RFH Quality Accounts 2011/12

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PART 1

INTRODUCTION AND STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

It gives me great pleasure to introduce the Royal Free's third set of quality accounts, designed to assure commissioners, patients and our local population that we provide the highest level of clinical care and continuously seek to improve what we do.

This year has been particularly significant because it culminated in our authorisation as an NHS foundation trust from 1 April 2012. This provides us with greater freedom and flexibility to innovate and invest in clinical services, allowing us to expand our critical care facilities, upgrade the imaging department and create a new institute of immunology. Through our new council of governors, we are also able to increase the involvement of patients and the local population in our future plans for high quality clinical care. The foundation trust application process has been very thorough and our authorisation is an endorsement of the quality and sustainability of our clinical services and our plans for the future.

During 2011/12 we can once again point to many achievements. We continued to focus on infection control, with a significant reduction in the number of c-difficile infections during the year. Our hospital standardised mortality rate continues to be among the best in the country. As promised in last year's quality accounts, we greatly improved our out-patient phlebotomy service and have significantly reduced the number of patient falls. We have also introduced a fast-track pathway for patients with a fractured hip which is significantly speeding up the time patients spend in A&E before being moved to the trauma ward.

We continue to promote public health and launched our new Fit at the Free campaign during the year to encourage our staff to take part in healthy activities.

There were a number of successful inspections during the year, the most important of which was a re-inspection by the Care Quality Commission (CQC) of some aspects of the care we provide for elderly patients. We have been working very hard to improve since the CQC's inspection of these services in March 2011. Other successful inspections were of our maternity service at the Royal Free Hospital and our renal service at St John and St Elizabeth Hospital.

The views of our various stakeholders have been very important to the development of these quality accounts and in the choice of our three high-level quality priorities for 2012/13. We have chosen our world class care programme as the top patient experience priority for the next year. This programme is designed to improve many of the areas that patients have told us are unsatisfactory, such as administration, communication with doctors and nurses and the way we give information about patients' conditions.

As the Royal Free London NHS Foundation Trust, we plan to focus even harder on our mission to provide world class care and expertise. Once again, the evidence provided in these quality accounts demonstrates our continuing commitment to providing the highest quality clinical care.

Finally, I confirm that to the best of my knowledge the information provided in these quality accounts is accurate.

David Sloman
Chief executive
Royal Free Hampstead NHS Trust

PART 2

OUR QUALITY PRIORITIES FOR 2012/13

Our mission to provide world class care and expertise reflects our desire to always provide the highest quality service to our patients. Each year we set three quality improvement priorities that are monitored by the trust board. One focuses on patient experience, one on clinical effectiveness and one on patient safety.

In order to set out three quality improvement objectives for 2012/13, we sought the views of our patients, staff and local community. We invited representatives from our commissioners, local LINKs and local councils to events where we were able to discuss quality priorities. We asked for input from our clinical teams and our governors. We asked our members to participate in an online survey and more than 400 gave their opinion of what our quality priorities should be. Finally, the board considered the responses we received and agreed the following three priorities for 2012/13.

Priority 1: World class care

We want to make sure that, as well getting the best clinical care, our patients have a good experience of us when they use our services. We know a number of factors affect the patient experience, such as the quality of administrative processes and how our staff interact with patients. We are also acutely aware that patient satisfaction is fundamentally linked to how happy staff are in their workplace.

As part of our world class care programme, which started in autumn 2011, we have listened to hundreds of our patients and staff members and have worked with them to develop a set of commitments and standards. Over the next year, this work will continue, with all staff taking part in a team workshop to set standards and expectations of each other and to agree priorities for improvement. This will support our aim to deliver world class care to every patient, every day.

We will measure our progress using results from our patient feedback kiosks, which are situated at various locations across the trust, and by national benchmarked surveys.

Staff satisfaction:

We will measure our progress by our performance in the national staff survey and from what staff tell us locally.

We have set ourselves targets for improvement in two areas of the staff survey, in which we have not performed as well as other trusts during 2011/12. These are:

Staff feeling valued by their work colleagues

2011 survey	2012 survey aim
72%	76%

Staff experiencing bullying, harassment or abuse from staff

2011 survey	2012 survey aim
24%	19%

Patient experience :

We will measure our progress by our performance in the national patient survey.

We will set ourselves targets for improvement in relation to two questions in the survey as follows:

- Overall, did you feel you were treated with respect and dignity while you were in the hospital?

- Overall, how would you rate the care you received?

We are currently awaiting the results of the latest patient survey. These are under embargo until May. When we receive these results, we will set specific improvement targets for 2012/13 in relation to our performance in the survey.

These specific targets will be added to the final quality accounts.

This priority is in the area of patient experience.

Priority 2: Further develop our clinical outcome measures

Over the last two years we have been working to develop a set of clinical outcome metrics (measurements) for all our clinical business units. As one of last year's quality account objectives, we said we would publish the full set of metrics. We report on progress towards this goal in section three.

We believe that this work is vital to the trust because it provides a strong focus on delivering excellent clinical outcomes. During next year, we therefore wish to expand this work further.

Our specific aims are to:

- Commence regular performance monitoring of our metrics through the clinical performance committee.

- Expand our portfolio of metrics by, for example, adding additional metrics from the many national clinical audits to which our specialties contribute.

- Work with other trusts in our academic health science partnership, UCLPartners, to develop common clinical outcome metrics that we can use to compare performance between organisations

This priority is in the area of clinical outcomes and is monitored by our clinical performance committee.

Priority 3: Managing the care of the deteriorating patient

We are committed to providing excellent standards of care at every stage of the patient pathway. An important part of this is making sure our staff can recognise when a patient is deteriorating and are equipped with the knowledge and skills to manage his or her care safely and effectively.

The trust has successfully implemented a patient at risk and resuscitation team (PARRT), who respond to the hospital's emergency resuscitation call-outs. This team operates 24 hours a day, seven days a week. The trust also uses an early warning system to promote early recognition of deterioration and to ensure prompt escalation and treatment to prevent patients from deteriorating further. There is collaborative multi professional working between critical care and other expert specialities within our organisation.

Nationally, we know a serious cause of patient deterioration and associated high mortality rates is due to severe sepsis and we are working with staff to raise awareness and education around sepsis. We are developing a pathway to support staff to recognise signs of severe sepsis at an early stage and use an evidence-based "sepsis six resuscitation bundle" to escalate treatment within the first hour. This includes a set actions which staff must undertake to ensure the best outcomes for patients.

This project has been introduced in acute medical wards, renal wards and A&E as pilot areas, with the aim of eventually continuing the improvement work to include all trust areas.

We plan to achieve the following in our pilot areas by April 2013:

95% of staff can demonstrate awareness of recognising and managing severe sepsis.

95% of patients with symptoms that suggest severe sepsis have received the sepsis pathway bundle.

95% of patients who receive the sepsis pathway receive all 6/6 resuscitation bundle interventions.

This priority is in the area of patient safety.

STATEMENTS RELATING TO THE QUALITY OF NHS SERVICES PROVIDED BY THE ROYAL FREE HAMPSTEAD NHS TRUST

This section contains eight statutory statements concerning the quality of services provided by the Royal Free Hampstead NHS Trust. These are common to all trust quality accounts and therefore provide a basis for comparison between organisations.

Where appropriate, we have provided additional information that provides a local context to the information provided in the statutory statement.

STATEMENT 1: REVIEW OF SERVICES

During 2011/12 the Royal Free Hampstead NHS Trust provided 27 NHS services.

The Royal Free Hampstead NHS Trust has reviewed all the data available to it on the quality of care in all of these services.

The income generated by the NHS services reviewed in 2011/12 represents **95.87% (NB based on month 11 figures)** of the total income generated from the provision of NHS services by the Royal Free Hampstead NHS Trust for 2011/12.

ADDITIONAL INFORMATION

In this context we define each service as a distinct clinical business unit that is used to plan, monitor and report clinical activity and financial information – this is commonly known as service line reporting. Each individual service line can incorporate one or more clinical services.

Clinical directorates routinely monitor demand and output data for all services and in aggregate this includes various quality measures. Few services are assessed as an isolated entity. Some very specialised services are routinely reviewed as part of the national commissioning group's processes.

STATEMENT 2: PARTICIPATION IN CLINICAL AUDIT

During 2011/12, 42 national clinical audits and two national confidential enquiries covered NHS services that the Royal Free Hampstead NHS Trust provided.

During that period, the Royal Free Hampstead NHS Trust participated in 98% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries in which it was eligible to participate in.

The national clinical audits and national confidential enquiries in which the Royal Free Hampstead NHS Trust was eligible to participate during 2011/12 are indicated in the table below.

The national clinical audits and national confidential enquiries that the Royal Free Hampstead NHS Trust participated in during 2011/12 are indicated in the table below.

The national clinical audits and national confidential enquiries in which the Royal Free Hampstead NHS Trust participated, and for which data collection was completed during 2011/12, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

NATIONAL CLINICAL AUDITS FOR INCLUSION IN QUALITY ACCOUNTS 2011/12	ELIGIBLE TO PARTICIPATE	PARTICIPATED IN 2011/12	DATA COLLECTION COMPLETED IN 2011/12	RATE OF CASE ASCERTAINMENT (%)
National diabetes audit	√	x	√	0%
National elective surgery PROMs: four operations	√	√	√	70%
Adult cardiac interventions: NICOR coronary angioplasty	√	√	√	100%
MINAP: acute myocardial infarction and other ACS	√	√	√	100%

National heart failure audit	√	√	√	100%
TARN: severe trauma	√	√	√	41-64%
Renal registry: renal replacement therapy	√	√	√	100%
NHS Blood and Transplant: renal transplants	√	√	√	100%
NHS Blood and Transplant: potential donor audit	√	√	√	100%
College of Emergency Medicine: sepsis	√	√	√	100%
College of Emergency Medicine: pain management	√	√	√	100%
RCPCH national paediatric diabetes audit	√	√	√	100%
British Thoracic Society: paediatric asthma	√	√	√	100%
NHS Blood and Transplant: liver transplant	√	√	√	100%
UK carotid intervention audit	√	√	√	100%
National joint registry	√	√	√	101%
British Thoracic Society (BTS): adult asthma	√	√	√	100%
Cardiac rhythm management	√	√	√	100%
National hip fracture database	√	√	√	100%
BTS: paediatric pneumonia	√	√	√	100%
National neonatal audit	√	√	√	100%
VSGBI: vascular surgery database	√	√	√	100%
ICNARC CMPD: adult critical care	√	√	√	100%
Acute stroke (SINAP)	√	√	√	55%
National lung cancer audit	√	√	√	100%

National bowel cancer audit	√	√	√	100%
National comparative audit of blood transfusion: medical use of blood	√	√	√	100%
National comparative audit of blood transfusion: bedside transfusion	√	√	√	100%
IBD: ulcerative colitis and Crohn's disease	√	√	√	100%
National audit of heavy menstrual bleeding	√	√	√	n=68 denominator unknown
Parkinson's UK: national Parkinson's audit	√	√	√	100% in 1 out of 3 modules
ICNARC: cardiac arrest	√	√	√	100%
BTS: bronchiectasis	√	√	√	100%
BTS: pleural procedures	√	√	√	100%
BTS: emergency use of oxygen	√	√	√	100%
BTS: adult community-acquired pneumonia	√	√	x	Still open
BTS: non-invasive ventilation	√	√	√	100%
National childhood epilepsy audit (epilepsy 12)	√	√	√	100%
National pain database: chronic pain services	√	√	√	unknown
National health promotion in hospitals audit: risk factors	√	√	√	100%
National audit of seizure management	√	√	√	100%
National care of the dying in hospitals audit	√	√	√	100%
Paediatric intensive care (PICANet)	x	n/a	n/a	n/a
Congenital heart disease	x	n/a	n/a	n/a

Adult cardiac surgery	x	n/a	n/a	n/a
NHSBT: cardiothoracic transplant	x	n/a	n/a	n/a
Head & neck cancer audit	x	n/a	n/a	n/a
Oesophagogastric cancer	x	RFH patients entered by UCH		
Prescribing in mental health	x	n/a	n/a	n/a
National audit of schizophrenia	x	n/a	n/a	n/a
Total: 50	42	41	41	
CLINICAL OUTCOME REVIEW PROGRAMME (PREVIOUSLY THE CONFIDENTIAL ENQUIRIES)				
NCEPOD: cardiac arrest	√	√	√	89%
NCEPOD: bariatric surgery	eligible for organisational survey only	organisational survey only	√	n/a
NCEPOD: alcoholic liver disease	√	√	x	Not open yet
National confidential inquiry into suicides and homicides	x	x	x	-
CENTRE FOR MATERNAL AND CHILD DEATH ENQUIRIES				
Maternal death enquiry: saving mother's lives	√	x	x	n/a
Perinatal mortality (MBBRACE-UK)	√	x	x	n/a
In addition, the Royal Free Hampstead NHS Trust participated in the following national audits by submitting data in 2011/12				
Maternal and perinatal mortality notification (as substitute for the two above enquiries which did not proceed)				
National colonoscopy audit				
British Association of Urological Surgeons: nephrectomy audit				
The Royal Free Hampstead NHS Trust reviewed the results of the following national audits and confidential enquiries which published reports but did not collect data in 2011/12				
NCEPOD: paediatric surgery: are we nearly there yet? (November 2011)				
NCEPOD: perioperative care: knowing the risk (December 2011)				
College of Emergency Medicine: renal colic				
College of Emergency Medicine: feverish illness in children under five years				

College of Emergency Medicine: vital signs
National mastectomy and breast reconstruction audit (4th report)
National falls and bone health

The reports of 34 national clinical audits (published in the calendar year 2011) were reviewed by the provider in 2011/12 and the Royal Free Hampstead NHS Trust intends to take the following actions to improve the quality of healthcare provided.

- Review and improve arrangements to capture specific data fields which allow risk-adjustment for mortality in national clinical audits.
- Introduce shared multidisciplinary team meetings between colorectal cancer and hepatobiliary cancer teams to review treatment options for patients with colorectal cancer that has spread to the liver.
- Undertake independent mortality case reviews for patients who died following colorectal cancer surgery.
- Extend the enhanced recovery programme.
- Introduce a discharge checklist and discharge asthma management plan for children with asthma admitted as an emergency.
- Take part in regional workshops on care of the dying.
- Define the Liverpool care pathway role within the palliative care team.
- Work with A&E departments in neighbouring trusts to ensure rapid transfer of patients suitable for acute primary coronary angioplasty.
- Extend the acute primary angioplasty service to patients suffering from a different form of heart attack (non-STEMI).
- Introduce a dedicated respiratory team with consultant input to guide use of non-invasive ventilation therapy in patients presenting to acute services.
- Introduce multidisciplinary team discussions (including the intensive care team) to discuss the provision of more invasive forms of respiratory support for patients in whom non-invasive ventilation proves insufficient.
- Introduce arrangements to give oxygen alert cards to patients identified at risk of hypercapnic respiratory failure, alerting future emergency responders of the precautions required when administering oxygen to these patients.
- Expand use of checklists and condition-specific documentation to reduce variations in care (eg care after death).
- Further staff training (eg non-invasive ventilation, care of the dying).

The 25 national clinical audits reviewed by the Royal Free Hampstead NHS Trust in 2011/12 were:

National comparative blood transfusion audit: transfusion practice 2011
National bowel cancer audit 2011
National lung cancer audit 2011
National care of the dying (round three)
National (adult) diabetes audit 2009-10 (June 2011)
National (paediatric) diabetes audit 2009-10 (July 2011)
Trauma audit & research network (2011)
College of Emergency Medicine: vital signs (April 2011)
College of Emergency Medicine: feverish Illness in children under five
College of Emergency Medicine: renal colic
Myocardial infarction national audit project 2010 (Sep 2011)
National angioplasty audit 2010 (Sep 2011)
National audit of cardiac rhythm management
Paediatric asthma (British Thoracic Society) 2011
Adult asthma (British Thoracic Society) 2011
Non-invasive ventilation (British Thoracic Society) 2011
Emergency use of oxygen (British Thoracic Society) 2011
National falls and bone health audit (May 2011)
Paediatric pneumonia (British Thoracic Society) (Sep 2011)
National neonatal intensive care audit
National potential donor audit
UK carotid endarterectomy audit (round three)
National hip fracture database
National mastectomy and breast reconstruction Audit (4th report)
National audit of seizure management in hospitals

The reports of 70 local clinical audits were reviewed by the provider in 2011/12 and the Royal Free Hampstead NHS Trust intends to take the following actions to improve the quality of healthcare provided.

- Review compliance with venous thromboembolism prevention guidelines, in areas where cases occur, through root cause analysis of all cases.
- Consider the attendance of a learning difficulties facilitator at the audiology clinic.

- Improve arrangements for obtaining full medical history prior to hearing clinic visits for adults with learning difficulties.
- Reduce the waiting list for hearing clinics for adults with learning difficulties.
- Restrict the number of different presenters at trial patient education sessions on cochlear implantation.
- Reduce the time from receipt to action of Ear Nose and Throat (ENT) Choose and Book referrals.
- Re-order operating lists to facilitate same-day discharge of major ENT cases.
- Monitor the potential unmet need for children's speech and language therapy services.
- Empower the ward clerk on the hepatology ward to clarify follow-up arrangements.
- Consider using the patient database to prompt dose calculations by body weight for patients requiring immunoglobulin replacement therapy.
- Increase the provision of clinical nurse specialists in the haematuria clinic.
- Establish nurse-led follow-up clinics for cystoscopy and bladder cancer.
- Assess the need among bladder cancer patients for enhanced information about complementary therapies.
- Increase the availability of hand gel in theatres.
- Add pregnancy status to our World Health Organisation (WHO) safe surgery checklist.
- Identify a team member responsible for completing each of the three stages of the WHO safe surgery checklist.
- Update the perioperative care plan, incorporating the WHO safe surgery checklist and pregnancy status.
- Include information about designated storage locations of anaesthetic emergency equipment in anaesthetic trainee induction pack.
- Increase recycling facilities in operating theatres.
- Improve compliance with routine assessment prior to commencing alitretinoin treatment, and with guidance on cessation.
- Pilot a nurse-led diabetic retinopathy clinic.
- Introduce multidisciplinary pressure ulcer risk assessments in orthopaedic patients.
- Consider a trial of home therapy for certain ankle fracture patients.

- Review the nutrition screening tool to prompt use of ward-level nutrition support pathway.
- Introduce end-tidal carbon dioxide monitoring for patients in intensive care who require transfer within the hospital.
- Consider the use of intermittent haemodialysis for selected stable patients on intensive care.
- Ensure the cellulitis pathway is used for patients referred directly to medical teams.
- Develop readmissions avoidance measures within the Triage, Rapid Elderly Assessment Team (TREAT) service.
- Consider the development of a rapid access falls assessment service.
- Develop community nurse and geriatrician roles.
- Expand the TREAT service to seven days with extended hours.
- Encourage referrals to the Post Acute Care Enablement (PACE) service from additional in-patient specialties.
- Introduce medicines passports in appropriate areas (eg health services for elderly people).
- Provide information on induction of labour for expectant mothers.
- Consider routine use of episiotomy for instrumental vaginal delivery.
- Develop a dedicated clinic for perineal injuries following childbirth.
- Undertake further staff training in:
    1. venous thromboembolism prevention, where completion of patient risk assessments is below target
    2. psychological support for bladder cancer patients
    3. prevention of pulmonary aspiration syndrome during Caesarean delivery
    4. high blood pressure in pregnancy
    5. immediate management of compartment syndrome in orthopaedics
    6. ward-level nutrition support pathway
    7. conditions requiring consultant-only discharge from A&E
    8. CT SPECT imaging and CT colonoscopy
    9. Safe use of intravenous radiology contrast media for patients with renal impairment
    10. Safe practice on gonadal shielding for X-ray procedures.
- Review our care pathways/guidelines for a number of conditions and diagnostic interventions:

1. venous thromboembolism, where cases cluster despite compliance with current guidelines
2. trans-rectal ultrasound-guided prostate biopsies
3. pain relief in children
4. high blood pressure in pregnancy
5. preoperative anaemia in patients for major joint replacement
6. specialist nuclear medicine ('MUGA') scanning.

- Expand the use of checklists and condition-specific documentation to reduce variations in care relating to:
    1. anticoagulation following liver transplantation
    2. medical discharge planning and follow-up arrangements (eg hepatology)
    3. triage of referrals to ENT urgent referral clinic
    4. preventative measures against pulmonary aspiration during Caesarean delivery
    5. induction of labour
    6. perineal injury following childbirth
    7. intensive care transfers within the hospital
    8. transient loss of consciousness presenting to A&E.

ADDITIONAL INFORMATION

The trust did not participate in this year's national diabetes audit as the data held on our current database is of poor quality. A new information system has been agreed and the trust intends to submit data to the next audit round.

Results of local clinical audits are reviewed in detail within the directorates. A summary of actions reported from local clinical audits was reviewed at the trust board at its April meeting.

STATEMENT 3: PARTICIPATION IN CLINICAL RESEARCH

The number of patients receiving NHS services provided or sub-contracted by the Royal Free Hampstead NHS Trust in 2011/12 that were recruited during that period to participate in research approved by a research ethics committee was 6,654.

ADDITIONAL INFORMATION

The above figure includes 4,071 patients recruited into studies on the National Institute for Health Research (NIHR) portfolio and 2,583 patients recruited into studies that are not on the NIHR portfolio. Recruitment data for non-portfolio studies has been captured and this has enabled more comprehensive reporting this year.

Since 2009/10 the number of patients receiving NHS services provided or sub-contracted by the Royal Free Hampstead NHS Trust has increased substantially. The figures reported for 2011/12 are more than double those reported for 2010/11. This increase is likely to be due to the work to capture such information, as well as the expansion of the research portfolio at the Royal Free. A target for 2012/13 will be to further improve the capturing of data around recruitment into non-portfolio studies, as the current non-portfolio recruitment data reflects a 61% response rate.

The breadth of research taking place within the trust is far-reaching and includes clinical and medical device trials, research involving human tissue and quantitative and qualitative research, as well as observational research.

STATEMENT 4: USE OF CQUIN PAYMENT FRAMEWORK

A proportion of the Royal Free Hampstead NHS Trust income in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between the Royal Free Hampstead NHS Trust and any person or NHS North Central London Commissioning Agency with whom we entered into a contract, agreement or arrangement with through the commissioning for quality and innovation payment framework.

Further details of the agreed goals for 2011/12 and for the following 12 month period are available electronically by emailing **rfquality@nhs.net**

ADDITIONAL INFORMATION

Our commissioning for quality and innovation (CQUIN) payment framework for 2011/12 was agreed with North Central London Acute Commissioning Agency as follows:

VTE assessment and prophylaxis
Improving patient experience
Enhanced recovery programme
Care closer to home
Safe care - pressure ulcers
Discharge planning
Consultant assessment in 12 hours
Long-term conditions

STATEMENT 5: STATEMENTS FROM THE CQC

The Royal Free Hampstead NHS Trust is required to register with the Care Quality Commission (CQC) and its current registration status is compliant without conditions at all locations.

The CQC has not taken enforcement action against the Royal Free Hampstead NHS Trust as of 31 March 2012.

The Royal Free Hampstead NHS Trust has participated in special reviews or investigations by the CQC relating to the following areas between 1 April 2011 and 31 March 2012:

The joint Ofsted and CQC inspection for safeguarding in health and social care for the London Borough of Camden, February 2012 and;

The CQC national inspection programme for termination of pregnancy (clinical services reviews) relating to the Abortion Act 1967 during March 2012.

The trust is awaiting the outcome results of both the inspection programmes.

Additional information

On 15 March 2011 the trust was subject to an unplanned inspection by the CQC in relation to outcome one (respecting and involving people who use services) and outcome five (meeting nutritional needs). The CQC reported moderate concerns in relation to both outcomes resulting in compliance

notices being issued. Improvement work was undertaken overseen by our risk, governance and regulation committee, which provided monthly progress reports to the trust board.

The trust declared itself compliant with both standards on 14 July 2012. A further unannounced CQC inspection on 19 July 2012 confirmed that the trust was compliant with both standards.

STATEMENT 6: DATA QUALITY

The Royal Free Hampstead NHS Trust submitted records during 2011/12 to the secondary uses service for inclusion in the hospital episodes statistics, which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- 99.20% for admitted patient care
- 99.27% for out patient care
- 95.57% for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care
- 100% for out patient care
- 100% for accident and emergency care.

STATEMENT 7: INFORMATION GOVERNANCE TOOLKIT ATTAINMENT LEVELS

The Royal Free Hampstead NHS Trust information governance assessment report score overall score for 2011/12 was 70% and was graded green.

STATEMENT 8: CLINICAL CODING ERROR RATE

The Royal Free Hampstead NHS trust was subject to the payment by results clinical coding audit during the reporting period by the Audit Commission and

the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

Primary procedures coded incorrectly – 11.5 %
Secondary procedures coded incorrectly – 9.6 %
Primary diagnoses coded incorrectly – 15.5 %
Secondary diagnoses coded incorrectly – 12.0 %
NB please note the above figures may change

ADDITIONAL INFORMATION

Clinical coding is the process by which medical terminology written by clinicians to describe a patient's diagnosis, treatment and management is translated into standard, recognised codes in a computer system. It is important to note that the clinical coding error rate refers to the accuracy of this *process of translation*, and does not mean that the patient's diagnosis or treatment was incorrect in the medical record. Furthermore, in the definition to determine the clinical coding error rate, 'incorrect' most commonly means that a condition or treatment was not coded as specifically as it could have been and not that there was an error.

PART 3

REVIEW OF QUALITY PERFORMANCE DURING 2011/12

During 2011/12 the Royal Free once again provided high quality clinical services.

In this part of our quality accounts we review our performance against our key quality priorities for 2011/12 and provide examples that illustrate how individual services and specialties are focused on quality improvement. We also provide key data relating to our performance.

PERFORMANCE AGAINST OUR KEY QUALITY OBJECTIVES

In the 2010/11 quality accounts, we set three key quality improvement objectives. These were:

Priority 1: Improve our out-patient phlebotomy service

Priority 2: Develop specific clinical outcome measures for all our services

Priority 3: Reduce patient falls

Here is how we performed against these objectives:

Priority 1: Patient experience - improve our out-patient phlebotomy service

During the last financial year, the trust has focused on developing a better phlebotomy service for our out-patients. The improvement process was driven by reports from several groups, who highlighted the need for an overall improvement to processes and the environment. As a result of this feedback, and a thorough internal review of the service, recommendations were made and a series of significant improvements were implemented. These included:

Service improvements:

- A new staff rota was introduced and the phlebotomy service is now open from 7.30am to 5.30pm Monday to Friday. All vacant posts have now been appointed to and all staff have now been trained in cannulation.
- A Saturday phlebotomy service was launched on 3 September 2011.It is open from 9am to 1pm.
- 91% of phlebotomy and cannulation staff have now completed customer service training. Continuous monitoring of staff is undertaken to ensure a high quality service is delivered.
- The patient survey carried out in October and November 2011 showed that the main problem was that 39% of patients were waiting 10 minutes or more. A second survey was undertaken in March 2012 which showed an improvement, with only 9% of patients waiting for 10 minutes or more10 minutes or less.
- An upgrade of IT equipment was undertaken on 28 October 2011 to manage the operational and audit requirements in the new unit. Weekly reports are provided that highlight any operational issues. The new blood test room opened on 23 January 2012.

Operational improvements:

- Lean processes of delivering the service have been introduced, which have ensured that waiting time targets are routinely being met.
- The cannulation team has integrated with the phlebotomy team. Having both teams co-located in the facility on the ground floor means that when there is less work on the wards, both teams can do out-patient work.

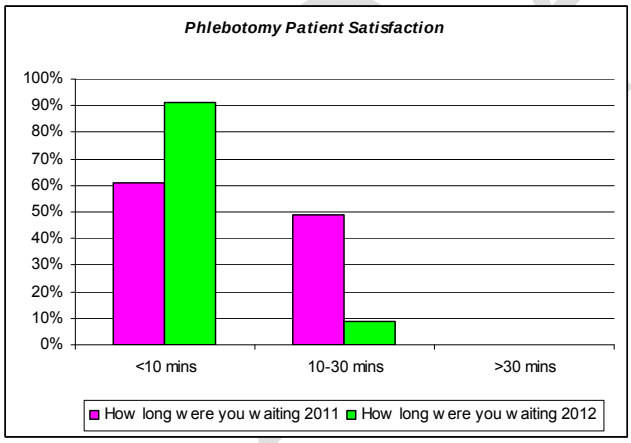
- On a daily basis, two to three phlebotomists work on the renal unit. This results in significant numbers of patients not having to attend the ground floor unit. Not only does this assist with the efficient throughput of other out-patients, but also provides the renal patients with a high quality service and all patients with high levels of satisfaction.

Our target by April 2012 was to ensure:

50% of patients to be seen within 10 minutes
80% of patients to be seen within 30 minutes
100% of patients to be seen within an hour

The audited performance against these targets is as follows

	50% of patients seen within 10 minutes	80% of patients seen within 30 minutes	100% of patients seen within 60 minutes
Old unit	55%	87%	98%
New unit	83%	98%	100%



Priority 2: Clinical effectiveness - develop specific clinical outcome measures for all our services

As reported in last year's quality accounts, we have asked each of our 27 clinical units (specialties) to specify three metrics (measurements) that would provide us with information about clinical performance. We requested that these should ideally:

- be measures of clinical outcome rather than clinical processes
- be measures that can allow comparison with other hospitals
- be measured monthly, quarterly or annually
- include an improvement metric focused on an area in which we need to do better

In addition, we developed nine trust-wide corporate metrics, three in clinical service, three in research and innovation and three in education and training. This reflects our mission to deliver world-class performance in each of these three areas.

In last year's quality accounts we said we would continue to develop our clinical outcome metrics, aiming to make them publically available. We have once again made excellent progress and a list of all the metrics is provided in appendix 1 of these quality accounts.

We will release the full set of metrics in detail in June 2012 to coincide with the publication of our 2011/12 quality accounts. The metrics can be accessed online at **www.royalfree.nhs.uk/outcomes**

NB (this is the preliminary website address. This will be confirmed in the final version of the quality accounts)

Priority 3: Patient safety – reduce patient falls

This year we made the reduction of patient falls our priority in the area of patient safety.

Our target is a 50% reduction in both the overall number of falls and falls that result in harm by April 2012.

During the financial year 2011/12, we developed a falls reduction programme to consolidate work which had already been undertaken. The programme brings together previously independent silos of work to form a comprehensive framework for addressing falls.

Work has focused on the key issues that are relevant to all areas, including improved post-incident review; real-time learning and reporting; improved

safety briefing and handover communication at ward level; reduced variance in staff education; and the development of reliable and useful falls care plan documentation.

Pivotal developments have been the establishment of local ward-based ’falls champions,’ who are supported by a bi-monthly training forum. Their role is to support staff in falls prevention by being a training resource and expert in the trust’s policies. They also oversee investigations where falls have occurred to identify local learning to prevent reoccurrence. A newly-developed falls page on the staff intranet, Freenet, is also a useful resource, with patient leaflets and tools, templates and guidance for staff.

As part of the falls prevention work we have introduced a post fall review form, and stocks of slippers for patients to use to minimise the risk of slipping while moving around the ward. We have introduced guidance for staff on when a patient requires one-to-one nursing care to minimise the risk of falls and mechanical devices (audible alarms / hip protectors) for high-risk patients to wear. All of these measures have been piloted on wards to ensure their effectiveness before being rolled out across the trust.

Further work is being undertaken to develop a fracture liaison service in collaboration with NHS North Central London (NCL) and increase access to the Royal Free falls clinic. In addition, we are currently developing a physiotherapist-led initial assessment to help patients who have suffered a fracture and are at high risk of further falls in order to avoid future harm and hospital admissions.

NB. Falls data chart to be inserted once March data is completed

FOCUS ON QUALITY AND IMPROVEMENT

Our mission to provide world class care and expertise reflects our desire to always provide the highest quality service to our patients. As a campus of UCL Medical School and founding member of UCLPartners, we conduct important research and train the healthcare professionals of tomorrow. Here are some examples of how we have continually improved the quality of service we provide over the past year.

A guide to quality at the Royal Free

As part of our recent foundation trust application, we undertook an extensive review of our quality governance. This included an assessment of how we performed against the quality governance framework used by Monitor, the independent regulator of foundation trusts. This subdivides quality governance into four main domains: strategy; cultures and capabilities; processes and structures; and metrics.

Based on this assessment and a resulting quality governance memorandum prepared for the trust board, we produced a guide to quality at the Royal Free. This describes how the trust ensures the provision of high quality services for its patients. It describes what quality means for the trust, and how the trust sets a culture of quality and high standards throughout the organisation.

Our quality guide describes the context in which we develop and manage the quality initiatives we describe each year in our quality accounts. We have therefore included the full text of the guide in appendix two.

Improving diagnosis and treatment of heart failure

Heart failure is common. It affects 1% of people in the UK and has a poorer prognosis than many cancers.

However, we know that patients who are referred to specialist heart failure services live longer and are less likely to be readmitted to hospital than those who are not.

In August 2010, the Royal Free was selected by the NHS improvement programme to pilot an in-patient heart failure service for patients admitted to our medical assessment unit ((MAU) which admits patients with a medical problem from A&E).

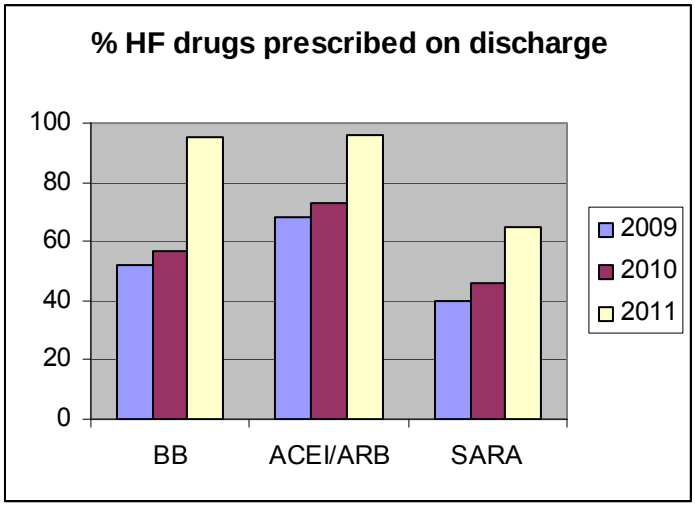
This means that all patients who are admitted to MAU suffering from breathlessness and a raised NT-proBNP (a marker of heart failure) receive a definitive diagnostic test (an echocardiogram) within 24 hours of referral. Previously, this test may have been done as an out-patient after the patient had been discharged.

Dr Carol Whelan, consultant cardiologist and clinical lead for heart failure said: “During 2011-2012, this has brought significant benefits to our patients. Before the pilot, 66% of heart failure patients received an in-patient echocardiogram prior to discharge compared to 100% now. This means patients are being diagnosed earlier and are therefore able to start the correct medication and treatment at an earlier stage, which in turn has had a positive impact on their prognosis and quality of life.”

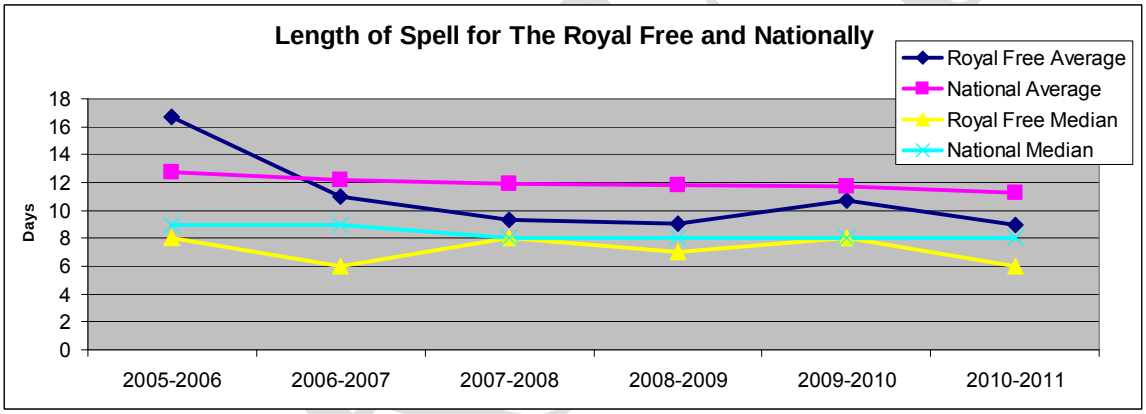
After a diagnosis of heart failure is confirmed, the patient is reviewed by the specialist heart failure team who prescribe the required medication and consider whether advanced treatments such as biventricular pacemakers or implantable cardiac defibrillators are needed. Patients are also invited to a dedicated heart failure clinic following discharge to follow-up on their progress. This approach has led to a reduction in the length of stay and a vast improvement in the percentage of patients receiving appropriate heart failure treatment.

The trust is now looking to provide dedicated heart failure clinics in the community to deliver specialist care closer to home.

The below graphs show how the pilot has improved patient outcomes in terms of the percentage of patients being prescribed heart failure medication on discharge and length of stay.



BB = betablocker
ACEI = angiotensin converting enzyme
ARB = angiotensin receptor blocker
SARA = selective aldosterone receptor antagonist



Improving waiting times for cancer patients

In order to improve outcomes for people diagnosed with cancer, the NHS has set all hospitals providing cancer services eight standards. These relate to timeliness of being seen, diagnosed, treated and receiving subsequent treatments.

The Royal Free has consistently achieved these standards. However, during August and October 2011, the trust failed two standards and was just meeting the target for a third. These were:

- All cancer patients to wait no more than 62 days from urgent GP referral to treatment

- All cancer patients to wait no more than 62 days for treatment following a referral from a screening service
- All cancer patients to wait no more than 31 days from diagnosis to first treatment

The trust board was very concerned about the quality of clinical care being provided and as a result a full review was undertaken. The review examined patient pathways to ensure that early appointments and high quality clinical care were being provided at every stage during the process.

Following the review, immediate action was taken. The trust now ensures that managers and clinicians working in cancer services are provided with detailed information identifying precisely where in the treatment pathway each patient is and how much time has elapsed in relation to each cancer standard.

When bottlenecks are identified, a clear policy sets out three levels of escalation to resolve the issue. The aim is for managers working with their clinical colleagues to intervene, resolve the bottleneck and ensure patients are provided with the care they need in accordance with the eight cancer standards. The highest level of escalation is to a member of the trust board.

As a result of these changes, the trust has achieved compliance with all eight cancer standards every month since October 2011.

NB. Three performance graphs to be inserted when they are available in May – to be obtained from Tony Ewart.

Award-winning diabetes initiative

An award-winning initiative is helping patients with diabetes at the Royal Free to receive safer care.

Our in-patient diabetes team has been providing tools and training to staff across the trust to improve the treatment of hypoglycaemia (a condition that occurs in patients who have diabetes when blood sugar levels are dangerously low) by standardising the prescription of intravenous insulin.

The initiative also aimed to reduce the rates of hypoglycaemia in the hospital by raising awareness of the condition and the importance of referring patients to the specialist diabetes team.

Ruth Miller, clinical lead and lead nurse for diabetes, explained: “We wanted to make sure that all our clinical staff were up to date with their knowledge of prescribing intravenous insulin and of best practice when treating patients with hypoglycaemia. We also needed to raise awareness of hypoglycaemia in general, as it was sometimes seen as an acceptable norm for patients with diabetes to experience this in hospital.

“We developed a number of training tools, which we piloted on five wards between 2008 and 2011. In late 2011, we rolled these out to the whole trust together with a training programme to more than 1,200 staff.”

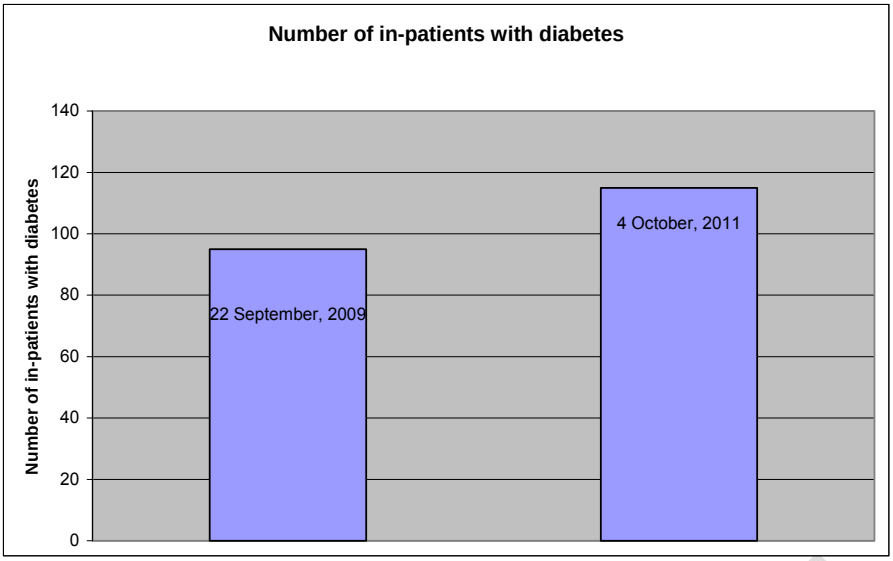
The tools include an insulin sliding scale procedure pack, which provides staff with all the information and tools they need to prescribe intravenous insulin appropriately, a new diabetes management chart (kept at the bedside of all patients with diabetes) and an algorithm to help standardise the treatment of hypoglycaemia.

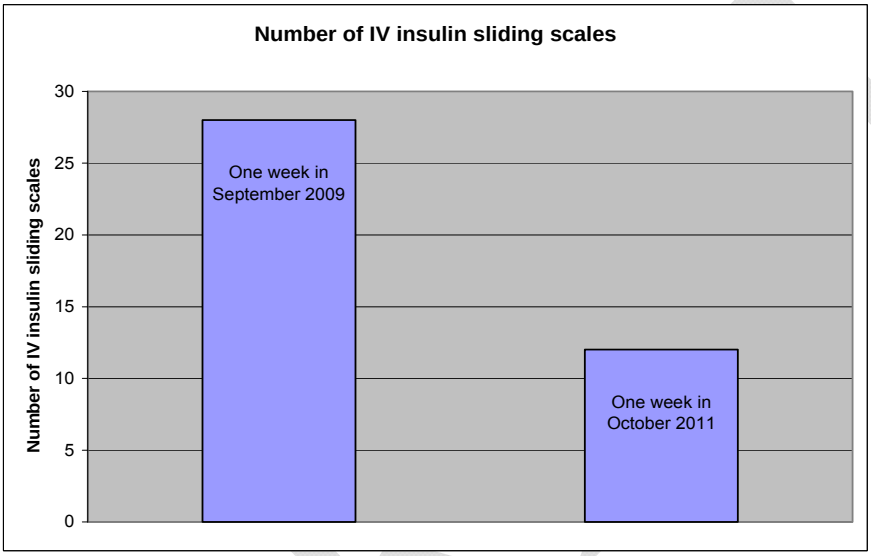
These have all had a positive impact on patient care. Data from the national in-patient audit has found that while the prevalence of in-patients with diabetes at the Royal Free increased by 17% from 2009-2011, rates of hypoglycaemia fell by 70%.

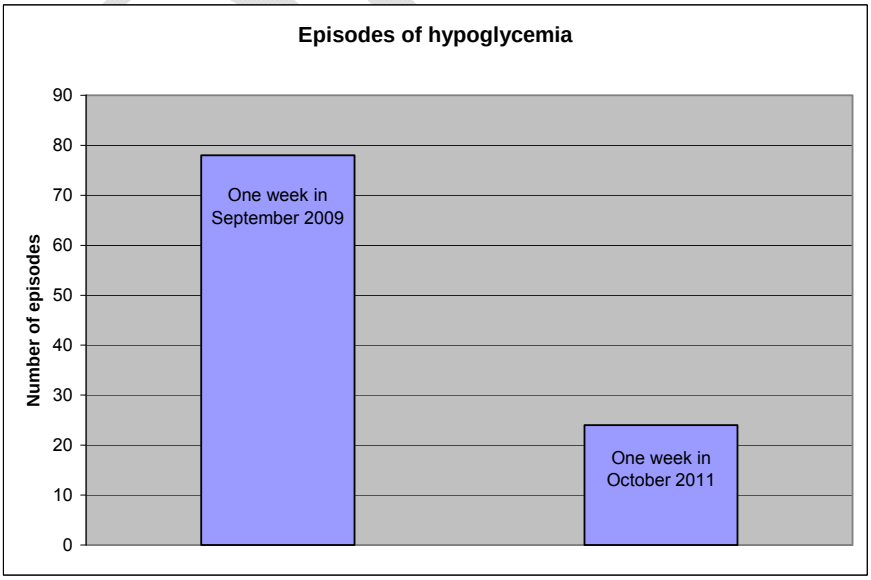
Meanwhile, trust-wide use of intravenous insulin fell by 58% during the same period, suggesting that clinicians are using the tools and are more questioning of its necessity, resulting in more appropriate prescribing.

The initiative’s success earned it an ‘improving services through training and development’ award at the Lean Healthcare Academy Awards in January, 2012. The initiative was also a finalist in the ‘best emergency/in-patient care initiative’ category in the Quality in Care Awards 2011.

The following graphs show the results of the national diabetes in-patient audit in 2011, compared with the results in 2009. The 2011 audit was conducted in October and the 2009 audit was conducted in September.


Number of in-patients with diabetes
Number of in-patients with diabetes
140
120
100
80
60
40
20
0
22 September, 2009
4 October, 2011


Number of IV insulin sliding scales
Number of IV insulin sliding scales
30
25
20
15
10
5
0
One week in September 2009
One week in October 2011


Episodes of hypoglycemia
Number of episodes
90
80
70
60
50
40
30
20
10
0
One week in September 2009
One week in October 2011

Ground-breaking haemophilia research

In 2011, the Royal Free and University College London (UCL) broke new ground with the trial of a new gene therapy for patients with haemophilia B.

Haemophilia B is bleeding disorder caused by a mutation in the gene which makes a protein called factor IX (9), which is essential for normal blood clotting. Patients with haemophilia B therefore bleed for a longer time than usual and may suffer from internal bleeding, usually around the joints and muscles, which can cause pain and stiffness and damage the joints over time.

There is no cure for haemophilia. However, treatment is available which involves injecting a genetically engineered clotting factor into the veins two to four times a week. In recent years, researchers have been investigating the concept of replacing the missing IX gene (gene therapy) as the ultimate treatment of patients

Over the past two years, researchers have been trialling a new gene therapy at the Royal Free's Katharine Dormandy Haemophilia Centre, with very promising results.

In the trial, six patients with severe Haemophilia B were given varying doses of a gene therapy designed to deliver a normal factor IX gene to their livers. Previous attempts to achieve this in the past 10 years failed but the latest attempt was the first successful trial, with all of the patients who volunteered for the study seeing benefits. At every dose level of treatment the blood level of factor IX rose from undetectable (which is associated with a severe bleeding tendency) to a level from 2% to 8% of normal. This converted the patients' condition from a severe to a moderate or mild bleeding tendency. In some instances, patients have had a sustained response for more than a year.

The trial is continuing with the aim of establishing a safe and effective dose to develop a gene therapy drug.

World class care - improving the patient experience

Compliments show that the Royal Free provides good quality care to its patients much of the time, and this is supported by its excellent clinical care and reputation for safety. Yet other patients' feedback, complaints and results from the national patient survey, show that there is still a significant opportunity to improve the quality of care for the people we serve.

During 2011- 2012 we embarked upon our world class care programme, which is designed to support our staff to provide a consistent culture of compassion, quality and personal responsibility and to deliver world class care to our patients every day.

As part of the programme, we have held "in your shoes" events to engage staff and patients and listen to their ideas. At the events, staff listened to patients' experiences and identified best practice and priorities for improvement. They used this knowledge and experience to formulate their own vision and their own standards of care to work alongside local service standards. The overall objective is to give every team the shared direction, energy, skills and support they need to deliver the consistently high-quality experience that they want for their patients.

The standards developed to deliver world class care consistently are:

- To be positively **welcoming**
- To be actively **respectful**
- To **communicate** clearly
- To be visibly **reassuring**

The trust will provide the support needed to make our patients and staff's vision of world class care a reality.

Deborah Sanders, director of nursing, said: "We will integrate these standards of care at every stage, from recruitment and induction to appraisal and performance management, so that everyone has a shared direction.

"We are committed to continually building on these standards and have developed a cascade approach so that all staff can set their own local standards and expectations from listening to what their patients want and need."

Patients who attended sessions to help develop our standards said:

"I felt like the hospital was really taking me seriously by inviting me today"

"I felt relieved to be able to talk about my experience at the hospital, I didn't want to complain but I did want someone to know how I felt"

"Staff were so welcoming; it felt very easy to talk about my care"

"I didn't want to offend anyone, but found it easy to talk frankly about the things that had worried me"

Staff engaged in the sessions said:

"*I think attitude and cultural challenges (empathy, communication, safety) could be improved if there was a trust vision to 'be the best''*

"I found it hard to listen to bad stories; I want to be proud of where I work"

"I was amazed by how different two people's journeys had been"

"I hadn't thought about what patients felt about their care, just about whether they got better, that nothing bad happened"

"It was good to hear so much positive stuff from patients. I was worried this would all be about what we do wrong"

Quality, innovation, productivity, prevention (QIPP)

We aim to provide high quality healthcare that provides value for taxpayers' money.

One of the ways we achieve this is through the quality, innovation, productivity, prevention (QIPP) programme. The programme enables us to:

- increase quality of clinical outcomes, patient safety and patient experience
- improve services by encouraging people to think creatively and work differently
- emphasise the need to make the most of the resources we have in terms of time, people and money

- keep people as healthy and well as possible to avoid unplanned admissions.

As part of our QIPP programme, in 2011/12 we implemented a new fast-track pathway for patients with hip fractures. The new protocol means that the radiology and trauma wards are contacted as soon as a patient with a suspected hip fracture arrives in A&E so that they know a patient is on the way and they can make the necessary preparations. After a hip fracture is confirmed by an initial assessment in A&E and X-ray, patients who are medically stable are then fast-tracked to the trauma ward for an orthopaedic or orthogeriatric assessment, instead of remaining in A&E.

The initiative reduced the length of time patients with hip fractures are in the A&E department and speeded up their transfer to the trauma ward. The ward is a much more suitable environment for patients with hip fractures who are medically stable as it allows them to spend less time on a trolley and be transferred to a bed fitted with a pressure-relieving mattress.

The PACE service and TREAT, described in more detail below, are also part of the QIPP programme and are having a positive impact on patients' length of stay in hospital.

With all our QIPP initiatives we ensure quality is maintained by conducting a full impact, risk and quality assessment, which are signed off by the medical director and director of nursing. A series of quality metrics are monitored each month and assurance is sought from the clinical performance committee.

Right care, right place, right time

We have been working hard to ensure that we deliver the right care at the right place and at the right time.

An example of how we are delivering this is through our post acute care enablement (PACE) service and triage rapid elderly assessment team (TREAT).

The PACE service, run in partnership with NHS community services and social care in Camden and Barnet, helps patients who are well enough to

receive the care they need at home rather than in hospital by ensuring that the right support is in place.

Specialist “case finders” work with consultants to identify in-patients who no longer need round-the-clock medical care. They then design a bespoke package of care to be provided in the community so the patients can continue their recovery at home, while still being under the supervision of a hospital consultant.

Fran Gertler, integrated care lead, explained: “Patients benefit from being able to receive care at home, once their medical condition has been stabilised. Patients tend to recover better when they’re in their own familiar environment. Over the past 12 months, over 1,100 patients have been able to benefit from the PACE service which has reduced length of stay across care of the elderly patients by an average of 1.9 days.”

In a similar vein, TREAT aims to help elderly people avoid a hospital stay by providing specialist assessments in the A&E department. The team, who are specialists in elderly care medicine, thoroughly assess elderly patients who have come to A&E, identifying those who are well enough to be discharged and ensuring that support is put in place so that they can receive the care they require at home.

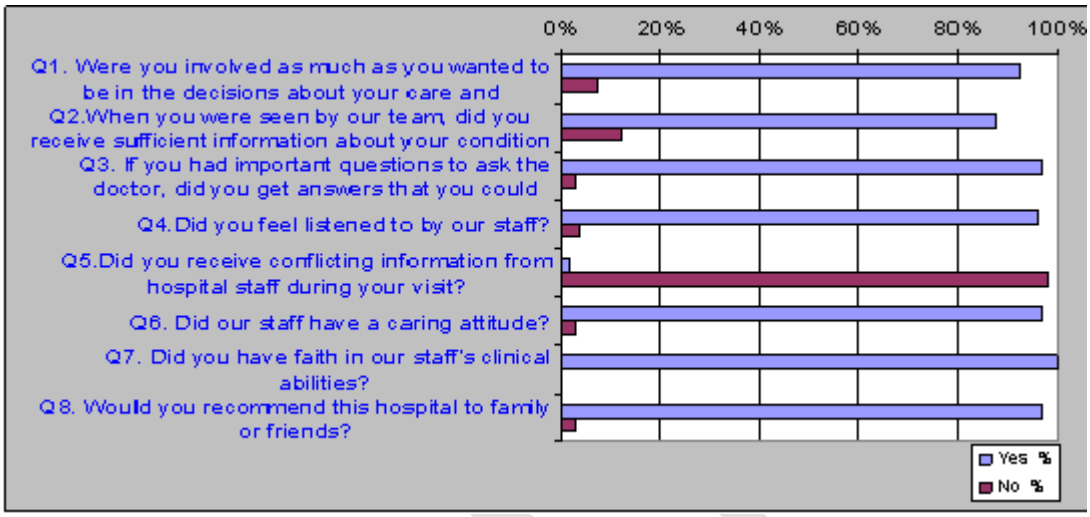
After assessing the patient, TREAT can organise investigations and support on the same day, such as X-rays, CT scans and occupational therapy, and put in place the relevant community healthcare and social services support if required. A “hot clinic” is also available post discharge for patients who need further assessment.

Over the past year, TREAT has undertaken nearly 2,000 consultations either in A&E or via the hot clinics. TREAT accepted 36% of the patients they triaged in A&E and as a result, 82% of these patients were discharged. Before the introduction of the team, almost all of these patients would have been admitted to hospital. The service has also reduced readmissions to hospital.

TREAT has now expanded its hours of operation to ensure that there is consultant cover seven days a week. Community nurses work with care homes to provide training and support for staff to help reduce hospital

attendances and a hot clinic is available for GPs to refer frail patients who are at risk of an imminent hospital attendance.

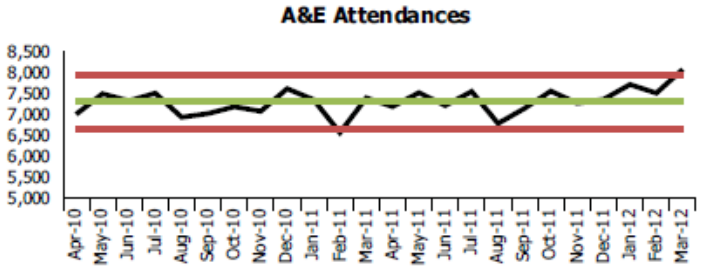
Between April 2011 and March 2012, patients who were successfully discharged from the Royal Free without being admitted were asked to take part in a phone questionnaire to find out what they thought of the TREAT service. The response was extremely positive, as shown in the graph below.



PERFORMANCE DATA

The trust measures many aspects of its performance and this data is regularly reviewed throughout the organisation. At board level, we review a performance dashboard each month that includes some of our key measurements (metrics) in the areas of patient safety, clinical effectiveness, patient experience and operational performance.

This section contains a sample of the key metrics that the trust board currently reviews on a monthly basis. Performance against each indicator is generally shown as a Statistical Process Control (SPC) chart, please see example below:

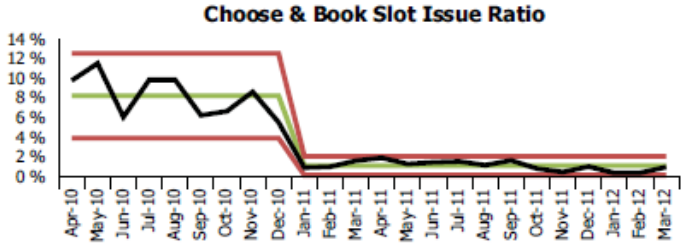


The purpose of these charts is to provide a simple view of performance over time, as well as an indication of whether any variation in performance is statistically important or not.

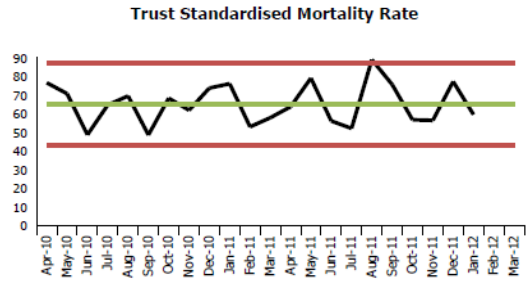
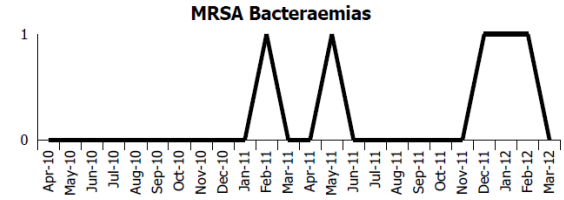
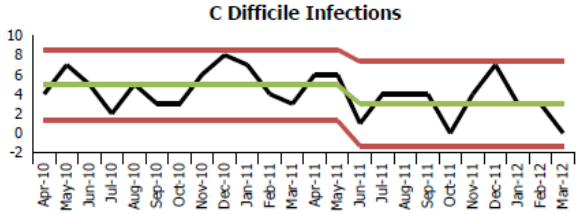
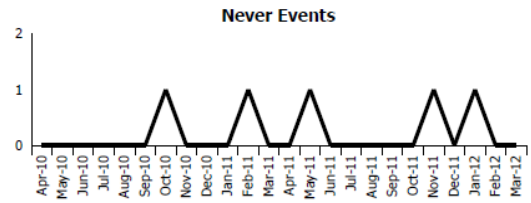
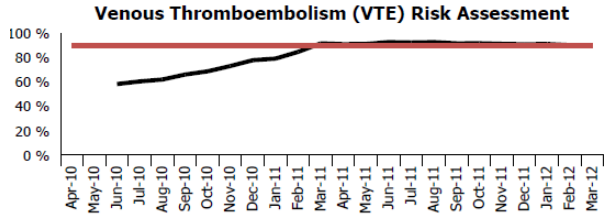
Each chart consists of four elements:

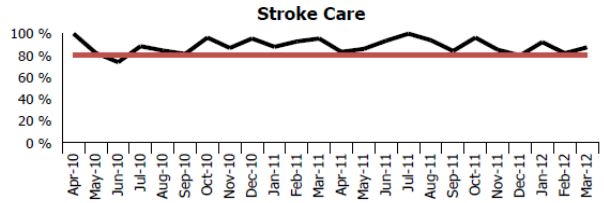
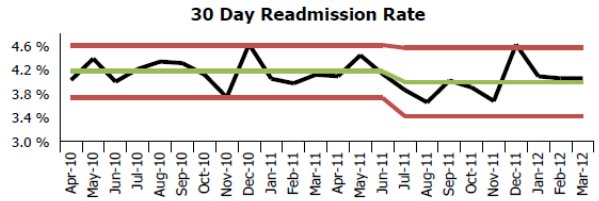
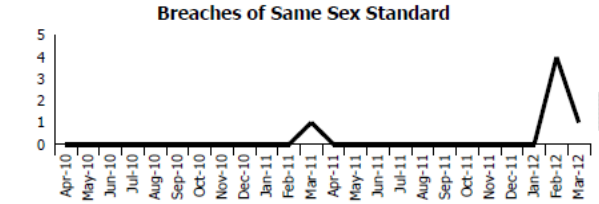
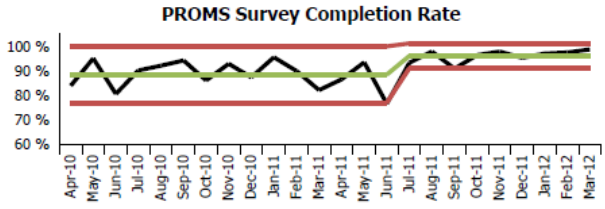
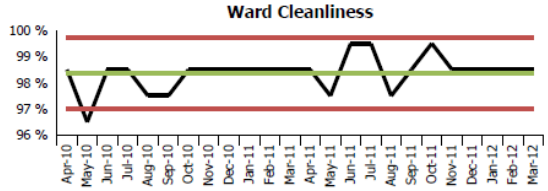
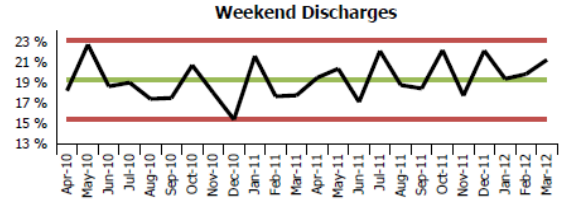
- the run chart for the indicator, showing performance by month over the last 24 months (Black Line)
- average (mean) performance during the period (Green Line)
- Upper and Lower Control Limits (UCL and LCL), which set out the expected range of variation for performance (2 standard deviations either side of the mean). Performance beyond these limits suggests a level of variation that has a probability of less than 2.5%.

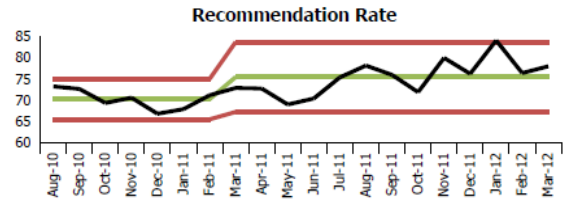
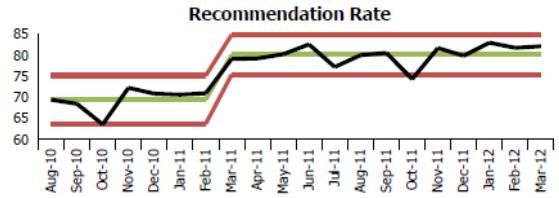
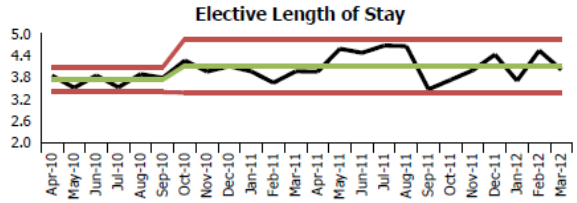
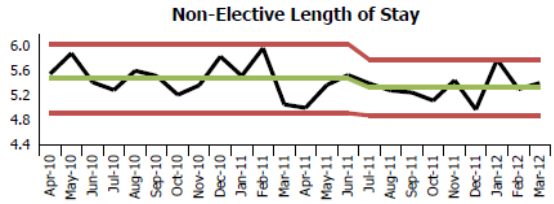
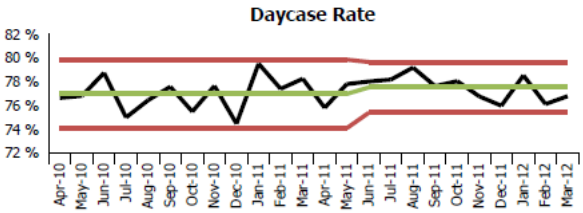
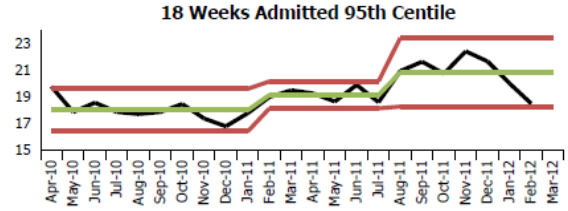
We also produce step change charts, a step change has been defined as 5 or more data points above or below the mean, or in the same direction (up or down), please see an example of the type of chart below:

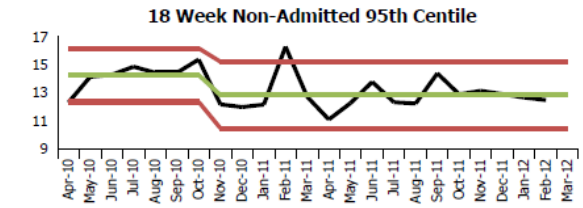
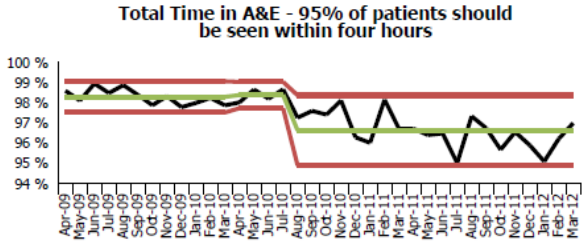
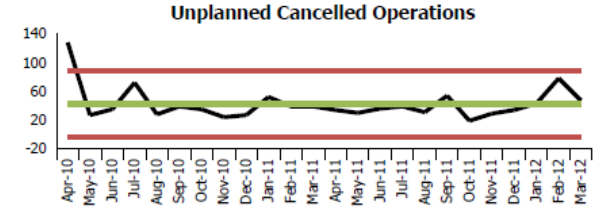
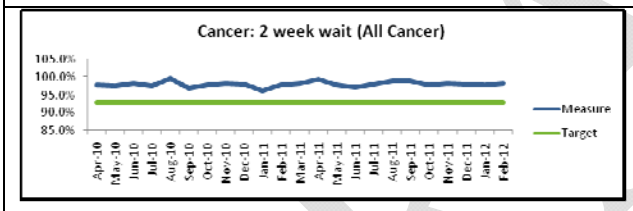
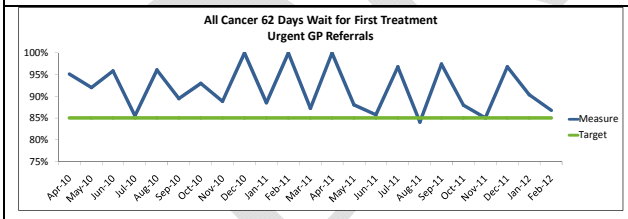


The data included is the most current available to March 31st 2012 apart from 18-weeks referral to treatment and cancer targets which is up to 29 February 2012.

Indicator	Commentary
	The hospital standardised mortality rate is a widely used measure which compares the expected death rate in hospitals with the observed rate. A lower rate is better. Over the course of the last 10 years the Royal Free is the best performing trust in England with a relative risk of in-hospital mortality 25% below that expected. Between April to December 2011 the mortality risk at the Royal Free was 74.6 (25% below expected); resulting in the trust having the 4th lowest relative risk of mortality out of 147 acute trusts.
	Low rates of acquired MRSA bacteraemias reflect good infection control. The trust recorded 4 cases in 2011/12. Whilst this was three more than last year and 1 more than our annual trajectory we did end the year by recording zero infections in March 2012.
	Low rates of C difficile infection also reflect good infection control. The Trust was set a maximum ceiling of 42 infections for the year which we achieved, ending the year with exactly 42 attributable infections, a reduction of 14 compared to the previous year. We ended the year recording zero infections in March 2012.
	Never events are a category of serious incident which the National Patient Safety Agency is particular focussed on preventing. 3 never events occurred within the Trust in 2011/12: ▪ Inappropriate administration of Methotrexate. ▪ Retained silicone template following cochlear implant. ▪ Retained naso-gastric tube.
	Venous thromboembolism (VTE) is when blood clots develop in the veins of the leg. In some cases this can result in a clot becoming lodged in the lung (pulmonary embolus) that can be fatal. VTE is associated with particular risk factors and, along with all Trusts, we now routinely assess the risk of VTE in

Indicator	Commentary
	individual patients when they are admitted to hospital. The Department of Health has set a standard requiring 90% of patients to be VTE assessed. The trust has maintained compliance with the 90% standard throughout the year.
	Evidence suggests that clinical outcomes are better, and the length of stay in hospital reduced, when stroke patients spend the majority of their stay in a dedicated stroke unit. The Department of Health requires 80% of patients to spend 90% of their stay on a stroke unit. The trust performed better than the national standard with a full year performance of 89%.
	A high emergency re-admission rate may suggest that patients have been discharged too early or have not received the quality of care required; the trust therefore monitors the rate with the expectation that over time it will reduce. For the full year 2011/12 the trust recorded a rate of 4%. As the step change chart suggests a reducing trend was observed last year.
	In order to maintain privacy and dignity hospitals are required to provide single sex patient accommodation. The trust recorded 5 breaches of the mixed sex accommodation standard this year. All occurred in February and March 2012 and were caused by ward beds not being available for patients requiring discharge from ITU.
	Since April 2009 the Trust is required to record patient reported outcome measures in 4 clinical procedures, Inguinal Hernia, Varicose veins, Knee and Hip replacement. The trust has remained consistently above the 80% target for the year.
	Target compliance achieved.
	Increasing the proportion of patients discharged at the weekends is considered to be indicative of good quality and robust clinical systems operating outside traditional working hours. For 2011/12 19.9% of discharges were

Indicator	Commentary
	recorded at the weekend, comfortably outperforming the target of 12.8% set by Commissioners.
Inpatient  **Outpatient**  	The trust records patient feedback in relation to the quality of their experience in both inpatient and outpatient settings. This indicator looks at the extent to which patients would recommend the trust to other people. Both charts record high recommendation rates and as the step change charts suggest the trend is improving.
 	A reducing length of stay is indicative of effective and efficient healthcare. For 2011/12 the trust recorded an Elective length of stay of 4.2 days compared to the target of 3.7. This indicator is monitored monthly as part of performance and quality reporting.
 	A reducing length of stay is indicative of effective and efficient healthcare. For 2011/12 the trust achieved the non-elective length of stay target of 5.3 days. This indicator is monitored monthly as part of performance and quality reporting.
 	Most patients prefer to be treated as daycases and with advances in medical knowledge and technology this provides a safe and cost-effective alternative to inpatient admission. For the year the rate of elective day case spells against all elective spells only just missed the target of 77.8% with a rate of 77.4%.
 	The Department of Health has a set a maximum wait time of 23 weeks for those patients waiting the longest for admission, measured at the 95th centile. Between April 2011 and February 2012 the trust recorded a wait time of 20 weeks against the 23 week standard with over 90% of patients admitted within 18-weeks.

Indicator	Commentary
	The Department of Health has a set a maximum wait time of 18.3 weeks for those patients waiting the longest for outpatient treatment, measured at the 95th centile. Between April 2011 and February 2012 the trust recorded a wait time of 12.8 weeks against the 18.3 week standard with over 95% of patients treated within 18-weeks.
	Waiting times of 4-hours or less are required for patients attending A&E departments. The trust's performance in March 2012 was 97% and for the full year performance was 96.3%, comfortably above the national standard of 95%.
	Operations cancelled on the day of, or following admission for non-clinical reasons, are extremely disruptive and upsetting for patients and indicative of poor patient experience. Compared to 2009/10 the trust has reduced the volume of operations cancelled by 40% from 799 to 477.
	The Department of Health as set a standard requiring 93% of patients referred urgently by their GP with suspected cancer to be seen in outpatients within 2-weeks. The trust has comfortably outperformed the standard throughout the course of the year.
	The Department of Health requires 85% of patients to receive their first cancer treatment within 62 days of referral. The trust achieved this standard in every month of the year apart from August 2011 and is forecasting compliance for March 12.

PART 4

THE VIEWS OF OUR STAKEHOLDERS

This section to be completed upon receiving responses from our stakeholders.

APPENDIX 1

CLINICAL OUTCOME METRICS

Nine metrics relate to performance across the whole trust. These are:

CLINICAL SERVICES:

- hospital mortality
- MRSA infection
- clostridium difficile infection.

RESEARCH AND INNOVATION:

- speed of research study approval
- staff publications
- recruitment into research studies.

EDUCATION AND TRAINING:

- General Medical Council (GMC) postgraduate doctors national training survey
- medical student teaching
- mandatory training.

All other metrics relate to the performance of individual specialties. They are listed below, grouped by specialty within our four clinical divisions.

URGENT CARE DIVISION

A&E and acute medicine:

- early warning score
- assessment of venous thromboembolism risk
- time spent in A&E.

Cardiology:

- door to balloon and call to balloon time for primary angioplasty
- echocardiograms performed to diagnose heart failure
- secondary prevention drugs prescribed following heart attack.

Respiratory medicine:

- percentage of patients with respiratory disease under the care of respiratory physicians
- readmission rates of patients with chronic obstructive pulmonary disease (COPD)
- treatment of patients with active TB.

Obstetrics and gynaecology:

- caesarian section rate
- consultant review within 12 hours of unplanned admission
- readmission rate in gynaecology.

Critical care services:

- catheter-related blood stream infections
- readmission to intensive care
- excessive time in the intensive recovery unit

Paediatrics:

- asthma plans for children
- children managed without a referral to tier four services
- median HbA1c in diabetic children

Health services for elderly patients:

- dementia care satisfaction
- pressure sore rate
- avoidable readmission rates.

SPECIALIST SERVICES DIVISION

Haematology:

- survival following an allogeneic stem cell transplant
- availability of laboratory results
- recruitment into clinical trials

Haemophilia:

- musculoskeletal assessment for patients with severe haemophilia
- recruitment into clinical trials
- efficiency of warfarin monitoring clinics.

Infectious diseases:

- reduction of HIV viral load
- effectiveness of HIV treatment
- communication with primary care.

Rheumatology:

- speed of assessing patients with connective tissue disorders
- treatment of patients with inflammatory arthritis
- speed of assessing pulmonary hypertension.

National amyloidosis service:

- rapid clinical review of new patients
- treatment of patients with CAPS
- follow up of patients with AL amyloidosis

Oncology:

- speed of cellular pathology reporting
- survival rates for breast cancer patients
- place of death for patients known to the community palliative care service.

TRANSPLANT & IMMUNOLOGY DIVISION

Ear Nose and Throat (ENT) and audiological medicine services:

- patient reported outcome measures after endoscopic sinus surgery for chronic rhinosinusitis
- Bamford-Kowal-Benc sentence scores following adult cochlear implantation
- hearing aid usage in children.

Gastroenterology:

- colonoscopy completion rate

- thromboprophylaxis in hospitalised patients with active inflammatory bowel disease
- management of carcinoid syndrome during hepatic embolisation.

Endocrinology:

- antenatal diabetes management
- diabetic foot management
- euthyroidismone year post radioiodine for thyrotoxicosis.

Liver services:

- graft survival following liver transplantation
- survival following pancreatic cancer surgery
- hepatitis C treatment success.

Renal services:

- patient survival on dialysis
- one year creatinine following kidney transplantation
- urinary infections following urological procedures.

Immunology:

- immunoglobulin levels in patients with antibody deficiency
- infections in patients with antibody deficiency
- number of days off work taken by patients with antibody deficiency.

TRAUMA & MANAGED NETWORKS DIVISION

General surgery:

- mortality following elective aortic aneurysm repair
- patient reported outcome measures following hernia repair
- 30 day post-operative mortality following colorectal cancer.

Trauma and orthopaedics:

- compliance with best practice for fractured neck of femur patients
- infection rate for post elective arthroplasty
- compliance with guidelines for open fracture of the tibia.

Eye services:

- timeliness of investigation in glaucoma
- outcome following cataract surgery
- timeliness of managing patients referred through diabetic retinopathy screening.

Neurosciences:

- response to rehabilitation referrals
- rehabilitation outcome following in-patient admission (NRC)
- rehabilitation outcome following in-patient admission (SAM)
- community neurological conditions management team multidisciplinary assessment within the last 12 months
- national sentinel stroke audit.

Pain management:

- reduction in pain intensity one month after pulsed radio frequency nerve treatment
- improvement in patient satisfaction scores after audit of patients' views
- improvements in self-efficacy, catastrophisation, depression and anxiety.

Plastic surgery:

- clinical infection rate: general, implants, hand trauma
- 30 day emergency readmission rate
- skin cancer complete excision rate.

Dermatology:

- dermatology life quality index (DLQI) in the inflammatory dermatoses
- psoriasis area and severity index (PASI) 75
- eczema area and severity index (EASI).

APPENDIX 2

A GUIDE TO QUALITY WITHIN THE TRUST

INTRODUCTION

This guide describes how the Royal Free Hampstead NHS Trust ensures the provision of high quality services for our patients. It sets out to describe what quality means for us and how we set a culture of quality and high standards throughout the organisation.

The guide has been adapted from the quality governance memorandum prepared for the trust board as part our foundation trust application. It is based on the quality governance framework used by Monitor, the independent regulator of foundation trusts. This subdivides quality governance into four main domains: strategy, cultures and capabilities, processes and structures and metrics.

What is quality?

The term 'quality' can be used in a number of different ways. In some circumstances it describes how a product measures up to a predetermined specification – did it do what it said on the tin? In other contexts quality is measured against expectation – was it what I thought it would be? Frequently it is simply used to mean excellence– a quality product.

At the Royal Free, our focus is on excellence and we therefore aim to provide services of the highest possible quality. This is reflected in the trust's logo – world class care and expertise. It is also embedded in our corporate objectives, which reflect our governing aims:

- To deliver excellent patient outcomes, teaching and research. Our aim is to be in the top 10% of our relevant peers. This means maintaining our excellent infection control and patient safety record, continuing to develop and invest in our research and research capacity and developing outcomes measures at clinical service line level.

- To offer excellent patient and staff experience. Our aim is again to be in the top 10% of our relevant peers. The main challenge here is addressing the variability of the patient experience and ensure we engage all staff in the running and development of the trust and give our staff the skills, resources and support they need to perform to the optimum of their ability.

- To deliver excellent financial performance and value for taxpayers money. Once again, we want to be in the top 10% of our relevant peers. We must have a major focus on productivity and service transformation as we meet the financial challenges ahead.

- To be strongly compliant with the law and the standards and targets set by our regulators and other relevant bodies. This includes health and safety legislation, the CQC regulatory standards and the standards and targets within the NHS operating framework

- To build a strong organisation fit for the future. We must ensure that we have the infrastructure, processes and people in place to enable us to deliver the four objectives described above.

The Royal Free already demonstrates high quality performance in many areas. For example:

- The trust consistently has one of the lowest hospital standardised mortality rates (HSMR) in England.

- During 2010/11 only one acquired MRSA (methicillin resistant staphylococcus aureus} bacteraemia occurred within the trust.

- The Royal Free stroke service was ranked in the top 25th percentile by the Royal College of Physicians in the latest round of the national sentinel audit 2010. We achieved 92% compliance overall, scoring 100 % in nine of the 12 areas.

- The trust has the second highest number of highly cited research publications of English NHS trusts.

There are also areas in which we know quality must improve. These include:

- the administrative processes which support patients and staff, such as our out-patient appointment system
- our phlebotomy (blood taking) service
- overall patient experience.

What is quality governance?

Monitor defines quality governance as the combination of structures and processes at and below board level to lead on trust-wide quality performance including:

- ensuring required standards are achieved
- investigating and taking action on substandard performance
- planning and driving continuous improvement
- identifying, sharing and ensuring delivery of best practice
- identifying and managing risks to quality of care.

Monitor requires that the board of directors of an applicant trust confirms, through a board statement and memorandum, that it is satisfied that:

- The trust has, and will keep in place, effective leadership arrangements for the purpose of monitoring and continually improving the quality of healthcare delivered to its patients.
- Due consideration has been given to the quality implications of future plans (including service redesigns, service developments and cost improvement plans).

In preparation for its foundation trust application, the trust has undertaken a review of quality governance led by the medical director and director of nursing. The board has approved the recommendations from this review and implementation has commenced.

The trust also commissioned KPMG to undertake an independent review of quality governance. Their report assessed the trust as amber/green against the Monitor quality governance framework and concluded that "there is sufficient evidence that the appropriate quality governance arrangements are in place to enable the board of directors to confirm, by way of a board statement and detailed board memorandum, they are satisfied that the trust has effective leadership arrangements for the purpose of monitoring and continually improving the quality of healthcare delivered to its patients."

The following sections describe our approach to quality in each domain of Monitor's quality governance framework.

STRATEGY

How quality drives the trust's strategy

Each year the board approves three high-level quality improvement objectives that are published in our annual "quality accounts. These are agreed following extensive consultation with external stakeholders. In order to develop our 2011/12 quality objectives, a series of discussions were held with the trust's shadow governors, Barnet and Camden Local Involvement Networks (LINKs), Barnet and Camden health scrutiny committees, North London Acute Commissioning Agency and NHS London. In addition, more than 300 of our trust members completed an online survey. Internally, discussions were held at board level and with staff groups.

Our 2011/12 quality improvement objectives are:

- In the area of patient experience, to improve our out-patient phlebotomy service. Our target is by April 2012 to ensure that 50% of patients are seen within 10 minutes, 80% within 30 minutes and 100% within an hour; and 100% of our staff working within the phlebotomy

service have undergone customer care training. The executive lead for this improvement priority is the director of operations.

- In the area of clinical effectiveness, to complete the development of our clinical specialty-based clinical outcome metrics and publish these in full by April 2012. The executive lead for this improvement priority is the medical director.

- In the area of patient safety, to reduce patient falls. Our target is to have achieved a 50% reduction in both the overall number of falls and falls that result in harm by April 2012. The executive lead for this improvement priority is the director of nursing.

The trust executive committee and the trust board receive quarterly updates on progress against these objectives.

The trust also drives quality improvement through its quality, innovation, productivity and prevention (QIPP) programme, led by the director of integrated care; and the commissioning for quality and innovation (CQUIN) scheme, led by the medical director. The QIPP programme incorporates transformational and transactional aspects of clinical management to support the delivery of quality services while at the same time reducing costs over the next five years. The programme responds both to financial pressures, resulting from flat income and expected increase in demand, and our commitment to delivering high quality services. There are currently more than 70 active QIPP projects. The CQUIN programme is agreed each year with our local acute commissioners following extensive discussion at a joint monthly clinical quality review group that now also includes input from local general practitioners.

In addition to our annual high-level quality objectives, QIPP and CQUIN programmes, the trust has demonstrated innovation in its approach to quality improvement. This includes development of adult and paediatric early warning systems, the first introduction in the UK of Schwartz rounding, introduction of the productive ward and participation in the Institute of Health Improvement's safer patient initiative. A selection of other quality improvement initiatives is described within our annual quality accounts. In the latest quality accounts, published in June 2011, we reported on projects to:

- improve care and safety for sick children through effective communication

- introduce a paediatric early warning system for children whose clinical condition is deteriorating

- improve the speed with which patients with heart attacks receive treatment

- improve the vaccination rates of children in our local communities

- introduce nurse rounding, a process by which nurses attend each patient on an hourly basis – research has shown this significantly improves patient safety and experience

- introduce ‘go see’ visits during which board members are teamed up with designated clinical areas that they visit regularly.

The board is particularly concerned that improvements occur with respect to patient and staff experience. For 2011/12 the patient experience improvement plan is focused on three areas of improvement:

- privacy and dignity

- reducing waiting

- developing leadership.

The trust communicates and discusses quality initiatives with staff, patients and other external stakeholders in a variety of ways. These include the annual quality accounts, which this year were published with our financial accounts in a single document, regular electronic briefings by the chief executive, meetings of governors, and staff QIPP engagement sessions. Nevertheless, the recent quality governance review recognised that communication could be further improved and as a result, a monthly electronic quality bulletin was introduced in autumn 2011.

How the board is aware of potential risks to quality

Our risk management strategy outlines the trust's approach to risk and details the processes in place to manage risk. The trust maintains a risk register and a board assurance framework, both of which are reviewed and revised on a regular basis. The risk, governance and regulation committee leads this process, but additional review is also undertaken at the trust executive committee, the audit committee and the board. The risk register is populated from a variety of sources including risk registers maintained within each clinical division, incident forms, audits, benchmarking and external reviews. The risk register and board assurance framework both contain actions to mitigate risk: these are also regularly reviewed.

The board also uses a variety of other mechanisms to assess potential risks to quality. These include, for example, our programme of 'go see' visits, in which directors are paired with clinical areas that they visit on a regular basis; regular reports to the board from the director of infection prevention and control (DIPC); a range of inspections by external regulators that are monitored by the risk, governance and regulation committee; our quality road map self-assessment process for CQC outcomes; and a wide range of metrics used to monitor performance (see section five). The trust participates in national in-patient and out-patient surveys, and uses patient experience trackers throughout the organisation to collect real-time feedback from patients and other users of our services. The trust encourages external stakeholders to identify risks to quality through a variety of formal and informal means. These include the patient advice and liaison service (PALS), patient representative groups, LINks forums, public board meetings, local commissioners, shadow governors and the local health scrutiny committees. The board's user experience committee has the key responsibility for monitoring and improving the quality of user and staff experience.

The QIPP programme, described in section two, is a key component of the trust's quality improvement process. However, we recognise that there is also a potential for some QIPP projects which primarily focus on cost reduction to have an adverse effect on quality. To avoid this all QIPP projects are assessed for their potential impact on quality before and after implementation, including a detailed quality impact assessment. Senior clinicians are included within the membership of both the QIPP steering group and the QIPP board,

and QIPP projects are separately reviewed by the medical director and the director of nursing for any potential negative impact on quality. In addition the board monitors a set of specific trust wide metrics that may be adversely affected by cost improvement projects.

CAPABILITIES AND CULTURE

How the board ensures it has the necessary leadership, skills and knowledge to deliver the quality agenda

The trust board consists of five executive directors (including the chief executive) and six non-executive directors (including the chairman). Three of the executive directors and one of the non-executive directors have clinical backgrounds. In addition, board meetings are attended by a number of other executives, including the four divisional directors, who are practicing clinicians. Board members have a wide range of experience and backgrounds, including other NHS organisations, other public sector bodies and the private sector.

The board committee structure is shown in figure one and has been designed to ensure that integrated quality governance is aligned with our governing principles and corporate objectives. A non-executive director chairs all board committees, with the exception of the trust executive committee. Four clinical divisions, established around strong clinical leadership, support the board.

Quality is central to the agendas of the board and all its committees, with a regular focus on quality metrics. Recent examples where the board has clearly taken a central role in quality improvement include the focus on infection control with a sustained reduction in acquired MRSA bacteraemias and the development of a set of around 90 clinical outcome metrics, mostly at specialty level.

The board participates in a comprehensive continuing development programme, which has included a recent external assessment of its skills and capabilities. Regular board seminars provide the opportunity for directors to expand their knowledge and skills of specific issues including quality governance.

How the board promotes a quality-focused culture throughout the trust

The board has promoted a number of quality strategies and initiatives that have been developed and implemented with extensive staff engagement. As already described, these include the development of the quality accounts, the drive to improve infection control, the QIPP programme, the safer patient initiative and the development of clinical outcome metrics for each clinical business unit. These and other quality-focused programmes have helped promote a quality-focused culture throughout the organisation. Senior executives are directly involved in quality improvement initiatives: for example the director of nursing is responsible for the current falls reduction programme; the medical director is responsible for the development of clinical outcome metrics and the CQUIN programme; the deputy chief executive is responsible for the QIPP programme; and a divisional director, acting with the DIPC (director of nursing), leads our infection control programme.

The board actively encourages staff to participate in quality initiatives. The recent EUREKA scheme encouraged staff to suggest quality schemes as part of the QIPP programme. Annual staff achievement awards recognise those individuals and teams that have made a significant contribution to high quality within the trust. Using our clinical incident reporting system, we encourage staff to report errors and adverse events that have, or could have, an adverse impact on quality. Staff receive training and experience in service improvement methodology through direct participation in quality improvement projects, such as our theatre improvement project. Quality improvement projects are reported and communicated by a number of means, including the annual quality accounts, Freemail (our regular staff news update) and the chief executive bulletin.

The trust carries out robust recruitment and HR practices that ensure we have a high quality workforce that is safe and responsible in delivering care. We review our policies and procedures regularly with service user involvement and our staff are equipped with the right skills and professional training to keep us compliant with our external and regulatory obligations.

PROCESSES AND STRUCTURES

Roles and accountabilities in relation to quality governance

The trust board is ultimately responsible for the quality of service provided by the Royal Free. It agrees the overall strategic direction for continuous quality improvement, encapsulated by the top 10% aspiration within the governing objectives; sets a culture which promotes the delivery and development of high quality services; and monitors how the trust performs against objectives. Trust board meetings do not treat quality as a separate agenda item as we believe quality should form an integrated part of discussions and decisions in all areas, clinical and non-clinical. Each year the board agrees three high level quality improvement goals that are published in the annual quality accounts.

The chief executive's scheme of delegation describes the responsibilities of individual executive directors. The medical director has overall accountability for the quality of clinical services and is responsible for clinical performance; the deputy chief executive is responsible for risk and safety; and the director of nursing is responsible for CQC compliance and patient experience.

Board committees are aligned with the governing objectives and have a key role in quality governance (annex four).

- The clinical performance committee meets quarterly and is responsible for seeking and securing assurance that the trust's clinical services, research efforts and education activities achieve the high levels of performance expected of them by the board, namely "outcomes consistently in the top 10% in the UK versus relevant peers". It monitors performance against the trust's three high-level quality indicators, reviews data concerning mortality by specialty and diagnostic group and undertakes reviews of specialties where concerns may have arisen regarding clinical quality. It is currently working with clinical business units (specialties) to develop a series of outcome measures which, whenever possible, will be benchmarked against other organisations.

- The user experience committee meets bi-monthly and is responsible for seeking and securing assurance that the trust's services are

delivered to its customers (GPs and patients) so as to achieve the high levels of performance expected of them by the board, namely "recommendation rates consistently in the top 10% in the UK versus relevant peers".

- The risk, governance and regulation committee meets monthly and is responsible for ensuring that the trust is fully compliant with all its regulatory duties and for ensuring that all material risks to trust objectives are understood and appropriately addressed.

- The trust executive committee meets weekly. The role of the committee is to support and advise the chief executive in running the trust, in meeting the requirements of the operating framework, and on strategic priorities and objectives.

- The finance and investment committee meets monthly and is responsible for seeking and securing assurance that the trust achieves the high levels of financial performance expected by the board, namely "consistently in the top 10% in the UK versus relevant peers".

- The audit committee meets five times annually. It provides the board with an independent and objective review of the effectiveness of the organisation's governance, risk management and internal control systems. It receives evidence and gathers assurance from a variety of sources about the overall quality of care provided by the trust.

- The remuneration committee meets at least quarterly and consists of the trust chairman and non-executive directors. It is responsible for all decisions concerning the remuneration and terms of service for corporate managers.

Beneath the level of board committees, other committees and working groups also play an important role in quality governance. These include groups that have a focus on a specific issue, such as the committee that ensures the trust is compliant with the Human Tissue Act, to those with a broader remit such as the education committee. The recent review of quality governance recommended that the majority of these groups should report directly to the trust executive committee, as this is the board committee that meets most

regularly and is able to address operational issues most rapidly. It also provides a key link to the trust's clinical divisions. Reports from these groups are also made available to other board committees, on a regular or ad hoc basis as appropriate.

The trust's clinical services operate within four divisions: specialised services, urgent care, transplant & immunology and trauma & managed networks. Each division contains a number of clinical business units. Divisions focus on quality within a variety of forums, but the recent quality governance review recommended the establishment of divisional safety and quality assurance boards to provide a specific divisional focus to quality governance. Chaired by the relevant divisional director, these boards will meet monthly from autumn 2011.

Processes for escalating and resolving issues and managing performance

The trust committee and reporting structure has already been described. In addition, the trust uses other mechanisms to gather and escalate quality issues. These include the risk register and the board assurance framework, risk management reports, clinical audit programmes and our internal audit plan. The trust has a whistleblowing policy that is available to all staff on our intranet.

The recent quality governance review also sought to strengthen the process of escalation by assigning trust executive sponsors to each committee and working group, and developing a standardised escalation policy.

How the board actively engages patients, staff and stakeholders

To emphasise our patient focused approach, each board meeting begins with 'patient voices' in which an executive director reads one recent letter of complaint and one of thanks.

The board actively encourages patients, staff and other stakeholders to engage in our drive for high quality through a variety of means. Examples include:

- The extensive engagement that was undertaken for our quality accounts.

- Patient focus groups that have been established in a number of specific areas eg phlebotomy.

- The trust's shadow council of governors and membership which have been in place since 2008. The board regularly consults the council and members concerning quality and responds to quality issues raised by the governors. Governors sit on the clinical performance committee and the user experience committee.

- The clinical performance committee has involved governors in the development of specialty clinical outcome metrics.

- Board members regularly undertake 'go see' visits to clinical areas, which involves speaking with patients.

- The user experience committee regularly reviews the results of patient and staff feedback.

- The board regularly engages with local LINKs and health scrutiny committees.

- The trust meets commissioners, including GP representatives, in a monthly clinical quality group, attended by the trust medical director.

- The trust has appointed a director of integrated care, who is responsible for working with commissioners and GPs to develop high quality community-based services.

- We are one of the few acute trusts to have appointed a public health lead who works within the trust and with our local community to promote screening and other preventive measures to improve the health of our patients and the wider population.

The trust is committed to making its quality performance outcomes as accessible as possible. For example, our comprehensive board performance

dashboard is included within the published papers of our quarterly public board meetings. Our quality accounts include a comprehensive set of quality data together with easily understandable descriptions of each metric. Performance metrics are also discussed with commissioners at regular monthly quality review meetings. We have recently begun placing performance metrics on our external internet site.

MEASUREMENT

How appropriate quality information is analysed and challenged

The trust already generates a large volume of metrics relating to the quality of operational performance, patient safety, patient experience and clinical outcomes. The trust metrics library currently consists of more than 200 measurements. This is supplemented by metrics provided by external agencies such as Dr Foster. Additional metrics are also under development; for example the clinical performance committee is developing 81 clinical outcome metrics at clinical business unit level and six education and research metrics at organisational level.

Since the appointment of a director of information management and technology in 2010, the board performance dashboard has undergone extensive development. This now provides a comprehensive set of clinical and non-clinical metrics and includes:

- metrics related to national priorities and regulatory requirements, eg A&E metrics

- metrics specifically related to safety, clinical effectiveness and patient experience, eg standardised hospital mortality; rapid access chest pain; net promoter score

- metrics specifically related to early warning of quality deterioration, eg patient falls, average length of stay

- metrics related to adverse events and harm, eg never events, MRSA rates

- risk ratings

- RAG rating and an overall commentary on performance.

The board dashboard is focused on those metrics that are most relevant to the governing principals and corporate objectives. Further metrics are reviewed in other trust committees: for example the operations board reviews a comprehensive set of operational performance metrics and the user experience committee reviews patient and staff survey metrics. Divisional dashboards include division-specific metrics. The trust executive committee reviews a ward-based 'heat map' of patient experience, workforce and safety metrics each month. The risk, governance and regulation committee reviews the trust's quarterly self-assessment of compliance with CQC standards.

The trust is currently implementing service line reporting within its clinical business units. This will facilitate better analysis of metrics at specialty and consultant level. Consultant level review will also be incorporated into our revalidation processes for medical practitioners.

The recent quality governance review recommended that a defined process should be introduced for future metric development and that each metric should be owned by the board committee; these recommendations are currently being implemented.

How the board assures the robustness of quality information

The data quality committee is responsible for monitoring and reviewing the quality of data captured by the trust's systems. This is supplemented by internal audit reviews and external reviews such as the Audit Commission payment by results audit. The Audit Commission has also reviewed the quality of data in our most recent quality accounts. Action plans are agreed following data audits and monitored by the relevant committee.

The accuracy of coding is reviewed as part of the payment by results audit and is reported in the quality accounts. The trust has established a clinical data quality group to drive improvement in clinical documentation and coding quality.

The trust is increasingly using electronic systems to capture and report key metrics and the information team is currently developing the automation of such reporting.

The trust actively encourages participation in national clinical audits and confidential enquiries. In 2010/11 we participated in 87% of the 49 national clinical audits for which we were eligible and in all of the four confidential enquiries for which we were eligible. The trust reviews the outcome from these audits and when concerns arise will undertake specific reviews.

How quality information is used effectively

The trust dashboard includes red, amber, green (RAG) rating of individual metrics against targets and shows trends of performance overtime. Wherever possible, the trust also benchmarks performance against comparable organisations. All reports include the most recently available data. The trust is increasingly working towards on-demand electronic availability of metrics from its extensive metrics library.

The regular review of metrics has helped drive a number of improvements in quality. Examples include:

- improvement in MRSA rates
- improvement in the number of cancelled operations
- most recently, reduction in patient falls.

All metrics are now presented in a consistent format within the board dashboard. Furthermore, descriptors are being developed that provide an easily understandable guide to the purpose and source for each metric: the 2010/11 quality accounts provide an example of this approach.

CONCLUSION

This guide describes how the Royal Free Hampstead NHS Trust approaches quality. It complements the trust's annual quality accounts, which report on the quality of our services over a specific 12-month period. The latest quality accounts are available on our website. In future, our intention is to revise this guide on a regular basis and also to include it as part of our quality accounts.