust's quality strategy and improvement work; as highlighted in our overarching quality priorities for 2016/17.

We have selected one additional aim in this area, on our dementia care priority:

Our chosen priority for 2016/17 is:

To further enhance and support dementia care initiatives across the trust, as previously identified in the National Audit of Dementia (NAD) 2013 and more recently in the pilot for national dementia 2015/16.

Linked with our patient experience priorities on dementia, we will work to improve our discharge co-ordination for patients with dementia and their carers.

We know from the results from the National Audit of Dementia that this is one of the areas for improvement. Therefore a priority within our quality improvement strategy will be to develop those metrics which will enable us to measure improvements in dementia care.

Priority three: Patient safety priorities for improvement 2016/17

Our aim is to become a zero avoidable harm organisation by 2020, initially by reducing the level of avoidable harm at the Royal Free London NHS Foundation Trust (as measured by incidents relating to NHSLA claims) by 50% by 31 March 2018. Thus our targets are focussed on our three year plan and we will be delivering key milestones along the way,

The measures for the next year set out below will be re-presented in the following year's accounts and will show each area against a three year trajectory, along with relevant milestones.

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Our chosen priorities for 2016/17 are:

Safer Surgery

- To improve compliance with the five steps to safer surgery to 95%.
- To reduce the number of surgical never events.

Falls prevention

- To achieve a 20% reduction of falls per 1000 bed days.

Acute Kidney Injury (AKI)

- To increase the number of patients who recover from AKI within 72
- hours of admission by 25%.

Deteriorating patient (DP)

- To reduce the number of cardiac arrests to less than 1 per 1000 admissions
- To reduce the number of incidents of deterioration relating to unborn babies

Sepsis

- To reduce severe sepsis-related serious incidents by 50% across all sites.

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Statements of assurance from the board

This section contains eight statutory statements of assurance from the board, regarding the quality of services provided by the Royal Free NHS Foundation Trust. This includes services provided across Barnet and Chase Farm hospitals.

Where relevant we have provided additional information that provides local context to the information provided in the statutory statements.

Review of Services:

Quality is monitored in each of our four clinical divisions; with regular review of safety, clinical effectiveness and patient experience. Assurance is provided from each division to our strategic quality committees.

During 2015/16, the Royal Free London NHS Foundation Trust provided; either directly or sub-contracted **(tbc)** relevant health services

The Royal Free London NHS Foundation Trust has reviewed all the data available on the quality of care in **(tbc)** of these relevant health services.

The income generated by the relevant health services reviewed in 2015/16 represents **(tbc)** of the total income generated from the provision of relevant health services by the Royal Free London NHS Foundation Trust for 2015/16

Participating in Clinical Audits and National confidential enquires

The Trust continues to participate in clinical audit programmes and steps are taken to review our processes; ensuring that we have demonstrable evidence of changes made to practice.

During 2015/16 44 national clinical audits and 2 national confidential enquiries covered relevant health services that the Royal Free London NHS Foundation Trust provides.

During 2015/16 the Royal Free London NHS Foundation Trust participated in 98% (43/44) of national clinical audits and 100% (2/2) of national confidential enquiries of the national clinical audits and national confidential enquiries that we are eligible to participate in.

The national clinical audits and national confidential enquires that the Royal Free London NHS Foundation Trust was eligible to and participated in, and for which data collection was completed during 2015/16 are listed in table 2

The national clinical audits and confidential enquires that the Royal Free London NHS Foundation Trust participated in during 2015/16 are listed in table 2

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The national clinical audits and national confidential enquires that the Royal Free London NHS Foundation Trust participated in, and for which data collection was completed during 2015/16, are listed in table 2, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Participation in national clinical audits and national confidential enquiries

Table2. Participation in national clinical audits and national confidential enquires

National clinical audits for inclusion in quality report 2015/16	Data collection completed in 2015/16	Eligibility to participate	Participation 2015/16	Rate of case ascertainment (%)
British Thoracic Society (BTS): Adult Community Acquired Pneumonia Audit - BTS 2014/15	√	√	√ BH	n=33/30 (110%)
		x	x CFH	N/A
		√	√ RFH	n=40/30 (133%)
BTS: Emergency Use of Oxygen	√	√	√ BH	n=48
		x	x CFH	N/A
		√	√ RFH	n=46
BTS: Paediatric Asthma	√	√	√ BH	n=40/20 (200%)
		x	x CFH	N/A
		√	√ RFH	n=14/20 (70%)
Cancer: National Bowel Cancer Audit 2013/14	x	√	√ BH	n=199/208 (96%)
		x	X CFH	N/A
		√	√ RFH	n=98/90 (109%)
Cancer: National Lung Cancer Audit 2014	x	√	√ BH	n=106
		x	x CFH	N/A
		√	√ RFH	n=113
Cancer: National Oesophago-gastric Cancer Audit 2012-2014	x	√	√ BH	n=112 (71-80%)
		x	x CFH	N/A
		√	√ RFH	n=67 (81-90%)
Cancer: National Prostate Cancer Audit 2014/15	x	√	√ BH	n=91 (21%)
		√	√ CFH	
		√	√ RFH	n=19 (90%)
College of Emergency Medicine (CEM): Procedural Sedation in Adults - RCEM	√	√	√ BH	n=42
		x	x CFH	N/A
		√	√ RFH	n=46

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National clinical audits for inclusion in quality report 2015/16	Data collection completed in 2015/16	Eligibility to participate	Participation 2015/16	Rate of case ascertainment (%)
CEM: VTE Risk in Lower Limb Immobilisation	√	√	√ BH	n=12
		x	x CFH	N/A
		√	√ RFH	n=45
CEM: Vital Signs in Children	√	√	√ BH	n=101
		x	x CFH	N/A
		√	√ RFH	n=42
Chronic Obstructive Pulmonary Disease Audit Programme: Pulmonary Rehabilitation	√	x	x BH	N/A
		x	x CFH	N/A
		√	√ RFH	n=10
Diabetes: National Diabetes Audit (NDA) 2014/15	√	√	√ BH	n=371
		√	√ CFH	n=626
		√	√ RFH	n=1533
Diabetes: National Foot care in Diabetes Audit 2014/15	√	x	x BH	N/A
		x	x CFH	N/A
		√	√ RFH	n=41
Diabetes: National Diabetes In-patient Audit (NaDIA)	√	√	√ BH	n=55
		x	x CFH	N/A
		√	√ RFH	n=103
Diabetes: National Paediatric Diabetes Audit (NPDA) 2014/15	√	√	√ BH	n=69
		√	√ CFH	n=57
		√	√ RFH	n=48
Diabetes: National Pregnancy in Diabetes 2014	x	√	√ BH	n=17
		x	x CFH	N/A
		√	√ RFH	n=20
Falls and Fragility Fractures Audit Programme (FFFAP): National Audit of In-patient Falls	√	√	√ BH	n=32/30 (107%)
		x	x CFH	N/A
		√	√ RFH	n=33/30 (110%)
FFFAP: Fracture Liaison Service Database - Patient audit	x	√	√ BH	N/A
		x	x CFH	N/A
		x	x RFH	N/A
FFFAP: National Hip Fracture Database 2015	√	√	√ BH	n= 370
		x	x CFH	N/A
		√	√ RFH	n= 196
Heart: National Audit of Percutaneous Coronary Interventions 2014	x	x	x BH	N/A
		x	x CFH	N/A
		√	√ RFH	n=829
Heart: Cardiac Rhythm Management 2014/15	x	√	√ BH	n= 295
		x	x CFH	N/A
		√	√ RFH	n= 267

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National clinical audits for inclusion in quality report 2015/16	Data collection completed in 2015/16	Eligibility to participate	Participation 2015/16	Rate of case ascertainment (%)
Heart: Myocardial Infarction National Audit Project (MINAP) 2014/15	x	√	√ BH	n=254
		x	x CFH	N/A
		√	√ RFH	n=561
Heart: National Heart Failure Audit 2014/15	x	√	√ BH	n=402
		x	x CFH	N/A
		√	√ RFH	n=260
ICNARC: National Cardiac Arrest Audit (NCAA) 2014/15	x	√	x BH	n=0
		x	x CFH	N/A
		√	√ RFH	n= 251
ICNARC: Case Mix Programme: Adult Critical Care 2014/15	x	√	√ BH	n = 813
		x	x CFH	N/A
		√	√ RFH	n = 1104
Inflammatory Bowel Disease (IBD) Biological Therapy Audit (Adult)	√	√	√ BH	n= 47
		x	x CFH	N/A
		√	√ RFH	n=0
IBD Biological Therapy Audit (Paediatric)	√	x	x BH	N/A
		x	x CFH	N/A
		√	x RFH	n=0
National Complicated Diverticulitis Audit (CAD)	√	x	x BH	N/A
		x	x CFH	N/A
		√	RFH	n=16/15 (107%)

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National clinical audits for inclusion in quality report 2015/16	Data collection completed in 2015/16	Eligibility to participate	Participation 2015/16	Rate of case ascertainment (%)
National Elective Surgery PROMs: Four Operations	x	√	√ BH	n=532 (43.6%) *(Apr-15 to Sep-15)*
		√	√ CFH	
		√	√ RFH	
National Emergency Laparotomy Audit (NELA)	√	√	√ BH	n=10 (5%)
		x	x CFH	N/A
		√	√ RFH	n=100 (83%)
National Joint Registry 2015	√	√	√ BH	n= 42
		√	√ CFH	n=573
		√	√ RFH	n=427
National Neonatal Audit Programme (NNAP) 2014	x	√	√ BH	n=1082
			x CFH	N/A
			√ RFH	n=309
National Pulmonary Hypertension Audit 2014/15	x	x	x BH	N/A
		x	x CFH	N/A
		√	√ RFH	n=1080
NHS Blood and Transplant (NHSBT): Audit of Lower Gastrointestinal Bleeding and the Use of Blood	√	√	√ BH	n=15 (100%)
		x	√CFH	
		√	√ RFH	n=8 (100%)
NHSBT: Audit of Patient Blood Management in Scheduled Surgery	√	√	√ BH	n=23 (100%)
		√	√CFH	n=8 (100%)
		√	√ RFH	n=30 (100%)
NHSBT: Audit of Red Cell and Platelet Transfusion in Adult Haematology Patients	√	√	√ BH	n=32 (100%)
		√	√CFH	n=15 (100%)
		x	x RFH	N/A
NHSBT: UK Transplant Registry Elective: 2014/15 Superurgent: 2010/15	√	x	x BH	N/A
		x	x CFH	N/A
		√	√ RFH	n=106 (100%)
Ophthalmology: Adult Cataract Surgery	x	√	√ BH	N/A
		√	√ CFH	N/A
		√	√ RFH	N/A
UK Parkinson's Audit: Neurology	√	√	√ BH	n= 33/20 (165%)
		x	x CFH	N/A
		√	√ RFH	n= 20/20 (100%)

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National clinical audits for inclusion in quality report 2015/16	Data collection completed in 2015/16	Eligibility to participate	Participation 2015/16	Rate of case ascertainment (%)
UK Parkinson's Audit: Elderly Care	√	x	x BH	N/A
		x	x CFH	N/A
		√	√ RFH	n= 20/20 (100%)
UK Parkinson's Audit: Physiotherapy	√	√	√ BH	n= 20/10 (200%)
		x	x CFH	N/A
		√	√ RFH	n= 10/10 (100%)
UK Parkinson's Audit: Speech Language Therapy	√	√	√ BH	n=0
		x	x CFH	N/A
		√	√ RFH	n=0
UK Parkinson's Audit: Occupational Therapy	√	√	√ BH	n=0
		x	x CFH	N/A
		√	√ RFH	n=0
Renal Replacement Therapy (Renal Registry) 2014	x	x	x BH	N/A
			x CFH	N/A
			√ RFH	n=2239
Rheumatoid & early inflammatory arthritis	√	√	√ BH	n=33
		√	√ CFH	n=10
		√	√ RFH	n=7
Sentinel Stroke National Audit Programme (SSNAP) 2014/15	x	√	√ BH	n=167 (90+%)
		√	√ CFH	
		√	√ RFH	n=147 (90+%)
Trauma Audit Research Network (TARN) 2014/15	x	√	√ BH	n=78 (29.4%)
		x	x CFH	N/A
		√	√ RFH	n=193 (100.5%)
National Vascular Registry 2014	x	x	x BH	N/A
		x	x CFH	N/A
		√	√ RFH	n=246

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National clinical audits for inclusion in quality report 2015/16	Data collection completed in 2015/16	Eligibility to participate	Participation 2015/16	Rate of case ascertainment (%)
Adult Asthma (BTS)	x	√	N/A	N/A
Adult Cardiac Surgery	√	x	N/A	N/A
Chronic Kidney Disease in Primary Care	√	x	N/A	N/A
Congenital Heart Disease (Paeds)	√	x	N/A	N/A
Cystic Fibrosis Registry	√	x	N/A	N/A
Head and Neck Cancer Audit (DAHNO)	x	x	N/A	N/A
Mental Health Clinical Outcome Review Programme	√	x	N/A	N/A
National Audit of Dementia	x	√	N/A	N/A
National Audit of Intermediate Care	√	x	N/A	N/A
Non-invasive Ventilation Audit - BTS	x	√	N/A	N/A
Paediatric Intensive Care (PICANet)	√	x	N/A	N/A
Paediatric Pneumonia Audit - BTS	x	√	N/A	N/A
Prescribing Observatory for Mental Health	√	x	N/A	N/A

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The Royal Free London NHS Foundation Trust also participated in the following national audits by submitting data 2015/16

National Audit Title
End of Life Care Audit
British Association of Urological Surgeons: Nephrectomy Audit
British Association of Urological Surgeons: Percutaneous Nephrolithotomy Audit
British Association of Urological Surgeons: Stress Urinary Incontinence
National Audit of Cardiac Rehabilitation
British Association of Endocrine and Thyroid Surgeons: Thyroid and Parathyroid Surgery
NHSBT: Kidney Transplantation Audit
NHSBT: Potential Donor Audit
Royal College of Anaesthetists: National of Perioperative Anaphylaxis

Clinical Outcome Review Programme (previously the National Confidential Enquiries, and Centre for Maternal and Child Death Enquiries):				
NCEPOD: Acute Pancreatitis	√	√	√ BH	n= 10/10 (100%) Clinical Questionnaire n=10/10 (100%) Case notes n= 3/3 (100%) Organisational Audit
		x	x CFH	
		√	√ RFH	
NCEPOD: Mental Health Acute	x	√	√ BH	N/A
		√	√ CFH	N/A
		√	√ RFH	N/A
NCEPOD - Non Invasive Ventilation	x	√	√ BH	N/A
		x	x CFH	N/A
		√	√ RFH	N/A
NCEPOD: Young People's Mental Health	x	√	√ BH	N/A
		√	√CFH	N/A
		√	√ RFH	N/A
Maternal, Newborn and Infant: Maternal Programme 2014	√	√	√ BH	n=1
		x	x CFH	N/A
		√	√ RFH	n=2
Maternal, Newborn and Infant: Perinatal Programme 2014	√	√	√ BH	n=TBC
		x	x CFH	N/A
		√	√ RFH	n=TBC

The reports of 44 national clinical audits were reviewed by the provider in 2015/16 and Royal Free London NHS Foundation Trust intends to take the following actions to improve the quality of health care provided:

Actions to improve the quality of healthcare provided:

- We are working towards the outcomes from the national clinical audits being presented at our strategic Clinical Governance and Clinical Risk Committee (CGCRC).

- We are working with our four clinical divisions to ensure that any key findings are reviewed and raised within the relevant divisional forum.

(A full list of specific actions are presented in Appendix B)

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Clinical Audit remains a key component of improving the quality and effectiveness of clinical care; with the aim to ensure that safe and effective clinical practice is based on nationally agreed standards of good practice and evidence-based care.

The Trust remains committed to delivering safe and effective high quality patient centred services, based on the latest evidence and clinical research. Through our four clinical divisions work is in progress to dovetail our clinical audits and quality improvement initiatives. This will provide better outcomes for our patients.

The reports of **(tbc**) local clinical audits were reviewed by the provider in 2015/16 and Royal Free London NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Actions to improve the quality of healthcare provided:

- To ensure that all local audits are monitored effectively throughout our clinical divisions, with an increased focus on identifying what were the outcomes and embedding recommendations.
- To ensure that any key themes which cross divisions are addressed appropriately

(A full list of specific actions are presented in Appendix C)

Participating in clinical research

Involvement in clinical research demonstrates the Trust's commitment to improving the quality of care we offer to the local community as well as contributing to the evidence base of health care both nationally and internationally. Our participation in research helps to ensure that our clinical staff stays abreast of the latest treatment possibilities and active participation in research leads to better patient outcomes.

Our reputation attracts outstanding staff and researchers from many different countries. The close collaboration between staff and the research department of the medical school is one of our unique strengths, enabling patients to be involved in research allowing our staff to provide patients with the best care available whilst working to discover new cures for the future.

The number of patients receiving relevant health services provided or sub-contracted by the Royal Free London NHS Foundation Trust in 2015/16 that were recruited to during that period to participate in research approved by a research ethics committee was 8420

The figure includes 2348 patients recruited into studies on the NIHR portfolio and 6072 patients recruited into studies that are not on the NIHR portfolio. This figure is higher than that reported last year.

CQUIN Payment framework

The Royal Free London NHS Foundation Trust income in 2015/16 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because the trust chose to opt for the Default Tariff Rollover (DTR) rather than the Enhanced Tariff Option (ETO).

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Registration with the Care Quality Commission (CQC)

Royal Free London NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered. Royal Free London NHS Foundation Trust has no conditions on registration.

The Care Quality Commission has not taken enforcement action against Royal Free London NHS Foundation Trust during 2015/16.

Royal Free London NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period

Information on the quality of data

This section refers to data that we submit nationally

Royal Free London NHS Foundation Trust submitted records during 2015/16 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

The percentage of records in the published data that included the patients' valid NHS numbers was:

% of records	2014/15	2015/16
For admitted patient care	98.8%	98.6%
For outpatient care	99.2%	98.62%
For accident & emergency care	92.6%	94.36%

Table 3: Percentage of patient records with a valid NHS data

Data which included the patients valid General Medical Practice Code was:

% of records	2014/15	2015/16
For admitted patient care	99.8%	99.95%
For outpatient care	99.9%	99.96%
For accident & emergency care	99.9%	99.94%

Table 4: Percentage of patient records with a valid GP Practice Code

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Information Governance (IG)

The Royal Free London NHS Foundation Trust Information Governance Assessment Report overall score for 2015/16 was 72% and was graded satisfactory.

	2014/15	2015/16
Information Governance Assessment Report score	70%	68%
Overall grading	**satisfactory**	**satisfactory**

The data for 2015/16 shows a slight 2% increase in comparison to our 2014/15 data.

Payment by Results

The Trust was not subject to a 'payment by results' clinical coding audit under the Audit Commissions Assurance Framework during 2015/16.

Data Quality

The Trust continues for focus on this area to ensure that high quality information is available to support the delivery of safe, effective and efficient clinical services. A data quality improvement plan was undertaken in February 2016 and approved by KPMG (internal audit)

The Royal Free London NHS Foundation Trust will be taking the following actions to improve data quality:

We will ensure that key factors identified within our data quality improvement plan are reviewed and monitored.

This includes:

- Ensuring that regular meetings are held with our clinicians and clinical coding teams to review the data.
- Ensure that effective feedback is provided to the coding team following audits.

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Review of Core indicators

The Royal Free London NHS Foundation Trust acquired Barnet and Chase Farm Hospitals NHS Trust on 1 July 2014. Prior to this date the Royal Free London NHS Foundation Trust was not accountable for the performance of the Barnet and Chase Farm Hospitals NHS Trust.

The data and commentary in the following tables presents the most recent data available from the nationally prescribed data source (Health and Social Care Information Centre, unless stated otherwise) however in accordance with NHS conventions data prior to the acquisition has now been merged, effectively combining the Royal Free London NHS Foundation Trust and Barnet and Chase Farm Hospitals NHS Trust for the periods both before and after 1 July 2014.

There are a number of exceptions to this position which include the following metrics:

1) Patient reported outcome measures which presents Royal Free London NHS Foundation Trust excluding Barnet and Chase Farm Hospitals NHS Trust data for the periods 2013/14 and 2014/15

2) The trust's Commissioning for Quality and Innovation indicator score which presents Royal Free London NHS Foundation Trust excluding Barnet and Chase Farm Hospitals NHS Trust data for the period 2013/2014 and Royal Free London NHS Foundation Trust including Barnet and Chase Farm Hospitals NHS Trust data for the period 2014/15

Details are presented on the following core indicators:

- Summary hospital-level mortality indicator (SHMI)
- Palliative care coded
- Patient Reported Outcome Measures (PROMS)
- Re-admission within 28 days of discharge
- Responsive to personal needs of our patients
- Recommending friends and family to use our services (staff)
- Recommending friends and family to use our services (patients)
- Venous thromboembolism (VTE)
- Clostridium difficile
- Patient safety incidents

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Summary hospital-level mortality indicator (SHMI)

SHMI (Summary Hospital Mortality Indicator) is a clinical performance measure which calculates the actual number of deaths following admission to hospital against those expected. It includes the majority of hospital admitted activity, takes into consideration mortality that occurs up to 30days post discharge and additionally does not adjust for palliative care episodes; it is therefore a more comprehensive indicator than HSMR.

Indicator	Jul 13 – Jun 14 (RFL)	Jul 14 – Jun 15 (RFL)	National performance	Highest trust	Lowest trust
The value and banding of the summary hospital-level mortality indicator for the trust	88.69 (15th out of 137)	85.25 (8th out of 136)	100*	66.05	120.89

Actions to be taken to improve performance

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre, referenced by Dr Foster Intelligence in Mortality Comparator.

The latest data available covers the 12 months to June 2015. During this period the Royal Free London NHS Foundation Trust had a mortality risk score of 85.25, which represents a risk of mortality 14.75% lower than expected for our case mix. This represents a mortality risk statistically significantly below (better than) expected with the Royal Free London NHS Foundation Trust ranked 8th out of 136 non-specialist acute trusts.

Consistent and equitable standards of care are confirmed by site analysis of the SHMI score which is significantly better than expected at the trust's three main acute sites (Royal Free hospital site, Barnet hospital site and Chase Farm hospital site).

The Royal Free London NHS Foundation Trust has taken the following actions to improve the mortality risk score and so the quality of its services:

- A monthly SHMI report is presented to the trust board and a quarterly report to the Clinical Performance Committee.
- Any statistically significant variations in the mortality risk rate are investigated; appropriate action taken and a feedback report provided to the trust Board and the Clinical Performance Committee at their next meetings.

*SHMI is a case mix adjusted relative risk, each organisation is compared with itself where a score of 100 would indicate performance exactly as expected

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Palliative care coded

Indicator	Jul 13 – Jun 14 (RFL)	Jul 14 – Jun 15 (RFL)	National performance	Highest trust	Lowest trust
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	28.4%	25.4%	26.0%	52.9%	12.4%

Actions to be taken to improve performance

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre.

The percentage of patient deaths with palliative care coded at either diagnosis or specialty level is included as a contextual indicator to the SHMI indicator. This is on the basis that other methods of calculating the relative risk of mortality make allowances for palliative care whereas the SHMI does not take palliative care into account.

The Royal Free London NHS Foundation Trust intends to take the following actions to improve the mortality risk score and so the quality of its services:

- Presenting a monthly report to the trust board and a quarterly report to the clinical performance committee detailing the percentage of patient deaths with palliative care coding.
- Any statistically significantly variations in percentage of palliative care coded deaths will be investigated with a feedback report provided to the trust board and the clinical performance committee at their next meetings.

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Patient Reported Outcome Measures Scores (PROMS)

Patient Reported Outcome Measures asks patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards. This helps hospitals measure and improves the quality of care provided.

Indicator	2013 – 2014 (RFL)	2014 – 2015 (RFL)	National performance	Highest trust	Lowest trust
Patient reported outcome measures scores for:					
(i) groin hernia surgery	Low Number rule Applies	Low Number rule Applies	0.08	0.15	-1.94
(ii) varicose vein surgery	Low Number rule Applies	Low Number rule Applies	0.10	0.15	0.00
(iii) hip replacement surgery	0.38	0.37	0.44	0.52	0.33
(iv) knee replacement surgery	0.30	0.28	0.32	0.42	0.20

Actions to be taken to improve performance

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre and compared to internal trust data.

A negative score indicates that health and quality of life has not improved whereas a positive score suggests there has been improvement.

For two of the indicators, groin hernia and varicose vein surgery national data has not been made available. This is on the basis that the sample size is so small there is a potential risk that individual patients could be identified; the "low numbers rule" exclusion therefore applies.

While the trust is not receiving a negative score against any of the outcome measures hip and knee replacement surgery patient feedback was identified as a risk in May 2015 by the Care Quality Commission (CQC) in their Intelligent Monitoring Report based on the 2013/14 data.

The Royal Free London NHS Foundation Trust intends to take the following actions to improve the patient reported outcome measure scores and so the quality of its services:

- Reviewing the initial consultation process to ensure that expected outcomes are clear and patient expectations are realistic, improving patient information to ensure that risks and benefits are outlined clearly and reviewing information provided at discharge to help patients achieve good outcomes post operatively

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Re-admissions within 28 days of discharge

Indicator	2013 – 2014 (RFL)	2014 – 2015 (RFL)	National performance	Highest trust	Lowest trust
The percentage of patients readmitted to the trust within 28 days of discharge for patients aged:	**Note: Trusts with zero readmissions have been excluded from the data**				
(i) 0 to 15	8.3%	10.1%	9.6%	4.4%	16.4%
(ii) 16 or over	6.4%	9.0%	9.9%	6.5%	16.8%
Actions to be taken to improve performance					

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from Dr Foster Intelligence, a leading provider of healthcare variation analysis and clinical benchmarking, and compared to internal trust data. The Dr Foster data-set used in this table presents Royal Free London NHS Foundation Trust performance against the Dr Foster University Hospitals peer group (specialist providers whose data is not unavailable are excluded).

The Royal Free carefully monitors the rate of emergency readmissions as a measure for quality of care and the appropriateness of discharge. A low, or reducing, rate of readmission is seen as evidence of good quality care.

In relation to adults the re-admission rate is lower (better) than the peer group average. The trust has undertaken detailed enquiries into patients classified as readmissions with our public health doctors, working with GP's, identifying the underlying causes of readmissions.

This is supporting the introduction of new clinical strategies designed to improve the quality of care provided and reduce the incidence of readmissions. In addition the trust has identified a number of data quality issues affecting the readmission rate, including the incorrect recording of planned admissions. The trust is working with its staff to improve data quality in this area.

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Responsiveness to personal needs of our patients

Indicator	2013 – 2014 (RFL)	2014 – 2015 (RFL)	National performance	Highest trust	Lowest trust
The trust's Commissioning for Quality and Innovation indicator score with regard to its responsiveness to the personal needs of its patients during the reporting period.	67.4	68.6	68.9	86.1	59.1

Actions to be taken to improve performance

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre and compared to published survey results.

The NHS has prioritised, through its commissioning strategy, an improvement in hospitals responsiveness to the personal needs of its patients. Information is gathered through patient surveys. A higher score suggests better performance. Trust performance is just below (worse than) the national average.

The Royal Free London NHS Foundation Trust intends to take the following actions to improve its responsiveness to the personal needs of its patients:

The trust has a comprehensive patient experience improvement plan overseen by the Patient and Staff Experience Committee, a sub-committee of the trust board.

During February 2016 the trust was inspected by the Care Quality Commission. The inspection was designed to assess the trust services against the following key questions:

1) Are they safe?

2) Are they effective?

3) Are they caring?

4) Are they responsive to people's needs

5) Are they well-led?

Once the Care Quality Commission inspection report is received the trust will identify which service elements require strengthening or improvement with the Trust Board and Patient and Staff Experience Committee overseeing targeted action including improvements in its responsiveness to the personal needs of patients should this be required.

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Recommending friends and family to use our services

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is vital in transforming NHS services and supporting patient choice.

The data below show information for staff and patients who would recommend their friends and family to our trust.

Staff who would recommend their friends or family the trust

Indicator	2014 (RFL)	2015 (RFL)	National performance	Highest trust	Lowest trust
The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	71.0%	72.1%	69.1%	85.4%	45.9%
Actions to be taken to improve performance					
The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre and compared to published survey results. Each year the NHS surveys its staff and one of the questions looks at whether or not staff would recommend their hospital as a care provider to family or friends. The trust performs significantly better than the national average on this measure. The Royal Free London NHS Foundation Trust activities to enhance engagement of staff have resulted in an increase of the percentage of staff who would recommend their hospital as a care provider to family or friends: The trust has implemented world class care programme embodying the core values of welcoming, respectful, communicating and reassuring. These are the four words which describe how we interact with each other and our patients. For the year ahead the continuation of our world class care programme anticipates even greater clinical and staff engagement.					

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Patients who would recommend their friends and family

Indicator	November 2015 (RFL)	December 2015 (RFL)	National performance	Highest trust (Dec 2015)	Lowest trust (Dec 2015)
Friends and Family Test scores for inpatients and patients discharged from Accident and Emergency departments.	85%	84%	88%	100%	58%

Actions to be taken to improve performance

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre and compared to internal trust data.

The Royal Free London NHS Foundation Trust intends to take the following actions to improve its Friends and Family Test rating:

- There has recently been a strong push from the trusts frontline services for additional information on results. On reading their weekly scores and comments clinical and support staff often wish to put in place improvements or more often why a failing might be being reported.
- As a learning tool for teams and departments the Friends and Family Test continues to be increasingly used.

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Venous thromboembolism

Venous thromboembolism (VTE) is the formation of blood clots in the vein. Many deaths in hospital result each year from Venous Thromboembolism (VTE), these deaths are potentially preventable.

The government has therefore set hospitals a target requiring 95% of patients to be assessed in relation to risk of VTE.

Indicator	April 2015- June 2015	Jul 2015 – Sept 2015	National performance (Jul- Sep 2015)	Highest trust (Jul – Sep15)	Lowest trust (Jul – Sep15)
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	97.0%	96.3%	95.8%	100.0%	75.0%
Actions to be taken to improve performance					
The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre and compared to internal trust data. The Royal Free performed better than the 95% national target and performed better than the national average. The Royal Free London NHS Foundation Trust intends to take the following actions to improve its VTE risk assessment rate: • The trust reports its rate of hospital acquired thromboembolism (HAT) to the quarterly meeting of the clinical performance committee. • Any significant variations in the incidence of HAT are subject to investigation with a feedback report provided to the clinical performance committee at its next meetings. • The Thrombosis Unit also conduct a detailed clinical audit into each reported case of HAT with findings shared with the wider clinical community.					

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Clostridium difficile (C.diff) infection

C. difficile can cause severe diarrhoea and vomiting, the infection has been known to spread within hospitals particularly during the winter months. Reducing the rate of C. difficile infections is a key government target.

Indicator	RFL (2014/2015)	RFL (2015)	National performance (2015)	Highest trust (2015)	Lowest trust (2015)
The rate per 100,000 bed days of cases of C. difficile infection that have occurred within the trust amongst patients aged 2 or over	17.5	20.4	15.5	1.12	65.4

Actions to be taken to improve performance

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health and Social Care Information Centre.

Royal Free performance was higher (worse) than the national average during 2014/15. However from April 2015 the trust's regulator, Monitor, assesses performance in relation to those infections deemed to result from "lapses in care". Against this measure of performance the trust has been compliant with its national trajectory for the entirety of 2015/16. However comparative data is not available for "lapses in care" infections.

The Royal Free London NHS Foundation Trust intends to take the following actions to reduce its rate of C. difficile infection:

- In order to demonstrate robust governance and ensure performance improvement during 2015/16 the trust provides detailed C. difficile infection data to both the monthly trust board and quarterly clinical performance committee meetings
- The data provides a view of all infections as well as the subset relating to "lapses in care". In addition the trust also provides comparative views of the infection data comparing the rate at the Royal Free London NHS Foundation Trust against teaching trusts and all acute providers.

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Patient safety incidents

Indicator	RFL (April 14-Sept 2014)	RFL (Oct 2014-March 2015)	National performance Oct 2014-March 2015)	Highest trust	Lowest trust
The number and rate of patient safety incidents that occurred within the trust during the reporting period	5,614 (31.4)	5,734 (34.7)	4,539 (37)	12,784 (62.5)	443 (3.75)
The number and percentage of such patient safety incidents that resulted in severe harm or death.	40 (0.71%)	43 (0.75%)	22.7 (0.37%)	2 (0.11%)	128 (5.2%)

Actions to be taken to improve performance

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the National Reporting and Learning System (NRLS).The data presents both total patient safety incidents as well as the rate of per 1,000 bed days. In relation to patient safety incidents resulting in severe harm and death the data presented is both the total number of such incidents and the rate against total patient safety incidents.

The National Patient Safety Agency regard the identification and reporting of incidents as a sign of good governance with organisations reporting more incidents potentially having a better and more effective safety culture. The trust reported a similar rate of incidents to the national average for the period October 14 to March 15.

The Royal Free London NHS Foundation Trust has taken the following actions to improve its reporting rate:

- The trust has developed a patient safety campaign with the aim of focusing on improving the patient safety culture, including encouraging staff to report incidents and providing timely feedback to staff on the outcomes and learning resulting from incident investigations.
- We have robust processes in place to capture incidents. However there are risks at every trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on every incident being reported. Whilst we have provided training to staff and there are various policies in place relating to incident reporting, this does not provide full assurance that all incidents are reported. We believe this is in line with all other trusts.
- There is also clinical judgement in the classification of an incident as ‘severe harm’ as it requires moderation and judgement against subjective criteria and processes. This can be evidenced as classifications can change once they are reviewed. Therefore, it could be expected that the number of severe incidents could change from that shown here due to this review process

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Part Three. Review of quality performance

This section of the quality report presents an overview of the quality of care offered by the trust based on performance in 2015/16 against indicators and national priorities selected by the board in consultation with our stakeholders.

The indicators also follow the three quality domains: patient safety, clinical effectiveness and patient experience

Overview of the quality of care in 2015/16

The Royal Free London NHS Foundation Trust acquired Barnet and Chase Farm Hospitals NHS Trust on 1 July 2014. As a consequence the trust inherited a number of deep seated challenges particularly in relation to meeting our regulators standards for cancer and 18-weeks waiting times.

During the course of 2015/16 significant progress has been made in terms of validating historically poor data. During June 2015 we re-established national reporting for 18-weeks, and modernising cancer tumour site pathways, particularly in relation to Urology.

This winter has seen unprecedented pressure on accident and emergency departments and urgent care pathways. At the Royal Free hospital site there was a 16.7% growth in all attendances and a 22.7% growth in ambulance attendances during January 16 compared to January 15. Looking at the Barnet hospital site there was a 12.8% growth in all attendances and a 12.7% growth in ambulance attendances.

Despite this extremely challenging operating environment for the period April 15 to December 15 the Royal Free London NHS Foundation Trust achieved 95.4% compliance against the 95% 4 hour standard. Over this period, the trust's three emergency departments recorded the third highest performance against the standard when compared with the eighteen London non-specialist acute providers.

In addition we continue to record some of the lowest mortality rates in the country and are ranked 7th and 5th best performing against the two main measures or mortality risk (HSMR and SHMI) compared to our peer group of 26 English Teaching trusts.

We continue to develop our world class care programme, which is designed to improve patient and staff experience and we have retained our focus on safety by continuing to promote our patient safety programme.

We have also concentrated our efforts on modernising our services and upgrading our estate. 2015/16 has seen a huge emphasis on cancer tumour site modernisation with many high-risk patients now able to receive diagnostic tests and biopsies on the same day as their first outpatient appointment. In terms of the estate we are now well on the way to rebuilding the Royal Free hospital A&E department with the planning application for the new hospital build on the Chase Farm site recently approved. These projects, and many

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others, will ensure we continue to deliver world class care for our current patients and generations to come.

Our focus for 2016/17 is in ensuring that all parts of our diverse trust reach and maintain the standards of the best performing hospital sites. Key challenges will include returning to compliance with the A&E 4-hour standard, Cancer 62 Days from GP referral target and 18-weeks from referral to treatment.

Performance against key national priorities

The Royal Free London NHS Foundation Trust acquired Barnet and Chase Farm Hospitals NHS Trust on 1 July 2014. The charts and commentary contained in this report represents the performance for the combined organisation (i.e. including the performance in aggregated form across all sites where services are provided by the Trust. This approach has been taken to ensure consistency with the prescribed indicators the trust is mandated to also include within the Quality Account. The prescribed indicators data are sourced via the Health and Social Care Information Centre where in the majority of cases data are also aggregated.

Where possible, performance is described within the context of comparative data which illustrates how the performance at the Trust differs from that of our peer group, English Teaching hospitals.

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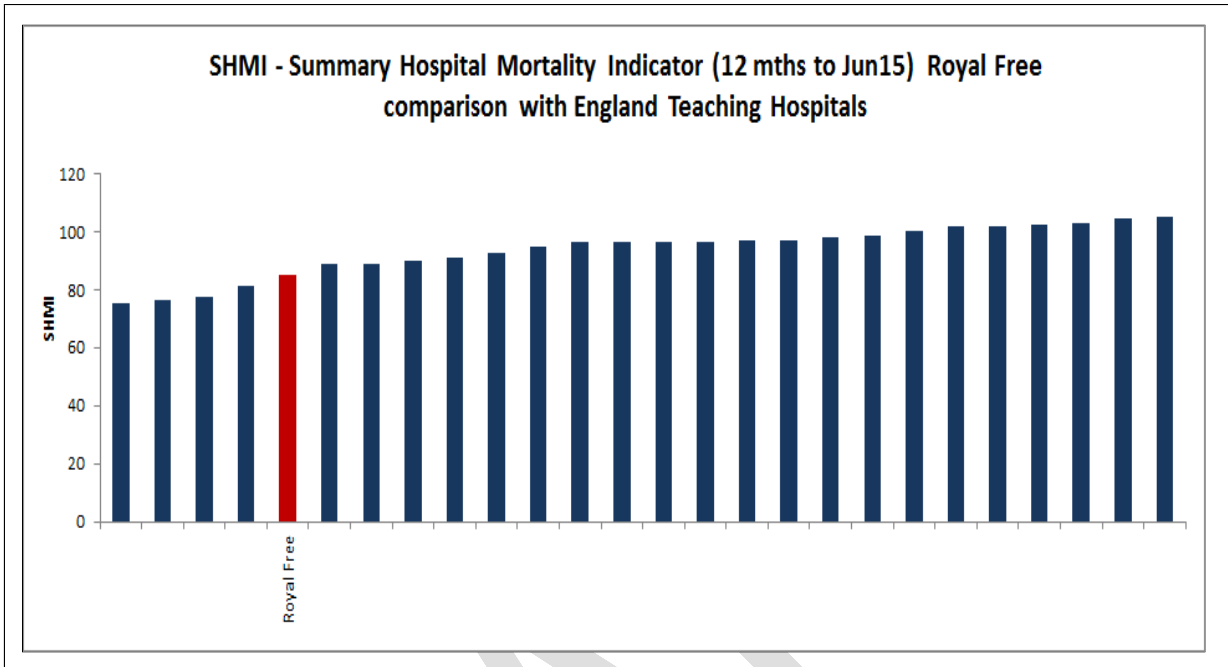
Relevant Quality Domain	Quality performance indicators
Patient Safety	• Summary Hospital Mortality Indicator (SHMI) • Hospital Standardised Mortality Ratio (HSMR) • Methicillin-resistant Staphylococcus aureus (MRSA) • C. difficile
Clinical Effectiveness	• Referral to treatment (RTT) • A&E performance • Day case rate • In- patient length of stay • Cancer waits • readmissions
Patient experience	• Last minute cancellations • Delayed transfer of care • Friends and family test

Patient Safety Indicators

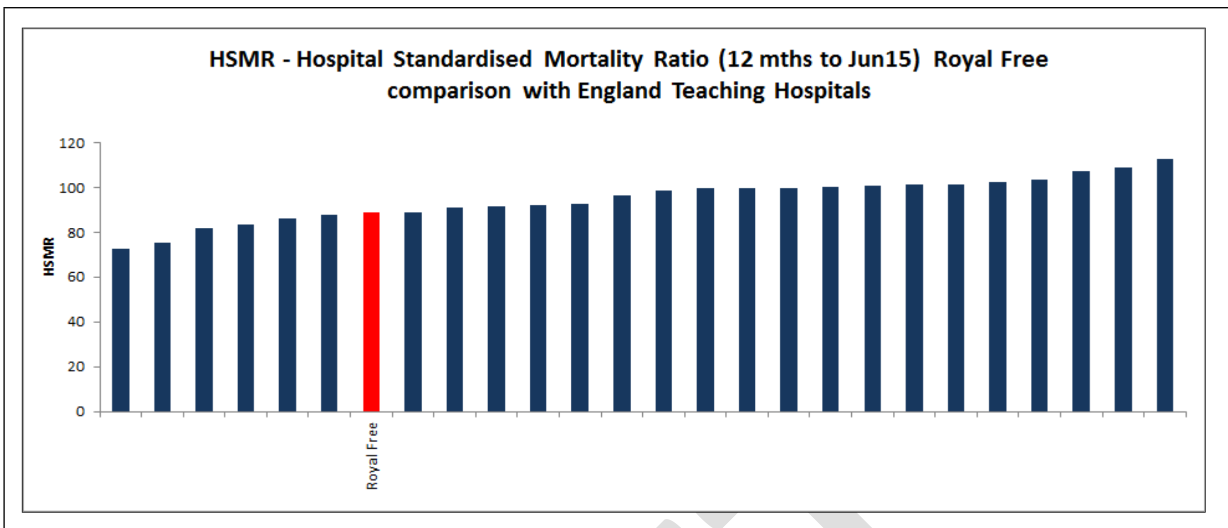


SHMI (Summary Hospital Mortality Indicator) is a clinical performance measure which calculates the actual number of deaths following admission to hospital against those expected. This expression of mortality risk includes all diagnoses groups and mortality occurring up to 30 days post discharge.

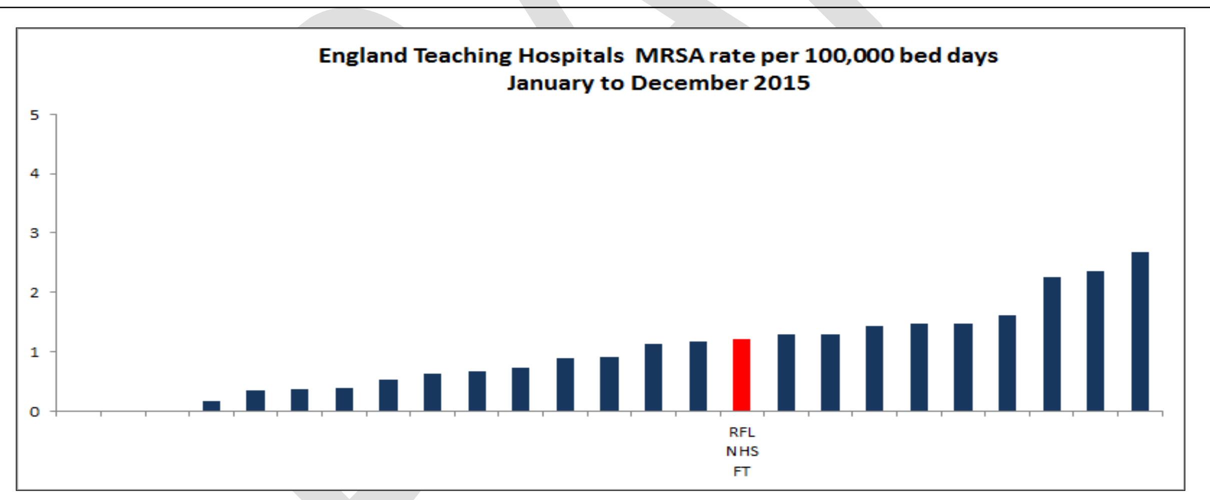
The observed volume of deaths is shown alongside the expected number (case mix adjusted) and this calculates the ratio of actual to expected deaths to create an index of 100. A relative risk of 100 would indicate performance exactly as expected. A relative risk of 95 would indicate a rate 5% below (better than) expected with a figure of 105 indicating a performance 5% higher (worse than) expected.

SHMI data is presented for the twelve month period ending June 2015 and therefore covers the twelve month period post-acquisition of Barnet and Chase Farm Hospitals NHS Trust. For this period the Royal Free London NHS Foundation Trust SHMI ratio was 85.25 or 14.75% better than expected. For this period the Royal Free had the 5th lowest relative risk amongst the 26 large England Teaching Hospitals.

(Data source: Dr Foster Intelligence/Health and Social Care Information Centre)

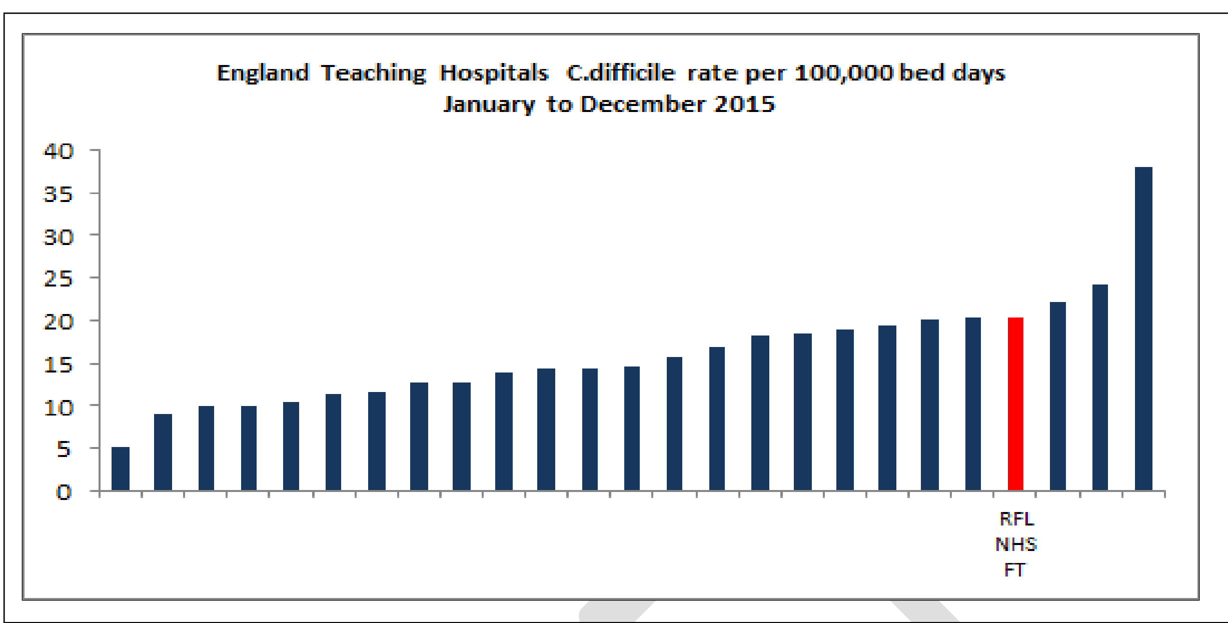


The HSMR (Hospital Standardised Mortality Ratio) includes 56 diagnoses groups responsible for 80% of deaths and only includes in-hospital mortality. Data shows that for the 12 months to the end of June 2015. The Royal Free London NHS Foundation Trust recorded the 7th lowest relative risk of mortality of any English Teaching Trust with a relative risk of mortality of 88.8 which is 12.2% below (statistically significantly better than) expected.
(Data source: Dr Foster Intelligence/Health and Social Care Information Centre)



MRSA is an antibiotic resistant infection associated with admissions to hospital. The infection can cause an acute illness particularly when a patient's immune system may be compromised due to an underlying illness. Reducing the rate of MRSA infections is key in ensuring patient safety and is indicative of the degree to which hospitals prevent the risk of infection by ensuring cleanliness of their facilities and good infection control compliance by their staff.

In the twelve months to the end of December 2015 the Royal Free reported 4MRSA bacteraemias. Against the 25 teaching trusts, the Trust is ranked 16th with a rate of 1.22 bacteraemias per 100,000 bed days.



In relation to C. difficile the trust's regulator, Monitor, assesses performance in relation to those infections deemed to result from "lapses in care". Against this measure of performance the trust has been compliant with its national trajectory for the entirety of 2015/16.

However comparative data is not available for "lapses in care" infections, looking therefore at all infections, including those not resulting from "lapses in care", the Royal Free London NHS Foundation Trust is ranked 22nd out of 25 English Teaching Hospitals for the period April to December 2015 with a reported position of 20.4 per 100,000 bed days.

(Data source: Public Health England)

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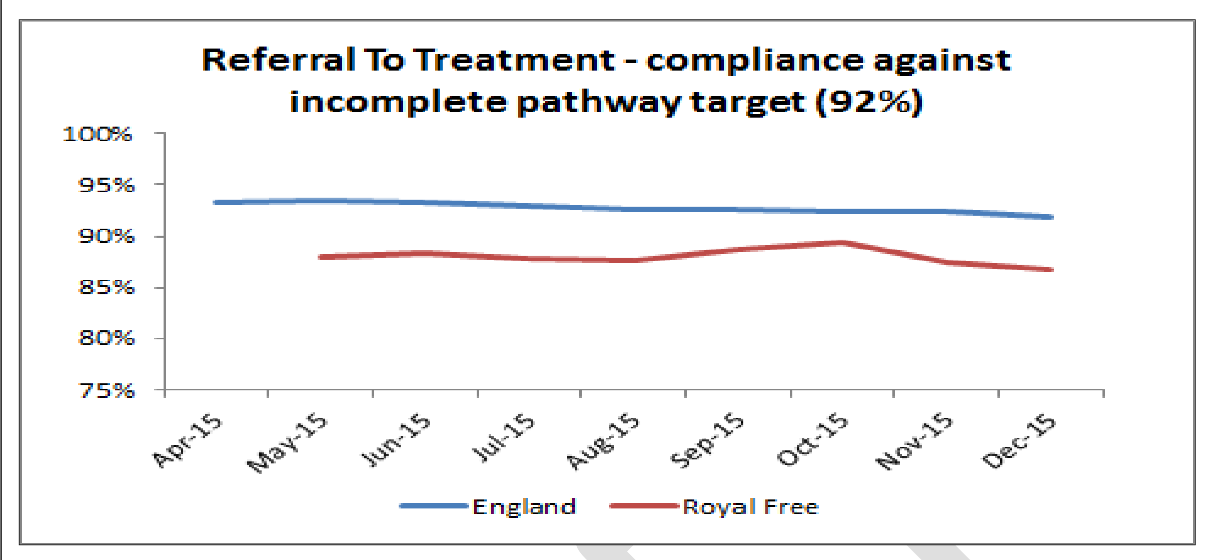
Clinical Effectiveness Indicators



Prior to the acquisition of Barnet and Chase Farm Hospitals NHS Trust the Royal Free London NHS Foundation Trust identified significant data quality and accuracy issues in relation to Barnet and Chase Farm Hospitals NHS Trust **referral to treatment** 18 weeks data.

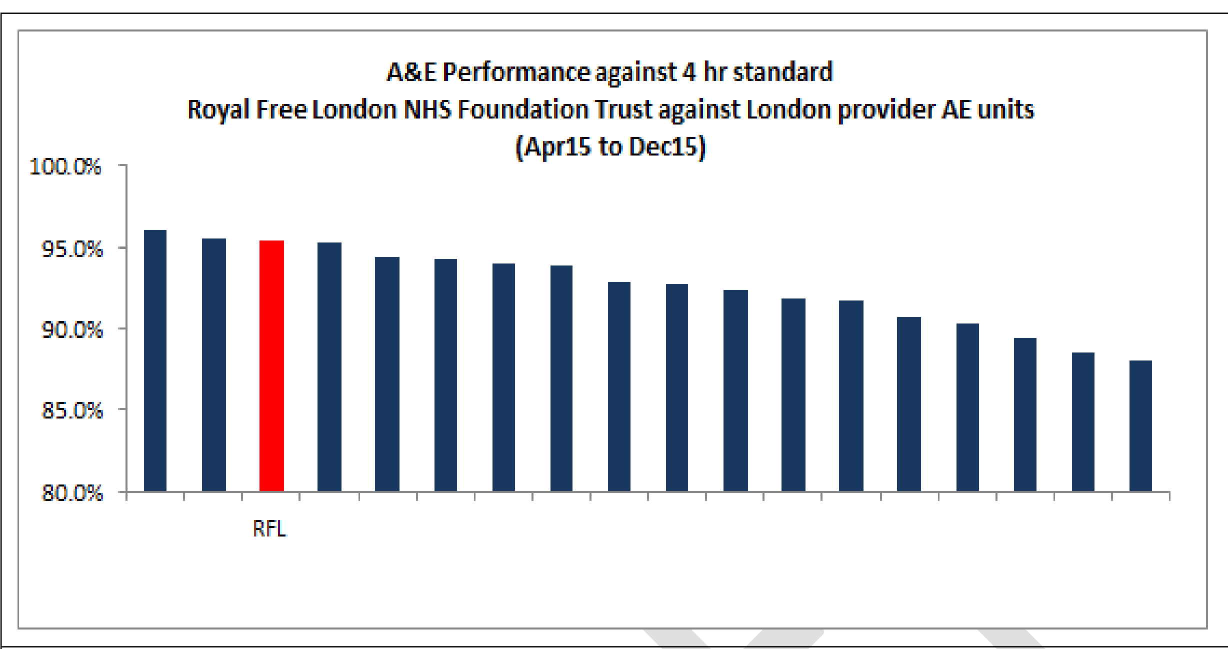
One of the largest data validation exercises in NHS history was commenced resulting in 1.9m pathways being extracted from the Barnet and Chase Farm Hospitals Trust Patient Administration System of which 75,090 required manual validation to determine true referral to treatment status and waiting time. During this process it was not possible to report performance against the referral to treatment indicators.

In May 2015 reporting resumed, however from September 2015 onwards, the NHS decided to focus reporting on pathways where the patient has yet to receive treatment and is actively waiting as the single measure of compliance with the NHS Constitution. For incomplete (open) pathways the national standard requires that no more than 8% of patients should be waiting longer than 18 weeks for treatment, or put another way 92% should be waiting less than 18 weeks.

Following the data validation and recovery exercise described a significant volume of long-waiting pathways were identified at the former Barnet and Chase Farm Hospitals site. A significant recovery project structure and trajectory were put in place with the aim of ensuring compliance with the 92% standard is achieved by September 2016. The trust is making good progress in delivering the recovery programme.

However, for the 8 month period for which data exists, the Royal Free reported a greater proportion of patients waiting longer than 18 weeks at the end of each month when compared to the average performance of English acute trusts.

(Data source: National Health Service England)



The **Accident and Emergency Department** is often the patient's point of arrival, especially in an emergency when patients are in need of urgent treatment.

The graph summarises the Royal Free's performance in relation to meeting the 4-hour maximum wait time standard set against the performance of London A&E departments.

The national waiting time standard requires trusts to treat, transfer, admit or discharge 95% of patients within 4-hours of arrival. A higher percentage in the graph is indicative of shorter waiting-times. During the period April 15 to December 15 the Royal Free London NHS Foundation Trust achieved 95.4% compliance against the 95% 4 hour standard.

Over this period, the Royal Free London NHS Foundation Trust's three emergency departments recorded the 3rd highest performance against the standard when compared with the 18 London non-specialist acute providers.

Pressure on A&E's has been increasing with more people than ever before selecting Accident and Emergency as their preferred means of accessing urgent healthcare.
In response the trust has invested heavily in modernising and extending its emergency service, this includes completely rebuilding the Royal Free hospital site A&E department now well underway.

(Data source: National Health Service England)

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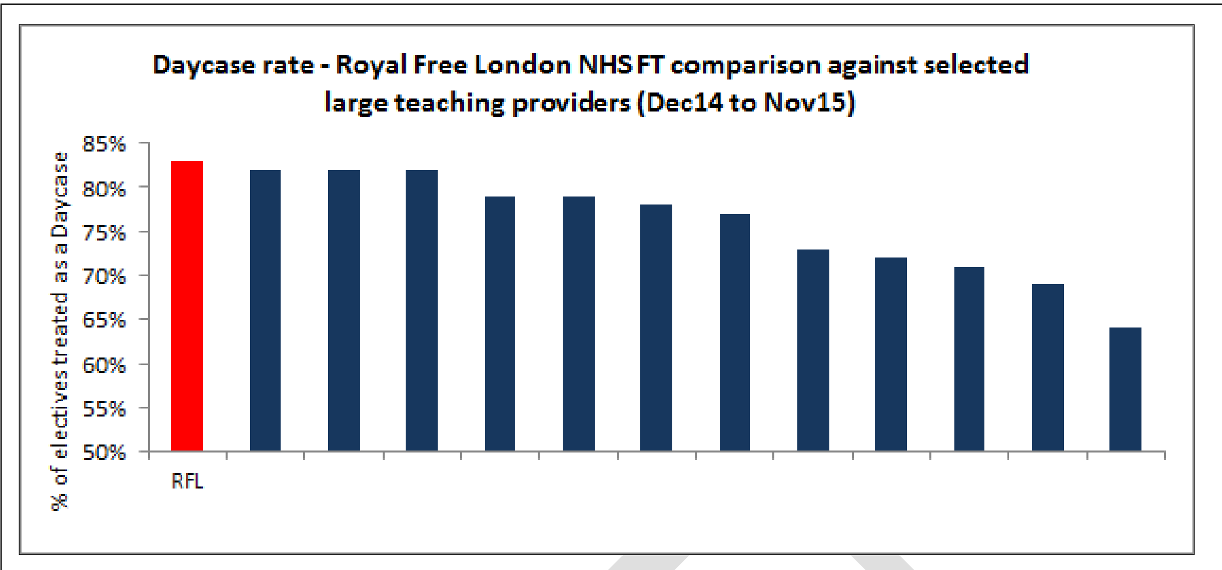
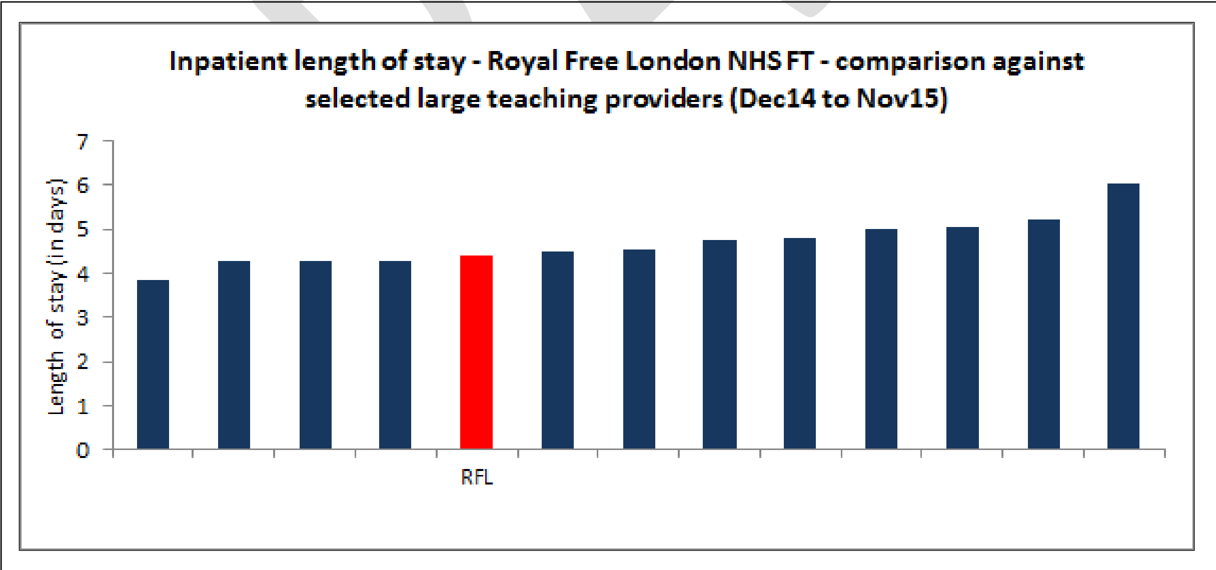


Day cases are procedures that allow you to come to hospital, have your treatment and go home, all on the same day. A high day case rate is seen as good practice both from a patient's perspective and in terms of efficient use of resources.

During the period covering December 14 to November 15, the Royal Free London NHS Foundation Trust treated 83% of elective admissions as day cases, this was the highest proportion across the group of large teaching providers.



Length of stay is also an important efficiency indicator with, in most cases, a shorter length of stay being indicative of well organised and effective care. Between December 14 and November 15 the Trust reported the 5th lowest average length of stay across the large teaching provider peer group.

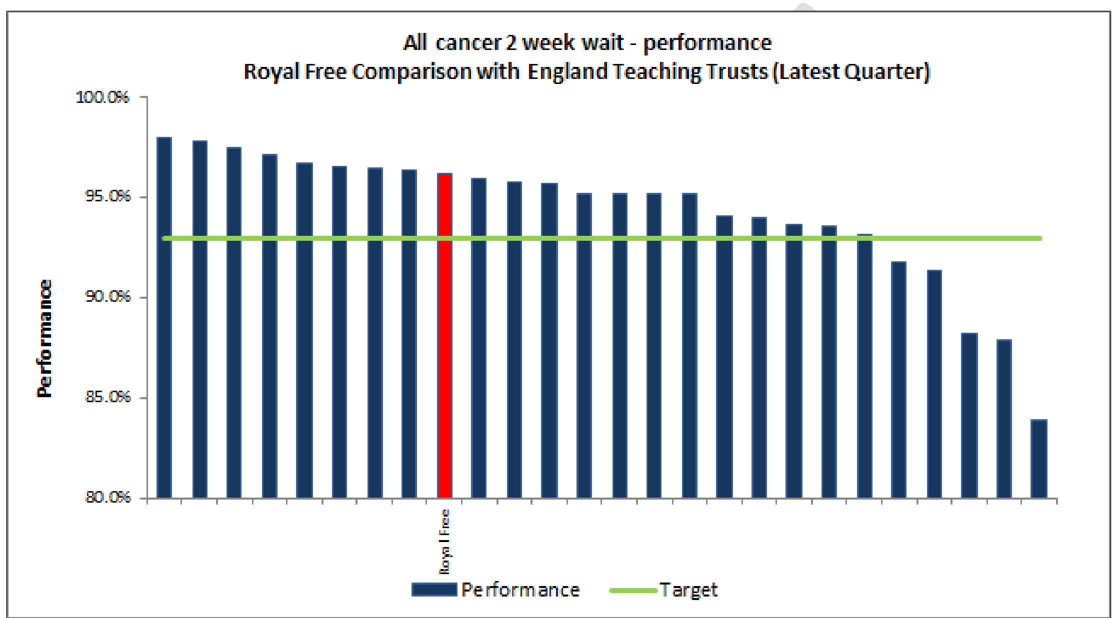
It is important to note that when producing comparative data of this type a variety of data quality issues will influence all trusts data and operational models will differ significantly between trusts as well as between trust sites.

(Data source: Dr Foster Intelligence Ltd)

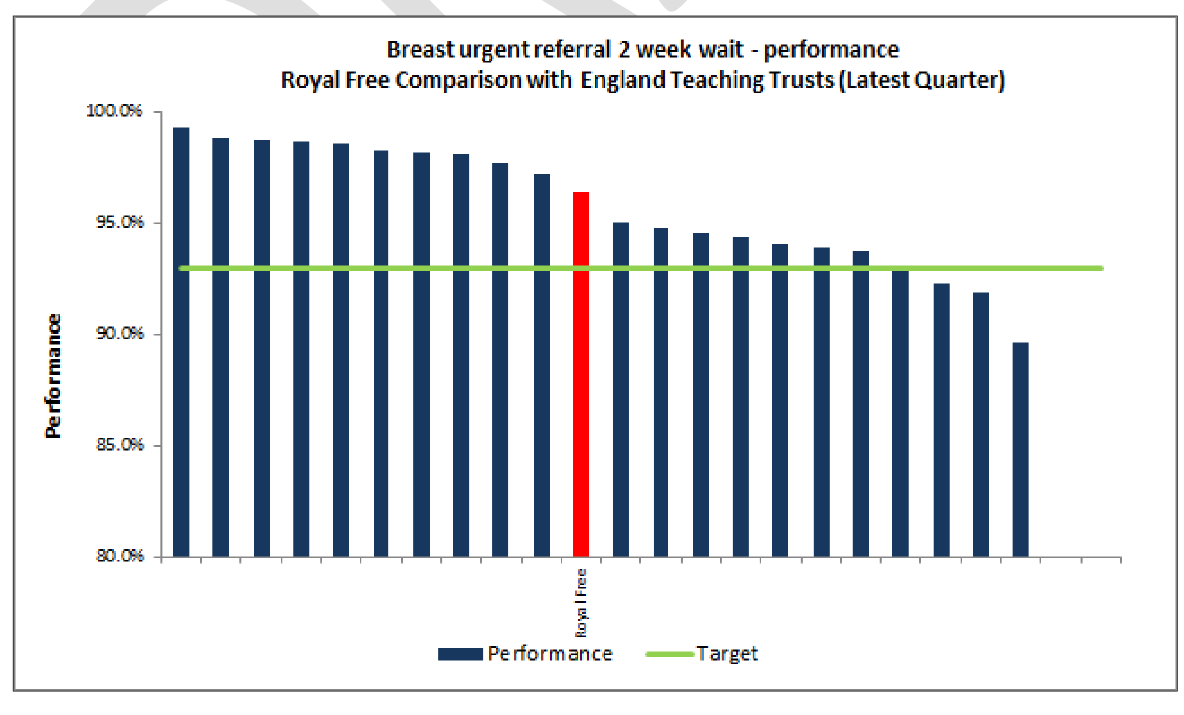
Clinical evidence demonstrates that the sooner patients urgently referred with cancer symptoms are assessed diagnosed and treated the better the clinical outcomes and survival rates.

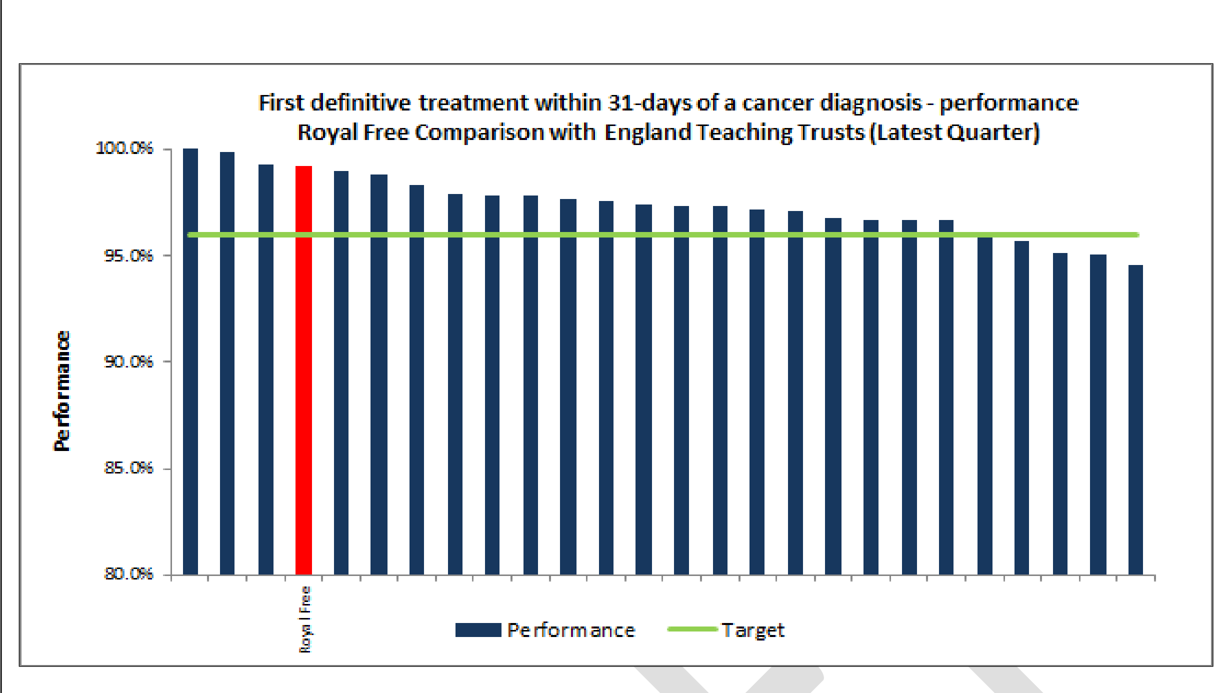
National targets require 93% of patients urgently referred by their GP to be seen within 2 weeks, 96% of patients to be receiving first treatment within 31 days of the decision to treat and 85% of patients to be receiving first definitive treatment within 62 days of referral.

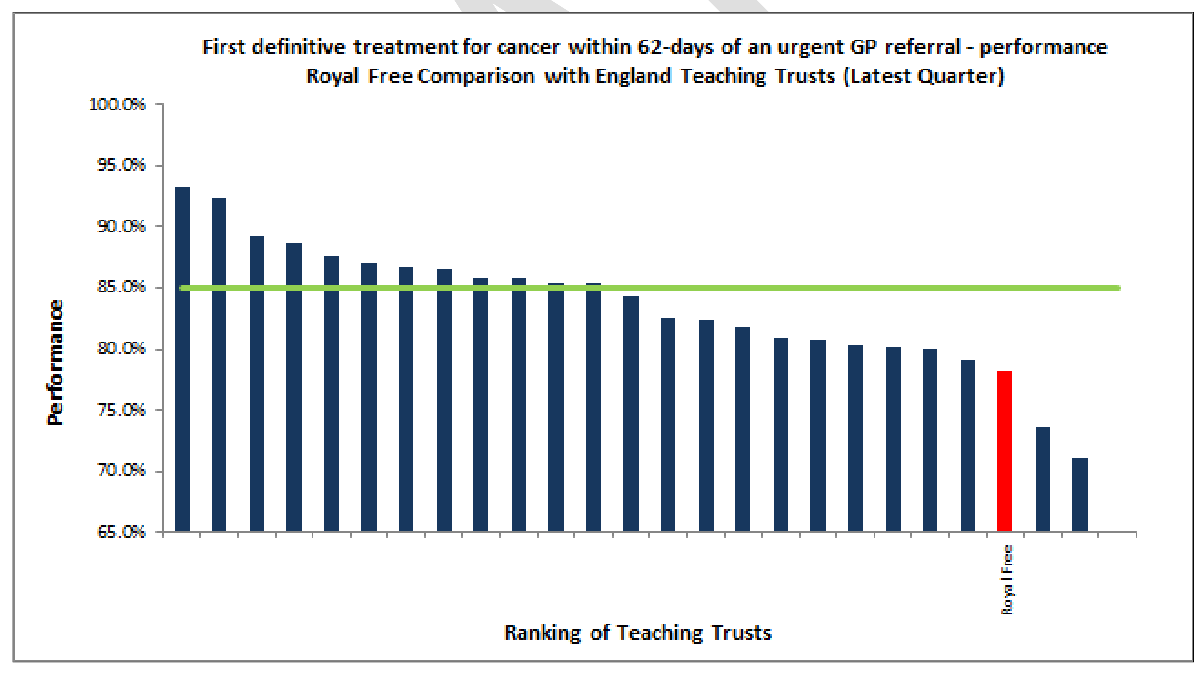
National data is provided for the period October 15 to December 15, the most recent available.



Over this time series the Royal Free London NHS Foundation Trust performed better than the national targets in relation to the two week wait and 31 day standards.







The trust underperformed against the 62 day standard. Underperformance is being driven by a build-up of breach backlog pathways across a number of tumour sites, most notably Urology where there have been significant capacity issues in the diagnostic and tertiary centre surgical stages of treatment, Skin and Upper Gastrointestinal.

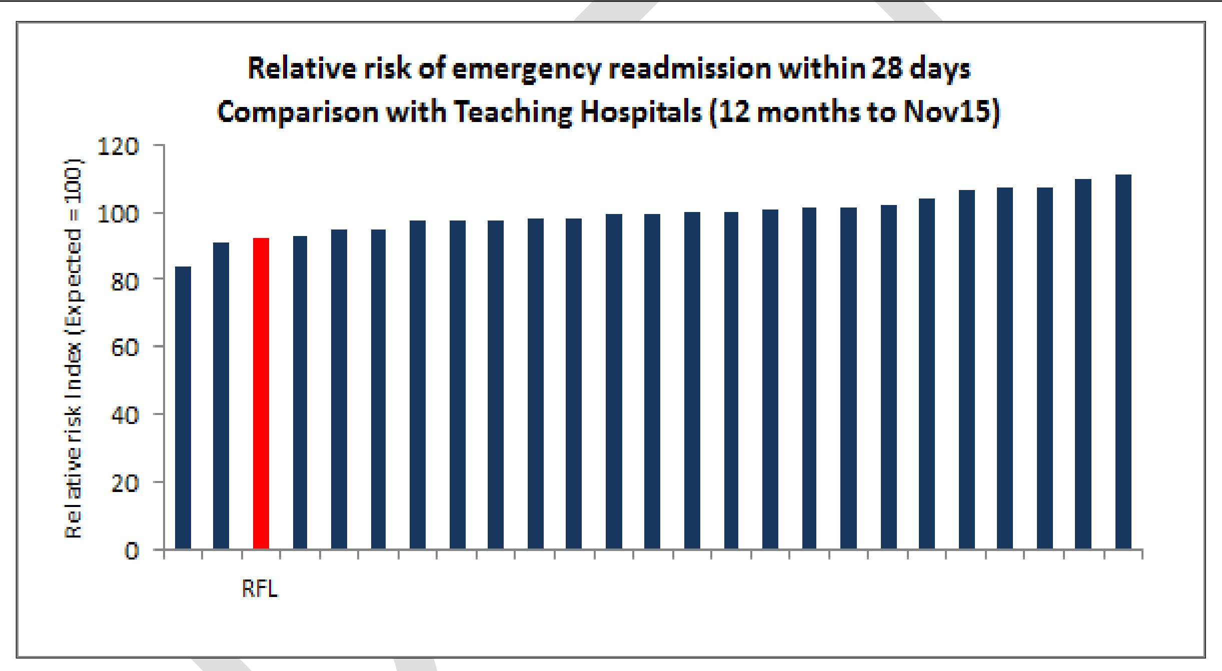
Specific issues in both the Urology and Skin pathway, such as imaging and biopsy diagnostic clinics, have been addressed, as have extended waiting times at tertiary treatment centres. Waiting times at the front end of tumour site pathways, such as initial referral to first appointment two week waits and waits for diagnosis are improving as a result.

However the trust is still working through considerable volumes of breach backlog pathways which built up prior to the implementation of the improvement programmes.

In response the trust has set out a detailed recovery plan to deliver a sustainable waiting list by end of March 2016 and a return to national target compliance from April 2016.

The graphs present the Royal Free London NHS Foundation Trust performance relative to English teaching trust performance and the relevant national target.

(Data source: National Health Service England)



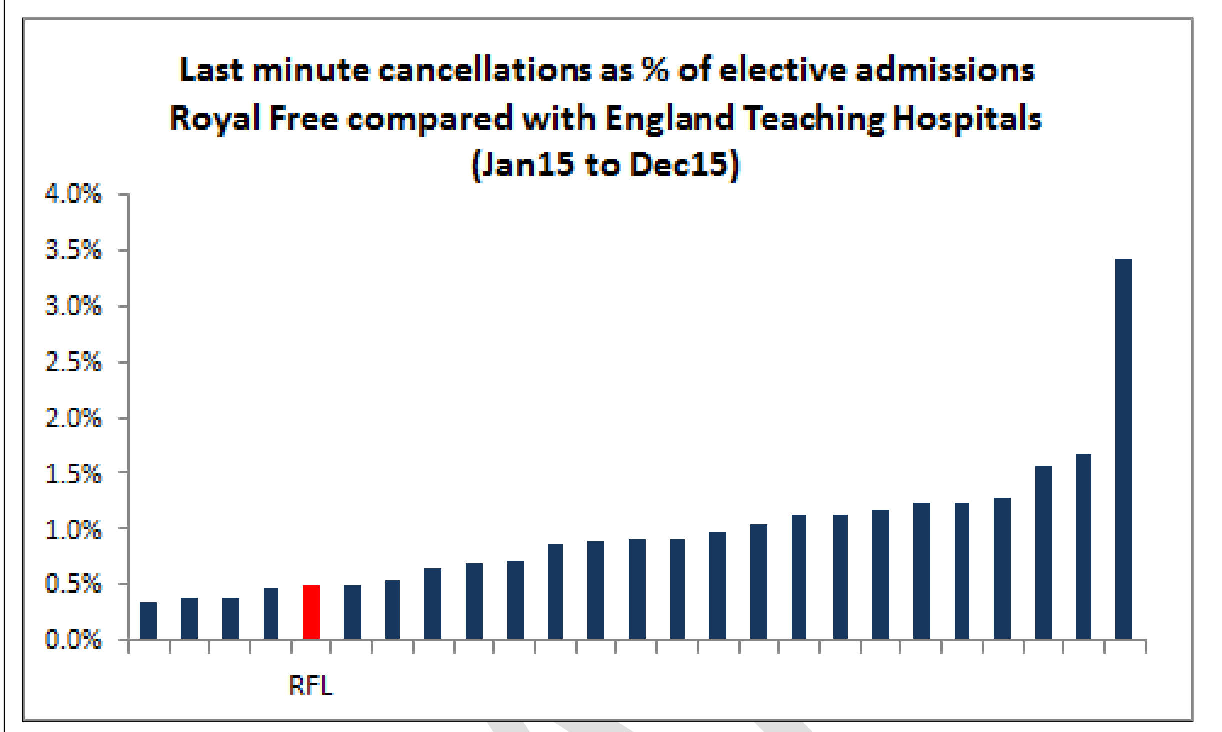
The Royal Free London NHS Foundation Trust carefully monitors the rate of **emergency readmissions** as a measure for quality of care and the appropriateness of discharge. The hospital is working with Commissioners, GPs and local authorities to provide enablement and post discharge support in order to reduce the rate of readmissions.

A low, or reducing, rate of readmission is seen as evidence of good quality care.

The chart presents the rate over the 12 month period shown; over this period the Royal Free London NHS Foundation Trust had the 3rd lowest relative risk of readmission across the English teaching hospital peer group of 25 providers.

(Data source: Dr Foster Ltd)

Patient Experience Indicators



Cancelling operations on the day of, or following admission, is extremely upsetting for patients and results in longer waiting times for treatment.

For the 12 months reported, from January to December 2015, the Trust cancelled admission for 459 patients at the last minute for non-clinical reasons. This translates into a rate of 5 cancellations per 1,000 admissions.
As a ratio, the Trust rate of 0.5% is the fifth lowest rate of cancellations across the English Teaching hospitals peer group.

Internal analysis shows that the cancellation rate was highest at Royal Free Hospital site at 0.7% and lowest across the Barnet and Chase Farm hospital sites (0.3%).

(Data source: NHS England)

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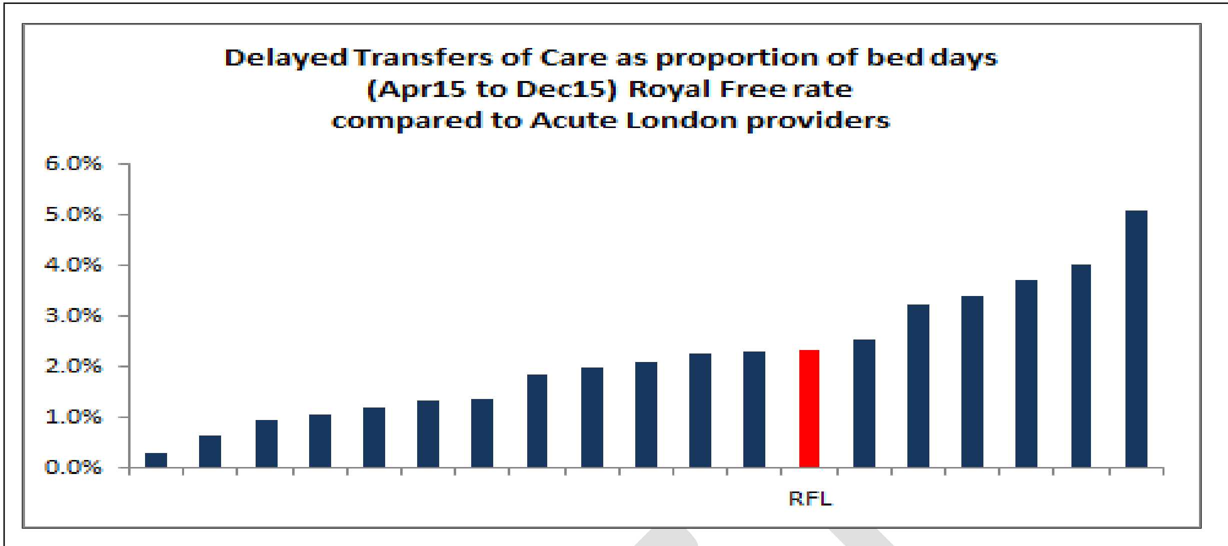
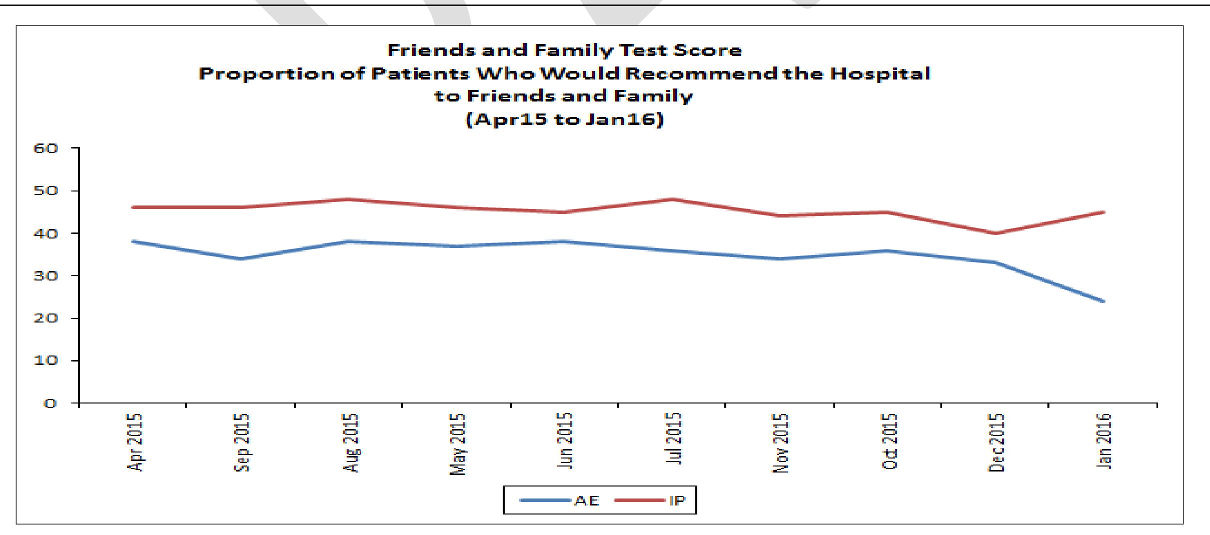


Delayed transfers occur when patients no longer need the specialist care provided in hospital but instead require rehabilitation or longer term care in the community. A delayed transfer is when a patient is occupying a hospital bed due to the lack of appropriate facilities in the community or because the hospital has not properly organised the patients transfer.

This results in the waste of hospital resources and inappropriate care for the patient, the aim therefore is to reduce the rate of delayed transfers.

(Data source: National Health Service England)



The Friends and Family Test (FFT) was introduced in April 2013. Its purpose is to track and therefore improve patient experience of care.

FFT aims to provide a simple, headline metric which, when combined with follow-up questions, can be used to drive cultural change and continuous improvements in the quality of care received by NHS patients. Across England the survey covers 4,500 NHS wards and 144 A&E services.

The chart describes the Friends and Family Test responses in 2015/16 YTD and relates to A&E and Inpatient wards.

Our local improvement plans

This section contains our local improvement plans additional areas which includes Care Quality Commission (CQC), patient safety and complaints and our most recent NHS staff survey. Throughout 2015/16 we have undertaken additional measures to support our delivery of world class expertise and local care and plans are in place to drive this.

Care Quality Commission

This year we had our planned comprehensive hospital inspection in February 2016 across our three main hospital sites of Barnet, Chase Farm and the Royal Free. The inspection report is anticipated later in the year and at the time of our inspection the CQC has not requested that we undertake any immediate actions.

Ahead of the inspection process the CQC asked us to tell them about our performance against each of the five key questions, summarising this at overall trust level as well as providing detail to highlight areas of good and outstanding practice, as well as telling them about where the quality of services is less good, and in these cases, what action we are taking. Below is the information provided to the CQC setting out our own view of our performance.

Which services or areas of the trust do you consider to be good or outstanding?	
Safe	Strong patient safety programme, an example of its work is the award winning Sepsis 6 quality improvement programme, designed by clinical staff in response to a series of serious incidents.
Effective	We have maintained a strong ED performance across the Trust despite the challenging operational environment. We have low mortality rates with no weekend variation. We regularly participate in around 50 national audits with outcomes reviewed at Board level.
Caring	We have hundreds of comments from patients on a week basis telling us our staff are caring.
Responsive	The Trust inherited a large RTT waiting list issue when we acquired Barnet and Chase Farm NHS Trust (BCF) in July 2014 which we have systematically addressed and our approach, particularly the clinical harm review process, has been held up by NHS England as best practice. We have successfully led the national NHS response to Ebola while facing significant operational challenge.
Well- Led	We have a stable senior leadership team with a strong record of delivery of clear strategic objectives, board governance is well established with clear strategy and set of values, developed by staff and patients and embedded throughout the Trust. We acquired BCF 18 months ago with no serious issues - widely recognised as one of the most successful recent NHS mergers. We buddied Basildon and Thurrock University Hospitals NHS FT to assist it out of special measures; asked to buddy other struggling trusts. There is strong commitment to clinical leadership supported by robust leadership programmes.

Which services or areas of the trust do you feel are your weaker areas?	
Safe	Post acquisition there is a new clinical governance structure with a significant investment which is beginning to embed. However we acknowledge this has been challenging for staff at Barnet and Chase Farm we have restructured. There are differential IT platforms in the organisation which are now in the process of being standardised resulting in some change management issues.
Effective	Work is continuing post acquisition to harmonise clinical policies and guidelines and our approach to NICE guidance, but work is not complete.
Responsive	We have been working on improving our complaint response time. We are currently not meeting 18 weeks RTT or 62 day cancer targets, largely due to inherited issues from acquit son of BCF however clear trajectories are in place to achieve targets (62 day target within next 2 months and RTT by quarter 2 2016/17)
Well- Led	The clinical leadership model is still embedding at Barnet hospital and Chase Farm hospital where it is a new structure.
Please describe what actions you are taking to address these weaker areas, Please include any support that you feel the trust may need (or has already sought) to address the challenges it is facing in ensuring the quality of care and patient safety.	
Safe	Our recently approved quality strategy to a significant upskilling of frontline staff in improvement methodology. This will support existing clinical governance structures and the already established patient safety programme. The impact of IT platform changes is reviewed weekly by the Trust executive committee.
Effective	We are working through our new clinical governance structures to complete harmonisation of policies and NICE guidance.
Responsive	We have strengthened the complaints team and increased monitoring including a weekly review. RTT and 62 cancer targets are reported and discussed at the weekly Trust executive committee in addition to monthly project boards. Both these projects have had external validation from the Intensive Support team.
Well- Led	The regular review of Board governance through Monitor well led framework is due in 2016. Recently approved as one of the 3 national acute care collaborative vanguards to develop a Royal Free group model; this involves a detailed review of our current clinical leadership model. There is continuous emphasis on leadership development through and internal programme run by Professor Richard Bohemer (Harvard Business School).

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Patient safety

As shown through our quality account priorities, patient safety remains integral to the delivery of safe and effective care for our patients. The current data for our patient safety incidents (as previously reported) covers between 01 October 2014 to 31 March 2015. However there will be a 6 month update in April 2016.

The following information outlines the additional measures that we have undertaken:

Implementing the duty of candour

We have been implementing Being Open across the Trust for many years, and approved our Duty of Candour policy in November 2014, to clarify the updated processes for staff. We have developed a monthly training package aimed at all levels of staff that has been delivered across all sites.

We have set up our incident reporting system (Datix) to enable us to monitor Duty of Candour compliance for those incidents that have resulted in moderate harm or above. We provide monthly reports to the Patient Safety Committee and our Commissioners detailing our compliance with duty of candour.

Patient safety improvement plan as part of the Sign up to Safety campaign

The Trust formally signed up to the NHS England's sign up to safety campaign in April 2015 to develop our Patient Safety Programme. We have committed to deliver a detailed improvement plan through building strong organisational relationships and engaging clinical and non-clinical staff to work together for shared purpose.

The patient safety programme has monthly collaborative meetings where clinical leads and safety champions come together to share learning and experiences around driving safety improvements.

As part of this work we are actively involved in our academic health science network, UCL Partners, safety collaborative, where we contribute to sharing and learning around safety issues, with many other organisations.

Learning from mistakes

From our Patient Safety Programme strategy launched in October 2014,we started our three year Patient Safety Programme in April 2015, with the aim to become a zero avoidable harm organisation by 2020, initially by reducing the level of avoidable harm at the Royal Free London NHS Foundation Trust by 50% by 31 March 2018.

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The key areas of focus have been determined following review of the serious incidents, incident trends, complaints and claims across the trust in the last 5 years and are listed in table five:

Table Five: Actions to support patient safety

Phases	Actions to support
Phase 1	1. Falls Prevention 2. Acute kidney injury 3. Deteriorating patient 4. Deteriorating unborn baby 5. Safer Surgery 6. Sepsis 7. Acute diabetic management
Phase 2	8. Missed and delayed diagnoses 9. Action on abnormal images 10. Medicines management 11. VTE prevention and inpatient anticoagulation management
Phase 3	12. Hospital associated infections, including catheter-related infection 13. Hydration and nutrition 14. Pressure ulcers

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In March 2016, the NHS published a league table of "Learning from mistakes", where the trust was ranked 190 / 230 and labelled as having "significant concerns about openness and transparency".

This ranking was based on 2 questions on the 2015 Staff Survey which were significantly worse than expected:

> Question 7. Percentage of staff able to contribute towards improvements at work
> Question 26. Percentage of staff experiencing harassment, bullying or abuse from staff

We are currently reviewing the results of the annual staff survey in order to identify ways we can further improve our processes and are committed to creating an atmosphere of openness and transparency in which all staff feel able both to raise and respond to concerns.

Learning from complaints

Feedback from patients, relatives and carers provides the trust with a vital source of insight about people's experiences of healthcare at our hospitals, and how our services can be improved. The aim of the trust's complaints process is to listen and respond to the issues being raised and use the information received to improve services and, in turn, the experience of our patients.

Complaints data is reviewed monthly by the trust executive committee alongside other data, including patient surveys, infection, falls, pressure ulcers and incidents. Complaints data, including lessons learnt and actions taken is included in:

- The divisional monthly quality & safety boards.
- The quarterly report taken to the patient and staff experience committee.
- An annual complaints report taken to the trust Board.
- The quarterly CLIPS (complaints, litigation, incidents, PALS and safety) report taken to the patient safety committee.

Themes and actions taken:

The table below shows the primary subjects from the complaints received in 2015/16 and is followed by some example actions taken in response to those issues.

1	**Clinical treatment**
2	**Communication**
3	**Appointments**
4	**Values and behaviours (attitude)**
5	**Car parking**

- Following review of an ENT complaint at the ENT audit and governance meeting, there was agreement that any patient presenting with a traumatic perforation should be followed up by the ENT team until the perforation has healed and there should be early referral for formal hearing testing via an audiologist. This should not be left for the GP to action.

- To improve the support that amyloidosis patients and families have, we have appointed a cardiac amyloidosis link nurse for 10 West ward – someone with a keen interest in this very specialist area who has spent time with senior doctors to learn about the disease but also to learn about what specific nursing needs this group of patients have and what input the family require. This nurse's role will also support the discussions around prognosis. Although we have a dedicated specialist haematology nurse for myeloma and amyloidosis, this nurse is part of the 10 West ward team and we hope that this new role will greatly improve communication with families and help address any concerns they may have as early as possible.

- We are looking at extending our ophthalmology clinic times into the early evening and have opened a further eye clinic at St Pancras Hospital, helping us to meet the ever increasing demand for ophthalmology services.

- The doctor concerned has reflected on her consultation with the patient and accepts that she need not have been so direct with the patient which, in hindsight, caused the patient stress. The clinical director has also taken the opportunity to review doctor's communication skills and has offered her advice on how best to discuss this element of care in future.

- Explanations and updates have been provided to visitors and blue badge holders with regard to the new parking arrangements on the Barnet and Chase Farm Hospital sites, and some penalty charge notices have been cancelled as a gesture of goodwill or as a result of the extenuating circumstances explained by the complainant. In addition, the reception staff and PALS team are very well versed in the parking arrangements are on hand to provide help and advice whenever required.

Actions taken by the complaints team

Two batches of the complainant questionnaire were sent out to complainants who had received responses from the trust in April 2015 and October 2015.

An overview of the key questions is provided in the table below:

Question asked?	April 2015	October 2015
Was your complaint treated seriously and with sensitivity?	Yes = 42% No = 58%	Yes = 62% No = 38%
Were all points raised in your complaint addressed by the response?	Completely or mostly = 50% Partially or not at all = 50%	Completely or mostly = 61% Partially or not at all = 39%
Was the response letter clear and understandable?	Yes = 58% N0 = 42%	Yes = 82% N0 = 18%
Were you kept updated about any delays with the investigation?	Yes = 9% No = 62% N/A = 29%	Yes = 61% No = 25% N/A = 14%
Overall, how well do you think your complaint was handled?	Very well or well = 33% Average 17% Poor or very poor = 50%	Very well or well = 50% Average 297% Poor or very poor = 21%
Was your disability taken into account during the process?	Yes = 0% No = 8% N/A = 82%	Yes = 18% No = 3% N/A = 79%

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The results are reflective of a period in which our complaint investigations were taking longer than expected and updates to complainants about those delays were not happening routinely and proactively. Change-over of staff and sickness within the divisional complaints teams had an impact but this has been resolved and, as of January 2016, all divisional complaints roles are filled with permanent full-time staff.

Overall, there is a positive trend in every question with October's data, which it is felt is largely reflective of the improvements that have been made since October 2015 with regard to turnaround times for completion of investigations and updates to complainants about delays. Our performance will continue to be monitored during 2016/17.

In an attempt to make our services and information more widely available, the trust's complaints and PALS posters were updated and revamped and displayed prominently on wards, in outpatient clinics and throughout our hospital buildings.

Feedback from our maternity action plan

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NHS Staff survey results 2015

For the national staff survey 2015, 3184 (38%) of 8347 eligible staff completed the Survey between 28th Sept and 10th Dec 2015. The response rate was 6% lower than 2014 (44%). Across the NHS the response rate in 2015 was 41%, 1% lower than in 2014 (42%).

For 2015 there was a substantial revision in the questionnaire, which means that some questions and key findings are not directly comparable to 2014 results. The survey comprised 30 questions (plus sub questions) and 3 local questions which the NHS analyses into 32 key findings.

This section outlines the most recent NHS staff survey results for indicators:

- KF21 (percentage believing that the trust provides equal opportunities for career progression or promotion).
- KF27 (percentage of staff reporting most recent experience of harassment, bullying or abuse).

KF21- Providing equal opportunities for staff

76% of staff felt that the trust provides equal opportunities for career progression or promotion, in comparison to 87% which was the national 2015 average for acute trusts.

KF27- staff reporting harassment, bullying or abuse

34% of staff/colleagues have reported most recent experience of harassment bullying or abuse, in 2014 the trust score was 38% (the higher the score the better).

Suggestions to improve the staff experience include five high priorities based on the analysis of results. These include:

1. A strong campaign on bullying and harassment.

2. Working closely with those leadership teams in units with the worst outcomes from the staff survey – developing locally owned plans and monitoring delivery.

3. Setting clear expectations of managers in relation to appraisal, staff engagement and team communication activity – measuring and monitoring as part of their management.

4. Progressing rapid delivery of the improved intranet with clear and easy to find policy procedures and forms etc.

5. Delivering leadership training and support to managers – with an expectation that those in poorer performing areas will complete it.

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Annexes

Annex 1. Statements from Commissioners, Healthwatch organisations and overview and scrutiny committees

Annex 2: 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.

Monitor 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 2015/16 and supporting guidance
- 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 2015 to [the date of this statement]
- papers relating to Quality reported to the board over the period April 2015 to [the date of this statement]
- feedback from commissioners dated XX/XX/20XX
- feedback from governors dated XX/XX/20XX
- feedback from local Healthwatch organisations dated XX/XX/20XX
- feedback from Overview and Scrutiny Committee dated XX/XX/20XX
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX
- the [latest] national patient survey XX/XX/20XX
- the [latest] national staff survey XX/XX/20XX
- the Head of Internal Audit's annual opinion over the trust's control environment dated XX/XX/20XX
- CQC Intelligent Monitoring Report dated XX/XX/20XX

The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered

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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 and

The Quality Report has been prepared in accordance with Monitor's annual reporting 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

NB: sign and date in any colour ink except black

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

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

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Annex 3 Limited assurance Statement from External Auditors

This will be added in the final version of the report.

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Appendices

Appendix A: Our quality strategy

Our new quality strategy was approved by the trust board at a public meeting in November 2015 and spans all three domains of quality: patient experience, clinical effectiveness and patient safety.

1.1 External context

Three 2013 reports on quality and safety in NHS – the Francis report, Keogh review and the Berwick report – stressed the need for NHS to prioritise patients and quality above all else, and to develop organisational cultures which relentlessly strive for higher quality through continuous improvement and learning.

Continuous improvement, and the leadership and care redesign associated with it, offer a route to higher quality care – often at lower cost – by motivating and empowering front-line staff to explore, test, discover and implement changes which improve quality and efficiency. An increasing number of NHS trusts are discovering that carefully-planned, multi-year efforts to embed continuous improvement into routine practice can deliver sustainably better performance on several dimensions[1]. Success requires this is designed and owned by organisations themselves; it cannot be led from outside.

1.2 Characteristics underpinning cultures of improvement in other organisations

Empirical evidence from NHS trusts supports placing primary emphasis on quality and building capacity in continuous quality improvement. Michael West[2] found that trusts which put into practice an inspirational, quality-focused vision and narrative, and those which deploy continuous learning and quality improvement outperform others on outcomes, patient-experience and staff experience.

Over the past two decades, drawing on experience from UK and internationally, three core characteristics for successful improvement can be identified, as follows (see Figure 1 for more detail):

1. Building will and a sense of purpose, resonant with people's professional values
2. Building alignment and ensuring focus, while enabling staff to focus on their priorities
3. Building capability, in people and in systems.

Crucially, successful organisations have gone beyond an "initiative" or "programme": they align the organisation's overall strategy with making improvement business as usual – governance, reporting, leadership, organisational development and operations. The "programme" to embed improvement as normal business is 5 years minimum, around a robust business case and sustainability plan, harnessing both existing in-house expertise and usually also working with an external partner.

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[1] See for example East London NHS FT's QI programme evaluation published October 2015: *Successes and lessons from the first year of ELFT's Quality Improvement Programme*; available at https://elftqualityimprovement.files.wordpress.com/2015/10/elft-qi-programme-evaluation-2015.pdf

[2] NHS Staff Management and Health Service Quality Results from the NHS Staff Survey and Related Data (2013), M West et al; available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215455/dh_129656.pdf

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Figure 1. Characteristics of successful quality improvement programmes

Building will and a sense of purpose, resonant with people's professional values

- Framing and communicating an overarching purpose, relevant and inspiring to all staff, in terms patients can understand
- Listening widely to understand staff priorities, opportunities and concerns
- Focusing simultaneously and explicitly on improving staff experience and well-being
- Involving patients and families directly in improvement work
- Celebrating success

Building alignment and ensuring focus, while enabling staff to focus on their priorities

- Ensuring tight alignment between organisational strategy and the improvement programme: e.g., aims, structures, performance management arrangements, related initiatives
- Having sustained, visible and unambiguous senior leadership and board commitment to the work. At every level, improvement is championed by the most credible leaders
- Linking the vision to a small number of organisation-wide priorities while simultaneously encouraging staff to translate these priorities into what matters most their local context
- Adopting a consistent core improvement method, organisation-wide – and using the same method across clinical, clinical support and non-clinical areas

Building capability, in people and in systems

- Building board/senior leader understanding and capability
- Investing in capability-building across the workforce, learning in teams addressing real-work challenges
- Developing internal coaching resource (to support delivery by the operating line)
- Fostering informal learning, and making it "OK to fail" (fail fast and at small-scale, and learn from it)
- Developing data capture, reporting and analytic infrastructure and support.

1.3 The financial case and business rationale for investing in quality and continuous improvement, and the concept of "value"

Better quality must be achieved within increasingly constrained resourcing and growing demand: financial and operational pressures are relentlessly rising. Focus on financial savings and operational performance is essential, but risks negative impact on staff morale and quality. Further, the areas of greatest inefficiency and waste often lie within the clinical processes themselves, and can only be addressed if clinically-led teams are motivated, skilled and supported to address them[3].

A business rationale for investing in quality and continuous improvement does exist (see Appendix 1 for further details). Best available evidence suggests well-executed improvement programmes can yield a financial return of 2 to 10 times their cost of investment[4]. The rationale centres on systematically reducing waste, reducing opportunities for harm and improving process efficiency. Success requires clinical teams themselves to own the realisation of gains and for the organisation to support them. The same methods can be used to address waste in non-clinical areas.

It may be beneficial to bring cost and quality together under the framing of "value"[5]. This emphasises the shared responsibility of everyone working in health care (in whatever role, profession or setting) to maximise the outcomes delivered and patient experience per pound spent. Improvement work can focus on maintaining quality while removing cost, or disproportionately improving quality for resources invested. Over time, we may wish explicitly to frame our quality and improvement work under the banner of "value".

1.4 RFL context

We employ over 10,000 dedicated and talented staff who strive to deliver outstanding results and experience for the 1.6m patients we serve each year. We have made substantial progress in quality and safety outcomes over recent years (for example, in falls, infection, sepsis and patient experience). Our current performance as defined by national metrics and standards is generally good or excellent, with some areas of challenge (such as MRSA and, historically, patient satisfaction and staff turnover/feedback). There is substantial variability of performance in most areas (e.g., by site, ward, over time and across services) which we are working to reduce.

We have a growing reputation as a strong organisation which delivers what it sets out to do. Having achieved FT status, we have focused over 2014 and 15 on effective integration to create "one trust" across multiple sites, investing to develop robust governance and risk management and reporting systems. We have developed and embedded the four WCC values and launched major programmes in safety and staff and patient experience, reinforcing and accelerating work at Divisional level.

This provides the basis on which to move forward and make continuous improvement a core part of RFL's ways of working. Developing a single trust-wide approach to quality improvement is one of our corporate strategic objectives for 2015-16. There is widespread recognition that RFL cannot consistently provide high-quality, efficient care across its services without a new approach to continuous improvement, which unleashes the energies and creativity of front-line staff at scale. Furthermore, a well-embedded, consistent operating model for existing sites is an essential foundation from which to move toward greater scale through our RFL Group aspirations and work as an NHS England Vanguard and through the Enterprise Group.

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[3] Swensen, Kaplan et al (2011) Controlling healthcare costs by removing waste, BMJ Qual & Saf
[4] Swensen, Meyer et al (2010) From cottage industry to post-industrial care, NEJM
[5] Porter (2010) What is value in health care, NEJM

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Continuous improvement should be central to delivery against each of our 5 governing objectives, as follows:

1. Excellent outcomes – to be in the top 10% of our peers on outcomes	• Clear focus on continuous improvement of outcomes that matter most
2. Excellent user experience – to be in the top 10% of relevant peers on patient, GP and staff experience	• Equal focus on continuous improvement of patient and staff experience • Link to WCC values
3. Excellent financial performance – to be in the top 10% of relevant peers on financial performance	• Continuous improvement of value (through removal of waste) as the most reliable route to financial health
4. Excellent compliance with our external duties – to meet our external obligations effectively and efficiently	• Applying continuous improvement to the trust's 'must-dos'
5. A strong organisation for the future – to strengthen the organisation for the future	• Raising morale, cohesiveness and enhancing reputation; quality and continuous improvement underpinning recruitment and retention • Contributing to a strong local health economy

Diagnostic on current approach to quality

The iQuasar programme undertaken in 2014-15 offers insight into leadership perceptions regarding quality improvement. Executive and Non-Executive Board members and senior clinical/divisional leads' survey responses suggested that areas for development include:

- Linking staff at all levels who are interested in getting involved with QI with relevant trust expertise and resources
- Linking the learning from different QI projects, and providing staff with opportunity for reflection on QI and integrating QI into educational activities
- Working with patients to identify and address QI priorities.

Additionally, iQuasar highlighted the need for a narrative around quality and improvement, and making QI "business as usual" across the trust, by defining and codifying a methodology that the trust chooses to adopt. Responses also highlighted the need for investment, including in a coordinated improvement function to train and support staff and in data/analytic infrastructure.

Interviews across clinical directors, service line leads and others to inform development of our quality strategy revealed five main themes (set out in greater detail in Appendix 2):

1. There is no widely-understood definition of quality, or a clear narrative to guide services
2. In general, although executives' commitment to quality is acknowledged, the "voltage-drop" into directorates and services is substantial. People aren't clear what is required or expected
3. There is less emphasis on the management and governance of quality vs. operational targets and money. Reporting "by exception" means that what matters most to services is often lost. Delivery is achieved through performance management, rather than by enabling improvement

4. Many change projects and programmes are ongoing, which creates some confusion. More clarity is also needed on what change support is available, and on how best to access and use it
5. Despite substantial investment in overall support to services, creating a “RFL-way” which includes continuous improvement will require addressing substantial gaps in capability and infrastructure.

2. Scope of the quality strategy

Quality for NHS was defined by the 2012 Health and Social Care Act as having 3 basic dimensions: safety, effectiveness and patient experience. While some organisations have chosen one dimension within quality around which to focus their strategy (must usually patient safety) the focus for our quality strategy should encompass all three dimensions of quality: this will allow it to dovetail with and accelerate delivery of the Safety and Patient & Staff Experience strategies, and help re-energise the work on service-specific effectiveness metrics. It will also make the quality strategy directly relevant to the work of each board committee focused on quality. Further, it links the quality strategy to addressing key operational challenges (e.g., those along CQC’s responsiveness domain, such as RTT) since these each impact one or more of the three dimensions. It also provides the best platform from which to link quality improvement to quality governance, risk management and audit, and allows broadening to a focus on quality and resource together – i.e., the continuous improvement of value.

3. Building-blocks of our strategy: the PDSA model, capability-focus and getting to scale, measurement, leadership and learning

3.1 The “PDSA” model for improvement

Numerous improvement models are available and can be effective in a wide range of contexts. Each is associated with a set of technical/analytic and behavioural tools. Evidence suggests key to success is less which model is chosen and rather its consistent application and reinforcement over time. The best-known model for improvement both in RFL today and the NHS is the “PDSA Model for Improvement”, used by the Institute for Healthcare Improvement (IHI) – see Figure 2. A key benefit of it is its simplicity: “Plan, Do, Study, Act” represents a cycle of designing and testing a change, measuring its impact and reflecting on the result. This discovery and learning cycle is re-run iteratively.

As such it is an extension of audit and evaluation with which clinicians are familiar. The key differences lie in the size of the measurement samples and the linking of cycles together in a way which rapidly delivers improved results. After successful tests under a wide range of conditions, the PDSA cycle is used to hardwire changes into the organisation’s infrastructure for sustainability.

The PDSA model will be at the heart of RFL’s approach to continuous improvement. The method is powerful since it provides a structured, iterative way for front-line teams to test possible solutions to key challenges in their daily work, and to obtain rapid feedback on these changes’ effectiveness, enabling successes to be built on and scaled up and tests which didn’t work to be stopped. As such, front line staff discover routes to better performance and sustainability, and have full ownership of the solutions.

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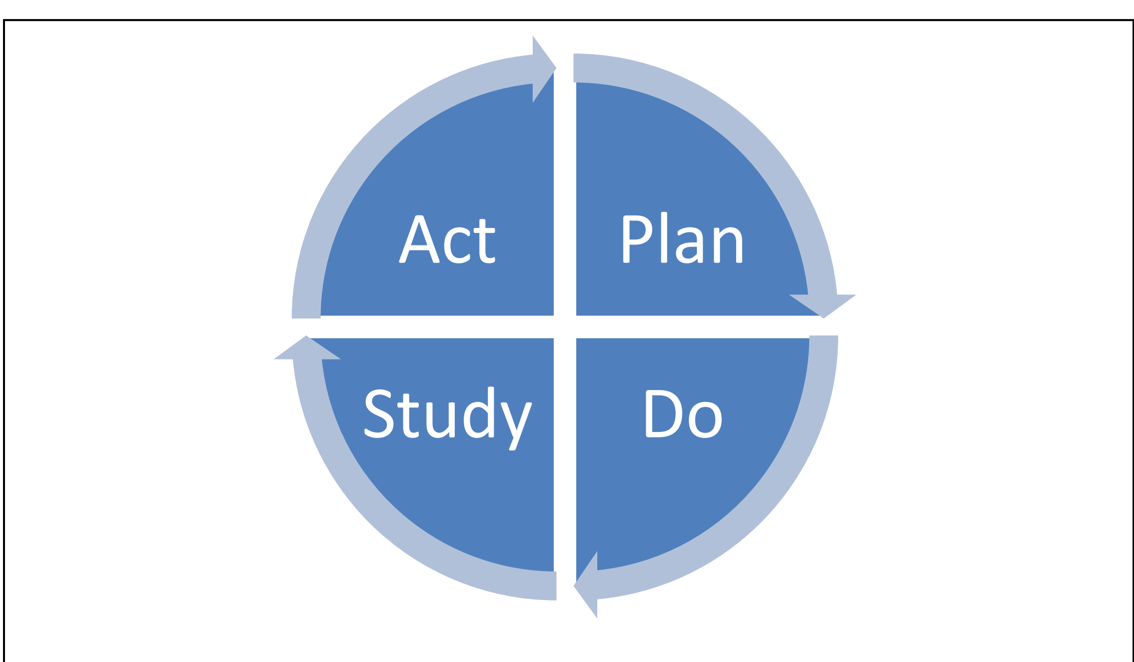
The model is equally applicable to work which spans different departments and multiple services as to work within one service; as such, "improvement" can be used to address complex challenges such as flow and safety. It is also equally applicable to clinical support services and non-clinical services as to clinical services: as such, it offers an unusual opportunity for staff of all backgrounds and departments to learn and deliver together.

Figure 2: The PDSA model for improvement



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3.2 A capability-building focus for the strategy, and getting to scale

RFL's quality strategy should not be about coordinating and resourcing a large portfolio of quality-improvement projects. We aim for the number of these to grow over time, but these will be primarily owned by the operating line. Rather, our quality strategy's central theme should be **capability-building at scale** which embeds our approach to continuous improvement into staff's daily work, and which also **supports learning and knowledge transfer** across the organisation. Without staff who have the capability, capacity and motivation to find, sustain and spread improvements we cannot deliver the strategy since today the great majority of staff do not have experience of the science and methodology of improvement.

Consequently a major capability-building exercise over several years is required. We will focus capability-building efforts on equipping staff with a method for systematically driving continuous improvement, and providing support in using that method. This support will include developing coaches and other experts to support teams undertaking improvement. We must ensure that the method is widely applied and adopted across professional groups and services. This applies to non-clinical and clinical support functions just as it does to clinical services. Additionally, senior leadership must have the understanding and skills to lead for improvement.

Achieving the coverage required will take several years even with rapid roll-out. Capability-building is needed both for front-line teams and for leaders, to include at minimum:

- Fundamentals of improvement thinking and improvement-centred approaches
- Patients' and families' roles in improvement
- Strategies for developing change ideas
- Systems thinking
- Measurement for improvement, and concepts of variation and reliability
- Flow
- Understanding of human factors
- Study-designs for testing changes
- Coaching and promoting learning
- Spread and scale-up.

These domains will be included in a variety of capability-building formats which we will develop through implementing this strategy. These formats range from introductory learning (for example at induction and as part of mandatory training for all staff) to generate basic awareness, to in-depth learning over time in real teams where learning is paired with application to address important challenges faced by the teams. We also need to tailor, scale-up and spread useful innovation from single contexts to greater scale – potentially trust-wide and beyond. We will deploy an approach to spread and scale which draws on proven methods[6] as we scale-up as rapidly as possible from small local tests of change to implementation at scale (as, for example, the patient safety programme is already doing).

Experience suggests for a trust of 10,000 staff, several hundred (including those in leadership roles) need deep applied knowledge of and commitment to QI to truly embed improvement into routine working. Overall we aim to create a movement for quality across the trust, which a "Quality Champions" concept (see Appendix 3) would support.

Staff will need dedicated time to learn and space to apply learnings in their everyday work. Implementing the strategy will establish trust-wide a common language and standard set of tools for improvement and learning. It is crucial we also establish tight alignment across the different elements of support and major initiatives which exist across the trust today.

3.3 Measurement for improvement, and analytic/information systems support

All improvement work must be underpinned by rigorous time-series measurement, tracking reliability on key inputs/processes and required checks and balances which inform and drive the outcomes we care about. Our measurement approach should enable services to answer the following deceptively simple questions:

1. *Do you know how good you are?* – which requires services to have defined by what metrics they are defining success
2. *Do you know where you stand relative to the best?* – where the relevant peer comparison may be local, national or international, depending on the nature of the service
3. *Do you know where and how much variation exists?* – toward reducing inappropriate variation, whether variation by different site, different teams, times of day or day of week

[6] *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement* (2003) IHI Innovation Series white paper, Institute for Healthcare Improvement, Boston (available at www.IHI.org); Massoud MR et al *A Framework for Spread: From Local Improvements to System-Wide Change* (2006). IHI Innovation Series white paper, Institute for Healthcare Improvement, Boston (available at www.IHI.org)

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4. *Do you know your rate of improvement over time?* – often the most important comparison of all, to oneself over time.

To implement the strategy we will need to invest in measurement, and the support for measurement and data management. Planning for this is being embedded into the trust's concurrent IMT strategy review, and two key areas include:

- Systems to capture key data required by teams in a time-efficient way, and to produce time-series data (eg SPC charts) directly to ward/clinic-level which provide the basis for interpreting PDSA cycle measurement
- Measurement and analytic expertise to support teams in their work.

3.4 Leadership for quality improvement

Successfully embedding improvement into daily work requires sustained and strong leadership and reinforcement at all levels, from "Board to Ward". As above (section 1.2), successful improvement efforts are characterised by sustained, visible and unambiguous senior leadership and board commitment to the work, with improvement championed by the most credible leaders at every level. We will need to consider how senior leaders build their own collective and individual capabilities to lead for improvement, and what leadership practices may best support delivery.

3.5 Learning from ourselves, and others

A culture of continuous improvement goes hand-in-hand with continuous learning – for individuals, teams and the whole organisation. Learning from one's own operational experience, and that of others, is a characteristic of excellent organisations, and is (strangely) not consistently present in health care. We will design-in mechanisms to maximise learning across professions, sites, services and divisions. Beyond RFL itself, the Enterprise Group represents an obvious channel for learning (Salford Royal and Northumbria FTs being well-known improvement-focused organisations). Other potential channels include UCLPartners and potentially joining NHS Quest, a national network of FTs focused on collaborative learning and improvement, convened by Salford Royal.

4. Alignment with existing major initiatives and the trust's organising principles

There is much work already underway across RFL to improve quality, efficiency and access. This takes a variety of forms, uses a variety of methods, and is anchored in various locations within the trust. The trust is aiming to streamline its approach to change and maximise synergies between initiatives, including through establishing a Change Board.

On this background it is especially important the quality strategy is executed in a way which builds alignment, reduces complexity and complements existing initiatives and workstreams – creating a "quality" or "improvement" silo would not be helpful. Successful delivery of the quality strategy will enable us to progress faster and more sustainably on existing priorities and daily work rather than charter multiple new initiatives.

To avoid creating additional complexity the quality strategy must be linked to the existing building blocks around which the trust is led and managed. Of three potential options (the trust strapline,

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WCC values and governing objectives), TEC's view was the most logical connection would be via the values. Recognising that the values have traction because they represent the voice of staff, we intend to explore with staff whether we should introduce a 5th value centring on "continually improving"[7].

By focusing the strategy on capability-building for improvement and by ensuring the detail of the strategy and its implementation are co-developed by those leading current, people with existing expertise and representatives of major professional groups, we will minimise the risk of developing something which does not dovetail with other initiatives or fails to meet the needs of front-line staff. Table 1 illustrates some ways in which the quality strategy will reinforce and support existing initiatives.

5. Principles underpinning RFL's quality strategy and tests of success

RFL's quality strategy aims to increase the likelihood that every patient receives the best possible care, in line with the trust's mission and values. We suggest the following **five principles to underpin the quality strategy**:

1. Everyone's primary goal and duty is improvement on things that matter to patients. Patients, families and carers will genuinely and consistently be at the centre of the work
2. We will constantly deploy iterative, reflective cycles of planned changes, linked to measurement over time, led by the multiprofessional teams which serve patients (or other 'customer')
3. We will build capabilities in continuous improvement, build capacity in coaching for improvement and build a learning organisation
4. Our approach will focus on equipping front-line staff to gain greater control of the systems that they work in – this is not about asking staff to work harder. This strategy will not increase the current number of centrally-driven initiatives: rather, it will focus on building capability and capacity better to deliver existing priorities across clinical care, clinical support and non-clinical support services
5. All trust initiatives and strategies (for example, patient safety & patient experience) and service support (for example, leadership/OD, Vision 2020/QIPP, pathway and service redesign, governance and audit) will dovetail and pursue the same goal of quality and continuous improvement. We will use formal mechanisms (such as job planning, recruitment and appraisal, committee and meeting agendas) to reinforce our approach and signal our priorities.

We will build evaluation into our delivery. The success of the strategy will primarily be determined by the number of staff who apply what they have learned to key improvement opportunities in daily work, and by overall staff feedback. While we expect the trust's "hard" quality – and efficiency – metrics to improve over time, these are driven by many internal and external factors. We therefore suggest the following **five tests of success of the strategy** for 2020**:**

- That critical numbers of staff have been trained in and meaningfully use RFL's approach to quality improvement in daily work. For example, at least 400 staff have completed the team-

[7] In current documentation accompanying the values (the "Living our values" Behaviour framework pamphlet), improvement is highlighted as one of three sub-elements under 'Visibly Reassuring': Prioritising safety, Speaking up, and Keep improving.

based, applied learning offer, and there are at least 200 Quality Champions across professions (and that this status is seen by staff as a 'badge of honour')
- That patients and carers are pleasantly surprised by how well their needs and preferences are anticipated and acted on – reflected in increased positive feedback and fewer complaints
- That all staff can articulate the quality metrics most relevant to the context in which they work, and are aware of current performance level and trend
- That staff morale, recruitment and retention rise. Over time, that people choose RFL as a place to work because of its reputation for embedding continuous improvement into routine practice
- That RLF's performance on "hard" system quality metrics and efficiency is exemplary and improving over time: for example, patients report greater satisfaction through better access and find services more responsive to their needs and preferences; staff report greater satisfaction from greater support and enhanced capabilities, reflected in national surveys.

6. Delivery of the strategy and next steps

The level of investment required and delivery plan are in development. Since this strategy represents an essential part of the operating model for RFL Group, we are seeking investment from NHS England through the Vanguard programme.

This is a major undertaking whose development will need at least 5 years trust (or Group)-wide. Our twin aims are: (i) to accelerate delivery of the highest quality, best value care, and best staff experience across RFL group by 2020, and (ii) to embed continuous improvement into daily operations at RFL and to ensure best support to services across RFL group. We plan to accomplish these aims through activities grouped into four themes – (a) building will, (b) creating alignment and deploying infrastructure, (c) building improvement capability, and (d) applying improvement to daily work. Application will be through two main tracks: first, major trust initiatives, including the Patient safety programme, Patient and staff experience programme and Transformation work (Vision2020: Wave1/2, QIPP, service/pathway redesign); second, through local priorities: each service/ward and non-clinical service to work to at least one local QI objective.

Governance: A programme of this strategic importance to the Trust should be sponsored by the Trust Board. Several choices exist for both Board-level and Executive-level reporting. Especially given the nature of the programme, it is important that patients/service users (potentially Governors), staff and non-executive directors are represented in the governance arrangements.

Structure: A core support team will be required, whose size and composition will depend in part on our ability to align across existing functions and initiatives, and with the operating line. We envisage internal secondments into this team for clinical and other staff not only to maximise efficiency but also to emphasise the relevance of improvement to mainstream daily work across professions.

We have set up a **working group** chaired by the Director of Quality, which includes membership from:

- Transformation (incl. Vision2020, QIPP, service and pathway redesign) and OD/LD
- Major quality initiatives already underway: safety and patient/staff experience
- Clinical audit and risk
- IMT and analytic services, and other key functions incl. finance and internal communications
- Professional education
- Medicine and nursing
- Operations: Divisions and service-lines.

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This approach will ensure that what we develop complements existing initiatives and functions, harnesses existing improvement expertise, and builds-in the "customer perspective" from medicine, nursing and operations. It also enables additional work to be done pending staffing the core support team.

Key activities for the next 6 months include:

- Listening to staff and patient priorities, and developing and deploying our quality narrative
- Agreeing the detailed components of our model, including links to existing functions and initiatives
- Determining the level of investment required, securing funding, and developing a full implementation plan
- Staffing the core support team
- Building an initial faculty and determining its capability-baseline and gaps
- Selecting a strategic partner for delivery.

7. Conclusion

An increasing number of leading NHS organisations are investing to create their "way" of continuous improvement. Investing over the coming five years to build our "way" for quality, centred on continuous improvement and learning will:

- Place relentless focus across the trust on the critical challenge of: "Are we improving on things that matter most to patients and staff?"
- Put patients and families ever-more at the heart of how we design and deliver care
- Provide the platform from which to deliver the highest possible quality of care, while also enabling RFL to meet ever-more challenging financial and operational hurdles. The result will be higher value care – delivered by front line staff through continuous removal of waste rather than cost-cutting
- Establish an operating model with greater ownership for delivery by front-line teams, supported by central structures and leadership
- Unleash and motivate staff of all types and in all departments, increasing RFL's attractiveness as a place to work
- Serve as an important enabler of successful integration to create "one organisation" across multiple sites, and provide a strong base to underpin further increases in scale through a Group model, as well as working with other organisations locally at whole system/pathway level.

TABLE 1: **How the quality strategy will reinforce and support existing initiatives**

Initiative (examples, not exhaustive)	How delivery of the quality strategy will support the initiative
Patient safety programme, and Patient/Staff experience programme	• Accelerate spread - & de facto expand capacity - by embedding the core methodology in front line staff, creating "pull" and capability for delivery
Vision 2020: e.g., Flow and discharge, Outpatients, Clinical Services Strategies	• Add to skillset of change agents and front-line staff • Increase ownership of front-line staff in change process – enabling functional teams to work on more 'fertile' ground; Create front-line "pull" and greater co-development with service lines
Service-line leadership programme (Bohmer programme)	• Complement leadership development and service operations work with front-line capabilities and coaching support to bring about change
Workforce	• Add important new skills into routine skillset across staff groups and increase attractiveness of RFL as a place to work; develop coaches drawn from various professions
24/7 patient	• Equip front-line teams with new methods and skills to find and implement practical solutions
IMT/analytics strategy	• Increase IMT/analytical experts' measurement-for-improvement capabilities (and skills/demands from services) • Focus analytic/data systems further on front-line team's requirements
RFL Group model	• Contribute to the more stable, codified operating base on which greater scale can be built (and which is championed by clinicians) • Develop a service-line/offer in QI, analytics and capability-building which RFL makes available to organisations joining the RFL Group.

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APPENDIX 1: **Financial case and business rationale for investing in quality and continuous improvement**

Providers exist to provide high quality care, and so investing in quality and continuous improvement can be seen purely as an ethical and practical imperative. Happily, this is there is increasing evidence these investments *also* make sound business sense, delivering measurable return on investment and showing how the disciplined application of continuous improvement techniques can systematically remove waste.

Greatest waste in healthcare is typically found within the clinical processes themselves, and can only be addressed if clinically-led teams are motivated, skilled and supported to address it[8]. High-quality, patient-centred care happens when processes have minimal waste and high reliability: removing waste reduces cost; high reliability means less frustration and wasted effort for staff, thereby improving staff satisfaction. This in turn has direct impact on outcomes and financial performance.

The best-documented evidence to date comes from USA where wasted spend has been estimated at 14-40% of total spend[9]. Reducing waste can be categorised in two main areas: (i) preventable harm and (ii) process inefficiency. Systematic re-engineering of care to achieve reliability against agreed standards has been shown across multiple US organisations to lead to sustained operating cost savings measured in millions of dollars per year, often with the additional benefit of avoiding the need for capital purchases or investments, revenue benefits, and better patient outcomes and staff/patient experience[10]:

(i) Preventable harm: Taking healthcare associated infections (HCAIs) as an example: Mayo clinic reduced central line infection rate by 50% from 2009-12, and calculate a $30k margin improvement per patient when complications are avoided (even allowing for additional revenue from treating complications). They also calculate that each bed is 3-4 times more productive without complications. Similarly, Cincinnati Childrens' hospital found work which reduced infections by 60% over two years also saved $11m in cost and released capacity equivalent to 5 beds due to reduced length of stay. Each bed generated $1m additional revenue/year when complications were avoided.

(ii) Process inefficiency: Various studies estimate that front-line staff spend around one-third of their clinical time and effort on non-value-adding activities (such as locating missing items, waiting, addressing defects and recovering errors)[11]. This reduces staff morale and can be addressed by applying improvement techniques. Work at Mayo Clinic to standardise hip and knee replacements across Mayo's 22 hospitals led to annualised cost savings of over $2.5m, driven by 40% reduced use of blood products, 30% reduction in LoS, 10% reduction in readmissions. Many of these also represent tangible improvements in quality for patients.

Overall, Mayo clinic calculate a typical 5:1 to 10:1 return from investments in quality improvement. Other US organisations report at least a 2:1 return[12]. Mayo has developed a structured tool with which to track financial return which distinguishes between "hard" financial impact (characterised by direct, short-term and quantifiable impact on cash flow) and "soft" impact (which may increase capacity, raise productivity without reductions in staffing, avoid future costs, and lower malpractice costs).

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[8] Swensen, Kaplan et al (2011) Controlling healthcare costs by removing waste, BMJ Qual & Saf

[9] Swensen, Meyer et al (2010) From cottage industry to post-industrial care, NEJM

[10] Swensen, Dilling et al (2013) The Business case for health-care quality improvement, J. Patient Safety

[11] Spear & Schmidhofer (2005) Ambiguity and workarounds as contributors to medical error, Ann Internal Med

[12] 2012 Institute of Medicine discussion paper "A CEO Checklist for High-Value Health Care". This contains numerous examples and is authored jointly by CEOs of Cincinnati Childrens' Hospital, Cleveland Clinic, Denver Health, Geisinger, HCA, InterMountain, Kaiser Permanente, Partners Health Care, ThedaCare & Virginia Mason

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The business case in NHS is less well documented, but evidence is emerging – taking 3 examples:

- Sheffield Teaching Hospital's Flow, Cost and Quality programme realised £3.2m annual cost saving in care of the elderly. Reduced length of stay enabled closure of two wards[13]
- Salford Royal estimate their safety work has saved £5m in cost & 25,000 bed days/year[14]
- Locally, East London FT have found work to reduce violence on one ward has generated annualised staffing cost savings of over £70,000 from reduced staff turnover and absenteeism[15].

Success is not guaranteed of course – many quality programmes have failed both on quality and return on investment. But as the examples above show, organisations are finding that a 'virtuous circle' of improvement in cost and quality can be realised. The same methods can be used in work on both cost and quality, and by teams working in non-clinical services.

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[13] Health Foundation newsletter, September 2014: available at http://www.health.org.uk/newsletter/eight-case-studies-show-you-can-improve-quality-while-also-saving-money
[14] HSJ The Case for Patient Safety, 2015
[15] ELFT verbal communication

APPENDIX 2: Messages from the organisation to inform RFL's Quality Strategy

To inform development of RFL's Quality Strategy, conversations were undertaken with clinical directors, divisional leadership, AMDs and others regarding current practices and how delivery could be better supported.

Despite substantial pressures, there is a sense that much is going right in the trust and a sense of optimism and excitement regarding opportunities ahead – people are restless to do better. Senior leadership is largely seen as authentic, focused on maximising quality for patients, and trying to be helpful to staff – wanting the same things that patients and staff care about. People throughout the trust are highly motivated to improve quality, balanced with to concern that capacity and focus may fall short when competing priorities bite. There is little appetite for "another initiative".

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Five key messages emerged, as follows:

- **There is no widely-understood definition of quality, or a clear narrative to guide services**
    - People's definition of quality (and of "improvement") vary
    - There is clarity on and strong support for the WCC values – widely seen as translating positively into daily attitudes and behaviours. However, the five governing objectives do not provide similar clarity or inspiration – they are seen as "managerial"
    - A narrative on quality which people own and can interpret locally is lacking. Below the headline of "top 10%", people are not clear what the Trust's quality priorities are, or how their actions contribute to delivering against the Trust's priorities. We lack the clarity and immediacy found at Salford Royal[16]: "We aim to be the safest organisation in the NHS…we will continue relentlessly to pursue giving our patients, families and carers Safe, Clean and Personal care every time".

- **In general, although execs' commitment to quality is acknowledged, the "voltage-drop" into directorates and services is substantial. People aren't clear what is required or expected**
    - There is variable ownership regarding quality measurement and reporting beyond external requirements. The most advanced services typically have particularly effective leader(s) and external goals or reporting – which create focus, profile and urgency
    - There is variable level of ownership on national audits. Some see these as aligned with their aims, others as an unhelpful burden and distraction from what matters most to patients
    - There is variable understanding of what skills and actions are required to drive quality, and the capability/capacity requirements
    - Accountabilities and expectations are unclear and overlapping: e.g., division vs. service, and roles within each (nurse, clinician, manager).

- **There is less emphasis on the management and governance of quality vs. operational targets and money. Reporting "by exception" means that what matters most to services is often lost. Delivery is achieved through performance management, rather than by enabling improvement**
    - Overall, more is reported and more time spent discussing operations and finance (e.g., in divisional committees) than quality, so the subtext is: "these really matter the most"
    - Quality metrics which are not externally-mandated can appear neglected. For services with advanced local ownership and ambition, this can be frustrating: these locally-determined quality metrics often better capture what matters most to patients

[16] Salford Royal Quality Improvement Strategy, 2015-2018

- Positive outlier results only variably reach senior leaders'/governance attention: "If it's not externally mandated, it's not an exception, so however good it is, it doesn't get up the chain"
- Features of performance management are more prominent than those of continuous improvement. Planned tests of change and reflection, encouraging local experimentation, understanding variation and exchange of learning are not prominent in the current approach. (There are a few notable exceptions to this, for example the "Sepsis 6" work)
- There is generally high appetite to learn more effectively from units' own experience, and from others – people want mechanisms for transferring learnings within/across divisions and services.

- **Many change projects and programmes are ongoing, which creates confusion. More clarity is also needed on what change support is available, and on how best to access and use it**
  - Programmes/initiatives underway include: QIPP, service redesign, pathway work, Wave1, PMO/integration; safety strategy and patient experience strategy
  - Both the people working in these functions, and their "customers" in the services are confused by the range and scale of activities (though customers are positive about the people providing support)
    - Services are not clear where to go for support, or "what we use when". There is demand for "how-to" guides and a single 'key account' interface (offering guidance on what to access and how)
    - People based in functional support teams equally want to understand better what others do
  - It is not clear on what basis support is allocated/prioritised: "Does it go to those who shout the loudest?"
  - It is not clear how these functions do (or should) dovetail with OD/Leadership and professional education.

- **Despite substantial investment in overall support to services, creating a "RFL-way" which includes continuous improvement will require addressing substantial gaps in capability and infrastructure**
  - Most trust capacity for change is currently in larger-scale change – transformation and care redesign, rather than continuous improvement (more incremental change). Pockets of continuous improvement expertise do exist–e.g., PARRT team frequently cited—but these are often localised and/or not recognised for the methods they use. These provide a basis from which to build
  - Capability gaps include: training in and applying a model for improvement (at various levels of seniority); developing and deploying experts/trainers in improvement; coaching skills; giving and receiving feedback; measurement and analytics
  - Gaps in infrastructure centre on data and analytics, and include:
    - Systems to capture and report locally-relevant quality metrics
    - Measurement for improvement (currently people need to purchase their own software)
    - Analytic capacity to support services' work.

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APPENDIX 3: **The “Quality Champions” concept**

There is substantial will and motivation across staff groups to improve care and to gain more control over the systems in which they work. To build skills and participation rapidly and at scale so that people apply improvement to their real-work challenges, we will establish a “Quality Champions” programme. This will be designed to harness and generate energy and excitement among those who get involved in improvement. Drawing on social movement and large scale change theory, design principles include:

- Open to all staff members across all grades and professions, and potentially patients and carers
- People can focus their work on any area within the broad umbrella of the quality strategy. Staff will be encouraged to work in multiprofessional teams and to involve patients wherever possible
- Personal commitment is key – participants must be self-nominating
- People will gain tiered accreditation – for example, “bronze” to “gold” as follows:
    - *Bronze*: with a relatively low bar for entry, such as participation in introductory training and application to a challenge relevant to the person’s work area
    - *Silver*: with some evidence of sustained commitment over time and implementation of successful improvement work within the trust
    - *Gold*: with substantial evidence of sustained commitment over time and driving successful improvement work in multiple settings across the trust, and supporting others to improve.

Carefully-chosen features will enhance the visibility & cachet of the programme – for example:

- Active sponsorship from CEO/executive and divisional leadership – e.g., regular opportunities to present work and receive feedback
- Creative internal communications – building awareness, sharing learnings and celebrating successes
- Visible markers to identify Quality Champions – e.g., modified ID badges displaying the tier achieved.

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Appendix B.

Details of specific actions undertaken as the result of a national clinical audit

National clinical audit	Actions to improve quality
NNAP Audit: In November 2015, the National Neonatal Audit programme 2015 report covering 2014 clinical data was published.	The NNAP data for Royal Free Hospital neonatal unit to be reviewed to check the validity of the audit results with the relevant stakeholders and an action plan to be developed to address any identified gaps/deficits.
The National Diabetes (core) adults	The Diabetes team are working with the database provider 'Diamond' to improve data collection for the 2016 audit.
The National Audit of Diabetes Inpatients (NaDIA) 2013	The NaDIA report for the 2015 audit has been recently published and currently under review. Improvements noted for foot assessments
The National Prostrate Cancer audit 2014-15 has published its Organisational report and First Year Annual Report.	Full compliance recorded against audit report findings. Actions to improve data entry for performance status and to consider increasing joint clinics to improve patient access, as recommended by NICE.
BAUS Audit data by individual surgeon	Reflecting the overall figures for the centre there were no individual outliers for the safety parameters.
Safeguarding- Section 11 Children Act Audits completed for Enfield, Barnet and Camden Safeguarding Children Boards.	On-going monitoring against section 11 continues to be led by the LSCB. The trust is compliant with section 11 of the Children Act. Most recent Section 11 audit completed and returned to BSCB 19.1.2016 with actions to improve effectiveness where identified.
Benchmark of recommendations from MBRRACE-UK 2015 Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enq Maternity services	Plans are in place with our maternity service in taking this forward.
Benchmark of recommendations from MBRRACE-UK 2015 Perinatal Confidential Enquiry Term, singleton, normally-formed, antepartum stillbirth.	The Maternity services benched marked itself against the report's recommendations and gaps were identified across the sites in Maternity and Paediatrics. A detailed action plan is in place.

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National clinical audit	Actions to improve quality
The National Oesophago-cancer audit report published in December 2015	The NOGCA report has shown a deficit in case ascertainment. An amber for case ascertainment (71-80% range) against expected HSCIC HES-based estimate. However, the HES data has been reported to be out of date. The deficit has been raised with the clinical area for feedback.
Rheumatoid and Early Inflammatory Arthritis report (1st cohort) published Jan 2016.	There have been issues with resource for recruitment and data entry at both RFH and BH, achieving only 6 at RFH and 24 at BH. The action plan includes a business case for an additional CNS, to improve patient flow into EIA clinics, patient education and assistance with audit.
Patient Report Outcome Measures (PROMS):	Actions to support this will include: • Obtaining data of actual number of procedures undertaken to compare with figures • Amending process at Barnet Hospital and Chase Farm Hospital for all submissions to come through governance team • Reviewing where pre-operative questionnaires are completed
CQC Maternity Survey- In December 2015, the CQC Maternity Survey was published.	The following actions are to be put in place: • The promotion of normality and the range of choice for women with regard to maternal positions in labour. • The promotion of the full range of communication strategies/media including the use of interpreting/translation services to facilitate women's understanding. • To ensure women receive consistent support and encouragement for infant feeding by promoting staff awareness via departmental meetings. • The Maternity services are working toward UNICEF Level 3 accreditation with an assessment due in April 2016.
Trauma Audit Research Network	Areas in the lowest quartiles for improvement: The quality of data submission was 94.6%.
National BTS COPD 2014 Audit	Improving referral for Pulmonary Rehabilitation-11% of patients are not being assessed for PR (better than the 44% national figure) but can be improved. This demands access to patients who are short-stay, especially at weekends, who do not see a member of the team. Again, the Camden process will consider this. Imperative to retain a PR class at RFH to facilitate this.

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Appendix C

Details of specific actions undertaken as the result of a local clinical audit

Local clinical audit	Actions to improve quality
Audit on Pain Management on the wards	Recommendations include; use of Abbey pain scale, implementation of verbal rating scale for cognitively intact, presentation to ED, meeting with ward managers to discuss.
To compare local practice to hospital guidelines for the need for thromboprophylaxis	Actions taken since have included: Consultants reminding junior staff, liaising with Pharmacy/Thrombophilia: Drug chart VTE section to be placed next to Tinzaparin prescribing section, and review dates to be placed within VTE prescription section.
NICE IV Fluids guidelines compliance audit (CG174)	Audit showed high compliance with some standards (prescription, rate, volume) but lower compliance with other standards (fluid management plan, fluid restriction, appropriate re-assessment). We have used these findings to improve fluid prescribing section of drug chart in conjunction with Pharmacy, and to design teaching, with plans to re-audit after new pan-RFH drug chart is introduced (currently expected June 2015).
Improving patient experience of cannulation/phlebotomy using USS guidance	To improve the technical ability of junior doctors in venepunture and cannulation by utilising ultrasound guided techniques, subsequently improving patient experience.
Use of PET in the investigation of paraneoplastic neurological syndromes.	Local guidelines formulated for more judicial use of investigations including CT and PET imaging in suspected paraneoplastic disease.
ITU Audit: Delirium	Actions include: • ITU staff educated in the importance of assessing delirium using CAM-ICU • Delirium levels to be re-audited in 2016 • Including auditing of how often delirium assessments are carried out.
Intensive Care Unit NG position testing policy	Actions include: • Improve supply/availability of stickers • New staff to be made aware of sticker in induction • Original length and current length to be recorded daily to ensure constant comparison

Appendix D: Glossary of definitions and terms used within the report

Five steps to safer surgery

Steps	Timings of intervention	What is discussed at this step
1.Briefing	Before list of each patient (if different staff for each patient e.g. emergency list)	Introduction of team/individual roles. List orde . Concerns relating to equipment/surgery. Anaesthesia.
2. Sign in	Before induction of anaesthesia	confirm patient/procedure/consent form Allergies. Airway issues. Anticipated blood loss. Machine/ medication check.
3. Timeout (stop moment)	Before the start of surgery Team member introduction. Verbal Confirmation of patient Information. Surgical/anaesthetic/nursing issues. Surgical site infection bundle. Thromboprophylaxis. Imagining available.	In practice most of this information is discussed before, so this is used as a final check. Surgeons may use this opportunity to check that antibiotics prophylaxis has been administered.
4. Sign out	Before staff leave theatre	**Confirmation of recording of procedure:** Instruments, swabs and sharps correct Specimens correctly labelled. Equipment issues addressed. Post-operative management discussed and handed over.
5. Debriefing	At the end of the list	Evaluate list Learn from incidents. Remedy problems, e.g. equipment failure. Can be used to discuss five – step process.

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Term	Explanation
Care Quality Commission (CQC)	The independent regulator of all health and social care services in England.
Clostridium difficile	A type of bacterial infection that can affect the digestive system
CQUIN – Commissioning for Quality and Innovation	CQUIN – Commissioning for Quality and Innovation (CQUIN) is a payment framework which allows commissioners to agree payments to hospitals based on agreed improvement work.
Multi-Disciplinary Team (MDT)	A team consisting of staff from various professional groups i.e. Nurses, therapist, doctors etc.
NHS NCL-	NHS- North Central London Clinical Network
NICE- National Institute of Clinical Excellence	An independent organisation that produces clinical guidelines and quality standards on specific diseases and the recommended treatment for our patients. The guidelines are based on evidence and support our drive to provide effective care.
PEWS - Paediatric Early Warning Score	A scoring system allocated to a patient's (child) physiological measurement. There are six simple physiological parameters which are: respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness.
SBAR- Situation, Background, Assessment, Recommendation	SBAR is a structured method for communicating critical information that requires immediate attention and action contributing to effective escalation and increased patient safety. It can also be used to enhance handovers between shifts or between staff in the same or different clinical areas.
Summary Hospital-level Mortality Indicator (SHMI)	The SHMI is an indicator which reports on mortality at Trust level across the NHS in England using a defined methodology. It compares the expected mortality of patients against actual mortality.
University College London Partners (UCLP)	UCLP is organised around a partnership approach: developing solutions with a wide range of partners spanning universities, NHS Trusts, community care organisations, commissioners, patient groups, industry and government. (http://www.uclpartners.com/).
Venous Thromboembolism (VTE)	A blood clot that occurs in the vein

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