Quality account 2016-17

world class expertise local care

Quality account 2016/17

Part one: embedding quality

1.1 Statement on quality from the chief executive

Part two: priorities for improvement and statement of assurance from the board

2.1 Progress on our quality priorities 2016/17

2.2 Priorities for improvement for 2017/18

2.3 Statements of assurance from the board

2.4 Reporting against core indicators

Part three: review of quality performance

3.1 Overview of the quality of care in 2016/17

3.2 Performance against key national indicators

3.3 Our improvement plans

Annexes

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committee

Annex 2: Statement of directors' responsibilities in respect of the quality report

Annex 3: Limited assurance statement from external auditors

Appendices

Appendix a: Quality improvement driver diagram: toward 50 initiatives by end of April 2018

Appendix b: Responses to stakeholder comments

Appendix c: Glossary of definitions and terms used in the report

Part one: Embedding quality

1.1 Statement on quality from the chief executive

Information to follow- (in line with themed statement in our Annual report 2016/17)

Part two: priorities for improvement and statements of assurance from the board

This section of the quality report describes the progress made against our priorities during 2016/17. It includes a look back on how the priorities were chosen and the process for monitoring and reporting improvements throughout the year. Our priorities for the year ahead are also presented, along with a series of mandatory statements on key quality activities, which are outlined within the section, statements of assurance from the board.

2.1 2016/17 quality improvement priorities

In 2015/16, following consultation with our key stakeholders, we agreed that during 2016/17 we would focus on three areas of quality; patient experience, clinical effectiveness and patient safety.

Table 1: Quality domains with designated trust lead and associated committee

Quality domain	Designated trust lead	Associated committee
Patient experience	Associate medical director for patient experience	Patient and Staff Experience Committee (PSEC)
Clinical effectiveness	Associate medical director for clinical effectiveness	Clinical Performance Committee (CPC)
Patient safety	Associate medical director for patient safety	Patient Safety Committee (PSC)

Improving quality: continual development of a strong organisation

In addition to the three key quality improvements, the trust also agreed to have an overarching quality priority - the continual development of a strong and highly capable organisation - that originated from the five principles identified within our quality strategy.

Principles for our quality strategy
1. Everyone's primary goal and duty is improvement on things that matter to patients. Patients, families and carers will genuinely and consistently be at the centre of the work 2. We will constantly deploy iterative, reflective cycles of planned changes, linked to measurement over time, led by the multi-professional teams which serve patients (or other 'customers') 3. We will build capabilities in continuous improvement, build capacity in coaching for improvement and build a learning organisation 4. Our approach will focus on equipping frontline staff to gain greater control of the systems that they work in. 5. All trust initiatives and strategies will dovetail and pursue the same goal of quality and continuous improvement.

Led by our director of quality, the priority centred on equipping staff with the capabilities to make continuous improvement central to their daily work. Progress was monitored by our trust board and Trust Executive Committee (TEC).

Improving quality priority for 2016/17

What did we aim to do?	What did we achieve?
For the trust board and senior leadership to work on their collective development, enabling them to provide effective leadership for improvement across our hospitals.	Workshops on 'leading for improvement' were led by Institute Healthcare Improvement (IHI). Attendees included: • Trust Executive Committee (TEC) • Trust board • 112 senior leaders across disciplines and professions trust-wide.
To use a diagnostic tool assessing our readiness for Quality Improvement (QI), helping us prioritise and focus our work to implement the quality strategy.	Trust-wide QI diagnostic assessment sessions were held with IHI in June 2016 over three days. In total, over 70 sessions were conducted with patients and over 500 staff participated.
To begin to build our trust-wide improvement team whose job is to support quality improvement work at the frontline across the trust.	The trust has developed a QI team and plans are in place to recruit members in the first half of 2017/18.

Priority one: Improving patient experience - delivering excellent experiences

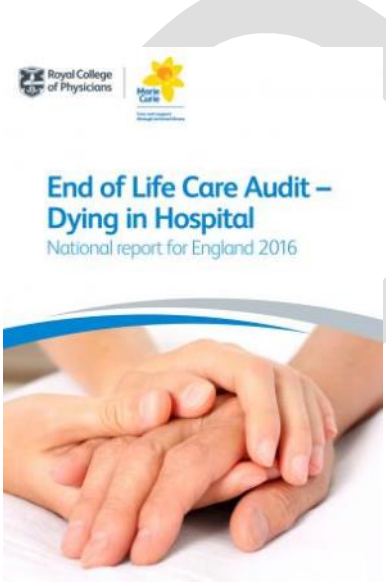
We aim to put the patient, carer and our staff at the heart of all we do in delivering excellent experiences. The trust's definition of patient experience is derived from the Beryl Institute: 'The sum of all interactions, shaped by the culture of the Royal Free, that influence patient and carer perceptions across their pathway'.

We are fully aware that in delivering this definition we need to do more than provide excellent clinical outcomes. At the start of each board meeting, patient stories are presented which articulates their experience of our care through a complaint and a compliment. It allows the board to see the impact of decisions they are making and how embedded our World Class Care values are in the organisation.

Building on our four-year patient experience strategy (which was published in autumn 2015) we continued to focus on making improvements for those who use our services, their carers and families; with an added emphasis on dementia and end of life care. Through the Patient and Staff Experience Committee (PSEC) we have monitored, measured and reported progress to achieving our priorities. The committee reports quarterly to the trust board.

Patient experience priorities for 2016/17

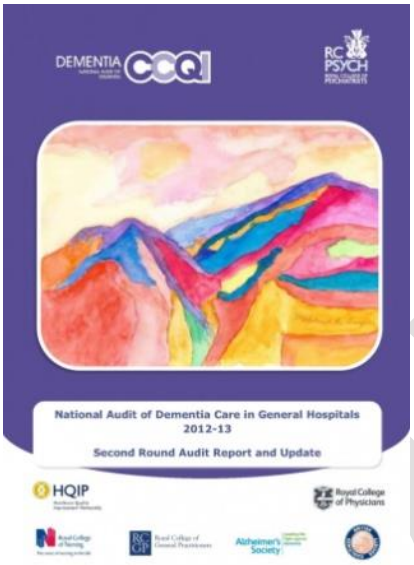
What did we aim to do?	What did we achieve?
To publish an annual report; to include a statement of dementia care on progress against the trust dementia strategy and fixed dementia care (Alzheimer's Society report) metrics	We successfully published our annual report in November 2016 and included a statement on progress against the trust dementia strategy. Our dementia lead has written the trust dementia strategy for 2017-2019 which has been approved and agreed by the Dementia Implementation Group (DIG) and is currently being implemented.
To allow flexible visiting times for carers of people living with dementia on 100% of inpatient wards (in line with the principle of John's Campaign).	For this priority, the trust choose to embed the principle of 'John's Campaign', which focuses on the right of people with dementia to be supported by their carers in hospital. John's Campaign was founded after the death of Dr John Gerrard in November 2014. John Gerrard had been diagnosed with Alzheimer's

	disease. The Dementia Implementation Group (DIG) has taken a non-prescriptive approach to implementing John's Campaign as we strongly feel that participation must be at the discretion of the ward manager and their matron. As a result, implementation of John's Campaign remains voluntary. We now have 71% of all wards signed up and actively practising John's Campaign. We have three champion wards across our sites, which collect feedback and data related to the campaign. DIG members from these wards will share this information and encourage the remaining wards to participate.
To achieve trust certification for The Information Standard by 2018 Health & care information you can trust The Information Standard Certified Member	Supported by NHS England, The Information Standard is a certification programme designed to ensure that public health information services adhere to: • a set of best practice principles, • use only recognised evidence sources • present all information in a clear and balanced way. In January 2016, we produced a patient information policy and are in the process of implementing this across the trust. This forms the foundation for the trust's future application for The Information Standard and to achieve certification by 2018.
To ensure that 95% of patients (identified as end of life) have an end of life care bundle in place. 	Subsequent to the Royal College of Physicians (RCP), National Care of the Dying Audit of Hospitals (2015), the palliative care team is working with renal, Intensive Care Unit (ICU), Health Services for Elderly People (HSEP) and cardiology teams to identify patients who are likely to be approaching the end of their lives to assess their capacity to be involved in decisions about their care. The assessment allows the patients to make known their wishes and preferences and to support them and their families in ethical decision-making about end of life care. The results of this work are in their infancy but will be available for publication in due course. The palliative care team has also contributed to the patient safety work around the deteriorating patient and we have applied for funding for an end of life care programme manager to further drive improvements in this area.

Priority two: improving clinical effectiveness - delivering excellent outcomes

Clinical effectiveness can be measured using various methods, including clinical audit, to ensure high quality patient care and outcomes. During 2016/17, we choose to further drive improvements in dementia care, building on the key messages that were identified from the National Audit of Dementia (NAD) 2013 and the pilot for national dementia 2015/16. Through the Clinical Performance Committee (CPC) we monitor, measure and report progress. The committee reports quarterly to the trust board.

Clinical effectiveness priorities for 2016/17

What did we aim to do?	What did we achieve?
To further enhance and support dementia care initiatives across the trust, as previously identified in the national audit of dementia (NAD) 2013 and more recently in the pilot for national dementia 2015/16. 	According to the national audit of dementia (2013), at any one time, a quarter of acute hospital beds are occupied by dementia patients. We recognise that caring for someone with dementia or a terminal illness can be stressful and difficult, so it is important our services provide people with dementia and their carers with the support they need. As a result, we have developed a passport that entitles carers of people with dementia to staff reductions in the canteen, reduced parking costs, free massages and companionship from our dementia volunteers.
Linked with our patient experience priorities on dementia, we will work to improve our discharge co-ordination for patients with dementia.	The trust is currently participating in the National Audit of Dementia, which is due to publish its findings in May 2017. The national audit supplier has recently commended both the Royal Free and Barnet Hospitals on their carer's questionnaire submission, asking for feedback on our process so it can be shared with other trusts.
To develop metrics to measure improvements in dementia care.	The metrics have been developed by our dementia lead and work is in progress to embed these across the trust.

Priority three: Improving patient safety - delivering safe care

Through the Patient Safety Committee (PSC) we have monitored, measured and reported progress made during 2016/17 to achieve the set priorities. The committee reports quarterly to the trust board.

Our aim is to become a zero avoidable harm organisation by 2020, initially by reducing the level of avoidable harm at the trust (measured by incidents relating to NHS Legislation Authority claims) by 50% by 31 March 2018. Our targets are set out in our three-year Patient Safety Programme (PSP) improvement plan and we will be delivering key milestones along the way.

While the Quality Account's focus is on patient safety (as determined by the legal framework), we also take our staff safety just as seriously. Throughout the progress updates reviewed here, there are references to communication, debriefs and huddles, and all of these help support our staff to provide quality care to our patients. Our chosen priorities for 2016/17 are as follows:

Falls prevention

Aims

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

Our 2016/17 milestones:

Falls chosen priority	Progress to date
We will continue to harmonise documentation relating to falls risk assessment, so we can introduce a falls package that includes assessments, a care plan, a bedrail assessment and a post-fall checklist. We will develop an amended 'immediate post falls care guideline' that can work across all sites. We will continue with the trust-wide IHI learning sessions and increase our informal meetings to share and review information.	We are actively counting the number of days since the last fall on each pilot ward to encourage engagement and develop healthy competition. During this reporting period we have so far achieved 12% reduction in the number of falls and a 73% reduction in the proportion of patients that experience moderate harm or above from falls. We submitted our falls improvement work to the Patient Safety Awards, where we were shortlisted as a finalist. We also presented our falls improvement work at the Falls Prevention and Management conference on 6 July 2016. We have shared our work at both national and international conferences: the 17th International Conference on Falls and Postural Stability (September 2016), The Science of Improvement Conference (November 2016) and National Patient Falls Improvement Collaborative run by NHS Improvement and NHS England where 21 trusts participated from across the UK. We have implemented small changes in pilot wards and assessed progress and shared learning in formalised learning sessions and webinars.

Acute Kidney Injury (AKI)

Aims

- To increase by 25% the survival for inpatients with AKI
- To increase by 25% the proportion of patients who recover renal function
- To reduce by 25% length of stay of AKI patients from 5 days to 3.5 days
- To measure and improve patient experience and wellness scores by 2018

Our 2016/17 milestones:

AKI chosen priority	Progress to date
We will co-design and deliver an educational package to build knowledge around recognition and treatment of AKI. We will co-design a care bundle package to support the local clinical teams to deliver interventions specific to AKI pathology, such as hypo-perfusion, toxicity, obstruction and primary renal disease. We will develop a reliable creatinine review and response system.	Initial AKI improvement work has started at the Royal Free Hospital before rolling out to the other sites. This improvement work is a collaboration between the renal team, Patient at Risk Resuscitation Team (PARRT), the Patient Safety Programme team, pharmacy services and dietetic services alongside DeepMind Health. Our AKI champions have been collecting and analysing 11 months of baseline data for Royal Free patients, which was presented at the regional UCLPartners Measurement day. We have developed an AKI portal on Freenet with training materials and resources. Changes that are currently been tested include the designing and testing of an Enhanced Care AKI Care pathway: a) A technology platform (AKI App), developed by DeepMind Health. It utilises the national mandated AKI detection algorithm and sends AKI alerts with other relevant data to the clinical responders. b) Response team, which consists of the on-call renal consultant and the renal registrar as primary responders. Secondary responders will include the PARRT team and renal pharmacy. c) An AKI care plan completed by the response team as a written handover to the clinical ward team. We are now also testing our AKI patient experience survey on 10 East ward (renal ward). This survey has been co-designed with AKI patients and our Patient Experience Team. We have analysed last year's data relating to the number of new AKI patients identified per ward. This data identified the six wards on which the highest number of AKI triggers were received. These are all non-renal wards: Emergency Department, 9 North, 8 West, 10 West, 8 North and 9 West. Our next step will be to develop a training pack and deliver AKI education to all multi-disciplinary teams on these wards.

Safer Surgery

Aims

- To improve compliance to 95% for each of the five steps to safer surgery by 2018
- To reduce by at least 50% the number of surgical never events from 10 in (2015/16) to 4

Our 2016/17 milestones:

Safer Surgery chosen priority	Progress to date
By scaling up our plan-do-study-act (PDSA) cycles, we will develop locally driven methods to robustly imbed the quality of the content within steps 1 and 5 (the brief and debrief) in the theatre lists across all sites. (See glossary of terms for details on the 5 steps for safer surgery) We will co-design and test interventions to improve team culture and 'buy in' across general theatres, particularly during sign in, time out and sign out (steps 2, 3, 4). This will include the co-designing and implementation of a local theatre/surgery faculty to build skills and knowledge. We will co-ordinate the development of an organisational framework for implementation and co-design local national standards for invasive surgical-related procedures.	We have continued to test the debrief tool (step1 & 5) in nine theatres. Testing of this tool started in Oct 2015 and we have now captured over 995 team debriefs. Current MDT contribution of the three most senior disciplines and observed 'buy-in' to the running debrief continues to be captured and measured monthly. In quarter 3, the following metrics were achieved: • 92% all attendance and 'buy in' at brief • 52% attendance and 'buy in' at debrief Recent learning includes improving the effectiveness of the debrief by testing the idea of weekly summaries of Monday-Friday debrief data. This is expected to be the most efficient method for collection, analysis and sharing of information from the debrief tool. Through this testing it has been highlighted that staff did not feel confident with how to escalate some issues raised. This has resulted in an escalation ladder to accompany the debrief tool, with clearer instructions and contact details for different categories of issues. We have co-ordinated the development of an organisational framework for implementation and co-design of local national standards for invasive surgical related procedures (NatSSIPs) and will include this within our approach as we develop our Safer Surgery improvement plan over the next two years. The Safer Surgery policy incorporates Local Safety Standards for Invasive Procedures (LocSSIPs). We have identified a more robust observational tool for counting swabs and instruments within Maternity Services (step 4). Our updated Swabs, Instruments & Needles Counting policy has been developed and dissemination of this includes a new peer review of competency of scrub practitioners. The collection of step 4 data started in February 2016 with weekly updates. The observational collection of counting swabs and instruments within Maternity Services (step 4 data) now happens on three sites and has seen an average compliance increase from 65% to 86% in reliability. In quarter 3, these metrics were observed 89% of the time.

Deteriorating unborn baby

Our initial work in this area is funded by the NHS Litigation Authority, based on the extremely high costs of claims. Therefore, our aim is to reduce of these claims, which will ultimately be reflected in a reduction in harm to the unborn baby. We realise that this is not a person-centred aim and are in the process of developing more relevant measures for this workstream.

Aims

- To reduce by 50%, the number of incidents resulting in a claim relating to deterioration of the unborn baby from a mean of two per year to a mean of one per year, during three years: 2015-2018.

Our 2016/17 milestones:

Deteriorating unborn baby chosen priority	Progress to date
We are setting up the unborn baby working group and will map out ideas for change/improvement. This will include the identification of a clear aim, driver diagram and process measures. We will identify pilot area champions within Barnet and Royal Free hospitals' labour wards.	Baseline data has been collected from incidents to provide a themed analysis to understand current barriers. The baseline data has been shared with staff at audit and perinatal meetings and will be absorbed into the online maternity 'lesson of the week' feedback processes. We have identified our initial champions and have hosted two maternity planning meetings with neonatologists, midwives and obstetricians where they have created the driver diagram. External collaboration with Scottish National Maternity Patient Safety team has enabled sharing of ideas and approaches including testing MDT huddles. We have spent time information gathering to triangulate data sources for the tracking of new-born episodes, including accessing the National database Badgernet and local maternity unit systems to capture babies transferred externally. A confidence survey for all maternity staff has now been completed. The data is currently being analysed and will help to influence the design phase of the planned Cardiotocograph (CTG) education package for 2017.

Deteriorating Patient

A deteriorating patient is someone who becomes acutely unwell in hospital. This deterioration is recognised by staff who monitor the patient's vital signs such as heart rate and blood pressure, and who will then deal with this deterioration by acting directly, or escalating issues to more senior staff when needed. Occasionally, a patient's deterioration is not identified, recognised, or not acted upon sufficiently rapidly and this can lead to sub-optimal care and a patient safety incident such as an unexpected cardiac arrest. By focusing on this area, we will improve the quality of care for all our patients.

Aims

- To reduce the number of cardiac arrests to less than one per 1,000 admissions at both Barnet and Royal Free Hospitals by 31 March 2018.

Our 2016/17 milestones:

Deteriorating Patient chosen priority	Progress to date
Five pilot wards have been identified across the trust (including obstetrics) where we will trial specific change interventions such as SBAR (Situation, Background, Assessment and Recommendation) handover quality, ward rounds, board rounds and safety huddles. These interventions will be measured so that staff receive timely feedback and PDSA cycles of improvement can be enacted. We will introduce ward-based metrics, such as ward cardiac arrest rates, so that staff can understand their baseline data and have real-time feedback on progress. We will undertake targeted case note review and audit of patient deaths (both unexpected and expected) in the pilot ward areas involving ward staff alongside members of the deteriorating patient workstream. Areas for improvement and lessons learnt will be shared back with ward staff.	We are drafting a communication bundle and are starting to define what to measure for handovers, ward rounds and board rounds and the risk and resuscitation team - PARRT - are testing a handover tool. We have observed a variety of handover and board rounds in pilot areas to develop understanding of the quality of staff–to-staff communication. We have undertaken 12 staff interviews at the Royal Free and Barnet Hospitals where strong themes have emerged and potential gaps have been identified. We have also hosted our first patient community focus group, with charity funding, where we tested narrative relating to clinical end of life discussions with patients and families. Coding of these interviews and discussions is being undertaken against the COM-B behavioural model to help narrow the focus on what to measure. Engagement with all cardiology MDT members has begun to scope barriers and levers to recognition, treatment and delivery of complex decision in cardiology patients. The clinical MDT on our cardiology ward has collaborated with PARRT to review processes around the recognition and management of the deteriorating patients. Initially a medical records review was undertaken relating to 31 patient deaths over a nine-month period (November 2015 – August 2016). This review identified 20 patient deaths that were expected, and 11 where resuscitation was undertaken, i.e. the death was not planned for. Of these 11 patients, four patients died less than 24 hours after PCI (Percutaneous Coronary Intervention) and the other seven had multiple co-morbidities. No problems in care or service delivery were identified as contributing to these patient deaths. These reviews identified the following themes that have been shared with consultants, cardiac Cath-lab and ward staff: • Delayed recognition of poor trajectories of chronic conditions • Delayed end of life decision making • All those patients who died following cardiac arrest were in a 'non-shockable' rhythm, which is indicative of expected very poor clinical outcomes, most often resulting in death. The initial planning phase on 10 west has identified team communication processes and lack of opportunity for MDT to make shared decisions as areas for improvement. Rapid PDSA cycles have commenced to re-design the content and structure of information on the ward white boards. These boards display significant pieces of clinical and social information to support anticipatory care planning discussions and help facilitate a planned weekly MDT meeting, supported by PARRT and palliative care teams. Recent testing has provided shared knowledge and learning around: • Early identification of complex patients with chronic poor trajectory of health conditions e.g. prompting questions of the number of admissions in past six months?

Deteriorating Patient chosen priority	Progress to date
	• Timely identification of patients that require MDT discussion e.g. complex social and medical needs have been highlighted. • How to better recognise patients ready for discharge, prompting discussion of potential discharge date and synchronising care packages accordingly.

Sepsis

Aims

- To reduce by 50% severe sepsis-related serious incidents across all sites to zero in 2017/18.
- To increase survival by 50% for those patients on the sepsis bundle across all sites.

Our 2016/17 milestones:

Sepsis chosen priority	Progress to date
We will use PDSA cycles to improve our compliance in the newer pilot ward areas such as Barnet Hospital's emergency department and maternity. We will test the behavioural theory-identified recommended modifications for improvement: standardisation of education sessions, partnership agreement, and frequently asked questions guidance in our pilot ward and measure this in practice. We will further develop the sepsis champion role in pilot areas to enable long term sustainability in all 10 pilot wards.	Over 2015/16 there was four serious incidents relating to sepsis, with an additional incident in 2016/17 to date. The majority of these incidents occurred in Barnet Hospital and so this has influenced our drive for sepsis improvements in this location for 2016/17. The sepsis bundle is now implemented in 10 of our clinical areas, which includes our labour wards and emergency departments (ED). In August 2016 at Barnet ED compliance with the sepsis six bundle was 65% - the highest compliance since pilot launch. Tests of change have included using a sepsis stamp for documentation and a sepsis trolley to ensure prompt treatment. Three nurse champions have now been recruited, though a new consultant is needed as sepsis lead. The severe sepsis pathway has now been added to the ED admission booklet. The maternity sepsis team published their sepsis improvement poster at the Royal College of Obstetricians and Gynaecologists (RCOG) conference in June 2016. This collaborative piece of work outlined the success of Obstetric Sepsis 6 improvement work on the Royal Free and Barnet labour wards, highlighting the benefits of sharing and learning from each other. Sepsis pathway triggers and pathways have been standardised across the trust with the implementation of sepsis stickers and sepsis trollies. Feedback from maternity staff has been that the implementation of a Sepsis 6 pathway has improved and simplified the management of severely septic women in the maternity service.

	Barnet labour ward has celebrated an achievement of 100% compliance for all sepsis 6 within an hour in August. Monthly sepsis improvement meetings continue and champions are encouraged to attend and present their own data. UCL Partners (UCLP) Sepsis Collaborative hosted an informative measurement day on 21 September 2016. The Royal Free London champions presented our approach at the final UCLP collaborative summit event on 2 December 2016. To support the sepsis improvement work across both the Royal Free and Barnet Hospitals, an awareness day was set up to support the clinical teams involved. Sepsis champions showcased their experiences of Barnet labour ward and ED successes. The event was held at Barnet Hospital and about 40 doctors, nurses and nursing students attended. This event was well supported by the trust executive team. In the session staff gained knowledge on: • The use of behavioural science research in the sepsis improvement work (COM-B model) • Current NICE guidance • Role of a sepsis champion • How to manage sepsis with a multi-professional team – demonstrated by simulation Joe Adams, one of our patients, has been treated at the trust for sepsis many times, and he kindly agreed to create a short video that documents his journey over the past 10 years as a patient. This video uses the power of transformational storytelling to positively influence and educate clinical teams with the delivery of the sepsis care bundle. This video will be incorporated into future internal e-learning packages and sepsis awareness raising events. Joe kindly also attended the event and pro-actively answered questions from staff. As part of our sepsis programme, we are also including the 2016/17 national sepsis goals which focus on timely screening, identification and treatment for sepsis in the following areas: ED, acute inpatient settings and paediatrics. Data collection will include: sepsis screening and documentation with observations recorded, and severe sepsis/shock and timely IV antibiotics within 1 hour and review of IV antibiotics at 72 hours. Baseline and quarter three data has been submitted to our commissioners.

2.2 Priorities for improvement 2017/18

This section of the quality account details what the quality improvement priorities will be for the year ahead. All three priorities fall within the quality domain and were drawn from our local intelligence, engagement with the Commissioning for Quality and Innovation (CQUIN), performance and feedback following consultation with key stakeholders. Progress in achieving the priorities will be monitored at our board level committees and our trust board.

Our consultation process

As part of our consultation process, external stakeholders, the council of governors, patients and staff were invited to share their views on our proposed priorities and were also asked if there were any other priorities that the trust should consider for 2017/18.

In addition, we consulted with both in-patients and out-patients at Barnet and Chase Farm Hospitals to ascertain their views on the trust priorities. On the whole, the patients were in agreement with our proposed priorities but suggested that a focus on nutrition could be considered.

Step 1

- The initial proposed quality improvement priorities were generated following discussion at the associated committee and drawn from our intelligence and performance.
- Our stakeholders were invited to attend our consultation event.

Step 2

- The stakeholders event was held on 13 January 2017 and was attended by over 80 people.
- Attendees included members for our council of governors, joint overview and scrutiny health committee, healthwatch and commissioners.

Step 3

- Feedback from the consultation event was analysed and changes were made accordingly to our quality improvement priorities.
- The priorities were agreed and signed-off by our trust executive committee.

Priority 1: Improving patient experience - delivering a world class experience

The approach to improving the patient experience remains linked to the different strands of work which are ongoing within the trust. The patient experience strategy (2015-2019) outlined the vision of being strong leaders of positive patient experiences so we can effectively serve our communities.

Our proposed quality priorities for 2017/18 are:

- To achieve trust certification for the Information Standard by 2018
- Improve how patients, carers and families can provide feedback to the trust. Each service must have at least three ways of allowing feedback about a person's experience
- To systematically analyse the experience of bereaved families and friends
- To further enhance and support dementia care initiatives across the trust through the delivery of the dementia strategy by 2018
- To recruit 30 Patient and Family Experience Partners*

*A partner is a person who:

- Wants to help enhance the quality of our hospitals care for all patients and family members.
- Gives advice to the hospital based on his or her own experience as a patient or family member
- Partners with hospital staff on how to improve the patient and family experience through short and/or long-term projects and volunteers his or her time.

Priority 2: Clinical effectiveness

The overarching plan for 2016/17 was that the clinical effectiveness priority will dovetail with the quality improvement initiatives. This would strengthen the delivery of the local and national effectiveness agenda and support the delivery of significant improvements in the quality of patient care.

By April 2018, the trust aims to deploy a trust-wide approach to managing unwarranted variations in clinical care, called Clinical Practice Groups (CPGs). CPGs interface very closely with the operating line.

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

The trust's priority is also to have at least 50 QI projects in place by the end of April 2018. The projects are required to have core features, which include a clear aim, change logic, ongoing PDSA and measurement linked to learning (see appendix a. for more details).

Therefore it was proposed that the 2016/17 clinical effectiveness priority on dementia would not be retained during 2017/18 as a specific quality priority as the trust has made significant improvements during 2016/17.

Our proposed quality priorities for 2017/18 are:

- To improve key effectiveness metric(s) relevant to 20 priority pathways by deploying multi-professional pathway teams to reduce unwarranted variation.

- Each pathway team to deploy a standardised approach to design and execution, within the umbrella of the CPGs.

Note: We are currently selecting our priority pathways and the metrics will be specific to the pathways selected.

Priority 3: Our focus for safety

The trust has set an ambitious target to become a zero avoidable harm organisation by 2020; initially reducing the level of avoidable harm by 50% by March 2018. The targets for safety follow a three-year plan, with discrete deliverables for 2017/18.

Our proposed quality priorities for 2017/18 are:

Falls

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

Acute Kidney Injury (AKI)

- To increase by 25% the survival for inpatients with AKI.
- To increase by 25% the proportion of patients who recover renal function from 68% to 85%.
- To reduce by 25% length of stay of AKI patients from 5 days to 3.5 days.
- To measure and improve patient experience and wellness scores.

Safer Surgery

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

Deteriorating Patient

- To reduce the number of cardiac arrests to less than one per 1,000 admissions.
- To reduce by 50%, the number of incidents resulting in a claim relating to deterioration of the unborn baby from a mean of two per year to a mean of one per year.

Sepsis

- To reduce by 50% severe sepsis-related serious incidents across all sites from one to zero.
- To increase survival by 50% for those patients on the sepsis bundle across all sites from 83% to 91%.

Overview of our key achievements

The Royal Free Hospital achieved the **highest** risk-adjusted **survival rates at 5 years** for **first adult kidney transplant in London, and better than the national average**	The Royal Free Hospital is in the **top 20 performing hospitals** nationally for **adult patients with type 1 diabetes receiving all 8 best practice recommended care processes**	**Our stroke patients receive a world class stroke service** with Barnet and Royal Free Hospitals amongst the **top 18% of teams** nationally
The Royal Free Hospital is **the 3rd best performing hospital** nationally for **paediatric diabetes** patients **receiving all 7 best practice recommended processes**	The Trust participated in **50** national audits and confidential enquiries	**Better than national and London** risk-adjusted **mortality at 90-days and 2-years** for **bowel cancer** surgery at Barnet Hospital
The Royal Free Hospital is in the **best 25% of hospitals** nationally for **diabetes care in pregnant women** for **blood glucose control for pregnancies in the first trimester and at 24 weeks+**	**More major trauma patients** presenting at the emergency department at Barnet and Royal Free Hospitals **survive compared to expected** based on the severity of their injury	**0% rate of stroke/ death reported for patients undergoing a carotid endarterectomy** at the Royal Free Hospital
Barnet Hospital **Intensive Care Unit**: • Achieved **best ratings for all RAG-rated quality indicators** • **Improved compared to previous year for 5/7 indicators** (reduction of high risk sepsis admissions, out of hours discharges to the wards and risk-adjusted mortality) • Has significantly fewer **unplanned readmissions within 48 hours than nationally**	Barnet and Royal Free Hospitals are both in the **best 25% of hospitals** nationally **for 5 best practice care process or outcomes** for **hip fracture** patients, including **best practice tariff achieved** at Barnet Hospital and **overall hospital length of stay** at Royal Free Hospital	The Royal Free Paediatric emergency department: • Is in the **best 25% of hospitals** nationally for **4/5 best practice criteria relating to vital signs** • **For all cases** where abnormal vital signs were present the **clinician recognised the abnormal vital signs and they were acted upon appropriately**

2.3 Statements of assurance from the board

This section contains eight statutory statements of assurance from the board, regarding the quality of services provided by the trust. Where relevant we have provided additional information for local context to the information in the statutory statements.

Review of services

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

During 2016/17, the trust provided and/or sub-contracted xx relevant health services.

The trust has reviewed all the data available on the quality of care in xx of these relevant health services.

The income generated by the relevant health services reviewed in 2016/17 represents xxx of the total income generated from the provision of relevant health services by the trust for 2016/17.

(Final data to be added)

Participating in clinical audits and national confidential enquiries

The trust continues to participate in clinical audit programmes and has integrated this within our quality improvement programme. We continue to review our clinical audit processes, ensuring we have evidence of improvements made to practice.

During 2016/17 42 national clinical audits and 8 national confidential enquiries covered relevant health services that the trust provides.

During that period the trust participated in 100% (42/42) of national clinical audits and 100% (8/8) of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the trust was eligible to participate in, and took part in, during 2016/17 are listed in table 2:

The national clinical audits and national confidential enquiries that the trust participated in, and for which data collection was completed during 2016/17, are listed in table 2 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 2: Participation in national clinical audits and national confidential enquiries, including validated participation rates provided to the trust by the audit supplier in 2016/17

*Validated participation rates for 2016/17 have not been made available by the audit provider. These figures relate to the most recent audit period, as indicated, for which validated participation rates are available.

National clinical audits for inclusion in quality report 2016/17	Data collection completed in 2016/17	Eligibility to participate	Participation 2016/17	Rate of case ascertainment (%) or number of cases (n) submitted if % not known
British Association of Endocrine and Thyroid Surgeons (BAETS)	√*	x	x BH	
		√	√ CFH	n= 543 (CF and RF) *2010/14
		√	√ RFH	
British Association of Urological Surgeons (BAUS): nephrectomy audit	√*	√	√ BH	See RF
		x	x CFH	
		√	√ RFH	n= 566 (130%) (BH and RF) *2013/15
BAUS: percutaneous nephrolithotomy (PCNL)	√*	x	x BH	
		x	x CFH	
		√	√ RFH	n= 84 *2014/15
BAUS: stress urinary incontinence	√*	x	x BH	
		x	x CFH	
		√	√ RFH	n= 12 *2014/15
British Thoracic Society (BTS): adult asthma	√	√	√ BH	n=13 (100%)
		x	x CFH	
		√	√ RFH	n=31 (100%)
BTS: paediatric pneumonia	x	√	√ BH	Audit due for completion 2017/18
		x	x CFH	
		√	√ RFH	Audit due for completion 2017/18
Cancer: national bowel cancer audit	√*	√	√ BH	n= 146 (108%) *2014/15
		x	x CFH	
		√	√ RFH	n= 80 (84%)
Cancer: national lung cancer audit	√*	√	√ BH	See RF
		x	x CFH	
		√	√ RFH	n = 314 (BH and RF) *2015
Cancer: national oesophago-gastric cancer audit	√*	√	√ BH	See RF
		x	x CFH	
		√	√ RFH	n= 194 (81-90%) (BH and RF) *2012/ 15
Cancer: national prostate cancer audit	√*	√	√ BH	See RF
		x	x CFH	
		√	√ RFH	n = 342 (82%) (BH and RF) *2014/15
Chronic obstructive pulmonary disease (COPD) audit programme: secondary care	x	√	√ BH	Audit due for completion 2017/18
		x	x CFH	
		√	√ RFH	Audit due for completion 2017/18
COPD audit programme: pulmonary rehabilitation	x	x	x BH	
		x	x CFH	
		√	√ RFH	Audit due for completion 2017/18
Dementia: national audit of dementia	√	√	√ BH	Organisational Audit: n=1 (100%) Clinical Audit: n=55 Carer Questionnaire: n=61 Paper Staff Questionnaire: n=55 Online Staff Questionnaire: n= 63
		x	x CFH	
		√	√ RFH	Organisational Audit: n=1 (100%) Clinical Audit: n=55 Carer Questionnaire: n=76

National clinical audits for inclusion in quality report 2016/17	Data collection completed in 2016/17	Eligibility to participate	Participation 2016/17	Rate of case ascertainment (%) or number of cases (n) submitted if % not known
				Paper Staff Questionnaire: n=56 Online Staff Questionnaire: n= 65
Diabetes: national diabetes audit (NDA)	√*	√	√ BH	n= 718 *2015/16
		√	√ CFH	n= 548 *2015/16
		√	√ RFH	n= 1726 *2015/16
Diabetes: national footcare in diabetes audit	√*	x	x BH	
		x	x CFH	
		√	√ RFH	n= 56 *2014/16
Diabetes: national diabetes in-patient audit (NaDIA)	√	√	√ BH	n= 57
		x	x CFH	
		√	√ RFH	n= 103
Diabetes: national diabetes transition audit	x	√	√ BH	NEW – first round of audit
		√	√ CFH	
		√	√ RFH	
Diabetes: national paediatric diabetes audit (NPDA)	√*	√	√ BH	n= 119 *2015/16
		√	√ CFH	n= 60 *2015/16
		√	√ RFH	n= 60 *2015/16
Diabetes: national pregnancy in diabetes (NPID)	√*	√	√ BH	n= 26 *2015
		x	x CFH	
		√	√ RFH	n= 37 *2015
Falls and fragility fractures audit programme (FFFAP): fracture liaison service database	√	√	√ BH	NEW – first round of audit
		x	x CFH	
		x	x RFH	
FFFAP: national hip fracture database	√*	√	√ BH	n= 370 (92.9%) *2015
		x	x CFH	
		√	√ RFH	n= 190 (85.4%) *2015
Heart: national audit of percutaneous coronary interventions	√*	x	x BH	
		x	x CFH	
		√	√ RFH	n= 829 *2014
Heart: cardiac rhythm management	√*	√	√ BH	n= 304 *2015/16
		x	x CFH	
		√	√ RFH	n= 167 *2015/16
Heart: myocardial infarction national audit project (MINAP)	√*	√	√ BH	n= 304 *2014/15
		x	x CFH	
		√	√ RFH	n= 289*2014/15
Heart: national heart failure audit	√*	√	√ BH	n= 402 (81%) *2014/15
		x	x CFH	
		√	√ RFH	n= 260 (76%) *2014/15
Intensive care national audit and research centre (ICNARC): national cardiac arrest audit (NCAA)	√*	√	√ BH	n=121 *2015/16
		x	x CFH	
		√	√ RFH	n=320 *2015/16
ICNARC: case mix programme: adult critical care	√*	√	√ BH	n=1017 *2015/16
		x	x CFH	
		√	√ RFH	n=1628 *2015/16
Inflammatory bowel disease (IBD): biological therapy audit Adult services	x	√	√ BH	Transition to IBD Registry. Next audit round due for completion 2017/18
		x	x CFH	
		√	√ RFH	Transition to IBD Registry. Next audit round due for completion 2017/18

National clinical audits for inclusion in quality report 2016/17	Data collection completed in 2016/17	Eligibility to participate	Participation 2016/17	Rate of case ascertainment (%) or number of cases (n) submitted if % not known
IBD: biological therapy audit Paediatric services	x	x	x BH	
		x	x CFH	
		√	√ RFH	Transition to IBD Registry. Next audit round due for completion 2017/18
National comparative audit of blood transfusion programme: re-audit of patient blood management in scheduled surgery	√*	√	√ BH	n= 23
		√	√ CFH	n= 8
		√	√ RFH	n= 23 *2015
National comparative audit of blood transfusion programme: re-audit of red cell and platelet transfusion in adult haematology patients	√*	√	√ BH	n= 32 *Jan-16
		x	x CFH	
		x	x RFH	
National elective surgery PROMs: four operations	√*	√	√ BH	n=748 (74.3%) *Apr-14/Mar-15
		√	√ CFH	
		√	√ RFH	
National emergency laparotomy audit (NELA)	√*	√	√ BH	n= 10 *2014/15
		x	x CFH	
		√	√ RFH	n= 92 *2014/15
National joint registry (NJR)	√*	√	√ BH	n= 42 * data to Dec-15
		√	√ CFH	n= 573 * data to Dec-15
		√	√ RFH	n= 427 * data to Dec-15
National neonatal audit programme (NNAP)	√*	√	√ BH	n=1255 *2015
		x	x CFH	
		√	√ RFH	n=368 *2015
National pulmonary hypertension audit	√*	x	x BH	
		x	x CFH	
		√	√ RFH	n= 1080 *2014/15
National vascular registry	√*	x	x BH	
		x	x CFH	
		√	√ RFH	n= 257 *2015
National ophthalmology audit: adult cataract surgery	√	√	√ BH	NEW – first round of audit
		√	√ CFH	
		√	√ RFH	
Renal replacement therapy (renal registry)	√*	x	x BH	
		x	x CFH	
		√	√ RFH	n= 229 *2014
Royal College of Emergency Medicine (RCEM): asthma (adults and children)	√	√	√ BH	n=101 (100%)
		x	x CFH	
		√	√ RFH	n=117 (100%)
RCEM: severe sepsis and septic shock-care in emergency departments	√	√	√ BH	n=101 (100%)
		x	x CFH	
		√	√ RFH	n=81 (100%)
Sentinel stroke national audit programme (SSNAP)	√*	√	√ BH	Case ascertainment = 90+% *2015/16
		x	x CFH	
		√	√ RFH	Case ascertainment = 90+% *2015/16
Trauma audit research network (TARN)	√*	√	√ BH	Case ascertainment = 66% *2015
		x	x CFH	
		√	√ RFH	Case ascertainment = 75-94% *2015

National clinical audits for inclusion in quality report 2016/17	Data collection completed in 2016/17	Eligibility to participate	Participation 2016/17	Rate of case ascertainment (%) or number of cases (n) submitted if % not known
Rheumatoid and early inflammatory arthritis	x	√	x BH	Audit did not collect data in 2016/17
		√	x CFH	
		√	x RFH	
Adult cardiac surgery	√*	x	x	
Congenital heart disease	√*	x	x	
Chronic kidney disease in primary care	√*	x	x	
Mental health clinical outcome review programme	√*	x	x	
PICANet	√*	x	x	
Prescribing observatory for mental health	√*	x	x	
Specialist rehabilitation for patients with complex needs	√*	x	x	
UK Cystic fibrosis registry	√*	x	x	
National lung cancer audit consultant-level data	√*	x	x	
National oesophago-gastric cancer audit - consultant-level data	√*	x	x	
National neurosurgical audit programme - consultant-level data	√*	x	x	

The Royal Free London NHS Foundation Trust also participated in the following national audits by submitting data 2016/17:

National audit title
7-day service audit
BTS: smoking cessation
Maternity and perinatal audit
National audit of cardiac rehabilitation
National complicated diverticulitis audit (CAD)
NHSBT: kidney transplantation
NHSBT: liver transplantation
Potential donor
RCEM: consultant sign-off
Royal College of Anaesthetists: national of perioperative anaphylaxis
The iBRA-2 study: a national prospective multi-centre audit of the impact of immediate breast reconstruction on the delivery of adjuvant therapy

National confidential enquiries for inclusion in quality report 2016/17	Data collection completed in 2016/17	Eligibility to participate	Participation 2016/17	Rate of case ascertainment (%)
Medical and surgical clinical outcomes review programme: physical and mental health care of mental health patients	√	√	√ BH	Clinical Questionnaire and casenotes: n= 15/15 (100%) Psychiatric Liaison Questionnaire: 5/5 (100%)
		√	√ CFH	
		√	√ RFH	

National confidential enquiries for inclusion in quality report 2016/17	Data collection completed in 2016/17	Eligibility to participate	Participation 2016/17	Rate of case ascertainment (%)
in acute hospitals				Organisational Audit: n= 3/3 (100%)
Medical and surgical clinical outcomes review programme: non-invasive ventilation	√	√	√ BH	Clinical Questionnaire and Casenotes: n= 5/5 (100%) Organisational Audit: n= 2/2 (100%)
		x	x CFH	
		√	√ RFH	
Medical and surgical clinical outcomes review programme: acute pancreatitis	√	√	√ BH	Clinical Questionnaire: n= 10/10 (100%) Casenotes: n=10/10 (100%) Organisational Audit: n= 3/3 (100%)
		x	x CFH	
		√	√ RFH	
Maternal, newborn and infant: maternal programme	√*	√	√ BH	100%
		x	x CFH	
		√	√ RFH	Case ascertainment = 100% *2015
Maternal, newborn and infant: perinatal programme	√*	√	√ BH	Case ascertainment = 100% *2015
		x	x CFH	
		√	√ RFH	Case ascertainment = 100% *2015
Learning disability review programme (LeDer)	x	√	√ BH	Enquiry due for completion 2017/18
		√	√CFH	
		√	√ RFH	
Child health clinical outcomes review programme: young people's mental health	x	√	√ BH	Enquiry due for completion 2017/18
		√	√CFH	
		√	√ RFH	
Child health clinical outcomes review programme: chronic neurodisability	x	√	√ BH	Enquiry due for completion 2017/18
		√	√CFH	
		√	√ RFH	

The reports of 49 national clinical audits were reviewed by the provider in 2016/17 and the trust intends to take the following actions to improve the quality of healthcare provided:

Actions to improve the quality of healthcare provided:

- We will continue to scrutinise and share learning from national audit reports at our corporate committee (clinical governance and clinical risk committee)
- We will use outcomes from national clinical audits to help us prioritise pathway work in our Clinical Practice Groups across our new group of hospitals.
- We will continue to make improvements to our clinical processes where national clinical audits suggest care could be improved.

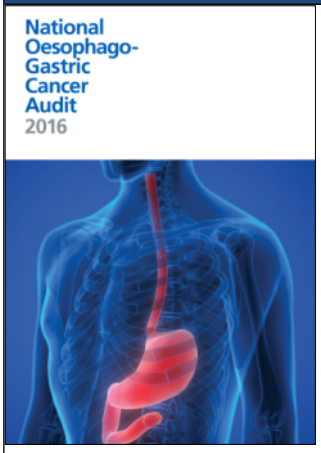
Table 3: Details of specific actions undertaken as the result of a national clinical audit

National clinical audit	Actions to improve quality
British Association of Endocrine and Thyroid Surgeons (BAETS) **Published:** Jan-16 **Reporting period:** 01/07/10 – 30/06/14 **Site:** Royal Free & Chase Farm	Data was submitted to the registry by three consultants who work across sites – none of whom have been identified as outliers. During the audit period the trust data shows that there were no post-operative deaths, that length of stay was the same or better than the national average and that better than national average rates were achieved for related re-admission, re-exploration for bleeding and late hypocalcaemia.

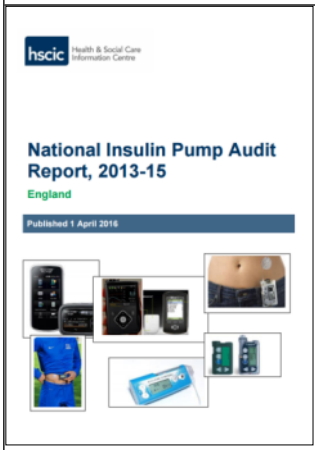
National clinical audit	Actions to improve quality
British Association of Urological Surgeons (BAUS) - nephrectomy audit **Published:** Sep-16 **Reporting period:** Barnet: 2013 and Royal Free: 2013-15 **Site:** Royal Free and Barnet	Neither the trust nor any of the eight consultants who submitted data to the audit are identified as outliers for complication rate, transfusion rate or mortality. Royal Free – No deaths were reported during the audit period, and the complication and transfusion rates are better than the national average. Barnet – The transfusion rate and mortality rate is 0. The complication rate is within control limits and not identified as an outlier.
BAUS - percutaneous nephrolithotomy (PCNL) audit **Published:** May-16 **Reporting period:** 2014-15 **Site:** Royal Free only	The data shows that the trust achieved a transfusion rate of 0% during the audit period, and that the post-operative length of stay is in line with the national average.
British Thoracic Society Better lung health for all **British Thoracic Society (BTS): adult asthma audit** **Published:** Feb-17 **Reporting period**: 01/09/16 - 31/10/16 **Site:** Royal Free and Barnet	Asthma is a common lung condition that causes occasional breathing difficulties. It affects people of all ages and often starts in childhood, although it can also appear for the first time in adults (*source: NHS Choices*). The performance of the respiratory team in the audit demonstrates areas of excellence in the care provided to our patients with the most recently published data showing that above average performance was provided at Barnet and Royal Free Hospitals for the following best practice criteria: • Awareness that patients with severe asthma and one or more adverse psychosocial factors are at risk of death. • Supplementary oxygen is provided to hypoxaemic patients with acute severe asthma to maintain an SpO_2 level of 94-98%. • People presenting with a severe or life-threatening acute exacerbation of asthma receive oral or intravenous steroids within one hour of presentation. • People with asthma who present with an exacerbation of their symptoms receive an objective assessment of severity at the time of presentation. • Hospital follow up arranged. In addition the Royal Free achieved above average performance for the asthma care bundle used and patients receiving each care bundle element (inhaler technique, medication review, written action plan and triggers considered). Barnet Hospital achieved above average performance for the smoking status recorded. Royal Free is in line with the national average for this criteria. No patient deaths were recorded and length of stay is similar to the national average.

National clinical audit	Actions to improve quality
British Thoracic Society Better lung health for all **BTS: national smoking cessation audit** **Published:** Nov-16 **Reporting period:** 01/04/16 – 31/05/16 **Site:** Royal Free and Barnet	Millions of people attend hospital as inpatients and outpatients each year, many of whom will be current smokers and at significant risk of development, or exacerbation of, tobacco-related disease. Treating tobacco dependence in hospitals therefore represents a significant opportunity to improve the lung and general health of our patients (*source: national audit report*). Our performance in the national audit demonstrates excellence in the care provided to our patients, with the most recently published data showing above average performance for smoking status recorded at the Royal Free Hospital; and for current smokers asked if they would like help to stop smoking at both the Royal Free and Barnet Hospitals. In addition the trust provides all organisational standards of best practice measured by the audit. Improvements made at the Royal Free Hospital to increase accurate recording and increase referrals include implementing annual education for junior doctors about the importance of accurate recording; sending reminders to staff on recording accurately; undertaking audits on ward performance with regards to the percentage of patients with smoking status recorded as 'unable to assess' and providing feedback on this to the junior doctors; and having a pharmacy lead. The implementation of electronic prescribing will further improve documentation. At Barnet Hospital audits on recording smoking status are undertaken. In addition pharmacy lead on improving its recording of patients smoking status, providing very brief advice (VBA), referral to smoking cessation services and education.
British Thoracic Society Better lung health for all **BTS paediatric asthma** **Published:** Nov-16 **Reporting period:** 01/11/15 – 30/11/15 **Site:** Royal Free and Barnet	Acute attacks of asthma are amongst the most common medical reasons for hospital admissions in children in the UK (*source: national audit report*). The performance in the audit demonstrates excellence in the quality of care provided to our patients across sites with the most recently published data showing that for: • Initial treatment of asthma: both sites provided above average care for provision of oxygen, treatment with a beta agonist, and treatment with ipratropium bromide. • Discharge planning: at Royal Free 100% of patients had a written asthma plan in place at discharge.
Cancer: national bowel cancer audit **Published:** Dec-16 **Reporting period:** 01/04/14 – 31/03/15 **Site:** Royal Free and Barnet **Data quality:** Barnet Hospital achieved the top 'green' rating for case	Bowel cancer is a major cause of illness, disability and death in the United Kingdom (UK) (*source: national audit report*). The performance of the trust in the audit demonstrates areas of excellence in our care, with the most recent published data showing better than average performance at both hospital sites for the proportion of patients seen by a clinical nurse specialist, major surgery carried out as a planned procedure and laparoscopic ('keyhole') surgery attempted. The audit data also demonstrates excellent outcomes for our patients. In particular, at Barnet Hospital the adjusted 90-day mortality, adjusted 30-day

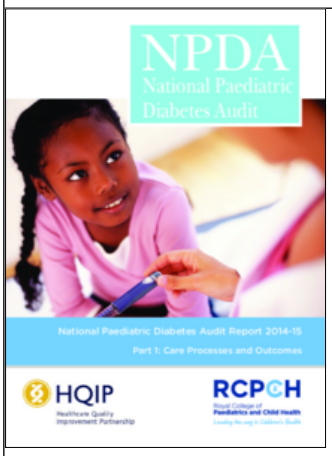
National clinical audit	Actions to improve quality
ascertainment and all four data completeness items reported by the audit. Royal Free Hospital achieved the top 'green' rating for all four criteria relating to data quality except pre-treatment staging which received an 'amber' rating. During the multidisciplinary meeting the pre-treatment staging is sometimes not available and therefore goes unrecorded. The new merged IT system will address this issue. All patients who underwent major surgery at both sites had their ASA recorded to allow risk-adjustment.	unplanned re-admission and two-year mortality rates are better than the national and network averages. The abdominoperineal resection (APER) rate is also better than the national average and the adjusted 18-month stoma rate while just above the national average is within control limits. At the Royal Free Hospital the audit again demonstrates better than average outcomes for 90-day mortality and 30-day unplanned readmissions, with the APER and 18-month stoma rates in line with the national average. The two-year mortality rate for patients seen at the Royal Free was identified as an outlier by the national audit. An internal mortality review was completed for 23 patients who underwent surgery during the audit period 01/04/12 to 31/03/13. From those patients, 13 underwent palliative surgery from the outset (disease was too advanced for surgery treatment) and death was not unexpected; three patients died due to peri-operative complications and death was unexpected although unrelated to the treatment; and a further seven died from causes unrelated to colorectal cancer or colorectal cancer surgery. No quality of care issues were identified through the mortality review.
Cancer: national lung cancer audit **Published:** Jan-17 **Reporting period:** 01/01/2015 – 31/12/15 **Site:** Royal Free and Barnet **Data quality:** Using a multitude of data feeds (Cancer Outcomes and Services Dataset feed, pathology reports, radiology reports, treatment events and death certificates) the national audit has identified an additional 6,000 lung cancer cases in England compared with historical national lung cancer audit records, an increase of 20%. Of the 314 cases assigned to us in the 2015 audit report, 220 were recorded as trust first seen and entered by the local teams. An additional 94 cases have also been allocated via the RCP algorithm and will be reviewed for appropriateness by the local teams once the patient-level data is received.	Lung cancer is the second most common cancer in the UK after breast cancer, and is the commonest cause of cancer-related death. Current survival rates for lung cancer are the second lowest out of 20 common cancers in England and Wales (*source: national audit report*). Trust-level performance in the audit demonstrates good practice and areas of excellence, with the most recently published data showing that performance is equal to or exceeds the recommended level for the: • Stage completeness i.e. the extent of the cancer, such as how large the tumour is and whether it has spread. • Pathological diagnosis. This is the preferred means of diagnosis, as it is more accurate and helps to determine the most appropriate form of treatment. Trust performance for pathological diagnosis has both improved compared to the previous patient cohort (2014 data) and is statistically better than the national average. • The use of chemotherapy for both non-small-cell lung cancer (NSCLC) patients and small-cell lung cancer (SCLSC) patients. Patient outcome is in line with the national average for survival to one year.

National clinical audit	Actions to improve quality
 **Cancer: national oesophago gastric cancer audit (NOGCA)** **Published:** Sep-16 **Reporting period:** 01/04/12 – 31/03/15 **Site:** Royal Free and Barnet	Oesophago-gastric cancer is the fifth most common cancer in the UK, affecting around 16,000 people each year. Overall, survival in England and Wales is poor, with only 15% of oesophageal cancer patients and 19% of gastric cancer patients surviving five years after diagnosis (*source: national audit report*). Patients diagnosed with high-grade Glandular Dysplasia (HGD) at Royal Free and Barnet Hospitals are referred to University College London Hospital (UCLH) for surgery. Excellence in terms of quality of care and data quality are demonstrated by our performance in the most recently published report, with the data showing that the trust achieved the top 'green' rating for adjusted rate of diagnosis after emergency admission, referral source and case ascertainment.
 **Cancer: national prostate cancer audit (NPCA)** **Published:** Feb-17 (revised data) **Reporting period:** 01/04/14 – 31/03/15 **Site:** Royal Free and Barnet **Data quality:** Areas highlighted for improvement by the national audit report include data completeness across key data items, specialist multidisciplinary team data items and External Beam Radiation Therapy (EBRT) (myelodysplastic syndromes	Prostate cancer is the most frequently diagnosed solid cancer in men and the second most common cause of cancer-related death in the UK (*source: national audit report*). The quality of care received by patients at the trust is demonstrated by an above average performance achieved for all patient reported experience measures (PREMS) for radical prostatectomy patients – with 100% rating their overall care as excellent, and 100% reporting they were involved in decisions about their care and provided information about their condition and treatment. The experience reported by radical radiotherapy - EBRT - patients was mixed. The data is currently under review within the specialty and an action plan is in development to improve further.

National clinical audit	Actions to improve quality
(MDS)-3) data items.	
Diabetes: national diabetes audit (NDA): care processes and treatment targets **Published:** Jan-16 **Reporting period:** 2013/14 and 14/15 **Site:** Royal Free and Barnet **Data quality:** We believe that some of our care processes were not captured reliably in our data submission for 2013/14. We made improvements to our data processes for 2014/15, including the introduction of Diamond; a diabetes IT management system, at the Royal Free Hospital. This improved data is reflected in the most recent NDA report published in January 2017. The IT system will be rolled out across our other sites in 2017; accompanied by a data validation and cleaning exercise across all sites prior to data submission.	Diabetes is a lifelong condition that causes a person's blood sugar level to become too high. There are two main types of diabetes with type 2 being far more common than type 1. In the UK, around 90% of all adults with diabetes have type 2 (s*ource: NHS Choices – Diabetes*). At Barnet and Chase Farm Hospitals performance was lower than expected for the provision of each of the eight best practice care processes for patients with type 1 and type 2 diabetes; and fewer patients were achieving the three treatment targets compared to the national average. Performance at Royal Free was mixed for the provision of the eight best practice care processes and the achievement of the three treatment targets.
Diabetes: national diabetes audit (NDA): care processes and treatment targets **Published:** Jan-17 **Reporting period:** 2015/16 **Site:** Royal Free, Barnet and Chase Farm	The results of the latest National Diabetes Audit report demonstrate improvements since the 2014/15 audit. The audit measures performance against eight best practice care processes, against which: • Performance has improved at all three sites for patients with type 1 and type 2 diabetes for all individual measures and as a composite measure. • For patients with type 1 diabetes performance is average or higher than average for seven measures at Barnet and Chase Farm Hospitals. Performance for smoking status is lower than expected at both sites but has improved from 8.2% (2014/15) to 60.7% at Barnet and from 18.4% (2014/15) to 63.9% at Chase Farm. Royal Free performance is average or higher than average for each of the eight measures. Performance on a composite measure (i.e. provision of all eight measures) has improved from 30.9% to 56.5%, placing the Royal Free in the best quartile nationally. • For patients with type 2 diabetes performance in 2015/16 is average or higher than average for seven measures across all three sites. Whilst lower than average performance is reported for foot surveillance, performance has improved from 18.3% (2014/15) to 63.8% at Chase Farm and from 44.3% (2014/15) to 68.8% at Royal Free. Whilst lower

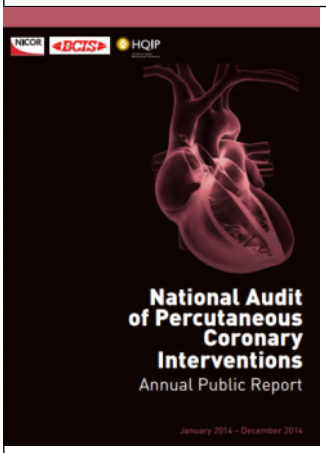
National clinical audit	Actions to improve quality
	than average performance is reported for smoking status at Barnet, performance has again improved from 5.6% (2014/15) to 52.6%. Actions are already planned to improve foot surveillance (see NDFA and NaDIA) and the documentation of smoking status (see BTS Smoking Cessation Audit). The percentage of patients with type 1 diabetes achieving all three treatment targets is above national average performance and has improved compared to previously at all 3 sites. Out of 96 participating sites nationally, Chase Farm is the second best performing trust for this measure, with the Royal Free fourth and Barnet 15th. The data is currently under review within the specialty and actions will be reported in next year's Quality Account.
 **Diabetes: national insulin pump audit** **Published:** Apr-16 **Reporting period:** 2013/14 and 14/15 **Site:** Royal Free and Barnet **Data quality** The trust has had challenges in the collection of data for this audit year due to limitations of the national Diamond diabetes data management system. Considerable work has been carried out internally and with the Diamond system developers to improve the quality and accuracy of data to reflect the quality of care provided.	Insulin pump therapy has a pivotal role to play in the management of type 1 diabetes; use in type 1 diabetes is associated with improved quality of life and glycaemic control in addition to reductions in hypoglycaemia, diabetic ketoacidosis (DKA) admissions and, according to more recent evidence, cardiovascular mortality (*source: national audit report*). The trust has now employed a specialist nurse lead for insulin pump therapy, which will further improve patient care quality, and data collection. Since joining in November 2016, the specialist nurse has reviewed the audit data and found that 60 patients with type 1 diabetes on insulin pump therapy had been incorrectly reported as type 2. Therefore 258 out of the 1,183 (22%) patients with type 1 diabetes were on insulin pumps in line with NICE best practice guidance, rather than 198 (7%) reported by the audit. The local review shows that more patients are receiving best practice care at the trust compared to 13.5% nationally.

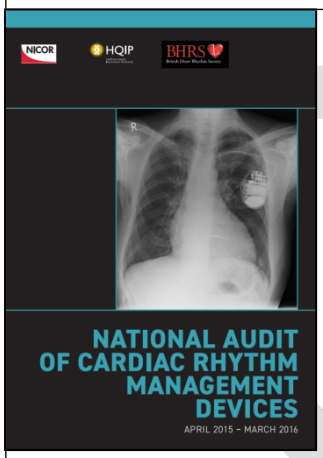
National clinical audit	Actions to improve quality
 **Diabetes: national diabetes foot care audit** **Published:** Mar-16 **Reporting period:** 14/07/14 – 10/04/15 **Site:** Royal Free **Data quality:** The service has reported the challenges experienced with the audit back to the audit provider. For example, patients must sign an initial consent form to be included in the audit. The leaflet that explains the audit is currently only available in English. The audit provider is investigating the feasibility of making the leaflets available in different languages. This would assist our participation in the audit as many of our patients do not have English as their first language.	The impact of diabetic foot disease on people with diabetes is profound. It can be associated with disability, amputation and premature mortality. Its cost to the health service is considerable (*source: national audit report*). Royal Free Hospital's performance in the national audit was mixed. Our diabetes team has submitted a bid to NHS England for a Multidisciplinary Diabetes Foot Team. This will enable the trust to implement a Hot Clinic and improve podiatry care to our in-patients.
Diabetes: national diabetes inpatient audit (NaDIA) **Published:** Jun-16 **Reporting period:** 21/09/15 – 25/09/15 **Site:** Royal Free and Barnet	The National Diabetes Inpatient Audit is a snapshot audit of diabetes inpatient care. Performance across sites is in line with or above national average: • At Royal Free Hospital for foot assessment (within 24 hours and during stay) and patients admitted with active foot disease seen by multidisciplinary foot care team (MDFT) within 24 hours. • At Barnet Hospital for appropriate blood glucose testing, good glucose days and patients admitted with active foot disease seen by MDFT within 24 hours. In addition performance against the patient safety indicators (medication, prescription, management and insulin errors) is better than the national average. Areas marked for improvement include reducing patient safety errors

National clinical audit	Actions to improve quality
	(medication, prescription, management and insulin) at the Royal Free, improving foot assessments at Barnet Hospital and reducing hypoglycaemic episodes across all sites. Action taken to reduce hypoglycaemic episodes includes the introduction of hypo boxes. In addition the diabetes team is working with the patient safety team to identify the underlying causes so that targeted action can be taken. The diabetes team is working with the podiatry service, and providing education to ward nurses to enable them to increase their provision of foot assessments. An NHS bid has also been submitted that, if successful, will include additional recruitment. The role will include assessing diabetic feet in the emergency department before the patient's admission to a ward.
 **Diabetes: national diabetes paediatric audit (NPDA)** **Published:** Jul-16 **Reporting period:** 2014/15 **Site:** Royal Free, Barnet and Chase Farm	Diabetes is a condition where the amount of glucose in the blood is too high because the body cannot use it properly. High blood glucose levels over time may cause complications associated with diabetes including damage to small and large blood vessels and nerves. Over time this can result in blindness, kidney failure, heart disease, stroke and amputations. However, with good diabetes care and blood glucose control, the risks of complications are markedly reduced, enabling children and young people with diabetes to live a healthy, happy and longer life (*source: national audit report*). The performance of the Royal Free Hospital in the audit demonstrates excellence in the quality of care provided to our patients with the most recently published data showing that the hospital is: • A positive outlier for all seven care processes performed for young people aged 12 years and older. • Above the national average for screening for thyroid disease and coeliac disease (Type 1 diabetes). Since the completion of the audit a new consultant has been appointed; additional paediatric diabetes specialist nurse and dietetic resources are now available; and an insulin pump service is offered at all three sites. This has always been in place at the Royal Free, and is being put in place at Barnet and Chase Farm hospitals, led by the newly-appointed consultant. In addition further discussions are underway to streamline the outpatient process across all three sites, and the use of volunteers and iPads to elicit feedback before a patient leaves the diabetes clinic will commence shortly.
Diabetes: national pregnancy in diabetes audit (NPID) **Published:** Oct-16 **Reporting period:** Pregnancies between 01/01/13 and 31/12/15 **Site:** Royal Free and Barnet	Most women with diabetes have healthy pregnancies and healthy babies. However, there are risks, and these sometimes cause serious health problems, either for the mother or the newborn child. So it is important expectant mothers with diabetes get the right care, support and information to help them and their baby stay well. For a healthy, safe pregnancy with diabetes, planning and care starts before conception (s*ource: NPID patient summary report*). The performance of the Royal Free Hospital in the audit demonstrates

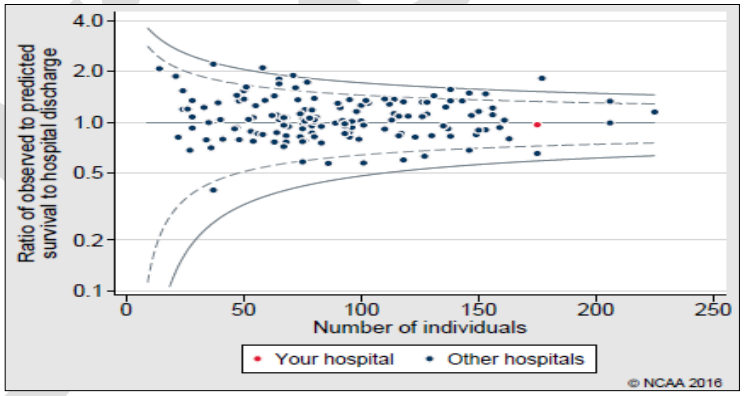
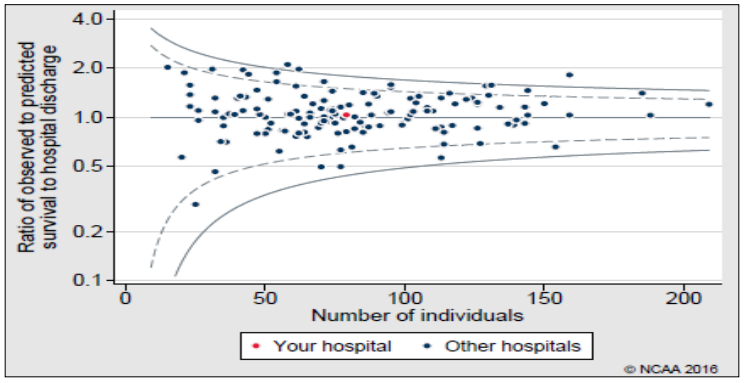
National clinical audit	Actions to improve quality
Data quality: The process of consenting for the audit has been changed for 2016 data. This should ensure that all data collected is submitted.	excellence in the quality of care provided to our patients with the most recently published data showing that the hospital is in the best quartile for blood glucose control (<48 mmol/mol) for pregnancies in the first trimester and at 24 weeks+. To improve practice further, the following actions will be undertaken: Barnet Hospital: • The process for the referral of patients with type 1 and type 2 diabetes to the joint endocrine clinics has been amended so that the GP referral letter is sent to the diabetes team, and will no longer be dependent on the antenatal booking midwife seeing the patient first. • Education will be provided to patients and GPs about the importance of early referral to the diabetes antenatal team. • A pathway is being drawn up to aid GPs in the early management and the referral of type 1 and type 2 diabetic patients. Royal Free Hospital: • Educating GPs about the importance of early referral. • Making GPs aware about the service of pre-conception counselling. • Developing a leaflet to give to type 1 and type 2 diabetes patients at postnatal discharge with advice for future pregnancies. • Making the patient and GPs aware of structured diabetes educational programmes.
End of life care audit (EOLCA): dying in hospital **Published:** Mar-16 **Reporting period:** 01/05/15 – 31/05/15 **Site:** Royal Free and Barnet	Nearly half of all deaths in England occur in hospitals – 22,3007 out of a total of 46,9975 in 2014 (*source: national audit report*). In 2016 the Care Quality Commission rated the provision of end of life care (EoLC) at the Trust as 'good' reporting that the EoLC team are a dedicated team providing holistic care for patients with palliative and EoLC care needs in line with national guidance. The quality of care provided to patients at the end of their life is also demonstrated by the trust-level performance in the national audit, which shows above average performance for three out of five clinical indicators of best practice: recognition that the patient would die; that the needs of the person important to the patient were asked about; and that a holistic assessment of the patients' needs was made in last 24 hours. Three out of eight organisational indicators were also met: bereaved relatives views sought; and formal training provided to both medical and nursing staff. In addition the audit data demonstrated improvements since the previous audit round in relation to communication with the family. The recommendations made by both the national audit and the NICE Quality Standard on EoLC for adults provide the evidence based upon which the Trusts' EoLC strategy has been developed. The strategy will drive the implementation of best practice care across the trust. In addition work is on-going with the Patient at Risk and Resuscitation Team (PARRT), as part of

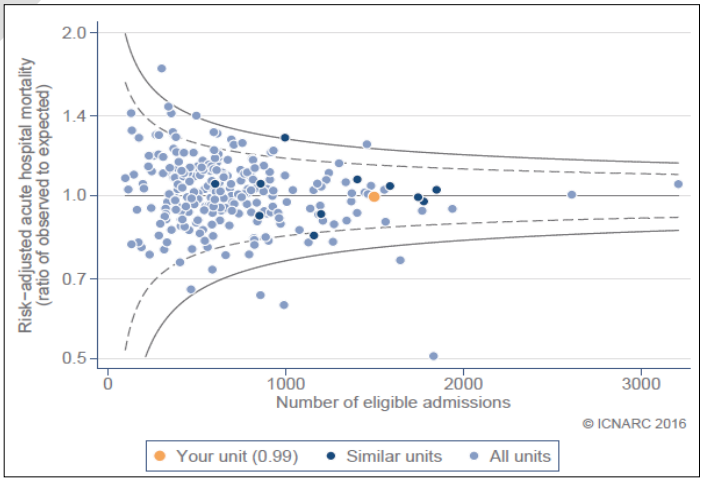
National clinical audit	Actions to improve quality
	the patient safety EoLC work stream on the deteriorating patient, to further improve the early identification of the dying patient. A seven-day palliative care service, which is already available at the Royal Free Hospital, will be available at Barnet Hospital from April 2017 following the recruitment of an additional clinical nurse specialist. Training is being developed on leading difficult conversations and accreditation for the course will be sought. Student nurse training provided in 2016 will be repeated in 2017. The curriculum is being rewritten to ensure students have the opportunity to care for dying patients, the development of a masters-level EoLC module is being looked into and clinical psychologist support for Barnet Hospital has been recruited.
 **Falls and fragility fracture programme (FFFAP): national hip fracture database (NHFD)** **Published:** Sep-16 **Reporting period:** 01/01/15 – 31/12/15 **Site:** Royal Free and Barnet **Data quality:** The absence of a final discharge destination is a constant challenge as our patients can be discharged to a number of locations, that may be different to their admitting location i.e. other hospital, care home, nursing home etc. Resources at present are limiting our ability to obtain this information for all patients.	For older people, hip fracture is the commonest serious injury; the commonest reason for emergency surgery; and the commonest cause of accidental death. Patients may remain in hospital for a number of weeks, leading to one and a half million bed days being used each year, which equates with the continuous occupation of over 4,000 NHS beds. Only a minority of patients will completely regain their previous abilities, most will encounter difficulty walking which increases dependency and means that a quarter will need long-term care. As a result, hip fracture is associated with a total cost to health and social services of over £1 billion per year (*source: national audit report*). Our performance in the national audit demonstrates excellence in the care provided to our patients with best quartile performance achieved by: • Barnet Hospital for mental test score recorded on admission, perioperative medical assessment provided, best practice tariff achievement, surgery on day of, or day after, admission and proportion of general anaesthetic with nerve blocks. • Royal Free Hospital for overall hospital length of stay and proportion of arthroplasties using techniques recommended by NICE (i.e. a cemented technique, sliding hip screw (SHS), intramedullary nail (IM)) and overall hospital length of stay. In addition, the risk-adjusted 30-day mortality rate at both Barnet and Royal Free Hospitals is better than the London average and similar to the national average. Whilst Barnet Hospital achieved the second lowest rate in London for hip fractures sustained as an in-patient, the rate at the Royal Free Hospital is similar to the London average and above the national average. A series of actions have been implemented as a result of the audit to improve patient care and outcomes further. At the Royal Free Hospital these include: • Ongoing work to improve education provided to junior medical staff involved in seeing patients on admission, which should improve the assessment of cognitive function on admission. • All hip fractures admitted during the week will be discussed at a multidisciplinary team and suitable patients will be offered total hip

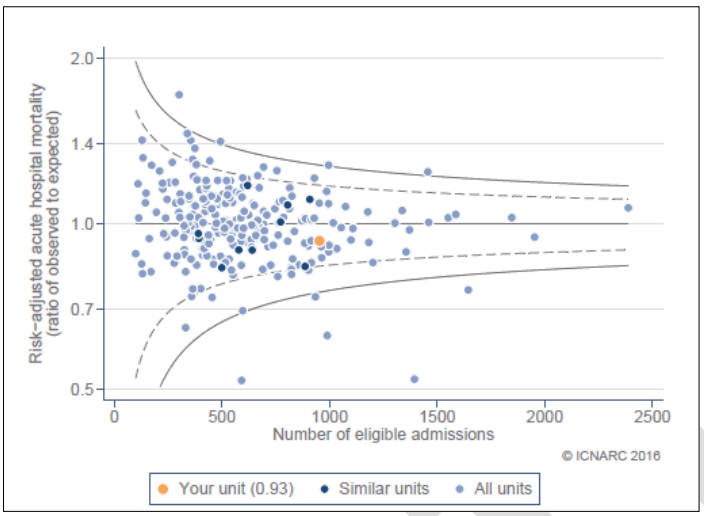
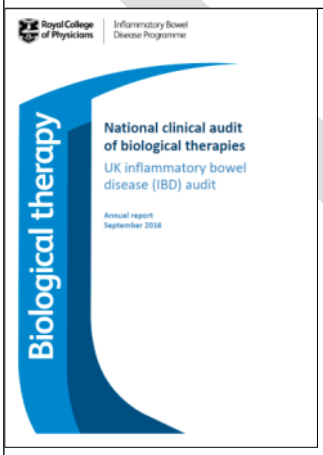
National clinical audit	Actions to improve quality
	replacement surgery. Day of admission will not impact the choice of therapy offered. • The lack of documentation on pressure ulcers has been highlighted to nursing staff and we believe this will address our documentation issues and we plan to audit this and other items on a periodic timescale. Barnet Hospital is the third busiest hip fracture unit in London. We have established a dedicated hip fracture physiotherapy team. To co-ordinate care and reduce the length of stay we are assessing patients earlier and discussing discharge planning every morning at the multi-disciplinary team meeting. We are also working on a number of quality improvement projects that will address haemoglobin check on day of surgery, mobilisation out of bed on day one and post-operative analgesia.
 **Heart: national audit of percutaneous coronary intervention (PCI)** (national audit and consultant-level data) **Published:** Mar-16 **Reporting period:** 01/01/14 – 31/12/14 **Site:** Royal Free	Coronary heart disease (CHD) is the largest cause of death and disability in the United Kingdom. It causes around 73,000 deaths in the UK each year and around one in five men and one in seven women will die from the disease. The PCI procedure works by mechanically improving blood flow to the heart. During the procedure, a small balloon is inserted which, when inflated widens the artery. In most cases a 'stent' - metal mesh scaffold - is implanted to keep the artery wall open (*source: national audit report*). The performance of the Royal Free Hospital in the audit demonstrates excellence in the quality of care and outcomes for our patients. The most recently published data shows that the hospital is: • Within expected range for the risk-adjusted measures survival at 30-days post PCI procedure and major adverse cardiac and cerebrovascular event (e.g. death, stroke, myocardial infarction caused by PCI and the need for emergency cardiac surgery because of a complication of PCI). • A positive outlier for the time between the first call for professional help and the time that the PCI procedure is performed (call to balloon time less than 150 minutes). • Above the national average for all other call to balloon times, as well as door to balloon times for both direct admissions and inter-hospital transfers. • Performing more PCIs within 72 hours of arrival for non-ST-elevation myocardial infarction (nSTEMI) or unstable angina, i.e. patients with heart attacks where the electrocardiogram (ECG) does not show a typical pattern of ST elevation, than the national average. To improve patient outcomes further on-going training is in place to help increase the number of procedures where arterial access was via the radial artery; and a new London Procurement Partnership (LPP) arrangement is in place that will increase access to, and the use of drug eluting stents, at the Royal Free Hospital. In addition an enhanced pathway and tools are in development to improve the inpatient management of nSTEMIs.
	The national audit is a development of the national device registry which

National clinical audit	Actions to improve quality
Heart: national audit of cardiac rhythm management (CRM) devices **Published:** Aug-16 **Reporting period:** 01/04/14 – 31/03/15 **Site:** Royal Free and Barnet	was the first in the world and now documents approximately a million device procedures. It collects information about all implanted cardiac devices and all patients receiving interventional procedures for management of cardiac rhythm disorders in the UK to improve the quality of care provided (*source: national audit report*). The data published by the national audit shows that activity at the Royal Free and Barnet Hospitals exceeds the minimum number of recommended new pacemaker implants per year, and the number recommended for a training centre. In addition the Royal Free Hospital exceeds the minimum number of recommended new implantable cardioverter defibrillator (ICD) or cardiac resynchronization therapy (CRT) implants per year. Atrial based pacing in sinus node disease is recommended by the National Institute of Health and Care Excellence (NICE). The proportion of patients receiving atrial based pacing implants for sick sinus syndrome has increased at both sites compared to previous (2013/14) and is within expected range nationally. Since 2014 two dedicated CRM consultants have been in post and an increase in the use of dual chamber pacemakers is expected to be reflected in the 2016/17 dataset. In addition work is ongoing to increase capacity in the catheter laboratory to enable more procedures to be undertaken at the Trust.
 **Heart: national audit of cardiac rhythm management (CRM) devices** **Published:** Feb-17 **Reporting period:** 01/04/15 – 31/03/16 **Site:** Royal Free and Barnet **Data quality** The reported number of	The 2015/16 data published by the national audit shows that activity at the Royal Free and Barnet Hospitals continues to exceed the minimum number of recommended new pacemaker implants per year, and the number recommended for a training centre. The proportion of patients receiving atrial based pacing implants for sick sinus syndrome as recommended by NICE has improved from 73% (2014/15) to 100% (2015/16) at the Royal Free. Barnet remains at 86% and is within typical range achieved by NHS trusts nationally. A recent local audit conducted at Barnet Hospital covering the period October 2015 to October 2016 shows that the complication rate remains low at 3.7 % and in line with previous years despite the increase in number of procedures.

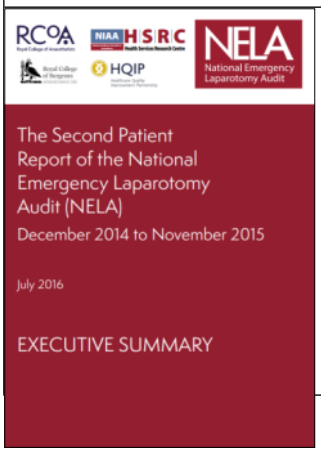
National clinical audit	Actions to improve quality
implantable cardioverter defibrillator (ICD) implants undertaken has been affected by data completeness issues and does not reflect clinical practice. This issue has been greater at Barnet than at Royal Free. The move of complex device implantation in November 2015 from Royal Free to Barnet has further exacerbated the issue. Cardiology is investigating how to resolve this.	
 **Heart: myocardial ischaemia national audit project (MINAP)** **Published:** Jan-17 **Reporting period:** 01/04/14 – 31/03/15 **Site:** Royal Free and Barnet	A heart attack occurs when the flow of blood to the heart is blocked, most often by a build-up of fat, cholesterol and other substances, which form a plaque in the arteries that feed the heart (coronary arteries). The interrupted blood flow can damage or destroy part of the heart muscle. This is known as a heart attack or myocardial infarction (MI). Typical symptoms include chest pain or discomfort, sweating, breathlessness, and sudden changes in blood pressure, heart rate, and heart rhythm, which may lead to collapse or sudden death (*source: national audit report*). The performance of the trust in the audit demonstrates areas of excellence in the quality of care provided to our patients with the most recently published data showing that the performance at both Barnet and Royal Free Hospitals is above the national average for the proportion of patients seen by a cardiologist, patients admitted to a cardiac ward and patients who received all secondary prevention medication for which they were eligible. In addition performance at Barnet Hospital has improved compared to previous (2013/14) for all three criteria, whilst Royal Free Hospital has either improved (percentage of patients admitted to cardiac ward) or remained consistently high (i.e. equal to or exceeding 99%). The average length of stay at both sites is in line with the national average for both non-ST-elevation myocardial infarction (nSTEMI) and ST-elevation myocardial infarction (STEMI) patients; and whilst the Royal Free performance for all five 'door to balloon time' and 'call to balloon time' criteria are above the national average, performance is lower for 4/5 criteria compared to previous (2013/14). This slight drop in performance reflects the increase in activity we are seeing and is something we will be watching carefully.
Heart: national heart failure audit **Published:** Jul-16 **Reporting period:** 01/04/14 – 31/03/15 **Site:** Royal Free and Barnet	Heart failure means that the heart is unable to pump blood around the body properly. It usually occurs because the heart has become too weak or stiff (*source: NHS Choices*). Approximately 900,000 people in the United Kingdom have heart failure. It causes or complicates about 5% of all emergency hospital admissions in adults and consumes up to 2% of total NHS expenditure (*source: national audit report*).

National clinical audit	Actions to improve quality
	The performance of the heart failure team at both the Royal Free and Barnet Hospitals in the audit demonstrates excellence in care, with the most recently published data showing that for: • In-hospital care, both sites provided above average use of appropriate specialist diagnostics, care on cardiology ward and input from specialist. • On discharge, both sites provided above average care for heart failure medication in line with best practice, and specialist cardiology follow up. The data also demonstrates improvement, with the audit data showing that at the Royal Free Hospital performance has improved by at least 20% for three out of the four in-hospital care criteria - cardiology inpatient, input from consultant cardiologist and input from specialist. Performance at Barnet Hospital has remained consistently high for all four criteria. To improve further, an improved pathway of care, and discharge process are being implemented, and additional clinical nurse specialist support is being sought.
Intensive care national audit and research centre (ICNARC) - national cardiac arrest audit (NCAA) **Published:** Jun-16 **Reporting period:** 01/04/15 – 31/03/16 **Site:** Royal Free and Barnet	The national cardiac arrest audit collects data on in-hospital cardiac arrests in the UK and Ireland (*source: ICNARC website*). The total rate of in-hospital cardiac arrests and survival at Royal Free and Barnet are displayed below. The risk-adjusted survival data produced by the audit shows that survival at both the Royal Free and Barnet Hospitals is in line with expected (1.0).  Royal Free  Barnet

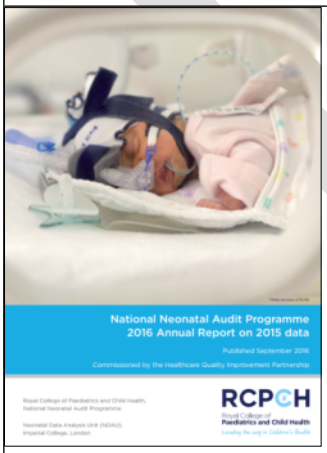
National clinical audit	Actions to improve quality
	This data has been used to drive local quality improvement activity to reduce the number of in-hospital cardiac arrests as part of the patient safety programme. A pilot is currently underway within cardiology at the Royal Free Hospital aimed at improving processes to identify and manage deteriorating patients. Current tests of change include the re-design and evaluation of team handover and recordkeeping and the trial of a weekly multi-disciplinary team meeting to assist complex decision-making.
ICNARC: case mix programme (CMP) **Published:** Jul-16 **Reporting period:** 01/04/15 – 31/03/16 **Site:** Royal Free and Barnet	The case mix programme is an audit of patient outcomes from adult, general critical care units covering England, Wales and Northern Ireland (*source: ICNARC website*). Trust-wide performance in the audit demonstrates excellence in quality, with the most recently published data showing that: • Barnet Hospital achieved a green rating (good to excellent) for 7/7 quality criteria reported by the audit. In addition performance improved for 5/7 criteria compared to previous results (2014/15). This includes the reduction of high risk sepsis admissions, out-of-hours discharges to the ward and risk-adjusted mortality. Performance for unplanned readmissions within 48 hours has improved compared to the previous year and the hospital is now a positive outlier for this criteria. • Royal Free Hospital achieved a green rating for 5/7 quality criteria. Delayed discharges from the Intensive Care Unit (ICU) at Barnet Hospital has been identified as an area for improvement and is now the subject of a local Commissioning for Quality and Innovation (CQUIN) target. The rate of unit-acquired infections in blood at Royal Free has been investigated as it appeared to be above the national average. It was thought that the length of stay of immunocompromised patients was associated with acquisition of infection. However, local review of patients admitted to ICU shows that the majority of patients suffered sepsis on the ward prior to admission to ICU. Improvement work is ongoing via the patient safety programme to improve the identification and treatment of patients with sepsis on the wards. Risk-adjusted mortality data shows that the mortality rate for the Royal Free and Barnet Hospitals is in line with expected (1.0).  Royal Free Hospital

National clinical audit	Actions to improve quality
	 Barnet Hospital
UK inflammatory bowel disease (IBD) audit **National clinical audit of biological therapies** (adult service) **Published:** Sep-16 **Reporting period:** 01/03/15 – 29/02/16 **Site:** Royal Free and Barnet	Over the last 10 years, biological therapies have transformed treatment for people with inflammatory bowel disease (IBD). Most of these drugs work by targeting a protein in the body called tumour necrosis factor alpha (TNFα). Overproduction of this protein is thought to be partly responsible for the chronic inflammation in people with IBD (*source: national audit report*). Insufficient cases were submitted in 2015/16 for detailed analysis by the national audit provider. Following the 2014/15 data collection period a number of actions were implemented to improve data input. Weekly multidisciplinary team meetings are held to capture the biologics data and, wherever possible, submit this information to the audit. We are in the process of appointing IBD nursing staff who, in addition to their clinical roles, will provide data management support in order to collect and input the relevant data.
 **UK IBD audit: national clinical audit of biological therapies** (paediatric service)	Ulcerative colitis (UC) is the most common type of inflammatory bowel disease (IBD); it is a lifelong, chronic, relapsing–remitting condition. Reported prevalence is as high as 505 per 100,000. This corresponds to 320,000 people in the UK with a diagnosis of UC. The cause of UC is unknown and, although it can develop at any age, the peak incidence is between the ages of 15 and 25 years, resulting in profound effects on education, work, social and family life. The three-month, per-patient cost for UC was calculated at £1211 in 2010, with the majority of this cost attributed to inpatient stays (*source: IBD national audit report*). The paediatric service did not participate in the national audit in 2015/16. Upon publication of the national report, the service compared its practice to the recommendations made, and in line with best practice the trust screens all patients prior to treatment with biological therapies (hepatitis B and tuberculosis); has clear arrangements in place for follow-up within three months; records the patients' disease activity score using a defined disease

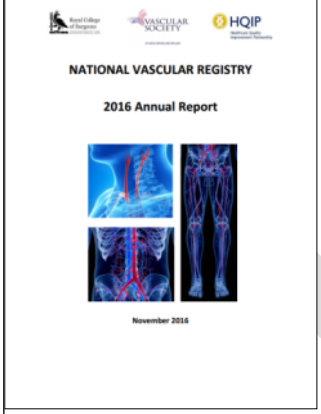
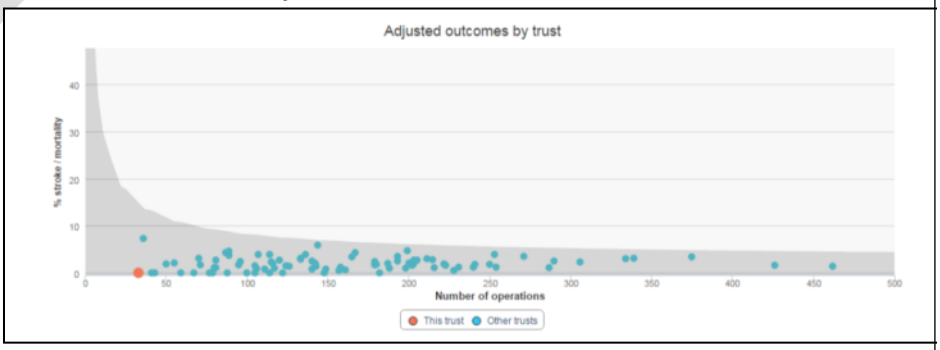
National clinical audit	Actions to improve quality
Published: Sep-16 **Reporting period:** 12/09/11 – 29/02/16 **Site:** Royal Free	activity index; has a reduction regime in place for all patients on steroids at first infusion; and records data on all patients on biologics, submitting it to the IBD Registry for national analysis.
National comparative audit of blood transfusion programme: audit of the use of blood in lower gastrointestinal bleeding **Published:** May-16 **Reporting period:** 01/09/15 – 01/12/15 **Site:** Royal Free and Barnet **Data quality:** The quality of the clinical data produced in the national audit report was affected by the low number of cases submitted nationally. In line with the majority of participating hospitals, a site-level report was not produced for the Royal Free due to the low number of cases. Actions are being put in place to address this issue.	Lower gastrointestinal bleeding accounts for up to 20% of hospital admissions for gastrointestinal bleeding a year in the UK (*source: national audit report*). Barnet Hospital demonstrated above average performance against the following audit standards: • All patients with lower gastrointestinal bleeding had a digital rectal examination (100%). • Platelet transfusion was offered to all eligible patients (100%). • Best practice procedures were performed for patients with rectal bleeding. • The cause and site of clinically significant lower gastrointestinal bleeding was determined following the early use (within 24 hours) of best practice procedures. Organisational audit demonstrates the provision of best practice services across both hospital sites.
National comparative audit of blood transfusion programme: audit of patient blood management in scheduled surgery **Published:** Summer-16 **Reporting period:** 01/02/15 – 30/04/15 **Site:** Royal Free, Barnet and Chase Farm **Data quality:** The quality of the clinical data produced by the audit was affected by the low number of cases submitted nationally.	Patient Blood Management (PBM) is a multidisciplinary, evidence-based approach to optimising the care of patients who might need a blood transfusion. National, regional and local audits in England consistently show inappropriate use of all blood components; 15-20% of red cells and 20-30% of platelets/plasma. Evidence shows that the implementation of PBM improves patient outcomes by focusing on measures for the avoidance of transfusion and reducing the inappropriate use of blood, and therefore can help reduce healthcare costs (*source: national audit report*). The hospital-level data produced by the audit has been reviewed locally and indicates that practice is in line with, or better than average, across sites against a number of criteria including: • Pre-operative anaemia optimisation (Barnet and Royal Free Hospitals). • Pre-operative anticoagulant and antiplatelet management (Royal Free Hospital). • Patient blood management in theatre and recovery (Chase Farm and Royal Free Hospitals). • Post-operative transfusion indicated (Barnet Hospital). • Patient blood management in the post-operative period (Chase Farm and Royal Free Hospitals).

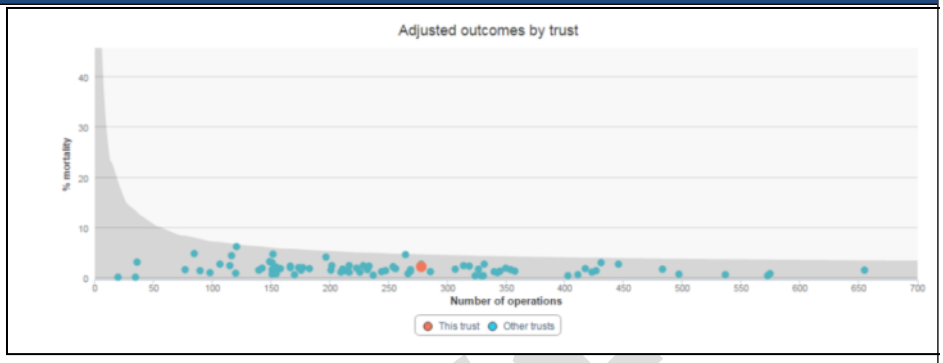
National clinical audit	Actions to improve quality
National comparative audit of blood transfusion programme: audit of red cell and platelet transfusion in adult haematology patients **Published:** Autumn-16 **Reporting period:** Jan-16 **Site:** Barnet	The audit aimed to examine the use of red cells and platelets in a sample of patients who had a known haematological condition and identify variation in practice and compare practice against guidelines (*source: hospital-level audit report*). A national audit report was not produced due to the small number of cases submitted nationally, which affected data quality and the audit supplier's ability to draw meaningful conclusions from the clinical data. Site-level data was however made available to participating trusts, which has been reviewed locally. Taking the small patient numbers into account, early indications show that good practice is being achieved against a number of criteria including: • Local written guidelines are available for the management of blood component transfusions in haematology patients. • Haemoglobin is measured within 24 hours prior to the transfusion of red cells if the patient is an inpatient or within 72 hours if the patient is a day patient • When platelets are prescribed for prophylactic use, this should not be more than one adult therapeutic dose.
National elective surgery PROMs: four operations **Published:** Aug-16 **Reporting period:** 01/04/14 – 31/03/15 **Site:** Trust-level data	Patient Reported Outcomes Measures (PROMs) is a national programme organised by NHS England looking at a number of elective procedures. The latest available data shows the trust is within control limits for adjusted health gain for hip and knee replacement primary procedures. This data has been reviewed and when we compare our clinical data with the data produced by the National Joint Registry (NJR) and National Hip Fracture Database (NHFD) our performance is above average and shows good care. Therefore it appears that the data is related to patients mismatched expectations regarding their condition post-operative. To address this we have a Joint School, where patients are informed of what to expect post-surgery and can manage their expectations of pain and mobility. For more up to date PROMS information for hip and knee procedures see the summary below on NJR consultant-level data. For hernias and varicose veins the numbers submitted were too few to be benchmarked. However work is ongoing with the pre-assessment teams, who give out the PROMs questionnaires, to improve patient participation.
	More than 30,000 patients undergo an emergency laparotomy each year in NHS hospitals within England and Wales. The majority of patients undergoing emergency bowel surgery have potentially life-threatening conditions requiring prompt investigation and management. These procedures are associated with high rates of postoperative complications and death. Recent studies have reported that overall 15% of patients die within one month of having an emergency laparotomy (*source: national audit report*). The clinical pathway for patients undergoing emergency bowel surgery is complex, and requires input from clinicians from several specialties including emergency departments, acute admissions units,

National clinical audit	Actions to improve quality
National emergency laparotomy audit (NELA) **Published:** Jul-16 **Reporting period:** 01/12/14 – 30/11/15 **Site:** Royal Free and Barnet **Data quality:** At Barnet Hospital very few patients were entered into the audit. Since the completion of the audit we have implemented a number of actions to address this issue and our participation for the year has increased from 10 patients to over 100. To improve further a new pathway has been created to ensure that best practice criteria are followed and also documented in a timely manner. The audit database has been set up on all operating theatres' computers to facilitate the management of patient's data.	radiology, surgery, anaesthesia, operating theatres, critical care and elderly care. Unlike elective (planned) care, there is often limited time to investigate and prepare these patients before surgery. This creates challenges in the delivery of care on a day-to-day basis and in bringing about long-term service improvement. The trust's performance in the audit demonstrated areas of excellence. To improve further at Barnet Hospital the recording of the risk score (P-Possum score) prior to operation has been mandated, and this is already showing significant improvement. In addition a consultant anaesthetist and surgeon will always be present in theatre for high-risk patients. At the Royal Free Hospital we have employed a consultant in specialised surgical medicine who has extensive geriatric experience and assesses all our elderly patients. We have implemented a new operating theatre booking form where risk scoring is mandatory so risk of death is documented prior to theatre booking. We have also taken action to improve the pre-operative review by a consultant surgeon and anaesthetist when the risk of death is higher than 5%.
National joint registry (NJR) annual report **Published:** Sep-16 **Reporting period:** Various **Site:** Royal Free, Barnet and Chase Farm **Data quality:** The trust's performance in the national audit clearly demonstrates excellent data quality with all three hospitals achieving the top 'green' rating for linkability (records submitted to the registry with valid NHS number). The Royal Free Hospital also achieved the top 'green' rating for consent rate. Consent rate has been identified as an area for improvement at	Hip, knee, ankle, elbow and shoulder joint replacements are common and highly successful operations that bring many patients relief from pain and improved mobility. Thousands of these joint replacement operations take place in the UK every year (*source: national audit website*). The trust's performance in the national audit clearly demonstrates excellent outcomes and with all three hospitals achieving the top 'green' rating for 90-day mortality and revision rates for hips and knees. To ensure our elderly patients have the best specialist input, our elderly care physicians are closely involved in the care of elective patients with more complicated health needs. The orthopaedic team at the Royal Free review their rate of cemented versus non cemented total hip replacement. We also continuously submit surgical site infection data to the Get it Right First Time (GIRFT) national surveillance team.

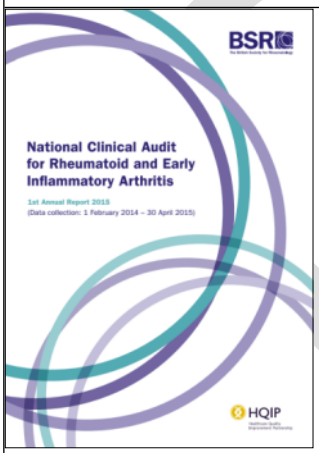
National clinical audit	Actions to improve quality
Barnet and Chase Farm Hospitals. Whilst consent to participate in the NJR is being taken appropriately for patients attending pre-assessment at Barnet Hospital, a copy of the consent form is not always received at Chase Farm Hospital for data entry into the NJR. Action is in place to improve this process and is being monitored.	
National joint registry (NJR) consultant-level outcomes **Published:** Jan-17 **Reporting period:** Various **Site:** Royal Free, Barnet and Chase Farm **Data quality:** In terms of data quality a better than expected rating was achieved for the Royal Free for consent rate and valid NHS number. This data also highlights consent as an ongoing area for improvement at Barnet. See section above for progress with actions to improve. The impact of these actions on data quality is expected to be shown in the 2017/18 data.	The latest consultant-level data from the national registry clearly demonstrates excellent outcomes with the Patient Reported Outcomes Measures (PROMs), 90-day mortality rate and revision rates within expected range for hip and knee surgery at Royal Free, Barnet and Chase Farm Hospitals.
 **National neonatal audit programme (NNAP)**	The national neonatal audit programme (NNAP) annual report summarises data which is collected from the NDAU (National Data Analysis Unit) database which takes data from the Badgernet system, used by all UK neonatal units, with data being added every day for each resident baby. The 2016 report reflects the 2015 data that was logged into the Badgernet system by either clinical, nursing or administrative staff on the trust's two neonatal sites – level 1 Special Care Baby Unit (SCBU) at Royal Free Hospital and the level 2 Neonatal Unit (NNU) at Barnet Hospital. The performance of the neonatal teams at Royal Free and Barnet Hospitals in NNAP demonstrates excellence in the quality of care provided to babies who are born too early, with a low birth weight or who have a medical condition requiring specialist treatment. Teams on both sites have improved the proportion of babies who are receiving some mother's milk at discharge.

National clinical audit	Actions to improve quality
Published: Sep-16 **Reporting period:** 01/01/15 – 31/12/15 **Site:** Royal Free and Barnet	At the Royal Free Hospital site, the team have improved eye (retinopathy of prematurity) screening for eligible babies to ensure more babies are screened at the correct time for optimal prevention of visual problems following neonatal care. The Barnet NNU has eradicated variation from best practice altogether on this important care process, with 100% of babies being screened. The audit data also shows that fewer babies developed lung disease as a consequence of neonatal care (bronchopulmonary dysplasia) compared to other UK neonatal units. The neonatal team at the Royal Free site has also made some progress in the documentation of when parents are consulted within the first 24 hours. Both neonatal sites allow parents on the ward rounds, and all babies are seen by a consultant or senior registrar on the daily ward rounds. Therefore there is a robust process in place for ensuring parents are consulted promptly. However, historically, our documentation of this element of care has been poor. In the most recent report, there is an improvement in the documentation of the proportion of parents who had a consultation with a consultant neonatologist within 24 hours of their baby's admission and further quality improvement is already in place to ensure the accuracy of the data submitted going forward.
National audit of pulmonary hypertension **Published:** Feb-16 **Reporting period:** 2014/15 **Site:** Royal Free	Pulmonary hypertension is raised blood pressure within the pulmonary arteries, which are the blood vessels that supply the lungs. In the UK, around 6,000-7,000 people have pulmonary hypertension. It is also thought that more remain undiagnosed. Pulmonary hypertension can affect people of any age, although some types are more common in young women (*source: NHS Choices*). The performance of the Royal Free Hospital in the audit demonstrates excellence in care, with the most recently published data showing that in line with best practice more patients treated at the Royal Free Hospital are started on a phosphodiesterase 5 inhibitor before other pulmonary hypertension drugs compared to the national average since 2010/11, and all other centres nationally since 2012/13. Mortality outcomes for all trusts are within the predicted range. The audit has highlighted some areas that require further attention. The time from referral to diagnosis may reflect the special nature of the population referred to at the Royal Free, namely those with connective tissue disease. This is the only population where screening for the future development of pulmonary hypertension is possible. To improve patient care and outcomes a detailed audit of our referral pathways is being conducted with external funding and aided by external audit providers to identify whether delays in the referral process are occurring.

National clinical audit	Actions to improve quality
National vascular registry (NVR) consultant-level outcomes **Published:** Sep-16 **Reporting period:** • **AAA:** 01/01/11 to 31/12/15 • **Carotid:** 01/01/15 to 31/12/15 **Site:** Royal Free	An **abdominal aortic aneurysm (AAA)** is a swelling (aneurysm) of the aorta - the main blood vessel that leads away from the heart - down through the abdomen to the rest of the body. AAAs are most common in men aged over 65. A rupture accounts for more than 1 in 50 of all deaths in this group and a total of 6,000 deaths in England and Wales each year (*source: NHS Choices*). The latest consultant-level data published by the national registry shows that for elective infra-renal AAA repair the risk-adjusted mortality rate is within expected range for the trust, and for each individual surgeon that performs the procedure at the trust. The surgical team strives for the achievement of excellent outcomes, and to help achieve this, has changed the composition of each firm to ensure clinicians have maximal opportunities for shared experience and learning when managing infra-renal aortic disease. **Carotid endarterectomy** is a surgical procedure to unblock a carotid artery. The carotid arteries are the main blood vessels that supply the head and neck. People who have previously had a stroke or a transient ischaemic attack (TIA) are at risk of having another stroke or TIA. Surgery can reduce the risk of a further stroke in people with severely narrowed carotid arteries by a third (*source: NHS Choices*). The latest consultant-level data from the national registry clearly demonstrates excellent outcomes, with a risk-adjusted 0% rate of stroke/ death for patients operated on at the Royal Free Hospital during the audit period at both trust-level, and for each individual surgeon performing the procedure.
 **National vascular registry (NVR) annual report** **Published:** Nov-16 **Reporting period:** 01/01/15 – 31/12/15 **Site:** Royal Free and Barnet	The latest annual report produced by the national registry shows excellent outcomes for the trust with a risk-adjusted stroke and/or death rate of 0% for carotid endarterectomy (see below). In addition the risk-adjusted in hospital mortality is within expected range for elective infra-renal abdominal aortic aneurysm (AAA) repair (see below), repair of ruptured AAA and lower limb revascularisation. **Carotid Endarterectomy**  **Elective Infra-Renal AAA Repair**

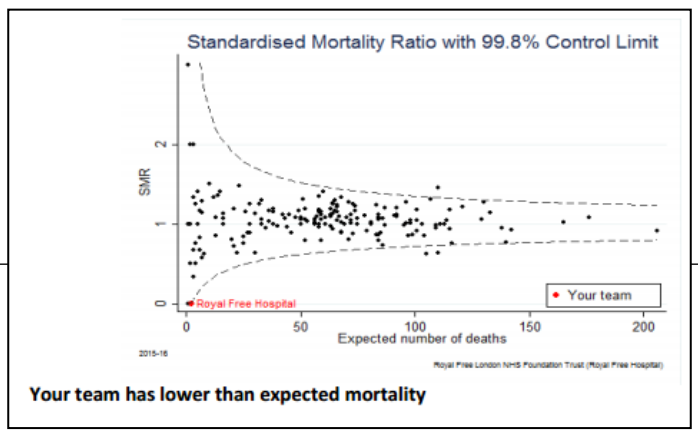
National clinical audit	Actions to improve quality
	 The audit identified that surgery for carotid endarterectomy is sometimes delayed beyond 14 days for some of our patients. We are working toward improving our surgical capacity to reduce these delays. The report also demonstrates excellence in patient care with above average performance for patients undergoing elective infra-renal AAA repair in the areas of receiving anaesthetic review and undergoing pre-operative CT/MR angiogram assessment. The vascular radiology and anaesthesia teams have worked hard to improve this part of the pathway. All aortic cases are discussed at the aortic multidisciplinary meeting, the timing of which was recently changed to accommodate as many clinicians as possible, making sure all our patients are discussed and reviewed by our specialists.

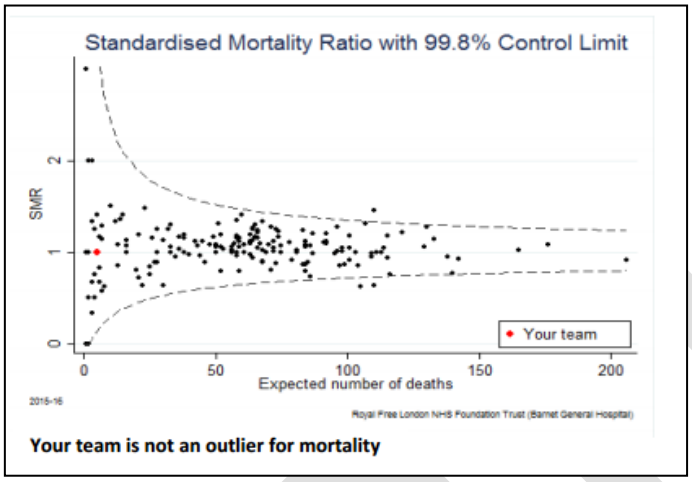
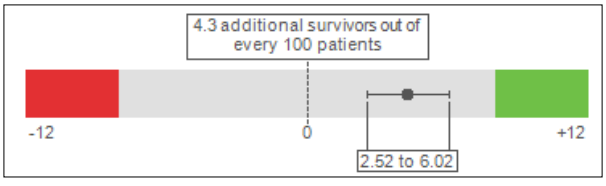
NHS Blood and Transplant: potential donor audit
 	
Published: Oct-16 (provisional data)
Reporting period: 01/04/16 – 30/09/16
Site: Trust-level data
	Trust-level performance in the audit demonstrates good practice and areas of excellence, with the most recently published data showing that:
	• The average number of organs donated per donor is above the national average. In particular donation after brainstem death (DBD) donors average 6.0 organs per donor compared to 3.8 nationally.
	• A statistically acceptable level was achieved for 8/9 measures of best practice (DBD and donation after circulatory death (DCD)), with the top gold rating achieved for:
	  ○ Referral to Senior Nurse-Organ Donation (DBD).
	  ○ Family approached with Senior Nurse-Organ Donation involved (DCD).
	  ○ Consent granted (DCD).
	• Neurological death tested (DBD) performance has improved from 50% (Apr-Sep 2015) to 89% (Apr-Sep 2016).
	
	To improve patient care a neurological death testing masterclass was given to all Intensive Care Unit (ICU) staff by the regional clinical lead for organ donation. Organ Donation Awareness Week and Medicine for Members events were held in September 2016 to raise awareness of organ donation to staff, patients, families and carers.
	
	To improve further we will recruit nursing and emergency department (ED) representation on the Organ Donation Committee; investigate the inclusion of organ donation on trust induction for medical and nursing staff; implement a trust wide teaching programme on nurse-led referral in ED and

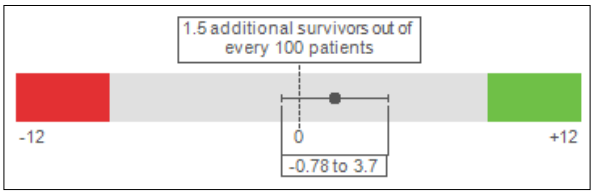
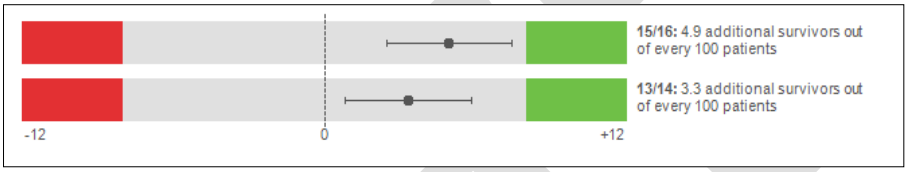
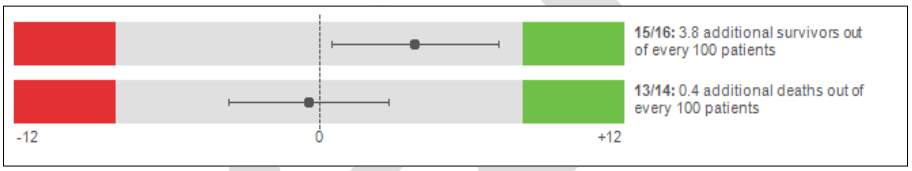
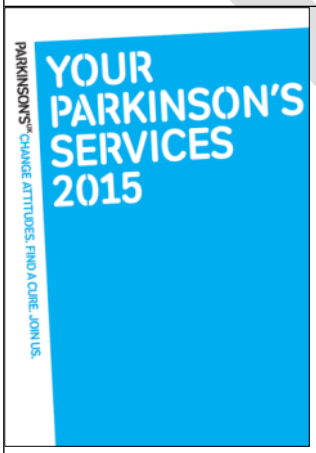
National clinical audit	Actions to improve quality
	ICU and implement training on breaking bad news – currently being developed at Barts Health NHS Trust.
 **UK renal registry** **Published:** Apr-16 **Reporting period:** Various **Site:** Royal Free and Barnet	The UK Renal Registry (UKRR) is part of the Renal Association, a not for profit organisation registered with the Charity Commission. The Registry is recognised as having one of the very few high quality clinical databases open to requests from researchers. The UKRR collects, analyses and reports on data from 71 adult and 13 paediatric renal centres nationally (*source: Renal Registry website*). **First adult kidney transplant:** The risk-adjusted five year patient and graft survival rates for both deceased and living donors at the Royal Free remained high in comparison to the previous report, and are above the national average and all other London centres, whilst the one year survival rates are in line with both the national and peer figures. **Adult patients on renal replacement therapy:** The one year after 90-day age adjusted survival for incident renal replacement therapy patients in the 2013 cohort at Royal Free (91.6%) is similar to the national average (91.4%). **Rate of infectious episodes in patients with established renal failure:** The rates of methicillin-resistant staphylococcus aureus (MRSA), methicillin sensitive staphylococcus aureus (MSSA) and clostridium difficile infection (CDI) per 100 dialysis patient years is better than the national average. The rate for Escherichia coli (E.Coli) has reduced from 2.21 to 1.90, but remains just above the national average (1.90 vs. 1.49).
 **National clinical audit for rheumatoid and early inflammatory arthritis** **Published:** Oct-16 **Reporting period:** 01/02/14 – 30/04/15 **Site:** Royal Free and Barnet	Rheumatic diseases, including inflammatory arthritis, account for significant ill health and disability, and cost, to the NHS, social care and wider economy. Dramatic advances have been made in the treatment of inflammatory arthritis by effective use of traditional disease modifying agents (DMARDs) as well as the introduction of newer biological therapies (*source: national audit report*). The performance of the rheumatology team in the audit demonstrates above average care for: • Assessment within three weeks of referral for people with suspected early inflammatory arthritis (EIA). • Effective treatment offered to people with newly diagnosed rheumatoid arthritis within six weeks of referral. • Monthly treatment escalation offered to people with active rheumatoid arthritis until the disease is controlled to an agreed target. • Advice received within one working day of contacting the rheumatology service for people with rheumatoid arthritis and disease flares or possible drug related side effects.

National clinical audit	Actions to improve quality
	To improve patient care and management further, an early inflammatory arthritis (EIA) service has been set up at all three sites and four community hospitals. A standardised referral form and EIA treatment plan have been developed. Care processes have been re-organised to allow for timely patient review so that disease-modifying medication can be started by the clinical nurse specialist or consultant as soon as possible. Telephone consultation slots have been introduced, patient information leaflets are available, and patients are encouraged to access the National Rheumatoid Arthritis Society resources. The improvement work at the Royal Free has been recognised as exemplary by the British Rheumatology Society in its national audit report. A strong team of clinical nurse specialists, strong IT and good team working are keys to our success. Good IT support includes an electronic referral form for EIA which is available to all the local clinical commissioning groups. Consultant electronic triage allows blood results to be checked once referrals are received and ordered if not already available prior to the patient's first appointment. The electronic patient record allows immediate access to all relevant patient information on all peripheral sites, and for (most) GP-ordered tests to be available to hospital clinicians.
Royal College of Emergency Medicine (RCEM): venous thromboembolism (VTE) risk in lower limb immobilisation **Published:** Jun-16 **Reporting period:** 2015/16 **Site:** Royal Free and Barnet	VTE is the formation of blood clots in the vein. When a clot forms in a deep vein, usually in the leg, it is called deep vein thrombosis (DVT). If that clot breaks loose and travels to the lungs, it is called a pulmonary embolism (PE). Collectively these are known as VTE and can be life threatening if not treated quickly. Patients who are treated for lower limb injuries and put into plaster casts are at significant risk of developing VTE (s*ource: national audit report press release*). The performance of the Royal Free Hospital in the audit demonstrates excellence in care provided, with the most recently published data showing that if a need for thromboprophylaxis is indicated, there was written evidence of the patient receiving or being referred for treatment. To improve further, VTE training and a VTE sticker have been introduced at the Royal Free. A re-audit will be undertaken 2017/18 to assess their impact on practice. To improve practice across sites the Royal Free VTE assessment pathway for patients immobilised with lower limb casts has been rolled out at Barnet and Chase Farm Hospitals.

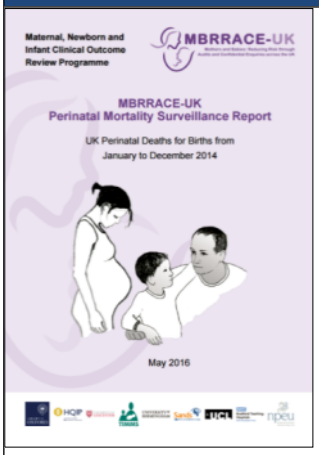
National clinical audit	Actions to improve quality
 **RCEM: vital signs in children** **Published:** Jun-16 **Reporting period:** 2015/16 **Site:** Royal Free and Barnet	Vital signs are important to record in children presenting at the Emergency Department (ED) because, if abnormal, they indicate that a patient may be at risk of a disease process with an increased risk of morbidity and mortality. The detection of abnormal vital signs, appropriate escalation and response can avoid patient deterioration and improve patient outcomes (*source: national audit report*). The performance of the Royal Free Hospital in the audit demonstrates excellence in care provided, with the most recently published data showing that: • A formal vital signs scoring system was used for 100% of patients. • Performance was in the best quartile nationally for 4/6 audit criteria, including complete set of vital signs measured and recorded, a further complete set of vital signs recorded within 60 minutes of the first set if abnormal vital signs were present, evidence the clinician recognised the abnormal vital signs (100% achieved), and that abnormal vital signs (if present) were acted upon in all cases (100% achieved). Since the completion of the audit the new paediatric ED has opened at the Royal Free Hospital, which includes an extra triage nurse. To improve further a common approach to the Paediatric Early Warning System (PEWS) will be implemented across all trust ED and Urgent Care sites. As such the patient documentation chart has been updated to include the PEWS and is currently being piloted at the Royal Free Hospital, prior to adoption across all our sites.
RCEM: procedural sedation in adults **Published:** Jun-16 **Reporting period:** 2015/16 **Site:** Royal Free and Barnet	The delivery of safe sedation is a key component of the skill-set of any emergency medicine physician. Newer agents, better monitoring and a larger caseload have substantially changed sedation practice in the Emergency Department (ED) over the last few years. Patients have benefited from this change in practice. Better sedation/analgesia has increased the success rate of many procedures, shorter-acting agents have allowed same day discharge of most patients and formal training and audit has promoted best practice and reduced the likelihood of complications. Sedating patients safely in EDs reduces admissions, pressure on theatre and costs. Importantly, no deaths were recorded as a consequence of a sedation performed in an ED in the national audit (*source: national audit report*). In line with the national picture, mixed results were achieved for the audit across sites. To improve documentation the Royal College of Emergency Medicine (RCEM) procedural sedation proforma has been adapted and will be rolled out at the Royal Free Hospital. A patient information leaflet has also been developed to be given out at discharge in line with best practice standards. To be re-audited locally 2017/18.

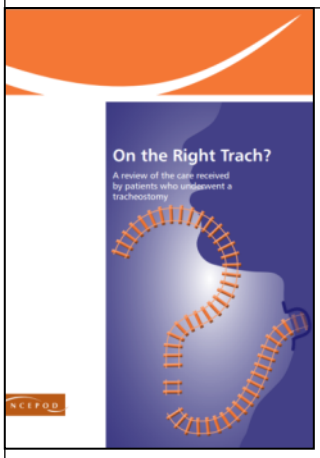
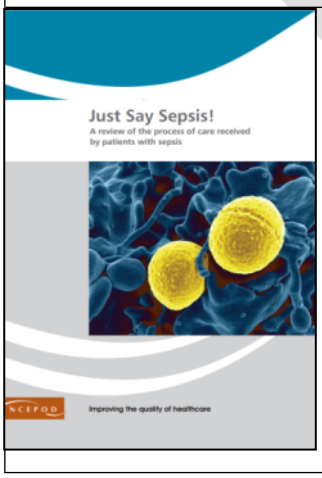
National clinical audit	Actions to improve quality
	At Barnet Hospital: • Teaching given to middle grade and senior doctors via the ED teaching programme now includes the use of end tidal CO_2 capnography in the non-ventilated patient, re-enforces the use of applicable guidelines in practice and teaching, and reiterates that procedural sedation must take place in resuscitation room only. • Compatible nasal prongs for end tidal CO_2 monitoring kit ordered into stock and used in all procedural sedation and other suitable cases (non-ventilated patients requiring end tidal CO_2 monitoring). • Implemented the RCEM document 'Pharmacological agents for procedural sedation and analgesia in the Emergency Department', which includes The World Society for Intravenous Anaesthesia (World SIVA) 'Reporting tool for sedation related adverse events' and the 'Post sedation advice information for patients'.
Sentinel stroke national audit programme (SSNAP) **Clinical audit** **Published:** Oct-16 **Reporting period:** 01/04/16 – 31/06/16 **Site:** Royal Free and Barnet **Organisational audit** **Published:** Sep-16 **Reporting period:** Services as of 01/07/16 **Site:** Royal Free and Barnet **Mortality data** **Published:** Jan-17 **Reporting period:** 01/04/15 – 31/03/16 **Site:** Royal Free and Barnet	A stroke is a serious, life-threatening medical condition that occurs when the blood supply to part of the brain is cut off (*source: NHS Choices*). Stroke remains the third commonest cause of death and the most common cause of complex disability in the UK, and can occur at any age. More than 80,000 people each year are admitted to hospital with a stroke in England, Wales, and Northern Ireland and while most people are elderly, a significant proportion are of working age, and of course stroke can affect children and young people too (*source: national audit report*). Performance in the clinical audit demonstrates excellence in quality of care provided at the Royal Free and Barnet Hospitals, with the most recently published data showing that: • Both hospitals are providing a world class stroke service – achieving an 'A' rating for overall performance (SSNAP level), placing them amongst the top 18% performing teams nationally. • Both sites achieved an 'A' rating for case ascertainment. Performance in the organisational audit clearly demonstrates the provision of best practice services, with the Royal Free Hospital meeting 9/10 key indicators of best practice, placing the stroke team within the top 10 performing teams nationally. Barnet Hospital met 7/10 key indicators of best practice, placing them within the top third of teams nationally. No deaths were recorded at Royal Free Hospital during the audit period, which is lower than expected. The number of deaths at Barnet Hospital equalled the number expected, and is not identified as an outlier.  Royal Free

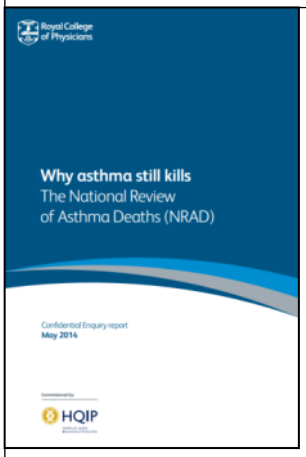
National clinical audit	Actions to improve quality
	 Barnet The multidisciplinary team regularly reviews the quarterly audit data to identify improvement actions. This has included encouraging the participation of health partners across North Central London in the audit, which has helped improve audit compliance around the referral process to early supported discharge. Multidisciplinary team meetings have led to an improved assessment process and the implementation of group therapy sessions. Multidisciplinary mortality and morbidity meetings have been set up across sites to discuss all stroke deaths to ensure learning is captured and fed back into improving clinical practice. Work is ongoing with the ambulance service to ensure patients are admitted to the appropriate hospital. To improve further the stroke team is actively seeking a full-time stroke co-ordinator at Barnet Hospital to assist in the identification and management of stroke patients.
TARN THE TRAUMA AUDIT & RESEARCH NETWORK **Trauma audit and research network (TARN) – online survival data** **Data quality:** TARN data entry shows good performance on data accreditation and completeness at the Royal Free Hospital.	Every year across England and Wales, 12,500 people die after injury. It is the leading cause of death among children and young adults of 44 years and under. In addition, there are many thousands who are left severely disabled for life (*source: TARN website*). The latest data shows that more patients presenting at both the Royal Free and Barnet Hospitals are surviving compared to expected (1.0) based on the severity of their injury. **Rate of survival: January 01 2013 – December 31 2016** Royal Free 

National clinical audit	Actions to improve quality
	Barnet  **Rate of survival: Yearly figures** Royal Free  Barnet  Royal Free: To improve the care provided to trauma patients the following actions are in progress; ward nurses are receiving training to provide basic swallowing assessments out of hours and proposals have been made to senior management and the trauma network on how to develop the trauma and rehabilitation coordinator roles which are much needed. Multi-specialty trauma governance mortality and morbidity meetings have been set up; the trauma calls have been rejuvenated and training is beginning to be implemented with a trauma team members course planned this year. Barnet: Additional specialist trainee (Grade 3) cover has been put in place to support junior staff 24 hours a day, 7 days a week. All middle grade doctors have received advanced trauma life support training and nursing staff have the opportunity to undertake a university accredited trauma module as well as Focused Assessment with Sonography (FAST) ultrasound training.
 **UK Parkinson's audit**	Parkinson's disease is a condition in which parts of the brain become progressively damaged over many years. One person in every 500 has Parkinson's. That's about 127,000 people in the UK. Symptoms and how quickly they progress are different for everyone. There's currently no cure, but drugs and treatments are available to manage many of the symptoms (*source: Parkinson's UK website*). Performance in the clinical audit demonstrates excellence in quality of care provided at the Royal Free and Barnet Hospitals, with the most recently published data showing that above national average performance was identified for: • Discussion of end-of-life care issues and care planning, and information offered about, or have set up a, lasting power of attorney with the elderly care team.

National clinical audit	Actions to improve quality
• Elderly care: clinical report • Neurology: clinical report and PREMs report • Therapies: clinical report **Published:** Aug-16 **Reporting period:** 2015/16 **Site:** Elderly care: Royal Free Neurology and Therapies: Royal Free and Barnet	• Patient reviewed by a specialist within the last year – 100% achieved for neurology services across sites. • Conversation with the patient and/or carer and/or provision of written information regarding potential side effects for any new medications – elderly care team and neurology services across sites. For patients referred to physiotherapy above national average performance was demonstrated for: • Time from referral to initial assessment for urgent or routine cases. • Reports made back to the referrer/other key people at the conclusion of the intervention period (or interim reports where treatment lasts a longer time). • Where a goal plan was included in the notes, outcome measures were used. The patient experience questionnaire showed that overall patients were happy with the quality of services at both sites, and that in comparison to the national average more neurology patients at both hospital sites felt involved in decisions about their care and listened to. Patients were happy with the amount of time available to them and at Barnet Hospital patients were happy with the level of information provided on Parkinson's disease, new medications and side effects, how to access support and information, and the role of social work for people with Parkinson's and their carers. Actions planned to improve performance further include: • Parkinson's UK information leaflets will be routinely available at the elderly care Parkinson's disease clinic, to supplement existing signposting to the Parkinson's UK website. • In the Neurology Parkinson's disease clinic, blood pressure and weight are now measured at all appointments. To improve the quality of information given to, and discussions with, the patient an information leaflet is being developed that will include information on the Parkinson's support worker, side effects of medications, bone health, driving and end of life care which will supplement the Parkinson's UK leaflets. A checklist of important issues to be discussed with the patient is also being developed as an aide memoir. • In addition, work is ongoing to improve the integrated care pathway for Parkinson's disease via London's Parkinson's Disease Excellence Network, University College London (UCL) Partners Parkinson's Disease Pathway redesign and Frailty Hub. Once the pathway of care is confirmed it will be included in the patient information making the care provided inside the hospital and across the network easier to navigate.

National confidential enquiry	Actions to improve
 **Mothers and babies: reducing risk through audit and confidential enquiries across the UK (MBRRACE-UK): perinatal mortality report: 2014 births** **Published:** May-16 **Reporting period:** 01/01/14 – 31/12/14 **Site:** Royal Free and Barnet	The work of the trust in providing excellent care to mothers and their babies is exemplified by our performance in the May-16 MBRRACE-UK report which clearly demonstrates excellent outcomes, with the data showing that: • The mortality rate for neonatal and extended perinatal deaths at the trust is more than 10% lower than the average for similar trusts and health boards. • The stillbirth rate is nearly 10% lower than the average for similar trusts and health boards. This is despite the local population having a high proportion of mothers with demographics associated with poorer outcomes. To improve patient care further, the team is reviewing and implementing a continuity of care pathway and introducing further measures to reduce the stillbirth rate. Midwives are working in hubs alongside other specialists in the community to reduce variation and improve co-ordination of care. The trust forms part of the National Maternal and Neonatal Health Safety Collaborative focusing on improving outcomes in perinatal mortality and morbidity nationally.
MBRRACE-UK: saving lives, improving mothers' care - surveillance of maternal deaths in the UK 2012-14 and lessons learned to inform maternity care from the UK and Ireland confidential enquiries into maternal deaths and morbidity 2009-14 **Published:** Dec-16 **Reporting period:** Various **Site:** Royal Free and Barnet	The trust makes continuous efforts to ensure that standards for the care of women, and ongoing work to reduce maternal deaths, continues to be part of the quality agenda of maternity services. Maternity services have benchmarked the current services against the report MBRRACE-UK: Saving Lives, Improving Mothers' Care - Surveillance of maternal deaths in the UK 2012-14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-14. These include the following areas: • The services across both Royal Free and Barnet Hospitals possess co-located obstetric and cardiac services. There are multi-disciplinary care plans and pathways for women with cardiac disease to support effective interdisciplinary working and communication. • Both Royal Free and Barnet Hospitals have Early Pregnancy and Gynaecology Assessment Units (Monday to Saturday) and a full range of maternity services (24/7) to assess this category of women. • It is established practice across the trust's maternity services that unwell antenatal women are only transferred to other units with on-site obstetric cover. • The consultant led maternity units across both sites have readily available, and seven days a week, access to an electrocardiogram (ECG) machine and echocardiography, as well as staff who can interpret ECGs.

National confidential enquiry	Actions to improve
	The recommendations of the report focus on messages for critical care, lessons for early pregnancy care and caring for women with hypertensive disorders in pregnancy and lessons on cardiovascular disease. There is work going on within maternity services to incorporate these key messages into local cross site guidance as well as to share these messages during local clinical audit and governance meetings.
 **National confidential enquiry into patient outcome and death (NCEPOD):** **Tracheostomy care: on the right trach?** **Published:** Jun-14 **Annual update on progress:** Feb-17 **Site:** Royal Free and Barnet	A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help you breathe. If necessary, the tube can be connected to an oxygen supply and a breathing machine called a ventilator. The tube can also be used to remove any fluid that's built up in the throat and windpipe (*source: NHS Choices*). Barnet Hospital is fully compliant with 20 out of 25 recommendations. This is an improvement from 13 in 2016. Actions implemented over the course of the last year include the provision of training (including blocked/ displaced tubes and airways) to all multidisciplinary staff. The Patient at Risk and Resuscitation Team (PARRT) attend the tracheostomy ward round with physiotherapy and the Ear, Nose and Throat clinical nurse specialist weekly. Speech language therapy referrals are made for all swallow impairments and patients with high risk factors. To further improve, staff training and competency levels will be taken into account at patient allocation meetings and all patients undergoing a tracheostomy without a trial of extubation will have the reason clearly documented in the notes. The Royal Free Hospital is fully compliant with 23 out of 25 recommendations. This is an improvement from 21 in 2016. Actions implemented over the course of the last year include the availability of capnography on all wards to confirm tube placement, supply of end-of-bed tracheostomy packs including a summary of care, safety and information posters, and a weaning plan from PARRT. To further improve, the Hospital IT system Cerner will be modified to enable the collection of electronic information on percutaneous tracheostomy insertion in the Intensive Care Unit (ICU) and ICU consultants will use the World Health Organisation checklist and document consent for all percutaneous tracheostomies.
	Sepsis is a systemic inflammatory response to microbial infection, causing damage to organs, then shock and ultimately death. The international prevalence is estimated at 300 per 100,000, suggesting that there are around 200,000 cases a year in the UK alone (s*ource: NCEPOD report*) The implementation of the study recommendations is being led by the sepsis work stream group, which is also leading on the sepsis work being undertaken as part of the Patient Safety Programme (PSP). For more information on the PSP work see Part 2: Priorities for Improvement. In relation to the NCEPOD study, the trust is currently fully compliant with 15 out of 19 applicable recommendations. To further improve the care provided to our patients with sepsis, local guidelines are in development to ensure

National confidential enquiry	Actions to improve
NCEPOD: sepsis: just say sepsis! **Published:** Nov-15 **Annual update on progress:** Oct-16 **Site:** Royal Free and Barnet	surgical site bundles are in place for any invasive procedure. The development of a video is being considered for patients and their relatives regarding the recognition of sepsis, its long-term complications, recovery and risk of occurrence. The head of coding has joined the sepsis work stream group and the need to include sepsis on the death certificate, when diagnosed, in addition to the underlying source of infection, will be added to staff education and training.
 **The national review of asthma deaths (NRAD)** Adults **Published:** May-14 **Annual Update on Progress:** Feb-17 **Site:** Royal Free and Barnet	It is not clear why the number of deaths per year from asthma in the UK has not reduced significantly from around 1,200 for many years, even though it is widely accepted that there are preventable factors in 90% of deaths. The aim of the project was to understand why people of all ages die from asthma so that recommendations could be made to prevent deaths from asthma in the future (*source: national review report*). The respiratory team has moved to full compliance with the implementation of 14 out of 14 applicable recommendations. In line with best practice, the trust has a designated consultant with a special interest in severe asthma. At both Barnet and the Royal Free Hospitals a clinical nurse specialist liaises with the emergency department reviewing asthma patients and arranging follow up. Every asthmatic has a personal asthma action plan, asthmatics in the out-patient clinic are usually seen more frequently than yearly, which exceeds the best practice target. Factors that trigger or exacerbate asthma and an assessment of recent asthma control form part of a standard asthma clinic review. Staff are aware of the features that increase the risk of asthma attacks and death, including the significance of concurrent psychological and mental health issues and refer patients where necessary to the health psychologist. Every patient staff are concerned about are referred to either our nurse specialist or to their GP practice nurse to go through inhaler technique. At every out-patient clinic appointment patients are asked about their adherence to therapy (GP prescription records or exhaled nitric oxide levels are sometimes checked to help this process) and patients are told how important their inhaled steroids are. Patients are not prescribed with a single agent long-acting beta-agonists. Patient self-management forms part of a standard asthma clinic review, which is also encouraged by our asthma clinical nurse specialists; and every patient attending clinic or admitted to hospital will be asked about their smoking history/exposure.

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

The reports of 18 local clinical audits* were reviewed by the provider in 2016/17 and we intend to take the following actions to improve the quality of healthcare provided.

(* the local audits undertaken relate to the divisional priority quality improvement projects)

Actions to improve the quality of healthcare provided:

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

(A full list of specific actions are presented in table 4)

Table 4: Details of specific actions undertaken as the result of a local clinical audit

Local clinical audit	Actions to improve quality
Surgery and Associated Services	
The anderson criteria: A model for improving patient handover and safety Divisional priority audit 2016/17	This audit was not undertaken in 2016/17. During the financial period the service's priorities changed to focus on improving its submission to the National Emergency Laparotomy Audit (NELA), which it has done over the past year across all sites. This audit is planned to be undertaken once the service is confident of sustained submissions to NELA.
Closing the loop: strategies to minimise preoperative delay in emergency general surgery at the Royal Free Hospital (re-audit) Divisional priority audit 2016/17	This audit focuses on issues highlighted by the National Audit of Emergency Laparotomy (NELA), assessing the extent to which emergency general surgery patients were facing unacceptable delays for surgery and whether or not this had improved following reconfiguration of emergency services. It is well recognised that delaying emergency general surgery operations, especially for patients with sepsis, results in poorer patient outcomes, including higher complication and mortality rates. Even for those without sepsis, delayed surgery leads to unnecessary prolongation of patient discomfort, recovery and hospital stay resulting in a significant cost for the NHS. The results of the latest audit demonstrate significant improvements compared to the first round with 96% of patients meeting the Royal College of Surgeons (RCS) time to treat recommendations. Only four cases (4%) exceeded the recommendations - a significant reduction from 25% identified in the first round of audit. None of the patients identified as exceeding the RCS time to treat recommendations were operated on at the weekend or out of hours. One of the areas identified as good practice was the reconfiguration of the emergency service with theatre access, which occurred after the first audit, and included separating the trauma and orthopaedic list from the main emergency theatre. This has resulted in improved compliance with the best practice standards set by RCS and the national confidential enquiry into patient outcome and death (NCEPOD). There is no evidence from this audit that emergency general surgical patients are disadvantaged by current weekend working practices. For patients admitted between 8am and 6pm on a week day the mean time between the decision to operate and the start of operation was 8.48 hours, compared to 7.95 hours for patients admitted out of hours which shows virtually no difference.
Ultrasound diagnosis of "U" classification thyroid nodules Divisional priority audit 2016/17	The U classification is essential in establishing correct pathways for the management of thyroid nodules by stratifying risk. Its increased use results in fewer fine-needle aspiration's (FNAs), fewer ultrasonograms (US), less clinic appointments and better patient experience, which result in lower costs to the trust. The quality improvement project used PDSA (plan, do, study and act) methodology to assess the percentage of ultrasound reports using the U classification for thyroid nodules between March 2015 and June 2016 following the implementation of a series of

Local clinical audit	Actions to improve quality
	interventions to improve practice. The data shows an improvement in the use of U classification from 23% to 88% over the audit period. This has been driven by the implementation of regular interventions to educate staff and promote the use of the U classification including discussions with radiologists, an update to the thyroid protocol (oral and maxillofacial surgery (OMFS) clinical rooms), a request to specify U classification on all orders by OMFS and Ear, Nose and Throat (ENT) clinicians, training provided to OMFS dental core trainees and the U classification laminated and put up on the wall in the radiology treatment rooms as a visual aid.
Virtual fracture clinic cross site comparison May-16 Divisional priority audit 2016/17	The virtual fracture clinic at Barnet Hospital was set up to mirror the clinic at the Royal Free Hospital. This audit compared the service plan assumptions to the actual challenges faced by the clinic following implementation at Barnet and aimed to address any issues found. The data analysis showed a number of improvements to the fracture clinic waiting area, patient flow and the discharge rate, which has improved from 23% to 34%. The audit also showed that the increase in demand for the service was not being met. Funds have now been agreed to resource three extra part-time sessions on a Monday, Tuesday and Friday. Additional administrative support for clinical staff has also been agreed for four hours a day and early talks are in progress regarding the implementation of an IT system to underpin the virtual fracture clinic process.
Swabs, needles and instrument count Divisional priority audit 2016/17	Following serious incidents in 2015/16 regarding retained swabs and needles, a new policy has been implemented in all theatres across the organisation and all staff have been assessed to ensure they are following the policy and are fully competent. Theatre areas are also doing monthly observational audits of swabs, needles and instrument count, using PDSA (plan, do, study, act) methodology. Results are reviewed locally by matrons and actions put in place to try to address any issues. Measurement then takes place again to check if the actions have been successful in solving these issues. The data is regularly reviewed at the monthly Safer Surgery Board meeting and later this year we will analyse all data to assess our improvement progress. Further action to improve will then be taken as required.
Transplant and Specialist Services (TASS)	
A local audit of tuberous sclerosis specialist service at the Royal Free Hospital for patients presenting with renal angiomyolipomas (AMLs)	Tuberous sclerosis is a multi-system genetic disorder, causing benign tumours to grow. This condition can affect any organ, but most commonly presents in the heart, lungs, kidneys, skin and eyes. The audit demonstrated excellent patient care. All patients referred to the clinic with renal AMLs had an individual care plan in place, all patients had the appropriate follow up arranged and all patients that required specialist input had been referred and an appointment arranged. To ensure patients have their renal scan ordered appropriately once a patient has been reviewed in clinic, a decision will be made as to when their imaging is next due for

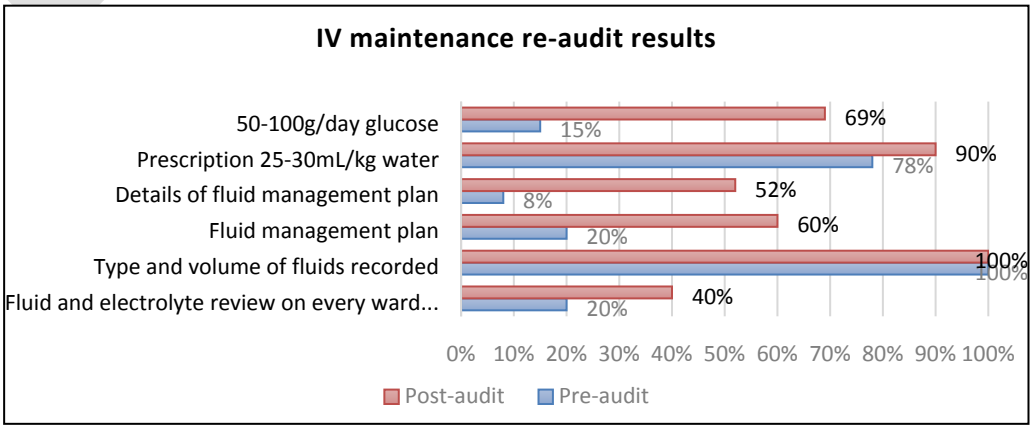
Local clinical audit	Actions to improve quality
Divisional priority audit 2016/17	review. This will be clearly documented in the patient notes and booked as soon as possible. Work is ongoing with the scanning department to ensure scans are booked in a timely manner. Some patients are needle phobic and are not keen to have blood tests. To improve the documentation of eGFR, the importance of recording clinical decisions to omit blood tests has been discussed with the renal genetics team (i.e. patient choice). Following the recent relaxation of the eligibility criteria for the genome project, it is now possible to enrol suitable patients with tuberous sclerosis complex (TSC). The study team has been informed and patients are now being approached at their clinic appointments.
Audit of fatigue syndrome presenting with joint hypermobility syndrome (JHS) on referral to service Divisional priority audit 2016/17	The initial screening 5-part JHS questionnaire has been posted to 160 prospective patients, of which 102 (64%) have been completed and returned. 69 of these report benign JHS, and these will be assessed further to confirm chronic fatigue syndrome and JHS using the Beighton and Brighton criteria for JHS diagnosis. 17 further patients who have either already been assessed and/or re-assessed by the physician in clinic post therapy for fatigue, or re-assessed by a graded exercise therapist for further fatigue treatment, have been diagnosed according to Beighton and Brighton criteria. These numbers are already higher than expected. The completion of this audit has been a challenge, with limited time and resource. However, we are committed to complete the audit and all data should be collected by the end of April 2017, which will allow analysis to be completed by the end of June 2017. Joint physician and physiotherapy clinics are being arranged to confirm the diagnoses in March and April 2017. The American Association of Rheumatologists will shortly release a new definition and criteria for some classes of JHS. This will be taken into account in the analysis, and we hope that the new criteria will be available before our planned audit completion date.
Renal dialysis patient reported experience measures (PREM) 2016-17: Patient experience and satisfaction with dialysis Divisional priority audit 2016/17	Whilst PREM data has been collected by the renal dialysis specialty for a number of years the short renal-specific PREM questionnaire has been used to examine patients' experience of and satisfaction with their dialysis treatment every year since 2013. The findings of the latest review are very similar to those in previous years and show that: • Nearly half of all respondents perceived their health to be good, very good or excellent, yet bodily pain remains an ongoing difficulty for patients. • More than half of respondents reported to have experienced at least moderate levels of bodily pain in the month prior to completing the questionnaire. However, although over one third of patients who had experienced pain had had no analgesia prescribed for them, patients experiencing severe or very severe pain reported taking medication for pain 'very often' suggesting that a number of respondents are likely to be taking medicines purchased over the counter.

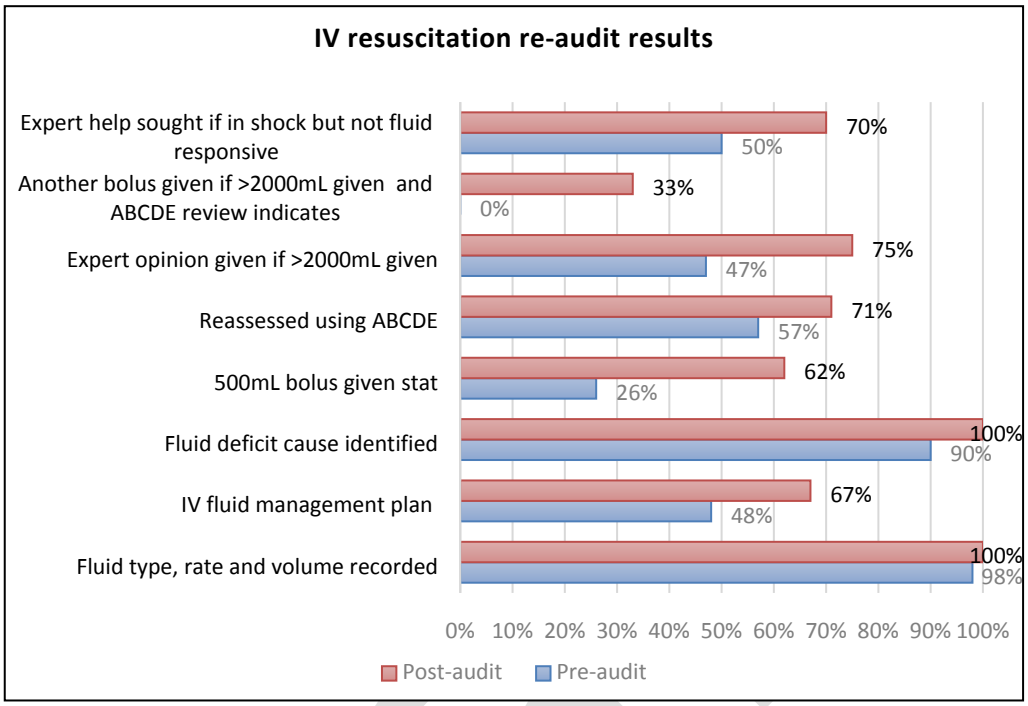
Local clinical audit	Actions to improve quality
	• Symptoms of depression were explored for the first time using Patient Health Questionnaire-9 (PHQ-9). Results indicated moderate levels of depressed mood with 39% of respondents experiencing moderately severe or severe symptoms of low mood, which could warrant antidepressant and/or psychological therapy. • Over the years, patient satisfaction has been consistently good with 59% of respondents scoring their care highly as an 8, 9 or 10. This year, far less variability in satisfaction was noted between dialysis units. • A number of positive comments commending the organisational qualities of their dialysis unit were received. The caring attitude of staff and the pleasant physical environment were also noted. Contrastingly, comments relating to the need for better patient-staff communication and more reliable transport, were frequently cited as suggestions for improvement. As a result of the audit a number of recommendations have been made and are in the process of being implemented: • Consultants should routinely enquire about patients' pain at each consultation. • Patients reporting psychological difficulties should be referred to the Renal Clinical Health Psychology service for assessment and treatment, or for signposting to more relevant mental health services. • Staff should attend the Trust's Sage and Thyme communication skills training course, which teaches staff to work effectively with patients in distress. To supplement this, dialysis staff should receive brief, accessible training to facilitate better understanding of common psychological problems experienced by patients receiving dialysis treatment. Training should be undertaken in dialysis units. To further improve practice, brief monthly training of dialysis staff in stress management and in the recognition of psychological distress in dialysis patients began at Tottenham Hale dialysis unit in September 2016. To be completed in June 2017.
Assessment of all patients who died within 30 days of chemotherapy Local audit of recommendations from the national confidential enquiry into patient outcome and death (NCEPOD) Divisional priority audit 2016/17	Undertaken periodically since 2009, the audit assesses our performance against the NCEPOD recommendations. The audit has already led to a number of improvements, including improved documentation of performance status, increased patient assessment by consultant staff and the development and implementation of a formal pathway for HIV positive patients. The most recent audit results show areas of excellent practice. All patients had systemic anti-cancer therapy (SACT) prescribed by a consultant or senior registrar, all prescriptions were checked by a senior pharmacist, all drugs that should have been dose-modified had the correct dose prescribed and performance status was generally well documented. Patient performance status is an important part of cancer care and treatment. It plays a role both in shaping prognosis and in determining the best treatment for a patient with cancer. Audit actions are in progress to improve the documentation of cause of death and to ensure that SACT related deaths in all patients are treated with curative intent, and all unexpected deaths and all deaths from neutropenia are discussed in depth at the mortality and morbidity meetings.
Adherence to treatment in the lupus and	Medicine compliance is an ongoing challenge with 35-50% of all medicines prescribed for long-term conditions not taken as recommended. This represents a personal and economic loss to patients, the healthcare system and society (*source: National Institute*

Local clinical audit	Actions to improve quality
vasculitis nephritis clinic Divisional priority audit 2016/17	*for Health and Clinical Excellence (NICE) clinical guideline 76: Medicines Adherence*). The specialist renal clinic at the Royal Free Hospital sees patients predominantly with vasculitis and systemic lupus erythematosus (SLE). These conditions are both characterized by their autoimmune nature, chronicity, multi-system involvement and polypharmacy, including long-term immunosuppression medication. Therefore issues surrounding adherence to treatment are particularly relevant to explore in these two groups. Poor adherence leads to poor clinical outcomes in patients with vasculitis and SLE, and the rates of non-adherence in SLE patients range from 3% to 76% depending on the assessment methods used, which are all subject to limitations. The aim of the audit was to assess patient self-reported adherence to prescribed treatment and perceived barriers to achieving medication adherence in this patient group. The survey findings demonstrated that the clinic was fully compliant with 16 out of the 19 NICE standards audited (84%), and partially compliant with 3 (16%). The audit data has been reviewed and a list of recommendations developed for action. These are: • The most common reason for non-adherence to the prescribed medications was "forgetfulness". To improve adherence the following have been recommended; the provision of practical tips and advice as part of an education session with the clinician or assisted by the pharmacy (such as dosset boxes/electronic reminders) and to identify patients with increased risk of forgetfulness and ensure they have access to additional support. • Keeping track of hospital appointments was one of the identified obstacles to adherence. This can be managed by further improving the hospital's notification and reminder services, aspiring to minimize outpatient appointments, and emphasising the importance of attendance and diarising for patients. • The major concern reported by patients was the immunosuppressants and their side effects. This can be addressed by enhancing education regarding the medication at the time of starting treatment and supporting the patients with provision of information leaflets and discussion about potential side effects and action plans if they experience them. Clear communication and correct direction to an appropriate helpline/advice line or to the clinic team will enhance confidence in treatment and prevent early discontinuation. • Flexible follow-up intervals and adjusting doses or changing medications as soon as patients start experiencing side effects will improve symptoms before they affect their adherence with medication. • Many of the medications prescribed for vasculitis and SLE patients are essential and cannot be minimized or stopped. Identifying personal barriers to treatment early during follow up consultations allows for intervention before adherence is affected. This should include specific questions about side effects and current adherence, adjusting dosing schedule/frequency to suit the patient, and considering an early change of medication where side effects are problematic.
Urgent Care	
In-patient falls Divisional priority audit 2016/17	The aim of the project is to reduce falls by 25%, as measured by incidents reported on DATIX by 31 March 2018. To date across the trust 33 PDSA (plan, do, study, act) cycles have been instigated - 17 completed, 15 in progress and 1 intervention abandoned. To reduce falls on: • **8 West:** A review of the toilet areas on the ward has been completed. A

Local clinical audit	Actions to improve quality
	thematic review (via staff focus groups) for falls prevention in patients with behavioural issues is being undertaken and all multidisciplinary team members are trialing writing their notes in the patient bays. • **Neurological rehabilitation centre:** A multidisciplinary falls assessment, falls care plan discussions at multidisciplinary team meetings and a multidisciplinary post-fall incident review have all been tested and implemented. The implementation of new falls documentation and toilet grab bags are in progress. • **Juniper Ward:** A shortened board meeting and inclusion of discussion on falls and risk management has been completed. The use of 4 A's Test (4AT), a short tool developed to increase rates of detection of delirium and cognitive impairment in acute general hospitals, and the use of bedside white boards are in progress. • **Medical Short Stay Unit:** Toilet grab bags have been implemented and testing is in progress on laminated pictorial mobility signs and staff education on falls prevention. • **Days since last harmful fall:** 8 West = more than 854 days, neurological rehabilitation centre = 487, Juniper Ward = 88 days and Medical Short Stay Unit = 24. The falls work stream is part of the patient safety programme. For more information see Part 2: Priorities for improvement - Patient safety priorities.
Deteriorating patient Divisional priority audit 2016/17	To achieve the project aim to reduce the number of cardiac arrests to less than one per 1,000 admissions by 31 March 2018, the following interventions have been tested using the PDSA (plan, do, study, act) methodology on 10 West: • Re-design and evaluation of the new team 'board round' content and function - trigger questions include current issue, recurrent hospital admissions, acute concerns, resuscitation status, clinical criteria for discharge, social criteria for discharge, estimated date of discharge and multidisciplinary team involvement. • The Patient at Risk and Resuscitation Team (PARRT), palliative care and parent team hold weekly multidisciplinary meetings – approximately six have been triggered to date. • Streaming nurse to nurse verbal handover. • Merging nursing, multidisciplinary team and medical written handover. The deteriorating patient work stream is part of the patient safety programme. For more information see Part 2: Priorities for improvement - Patient safety priorities.
Acute kidney injury (AKI) Divisional priority audit 2016/17	The aim of the project is to increase the number of patients who recover from AKI within 72 hours of admission by 25% by 31 March 2018. To meet this target: • A technology platform (AKI App) has been developed by DeepMind Health. It utilises the national mandated AKI detection algorithm and sends AKI alerts with other relevant data to the clinical responders. • 15 to 20 alerts are received a day with an average of 5-6 patients to be seen. Over 26 clinicians are currently using the device. • The Emergency Department (ED) and Medical Admissions Unit (MAU) teams actively participated in the process mapping of the AKI pathway; 'STREAMs' alerts have been designed and deployed; and further updates and upgrades have been made to the AKI App based on the testing phases in the ED and in patient areas. • An ED capability package is currently being developed. ED observations data for processes of taking blood samples, gaining blood results and escalation to

Local clinical audit	Actions to improve quality
	interventions is underway; and various iterations and changes have been made based on the feedback received. • A real time study is in progress to identify the time saved by clinical teams using the app over the computer. The AKI work stream is part of the patient safety programme. For more information see Part 2: Priorities for improvement - Patient safety priorities.
Sepsis Divisional priority audit 2016/17	The project aims for a 50% reduction in serious incidents related to sepsis. • It has been 280 days since the last sepsis related serious incident. • Since 2011 the total number of sepsis pathways started in the Emergency Departments (ED) at both hospital sites is 2500. • Current compliance with the provision of all six sepsis interventions within an hour is 80% at Barnet Hospital ED, and 66% at the Royal Free Hospital ED. • An E-learning video is being filmed with the ED champions that will include acute kidney injury (AKI) and neutropenic sepsis. • The use of a sepsis grab bag is being tested at Chase Farm Urgent Care Centre. • The ED and 8 North are both participating in the Sepsis Commissioning for Quality and Innovation (CQUIN) scheme. The sepsis work stream is part of the patient safety programme. For more information see Part 2: Priorities for improvement - Patient safety priorities.
Diabetes Divisional priority audit 2016/17	The aim of the project is for zero avoidable harm from hyperglycaemia and hypoglycaemia events in a pilot ward by 2018. The project is being undertaken on wards 10 West and 10 South. • Currently time to control hypoglycaemia in less than 30 minutes is achieved by 30% of patients, and in less than six hours by 76% of patients. • Collaborative support is being provided by staff from 10 West to 10 South. • Patient safety team to design confidence survey with 10W champions. • The trust aims to reduce incorrect medical record number mistypes to less than 19%. • PDSA (plan, do, study, act) methodology is currently being used to test the hypoglycaemia pathway with additional glucometer and timer on 10 West. The diabetes work stream is part of the patient safety programme. For more information see Part 2: Priorities for improvement - Patient safety priorities.
Improving quality of endobronchial ultrasound (EBUS) coding	A monthly submission of EBUS procedures is made to the head of clinical coding who then ensures that correct codes have been applied and provides training to coders to improve coding quality further. The monthly return also allows the trust to correct billing in time. Coding accuracy has improved from 50% (February 2016) to 100% (November and December 2016).
Improving the patient pathway for patients with breathlessness	The specialist complex unexplained breathlessness (CUB) clinic organises pre-visit investigations and uses a multidisciplinary team approach (physician, psychology and physiotherapy) in managing these patients. Compared to 'usual care' patients, the CUB clinic had a significantly shorter time from referral to discharge (CUB: 137 days vs. usual care 251 days), fewer clinic attendances (1.5 visits vs. 2.7 visits) and better patient related outcome measures for the criteria: better understanding of condition, greater confidence in ability to self-manage breathlessness, feel less distressed about my breathlessness and overall satisfaction. This is likely to result in whole system cost

Local clinical audit	Actions to improve quality
	reduction.
Outlying patients under acute medicine	An audit completed in 2012/2013 found that the average length of stay for outlying patients' (acute medicine patients not admitted onto the Medical Admissions Unit (MAU)) was 3.38 days longer than patients on the MAU. As a result of the audit, the following actions were implemented to improve the care provided to patients on outlying wards: • Dedicated outlier consultant ward round implemented Monday, Tuesday, Thursday and alternate Fridays. • Flexible staffing – increased use of ward team to cover outliers. The repeat audit undertaken in February 2016 demonstrated that there had been a reduction in the difference in mean length of stay to 0.47 days; however the length of stay of patients on outlying wards has increased and their discharge continues to occur later in the day. To improve consideration is being given to electronic and other improved handover, and bed management processes.
Improving HIV testing in acute medical admissions	HIV screening in acute medical admissions has been recommended in national guidance since 2008. Baseline data showed that 13% of patients less than 80 years old are being screened. The quality improvement methodology PDSA (plan, do, study, act) has been used to improve practice, which has included the introduction of stickers for notes, posters to educate staff and feedback of data collected by the team. Initial improvements were seen at launch, although these have been difficult to sustain. This is an ongoing quality improvement project, extended to August 2017.
IV fluid prescribing in acute medicine inpatients	The aim of the audit is to improve compliance with National Institute for Health and Clinical Excellence (NICE) guidance on IV fluid prescribing. To improve practice changes have been made to the drug charts in line with recommendations for fluid and electrolyte prescriptions and teaching has been provided as both formal sessions and ad-hoc for nurses and junior doctors. This has resulted in improvements across all criteria – see data below. To improve practice further the Step Up to Lead group are working on improved fluid prescribing in acute kidney injury (AKI) and complex patients and new fluid balance charts will be developed to improve documentation of fluid management plans. 

Local clinical audit	Actions to improve quality
	

Women's, Children's and Imaging	
Two person swab count audit Divisional priority audit 2016/17	This is an on-going quality improvement project led by the Royal Free and Barnet labour ward matrons in conjunction with the patient safety team. On-going observational audits continue and there have been a number of improvements made such as the introduction of white boards and a theatre checklist in the obstetric theatres on the Royal Free Hospital site. The process for counting swabs, needles and instruments has undergone a detailed process mapping exercise. Work is currently being undertaken in relation to cross site harmonisation of the operational theatre policy and revision of the perineal trauma and repair, including 3rd and 4th degree tears (OASIS) guideline, to align with the process mapping.
Post-menopausal bleeding management audit Divisional priority audit 2016/17	The aim of the audit, which commenced in January 2017, is to assess whether the pathway of care for women presenting with post-menopausal bleeding is being followed, and is appropriate given the presenting nature of their condition. A data collection proforma has been agreed for cross-site use. At the Royal Free, data collection has commenced and the audit is due for completion in June 2017. At Barnet Hospital, the audit is due to commence at the time of publication of this report.
Paediatrics early warning score (PEWS) cross-site Divisional priority audit 2016/17	This project aims to implement PEWS charts and monitor compliance and performance through PDSA (plan, do, study, act) cycles. This quality improvement project is linked to the Institute for Health Improvement work, and has been introduced at the Royal Free London involving a revision of the PEWS charts. The timescale for completion of the first PDSA cycle is expected to be quarter one 2017/18, with cross-site implementation by quarter two 2017/18. The first revision of the PEWS chart is undergoing piloting.
Neonatal safety	This project aims to introduce safety huddles to neonatal clinical areas on both sites.

Local clinical audit	Actions to improve quality
huddles Divisional priority audit 2016/17	This quality improvement project focuses on the development of the structure of the huddles and the recruitment of a representative from the core team, and champions in each area at both sites. The first improvement cycle has been launched and it is undergoing piloting in the neonatal settings.
Emergency CT head report authorisation (re-audit) Divisional priority audit 2016/17	The aim of the audit was to assess the process for CT head investigations to be reported in a timely fashion and subsequently authorised by a neuroradiologist, as per National Institute for Health and Clinical Excellence (NICE) guidance. It was undertaken at the Royal Free Hospital in quarter four 2016/17, comparing practice to the previous audit completed in quarter four 2015/16. The audit was completed at Barnet Hospital in January 2017. Key findings were: • For ward patients the average time to report was 2.16 hours with 46% within the one hour standard. • For ward patients the average time to endorse a report was 92.3 hours with 72% of all reports being endorsed at all and 9% of reports being endorsed within the one hour standard. • For Emergency Department patients the average time to report was 5.8 hours with 54% within the one hour standard. • For Emergency Department patients the average time to endorse a report was 21.1 hours with 74.4% of all reports being endorsed at all and 14% of reports being endorsed within the one hour standard. The limitations of the audit are that the option for endorsement drops off after 30 days; if the report is reviewed on PACS then there is no need to endorse the report and there is no trust guidance/protocol regarding endorsement. The following actions were recommended as a result of the re-audit and discussed at the Imaging Audit Presentation Day in January 2017 for implementation: • Formal trust guidance regarding endorsement target. • If there is no viewable report on PACS then this must be checked on the Powerchart. • Limiting access to the report unless willing to endorse. • Consider named person responsible for endorsing ('Nurse in Charge').
Novasure endometrial ablation	This project is linked to the introduction of a new interventional procedure. This audit is currently being undertaken on the Royal Free Hospital site since the finalisation of the methodology and standards by the gynaecology team. The results from this audit are anticipated to be available in April 2017. Discussions continue to determine the applicability of this intervention to Barnet Hospital site.
Truclear hysteroscopic tissue removal system	This new interventional procedure has been audited on the Barnet site, with a re-audit being undertaken and presented in December 2016 showing progress on the first audit on time taken, polyps removed, pain experienced by the women, and willingness to recommend the service to a friend. Following advice from senior colleagues, future plans include making the Truclear system available in day surgery and main theatres and training the nursing staff to set the machine. A similar prospective audit has begun at the Royal Free, with a report anticipated in May/June 2017.

Local clinical audit	Actions to improve quality
Percutaneous radiofrequency ablation (RFA) for lung cancer	This new interventional procedure has established datasets on both sites. The Royal Free site data has undergone analysis which found that: • There were 58 lung RFAs between December 2007 and June 2016. • 50% of these patients had no complications, 21 patients (36.2%) had complications but these had no clinical significance and eight patients (13.8%) had complications with some clinical significance. • In 47 patients (81%) track ablation was achieved. • 57 patients (98.3%) had a successful procedure. The Barnet Hospital site dataset is undergoing analysis.
Manual vacuum aspiration for termination	This new interventional procedure has been recently audited on the Royal Free site. • All 24 patients audited had a successful procedure and did not require further surgical or medical treatment. • Patient satisfaction was very high with 98% satisfied with their procedure. Only one was moderately satisfied with the procedure. • 95.9% would recommend this procedure to a friend and 4.1% would not recommend it. Of the 24 respondents only 19 answered the question on pain after procedure. Three out of 19 (15.8%) had pain for 2-3 days post procedure. As for pain during the procedure only 8.3% recorded the pain as moderate or more, while 91.7% recorded mild to minimal pain. 12.5% recorded no pain at all. These findings are in keeping with the evidence available in literature of 79% of patients experiencing minimal pain. No allergic reaction was noted in any of our patients and none required an overnight stay or Entonox for pain relief. Pain post procedure appeared to be the only complication. The complication rate was much less than that reported in the published literature where retained products, cervical rigidity, allergic reaction and false passage were highlighted although the numbers are small. This may well be due to routine use of cervical priming, screening for allergy at pre-assessment and ensuring completeness using an ultrasound post-procedure at the Royal Free Hospital site.
Fetal pillow	This new interventional procedure has been audited at Barnet Hospital site maternity unit and is the subject of a continuous audit managed by the clinical lead. The findings of the initial audit were: • There were eight cases where the fetal pillow was used and seven case notes were reviewed. • There were no major complications in relation to maternal or fetal outcomes. Although the numbers are small the results are promising and the fetal pillow is noted to be easy to use. A similar prospective audit began at the Royal Free site in November 2016, with the report anticipated in May/June 2017.
Engaging parents in 6 north safety culture (Royal Free only)	Multidisciplinary ward safety huddles to improve situation awareness have been embedded on the paediatric ward on Royal Free Hospital site (6 North) for the last two years. During these twice-daily huddles, children at risk of deterioration are identified and discussed by means of their paediatric early warning score (PEWS), clinician impression or parental concern. Parental concerns were identified as not being reliably

Local clinical audit	Actions to improve quality
	brought to the huddle by staff members or registered on the PEWS chart. The aim of the quality improvement project was to engage parents in the ward safety culture and to ensure any concerns regarding their child are highlighted to the multidisciplinary team as soon as possible. As part of the project, parents were engaged in the design of bedside safety information packs and daily plan whiteboards to improve communication with the multidisciplinary team and parents/carers. A traffic light system has recently been developed by frontline clinicians using the Model for Improvement to assess parental concerns: green - happy their child is getting better, amber- unsure they are getting better, and red - worried they are not getting better. An interview of 30 parents on the ward revealed that 12 felt their concerns were 'green', 12 were 'amber', and 6 were 'red', but none of the parents with 'red' concerns were highlighted at the huddle. The following actions for improvement have been implemented: • A traffic light concern chart has been put next to every bed on ward 6 North. This will open a discussion between the parent and the nurse to identify the concerns early. • The aim is for the traffic light data to be collected by the housekeeping staff (who visit every parent on their breakfast round) and brought to the morning safety huddle. Using the Model for Improvement, the service shall continue to measure the percentage of parental concerns that are discussed at the huddle and test our approach using PDSA (plan, do, study, act) cycles.
Paediatric intensive care retrievals to provide learning and feedback to the multidisiciplinary team	A multi-disciplinary team of anaesthetists, emergency physicians, paediatricians, Patient at Risk and Resuscitation Team (PARRT) nurses and the children's acute transfer service (CATS) is involved in the acute management and stabilisation of children being transferred from our Emergency Department (ED)/Ward 6N to a tertiary paediatric intensive care unit (PICU). This project focuses on the management of this patient group and the aims were to identify areas for improvement, share the learning and enhance patient safety and care. A modified version of the Rapid Evaluation Cardio-respiratory Arrest with Lessons for Learning (RECALL tool) has been used for analysis of children transferred from ED/Ward 6 North to PICU. This tool provides a structured template to review notes of children who deteriorate and identify areas for improvement. It focuses on assessment (recording of early warning scores), escalation in response to deterioration, clinical reviews at appropriate points, interventions implemented and additional information (staffing, parental concerns). The cases are analysed monthly by a multidisciplinary group and one case is identified to be presented at the clinical risk meeting (to highlight learning or excellent care). Learning is disseminated to the teams by email and displayed in clinical areas. The paediatric services have set up a new teaching session (last Friday of every month) providing feedback and learning themes. The services have also implemented the following: • Debriefs within a week of every CATS transfer (being documented on the high

Local clinical audit	Actions to improve quality
	dependency unit (HDU) patient forms). • Monitoring of the incidence of CATS transfers within our trust. • A new monthly clinical risk meeting focused on CATS liaison and transfers within the hospital. The initial feedback from trainee doctors prior to interventions was that they felt 'supported but anxious, stressed, worried, concerned, nervous, apprehensive, uncomfortable, frightened and uneasy'. Following two focused meetings to date, paediatric trainees are feeling less anxious and stressed about the retrievals and are keen for the teaching to continue. The following actions have been taken for improvement: • New monthly trust-wide newsletter to paediatric consultants, anaesthetic team and PARRT team. • New monthly learning topics newsletter to paediatricians and allied staff - placed on news boards and sent out as email. • A monthly CATS learning meeting. There are ongoing plans to continue this intervention and the dissemination of learning, and to widen the teaching sessions across the trust.
Asthma tool kit for clinic pilot for Royal Free Hospital site	There has been increased focus on asthma and as part of this quality improvement work there has been a pilot project on reducing the variability in assessment of wheeze/asthma patients in the allergy clinic on the Royal Free Hospital site. The aim is for 100% patients with wheeze/asthma to have structured documented assessment and a discharge plan as per British Thoracic Society (BTS)/National Institute for Health and Clinical Excellence (NICE) asthma guidelines i.e. correct assessment and discharge in the domains of smoking cessation, written asthma plan, flu vaccination recommendation and inhaler technique assessment. High levels of variation in practice were found in the first eight weeks of the audit and this was noted to be dependent on clinicians. Smoking cessation and flu vaccine recommendation were the areas which showed the greatest opportunity for improvement. As part of this quality improvement project ideas were collected from staff as to how to improve practice and it was agreed that a crib sheet would be helpful as a reminder to staff. This has been instituted and a further pilot is in progress to incorporate the crib sheet in the EDRM (electronic patient record system).
Too much huff, not enough puffs	This quality improvement project was initiated to improve the low confidence parents may have in managing wheeze at home, which can lead to unnecessary presentations to the Emergency Department (ED). The aim of the project is to ensure that all parents of children who have previously presented with wheeze have confidence to administer 10 puffs of Salbutamol to their child before bringing them to ED. 15 measures collected, 4/15 gave 10 puffs, 1/15 gave more than 10 puffs (15), 10/15 gave less than 10 puffs.

Local clinical audit	Actions to improve quality
	As part of this quality improvement project ideas were collected as to how to improve and the most popular idea amongst staff and parents was a sticker to put on inhaler boxes outlining a condensed wheeze plan. This sticker is in the process of being designed and printed.
Learning from excellence	This quality initiative was introduced with the aim to celebrate and learn from our everyday success, to share good practice and improve staff morale by embedding the little fixes we undertake to deliver high quality paediatric patient care. Electronic nominations via the IT incident reporting system DATIX were launched in November 2016 following successful implementation of paper nominations at Barnet Hospital paediatric department. There are now an increasing number of nominations from the Royal Free Hospital and work is underway to encourage nominations from other specialties.

Participating in clinical research

Involvement in clinical research demonstrates the trust's commitment to improving the quality of care we offer to the local community as well as contributing to the evidence base of healthcare both nationally and internationally.

Our participation in research helps to ensure that our clinical staff stay abreast of the latest treatment possibilities and leads to better patient outcomes.

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

The number of patients receiving relevant health services, provided or sub-contracted by the Royal Free London NHS Foundation Trust in 2016/17, that were recruited to participate in research approved by a research ethics committee was 11,725.

The figure includes 4,030 patients recruited into studies in the National Institute for Health Research (NIHR) portfolio and 7,695 patients recruited into studies that are not in the NIHR portfolio. This figure is higher than last year.

The trust is supporting a large research portfolio of over 700 studies, including both commercial and academic research. 183 new studies were approved in 2016/2017. The breadth of research taking place within the trust is far reaching and includes clinical and medical device trials, research involving human tissue, quantitative and qualitative, and observational research.

CQUIN Payment framework

A proportion of the trust income in 2016/17 was conditional on achieving quality improvement goals agreed between us, and any person or body we entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment Framework.

Further details of the agreed goals for 2016/17 and for the following 12-month period are available electronically at xxxx weblink (further information to be included in the final report)

In 2016/17 a total of xxx of the trust's income was on the condition of achieving quality improvement and innovation goals xxx the final figure is still to be agreed with our commissioners.

CQUIN scheme priorities 2016/2017	Objective rationale
Staff health & well being	This national initiative made up of three areas of improvement: 1) Introduction of health and wellbeing initiatives covering physical activity, mental health and improving access to physiotherapy for people with musculoskeletal issues. 2) Healthy food for NHS staff, visitors and patients. 3) Improving the uptake of the flu vaccination for frontline staff.
Sepsis	Timely identification and treatment of sepsis in emergency departments and acute inpatient settings. Sepsis is a common and potentially life-threatening condition with around 32,000 deaths in England attributed to sepsis annually.
Antimicrobial	Reduction in antibiotic consumption across the trust and an empiric review of antibiotic prescriptions. Antimicrobial resistance has risen alarmingly over the last 40 years and inappropriate and overuse of antimicrobials is a key driver.
Discharge summaries	Improvement of discharge summaries in Accident and Emergency (A&E) and the Medical Admissions Unit. The trust has worked closely with Barnet Clinical Commissioning Group and local GPs to improve the accuracy and detail in its discharge summaries, which is important in providing better patient care and management of long terms conditions as well as reducing readmissions and A&E attendances.
Cancer referrals	Streamlining urgent GP referrals for suspected cancer for a first appointment within a target of two weeks for all cancers. Review of cancer patients waiting longer than 104 days from urgent GP referral to first definitive treatment. Ensuring efficient investigation, diagnosis and treatment of cancer is essential to ensuring a positive patient experience.
Maternal & child health	To embed a public health approach and implement a maternal and child health programme across the trust. Beginning at the first antenatal booking, through maternal health and paediatric care up to the age of sixteen. This affords huge potential to support, educate and refer patients early on for a range of health and

CQUIN scheme priorities 2016/2017	Objective rationale
	social risk factors and to help prevent future ill health.
Hepatitis C virus (HCV)	Supporting the infrastructure, governance and partnership working across healthcare providers working in HCV networks in their second and third years of operation to increase engagement with patients, rollout new clinical and cost effective treatment guidance, improve participation in clinical trials and enhance data collection.
Severe haemophilia	The HAEMTRACK patient reporting system is an electronic (or paper) patient-reported record of self-managed bleeding and blood product home therapy usage. This scheme aims to establish the use of the Haemtrack patient home therapy diary as an integral part of clinical care. The scheme offers financial support to all centres to improve recruitment and data quality, and to use Haemtrack as a one of the tools to optimise individual treatment.
Dose banding adult intravenous SACT	A national incentive to standardise the doses of SACT (Systemic Anticancer Therapy) in all units across England in order to increase safety, efficiency and to support the parity of care across all NHS providers of SACT in England.
Adult critical care (ACC) timely discharge	To reduce delayed discharges from ACC to ward level care by improving bed management in ward based care, thus removing delays and improving flow.
Telemedicine	To improve patient experience by reducing the number of times a patient is required to attend a face-to-face outpatient appointment but instead has their follow-up care and advice conducted remotely.
Antiretroviral drug cost effective prescribing	The scheme has identified a number of switches of drug regimen making the best use of available antiretroviral drugs that have all been agreed by the clinical and patient leadership of the National HIV Clinical Reference Group Drugs Sub-Group. This ensures there is opportunity for clinicians to make choices of commissioned treatments which meet the needs of individual patients, whilst being able to maintain an effective overall approach to cost management.
Multisystem autoimmune rheumatic disease	This CQUIN is to support the development of coordinated MDT clinics for patients with multisystem auto-immune rheumatic diseases. This MDT arrangement will also enable longitudinal data collection, particularly of outcome measures using validated tools and the use of patient activation measurement (PAM).
Dental	Collection and submission of data on priority pathway procedures by tier, to participate in referral management and triage, and have active participation in Managed Clinical Networks (MCN).

Registration with the Care Quality Commission (CQC)

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

The CQC has not taken enforcement action against the trust during 2016/17. The trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The CQC undertook a full comprehensive hospital inspection during the week 1-5 February 2016. The trust was rated good overall as a provider and rated good at each hospital site and for each core service at all sites, which is an unprecedented rating for a London trust. (See Part Three for further information on CQC)

Comments from the CQC

Professor Sir Mike Richards, the Chief Inspector of Hospitals

Professor Ted Baker, the Deputy Chief Inspector of Hospitals

Information on the quality of data

Good quality information ensures the effective delivery of patient care and is essential for quality improvements to be made. Improving information on the quality of our data includes specific measures such as recording ethnicity, and other equality data, which will improve patient care and increase value for money.

This section refers to data that we submit nationally.

The Patient's NHS number

A patient's NHS number is the key identifier for patient records. It is a unique 10- digit number, which is given to everyone who is registered with the NHS and allows staff to find patient records and provide our patients with safer care.

The Royal Free London NHS Foundation Trust submitted records during 2016/17 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

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

% of records	2014/15	2015/16	2016/17
For admitted patient care	98.8%	98.6%	98.15%
For out-patient care	99.2%	98.6%	98.65%
For accident & emergency care	92.6%	94.4%	94.89%

General Medical Practice Code

Accuracy is essential when transferring clinical information from the trust to a patient's GP. The percentage of records which included the patient's valid General Medical Practice Code were:

% of records	2014/15	2015/16	2016/17
For admitted patient care	99.8%	99.95%	99.92%
For out-patient care	99.9%	99.96%	100%
For accident & emergency care	99.9%	99.94%	100%

Information Governance (IG)

The Royal Free London NHS Foundation Trust Information Governance assessment report overall score for 2016/7 was 66% and was graded satisfactory

	2014/15	2015/16	2016/17
Information governance assessment report score	70%	68%	66%
Overall grading	**satisfactory**	**satisfactory**	**satisfactory**

Payment by Results

The Royal Free London NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission

Data quality

The trust continues to focus on this area to ensure that high quality information is available to support the delivery of safe, effective and efficient clinical services.

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

We have recently implemented a revised data improvement strategy which sets out how data will be assured in the trust. The strategy sets out:

- A set of principles to support production, and assurance, of high quality data and its management and defines what high-quality data means in practice, along with the national and local information governance standards to which the trust works;

2.4 Reporting against core indicators

This section of the report presents our performance against eight core indicators, using data made available to the trust by NHS Digital. Indicators included in this report, show the national average and the performance of the highest and lowest NHS trust.

Areas covered will include:

1. Summary hospital-level mortality (SHMI)
2. Patient reported outcome measure scores (PROMS)
3. Emergency readmissions within 28 days
4. Responsiveness to the personal needs of our patients
5. Friends and Family test (Staff)
6. Venous thromboembolism (VTE)
7. C difficile
8. Patient safety incidents

Summary hospital-level mortality (SHMI)

Indicator:

(a) The value and banding of the summary hospital-level mortality indicator ('SHMI') for the trust for the reporting period.

Royal Free Performance Jul 12 - Jun 13	Royal Free Performance Jul 13 - Jun 14	Royal Free Performance Jul 14 - Jun 15	Royal Free Performance Jul 15 - Jun 16	National Average Performance Jul 15 - Jun 16	Highest Performing NHS Trust Performance Jul 15 - Jun 16	Lowest Performing NHS Trust Performance Jul 15 - Jun 16
0.8066 (lower than expected)	0.887 (lower than expected)	0.853 (lower than expected)	0.9053 (as expected)	**1.0** (as expected)	0.6939 (lower than expected)	1.1712 (higher than expected)

The trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre.

SHMI (Summary Hospital Mortality Indicator) is a clinical performance measure which calculates the actual number of deaths following admission to hospital against those expected.

The latest data available covers the 12 months to June 2016. During this period the Royal Free had a mortality risk score of 0.9053, which represents a risk of mortality 11.5% lower than expected for our case mix. This represents a mortality risk significantly below (better than) expected with the Royal Free ranked 19th out of 137 non-specialist acute trusts.

The trust has taken the following actions to improve the mortality risk score:
- A monthly SHMI report is presented to the trust board and a quarterly report to the clinical performance committee.

- Any statistically significant variations in the mortality risk rate are investigated, appropriate action taken and a feedback report provided to the trust board and the clinical performance committee at their next meetings.

https://indicators.hscic.gov.uk/webview/

Patient deaths with palliative care code

Indicator:

(b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.

Royal Free Performance Jul 12 - Jun 13	Royal Free Performance Jul 13 - Jun 14	Royal Free Performance Jul 14 - Jun 15	Royal Free Performance Jul 15 - Jun 16	National Average Performance Jul 15 - Jun 16	Highest Performing NHS Trust Performance Jul 15 - Jun 16	Lowest Performing NHS Trust Performance Jul 15 - Jun 16
24.8%	28.4%	25.4%	**25.6%**	**29.5%**	54.8%	0.1%

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

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

The trust intends to take the following actions to improve the mortality risk score and so the quality of its

services:
- Presenting a monthly report to the trust board and a quarterly report to the clinical performance committee detailing the percentage of patient deaths with palliative care coding.

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

https://indicators.hscic.gov.uk/webview/

Patient reported outcome measures scores (PROMS)

Royal Free Performance 2012/13	Royal Free Performance 2013/2014	Royal Free Performance 2014/2015	Royal Free Performance 2015/2016	National Average Performance 2015/2016	Highest Performing NHS Trust Performance 2015/2016	Lowest Performing NHS Trust Performance 2015/2016
Indicator: Groin hernia surgery						
0.07	Low number rule applies	Low number rule applies	Low number rule applies	**0.09**	0.16	0.02
Indicator: Varicose vein surgery						
0.08	Low number rule applies	Low number rule applies	**0.12**	**0.09**	0.15	0.02
Indicator: Hip replacement surgery						
0.38	0.38	0.74	**0.43**	**0.44**	0.51	0.32
Indicator: Knee replacement surgery						
0.26	0.30	0.68	**0.31**	**0.32**	0.40	0.20

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

The NHS asks patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards. This helps hospitals measure and improve the quality of care provided.

http://content.digital.nhs.uk/proms

Emergency readmissions within 28 days

Indicator:

The percentage of patients readmitted to a one of our hospitals within 28 days of being discharged from our trust during the reporting period.

Royal Free Performance 2012/2013	Royal Free Performance 2013/2014	Royal Free Performance 2014/2015	Royal Free Performance Calendar Year 2016	National Average Performance 2015/2016	Highest Performing NHS Trust Performance 2015/2016	Lowest Performing NHS Trust Performance 2015/2016
Patients aged 0 to 15 years old						
4.31	4.03	NHS digital reports not available	6.67%	**8.77%**	10.73%	2.03%
Patients aged 16 years old or over						
8.21	7.52	NHS digital reports not available	6.79%	**8.00%**	11.03%	5.92%

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from Dr Foster, a leading provider of healthcare variation analysis and clinical benchmarking, and compared to internal trust data. The Dr Foster data set used in this table shows our performance against non-specialist providers throughout England.

We carefully monitor the rate of emergency readmissions as a measure for quality of care and appropriateness

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

The rate of readmissions at the trust for children is significantly lower (better) than expected with a relative risk of 17.31%. The readmission rate is ranked 38th lowest of the 136 non-specialist acute providers in England.

Comparatively, the rate of readmissions across the trust is 6.79% which is 10th lowest amongst non-specialist providers in England. The relative risk of a readmission within 28 days of a previous discharge is significantly lower than expected at 9.75%.

http://content.digital.nhs.uk/article/6965/Domain-3---Helping-people-to-recover-from-episodes-of-ill-health-or-following-injury

Responsiveness to the personal needs of our patients

Indicator:

The trust's responsiveness to the personal needs of its patients during the reporting period.

Royal Free Performance 2012/2013	Royal Free Performance 2013/2014	Royal Free Performance 2014/2015	Royal Free Performance 2015/2016	National Average Performance 2015/2016	Highest Performing NHS Trust Performance 2015/2016	Lowest Performing NHS Trust Performance 2015/2016
65.6	67.4	68.6	69.9	**69.6**	86.2	58.9

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

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

Friends and Family Test (Staff)

Indicator:

The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.

Royal Free Performance 2013	Royal Free Performance 2014	Royal Free Performance 2015	Royal Free Performance 2016	National Average Performance 2016	Highest Performing NHS Trust Performance 2016	Lowest Performing NHS Trust Performance 2016
76%	71%	72%	**75%**	**70%**	85%	49%

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

Each year the NHS surveys its staff and one of the questions looks at whether or not staff would recommend their hospital as a care provider to family or friends. The trust performs significantly better than the national average on this measure.

Trust activities to enhance engagement of staff have resulted in an increase of the percentage of staff who would recommend their hospital as a care provider to family or friends.

The trust has implemented a world class care programme embodying these core values; welcoming, respectful, communicating and reassuring. These are the four words which describe how we interact with each other and our patients. For the year ahead the continuation of our world class care programme anticipates even greater clinical and staff engagement.

http://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2016/

Venous thromboembolism (VTE)

Indicator:

The percentage of patients who were admitted to hospital and risk assessed for venous thromboembolism during the reporting period.

Royal Free Performance Oct 13 - Dec 13	Royal Free Performance Oct 14 - Dec 14	Royal Free Performance Oct 15 - Dec 15	Royal Free Performance Oct 16 - Dec 16	National Average Performance Oct 16 - Dec 16	Highest Performing NHS Trust Performance Oct 16 - Dec 16	Lowest Performing NHS Trust Performance Oct 16 - Dec 16
98.0%	96.1%	97.1%	**96.6%**	**94.5%**	100.0%	76.5%

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

data.

The Venous Thromboembolism (VTE) data presented in this report is for the period July to September 2014 and October to December 2014. On 1 July 2014 the trust acquired Barnet and Chase Farm Hospitals NHS Trust. Therefore the period reported includes VTE data for all trust sites including the Royal Free, Barnet and Chase Farm Hospitals.

Many deaths in hospital result each year from Venous Thromboembolism (VTE), which are potentially preventable. The government has therefore set hospitals a target requiring 90% of patients to be assessed in relation to risk of VTE.

The trust performed better than the 95% national target and the national average, achieving 96.6%.

We intend to take the following actions to improve our VTE risk assessment rate:

- The trust reports its rate of hospital-acquired thromboembolism (HAT) to the monthly meeting of the trust board and the quarterly meeting of the clinical performance committee.
- Any significant variations in the incidence of HAT are subject to investigation with a feedback report provided to the trust board and clinical performance committee at their next meetings. In addition the thrombosis unit conduct a detailed clinical audit into each reported case of HAT. Findings were shared with the wider clinical community.

https://www.england.nhs.uk/statistics/statistical-work-areas/vte/vte-risk-assessment-201617/

C. difficile

Indicator:

The rate per 100,000 bed days of cases of C. difficile infection that have occurred within the trust amongst patients aged 2 or over.

Royal Free Performance Oct 12 - Mar 13	Royal Free Performance Oct 13 - Mar 14	Royal Free Performance Oct 14 - Mar 15	Royal Free Performance Oct 15 - Mar 16	National Average Performance Oct 15 - Mar 16	Highest Performing NHS Trust Performance Oct 15 - Mar 16	Lowest Performing NHS Trust Performance Oct 15 - Mar 16
2,528 (6.3)	2,422 (6.9)	5,734 (34.7)	5,915 (36.5)	**3,643 (47.9)**	11,998 (40.9)	334 (16.1)

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

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

Royal Free London performance was significantly higher (worse) than the national average during 2012/13. While the rate has reduced significantly it remains above the national average during 2013/14. More recent internal trust data for the period 2014/15 demonstrates that for the period April 2014 to February 2015 the Royal Free Hospital had recorded 25 infections against a plan of 35 and was therefore compliant with its national trajectory. However it should be noted that during this period the trust acquired Barnet and Chase Farm Hospitals NHS Trust, and with those sites included the trust recorded more infections that its annual plan.

The trust intends to take the following actions to reduce the rate of C. difficile infections:

- In order to demonstrate robust governance and ensure performance improvement during 2013/14 the trust asked for independent scrutiny, via a national expert of our infection control processes. The trust also invited two other national experts to review adherence to infection control policy. The action plan arising from the reviews has been considered and fully implemented.
- In addition the trust is ensuring that all staff adhere to the trust's infection control policies, including hand hygiene and dress code.

https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data%20

Patient safety incidents

Indicator:

(a) The number and rate of patient safety incidents that occurred within the trust during the reporting period and;
(b) The number and percentage of such patient safety incidents that resulted in severe harm or death.

Royal Free Performance Oct 12 - Mar 13	Royal Free Performance Oct 13 - Mar 14	Royal Free Performance Oct 14 - Mar 15	Royal Free Performance Oct 15 - Mar 16	National Average Performance Oct 15 - Mar 16	Highest Performing NHS Trust Performance Oct 15 - Mar 16	Lowest Performing NHS Trust Performance Oct 15 - Mar 16
2,528 (6.3)	2,422 (6.9)	5,734 (34.7)	5,915 (36.5)	**3,643 (47.9)**	11,998 (40.9)	334 (16.1)
25 (0.99%)	22 (0.91%)	43 (0.75%)	26 (0.44%)	**20.09 (0.55%)**	0 (0.00%)	119 (3.00%)

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the National Reporting and Learning System (NRLS).

The National Patient Safety Agency regards the identification and reporting of incidents as a sign of good governance with organisations reporting more incidents potentially having a better and more effective safety culture. The trust reported significantly less incidents than the national average during October 2013 to March 14.

The trust has implemented a number of actions to improve the quality and coverage of reporting:

1) The trust purchased a web-based reporting tool with the aim of simplifying the process for staff to report incidents and to export data to NRLS. Experience from other trusts has indicated that the introduction of a web-based tool significantly increases the volume of forms submitted by staff. The web-based system went live during February 2013.

2) In addition the trust has developed a patient safety campaign with the aim of focusing on improving the patient safety culture, including encouraging staff to report incidents and providing timely feedback to staff on the outcomes and learning resulting from incident investigations.

We have robust processes in place to capture incidents. However there are risks at every trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on every incident being reported. Whilst we have provided training to staff and there are various policies in place relating to incident reporting, this does not provide full assurance that all incidents are reported. We believe this is in line with all other trusts. There is also clinical judgement in the classification of an incident as 'severe harm' as it requires moderation and judgement against subjective criteria and processes. This can be evidenced as classifications can change once they are reviewed. Therefore, it could be expected that the number of severe incidents could change from that shown here due to this review process.

https://indicators.hscic.gov.uk/webview/

Part three: review of quality performance

This section of the quality report presents an overview of the quality of care offered by the trust based on performance in 2016/17 against indicators and national priorities selected by the board in consultation with our stakeholders.

Our external auditors PricewaterhouseCoopers LLP (PwC) are required under NHS Improvement requirements for quality reports; *Detailed Guidance for External Assurance on Quality Reports'* to perform testing on two national indicators. A detailed definition and explanation of the criteria applied for the measurement of the indicators tested by PwC is included below.

(This section will be completed following external assurance from our auditors which will be undertaken in April 2017)

3.1 Overview of the quality of care in 2016/17

In 2016/17, the trust has continued to address some of the challenges it has faced since the acquisition of Barnet and Chase Farm Hospitals in July 2014. In the case of the 18 week Referral to Treatment (RTT) and 6 week diagnostics waiting time standards, significant progress has been made as a result of work to validate historically poor data and to clear backlogs. The trust returned to standard against diagnostics in March 2016 and we anticipate compliance for the year. It also returned to standard against RTT in June 2016 and has been compliant since.

The trust has continued work to improve our cancer pathways, with a full recovery programme for the 62-day GP referral to first treatment waiting times standard in operation since July 2016. Progress to date has seen performance sustained above 80% since November and the trust is working towards compliance with the 85% standard by the beginning of 2017/18. Particular progress has been made in ensuring prostate cancer patients receive diagnostic imaging and biopsies on the same day, significantly reducing waiting times.

Performance against the four hour Accident and Emergency (A&E) waiting time standard over 2016/17 has continued to be challenging and the trust is currently ranked 10th in comparison to other London A&E providers. The trust is working closely with its system partners to deliver a programme of work that will address these issues in 2017/18.

We are ranked between seventh and ninth best performing against the two main measures of mortality risk compared to our peer group of 26 English teaching trusts.

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

Our estate modernisation programme has continued with the first two phases of the new emergency department redevelopment being completed and open to the public. The new dedicated paediatric department, ambulatory emergency care and temporary short stay wards opened in August 2016 and the new waiting room and reception area were commissioned in February 2017. The Chase Farm Hospital new build is currently on schedule to open in autumn 2018.

Our focus for 2017/18 is to ensure that all parts of our trust can reach and maintain the standards of our best services. The group model developments, including the new clinical practice groups, will be core to delivering this. Our key challenge will be to return to compliance with the A&E four-hour standard while maintaining performance against the other waiting time standards.

3.2 Performance against key national indicators

The charts and commentary contained in this report represents the performance for all three of our hospitals (i.e. including the performance in aggregated form across all sites where services are provided by the trust). This approach has been taken to ensure consistency with the prescribed indicators the trust is mandated to include in the quality accounts. The prescribed indicators data is sourced from the Health and Social Care Information Centre where in the majority of cases data is also aggregated.

Where possible, performance is described within the context of comparative data which illustrates how the performance at the trust differs from that of our peer group of English teaching hospitals. The metrics reproduced in this section are a list of well-understood metrics that help measure clinical outcomes, operational efficiency, waiting times and patient safety.

The Trust presents a number of non-prescribed indicators that describe our performance on a number of indicators that cover; patient safety, clinical effectiveness and patient experience.

Relevant quality domain	Quality performance indicators
Patient safety	• summary hospital mortality indicator (SHMI) • hospital standardised mortality ratio (HSMR) • methicillin-resistant staphylococcus aureus (MRSA) • C. difficile
Clinical effectiveness	• referral to treatment (RTT) • Accident and Emergency performance • day case rate • in- patient length of stay • cancer waits • readmissions
Patient experience	• last minute cancellations • delayed transfer of care • friends and family test

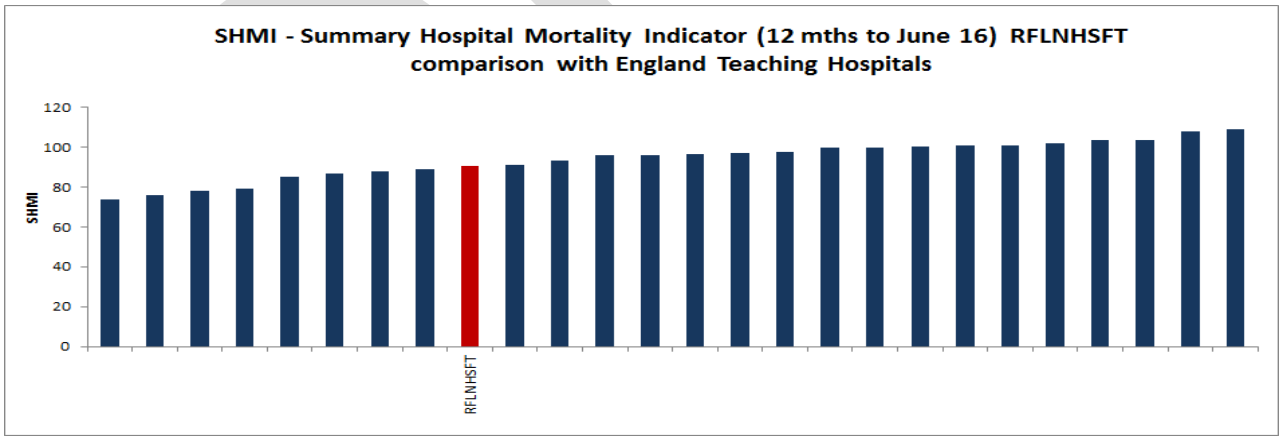
Summary of our performance against key national indicators

Our **SHMI** ratio was **90.53 or 9.47% better than expected.** For this period the Royal Free had the **9th** lowest relative risk of mortality amongst the 26 large England teaching hospitals	We recorded the **7th** lowest relative risk of mortality **(HSMR)** of any English teaching trust with a relative risk of mortality of **92.36** which is **7.64%** below (statistically significantly better than expected)	Against the 25 teaching trusts, the Trust is ranked **8th** lowest with **a rate of 1.21 MRSA bacteraemias per 100,000** bed days
For **C.diff**. the trust is ranked **23rd** out of **25** English Teaching Hospitals for the 12 month period to end January 2017 with **a reported rate of 41.8** per 100,000 bed days	The trust **returned to compliance** against the **(RTT)** incomplete pathway standard in **June 2016** and continues to maintain compliance	During the period April 2016 to January 2017, we achieved **87.92%** compliance against the **95% 4 hour standard** for our **A&E performance**

We **performed better than the national targets** in relation to the **two week** and **31** day cancer waiting time standards.	We treated **84.7%** of elective admissions as **day cases**; this was the **highest proportion** across the group of large teaching providers	We reported the **10th lowest** average **length of stay** across the large teaching provider peer group.
The trust **underperformed** against the **62** day cancer waiting time standard.	As a ratio, the trust rate of **0.2%** is the **eighth** lowest **rate of cancellations** across the English teaching hospitals peer group	**30%** of the **delayed transfers of care** observed across the trust were attributable to social care delays

Patient Safety

Summary Hospital Mortality Indicator (SHMI)

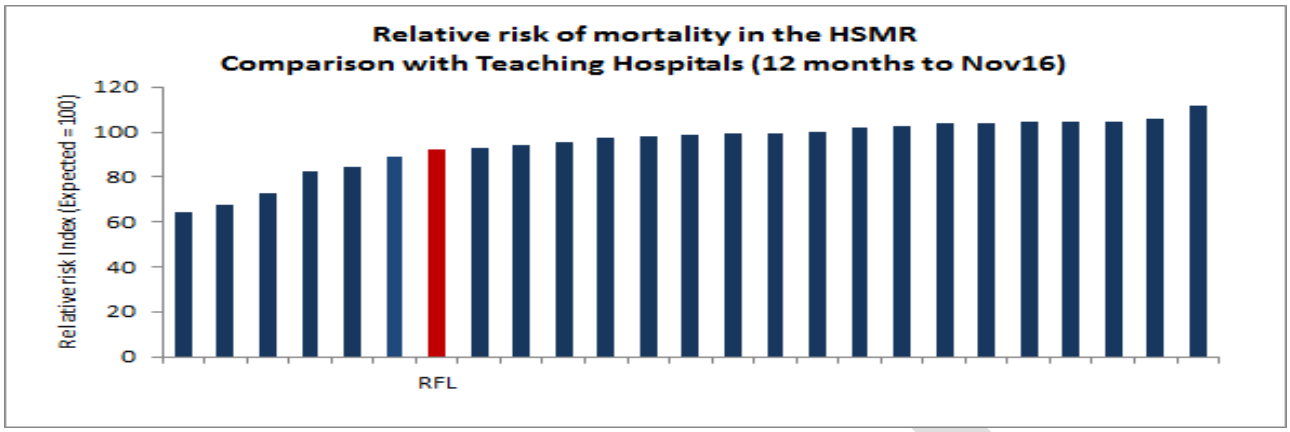


SHMI (Summary Hospital Mortality Indicator) is a clinical performance measure which calculates the actual number of deaths following admission to hospital against those expected. This expression of mortality risk includes all diagnoses and mortality occurring up to 30 days post discharge.

The observed volume of deaths is shown alongside the expected number (casemix adjusted) and this calculates the ratio of actual to expected deaths to create an index of 100. A relative risk of 100 would indicate performance exactly as expected. A relative risk of 95 would indicate a rate 5% below (better than) expected with a figure of 105 indicating a performance 5% higher (worse than) expected. SHMI data is presented for the 12-month period ending June 2016 and therefore covers the period post-acquisition of Barnet and Chase

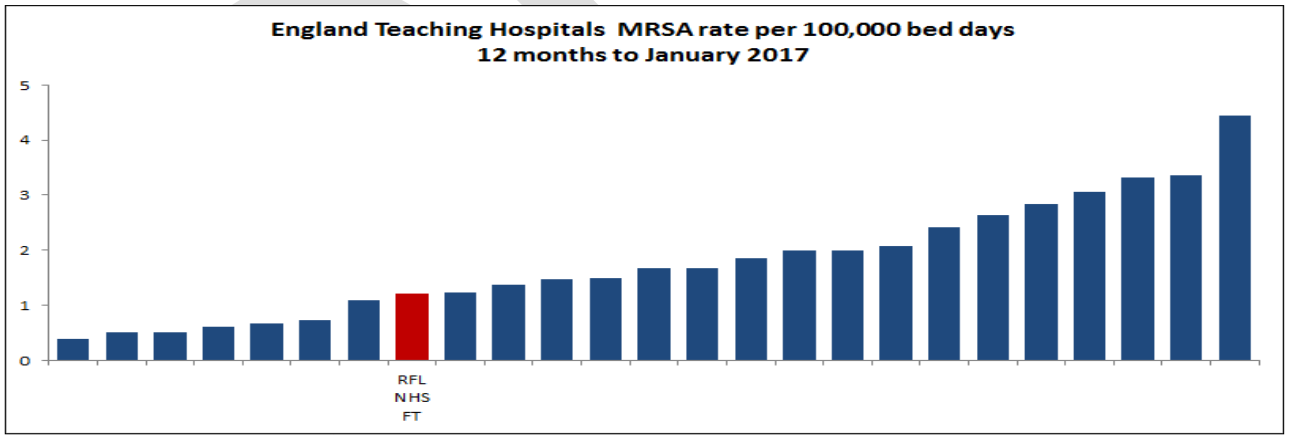
Farm Hospitals NHS Trust. During this time, the trust SHMI ratio was 90.53 or 9.47% better than expected and we had the 9th lowest relative risk amongst the 26 large English teaching hospitals (Data source: Dr Foster Intelligence/Health and Social Care Information Centre).

Hospital Standardised Mortality Ratio (HSMR)



The HSMR (Hospital Standardised Mortality Ratio) includes 56 diagnoses responsible for 80% of deaths and only includes in-hospital mortality. Data shows that for the 12 months to the end of November 2016, the trust recorded the 7th lowest relative risk of mortality of any English teaching trust with a relative risk of mortality of 92.36, which is 7.64% below (statistically significantly better than expected). (Data source: Dr Foster Intelligence/Health and Social Care Information Centre).

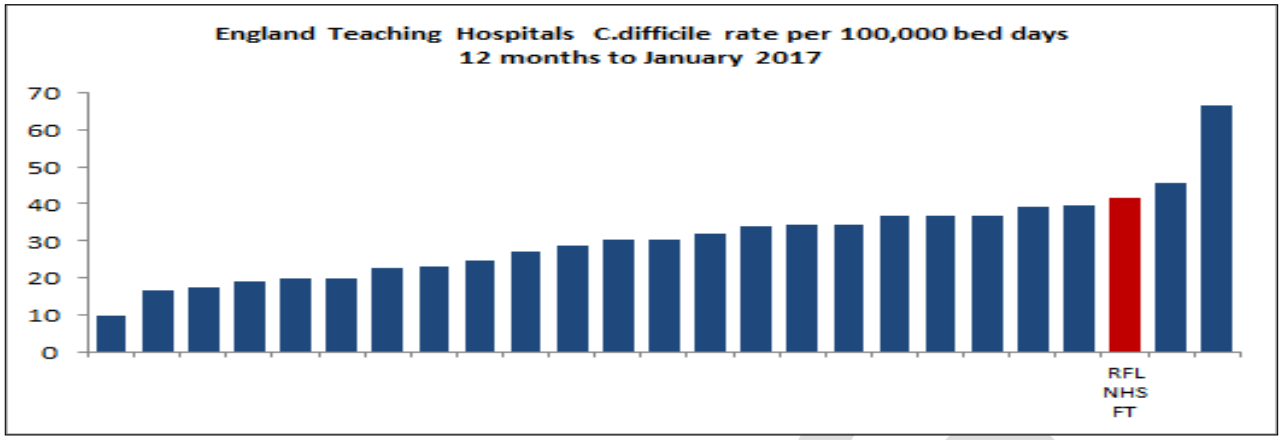
Methicillin-resistant staphylococcus aureus (MRSA)



MRSA is an antibiotic resistant infection associated with admissions to hospital. The infection can cause an acute illness particularly when a patient's immune system may be compromised due to an underlying illness.

Reducing the rate of MRSA infections is key in ensuring patient safety and is indicative of the degree to which hospitals prevent the risk of infection by ensuring cleanliness of their facilities and good infection control compliance by their staff. In the 12 months to the end of January 2017 the Royal Free London reported two MRSA bacteraemias. Against the 25 teaching trusts, the trust is ranked 8th lowest with a rate of 1.21 bacteraemias per 100,000 bed days (Data source: Public Health England).

C. difficile



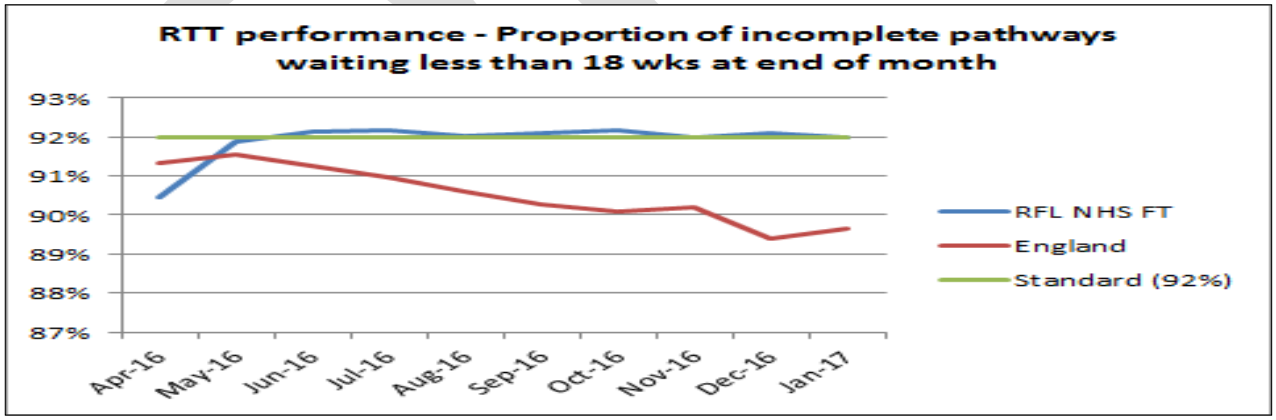
In relation to C. difficile the trust's regulator, Monitor, assesses performance for those infections deemed to result from lapses in care.

The trust has been compliant with its national trajectory for the entirety of 2015/16, ranked 23rd out of 25 English teaching hospitals for the 12-month period ending January 2017 with a reported rate of 41.8 per 100,000 bed days.

It is important to note that the objective for C. difficile cases in 2016-17 was rolled over from 2015-16 and remained at 66 cases. The rate represented by our numerical objective is 41.9 infections per 100,000 bed days. The Trust is therefore compliant with this objective for the most recent 12-month period for which data is available. (Data source: Public Health England).

Clinical Effectiveness

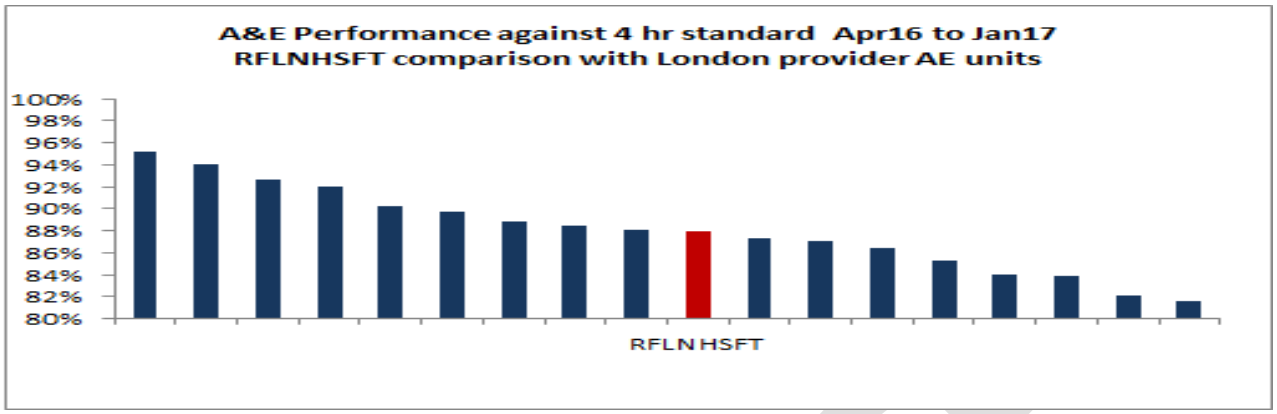
Referral to treatment (RTT)



In England, under the NHS Constitution, patients have the right to access consultant-led services within a maximum waiting time of 18 weeks. This is known as referral to treatment (RTT) and we report our performance to the Government on a monthly basis.

There is one single national measure of performance, incomplete pathways (patients waiting for treatment), with the expectation that 92% of patients will have been waiting less than 18 weeks at the end of each month. The trust returned to compliance against the incomplete pathway standard in June 2016 and continues to maintain compliance (Data source: National Health Service England).

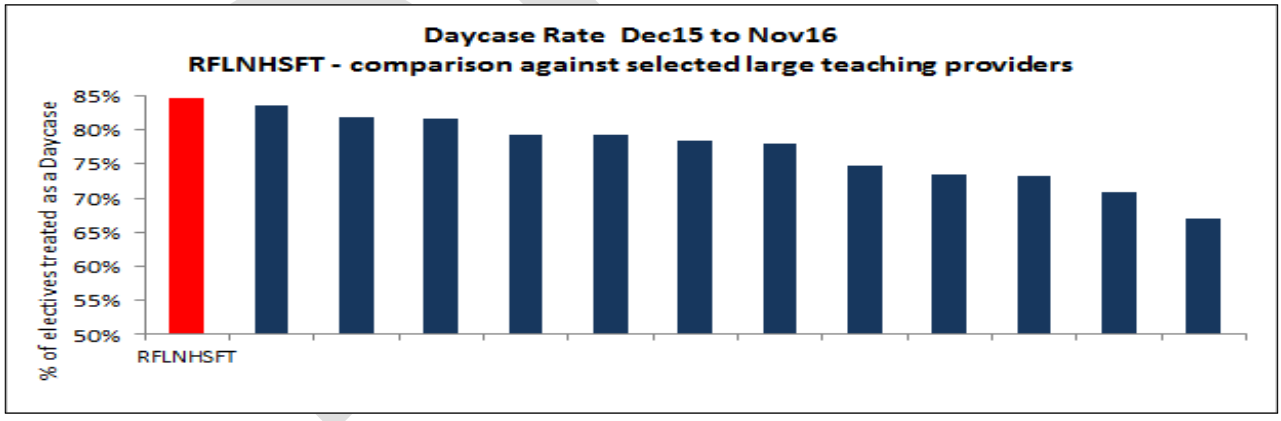
A&E performance



The graph summarises the Royal Free London's performance in relation to meeting the 4-hour maximum waiting time standard set against the performance of London A&E departments. The national waiting time standard requires trusts to treat, transfer, admit or discharge 95% of patients within 4 hours of arrival. A higher percentage in the graph is indicative of shorter waiting times. During the period April 2016 to January 2017, the trust achieved 87.92% compliance against the 95% 4-hour standard. Pressure on A&E has been increasing with more people than ever before selecting Accident and Emergency as their preferred means of accessing urgent healthcare.

In response the trust has invested heavily in modernising and extending its emergency service. This includes completely rebuilding the Royal Free Hospital A&E department. (Data source: National Health Service England).

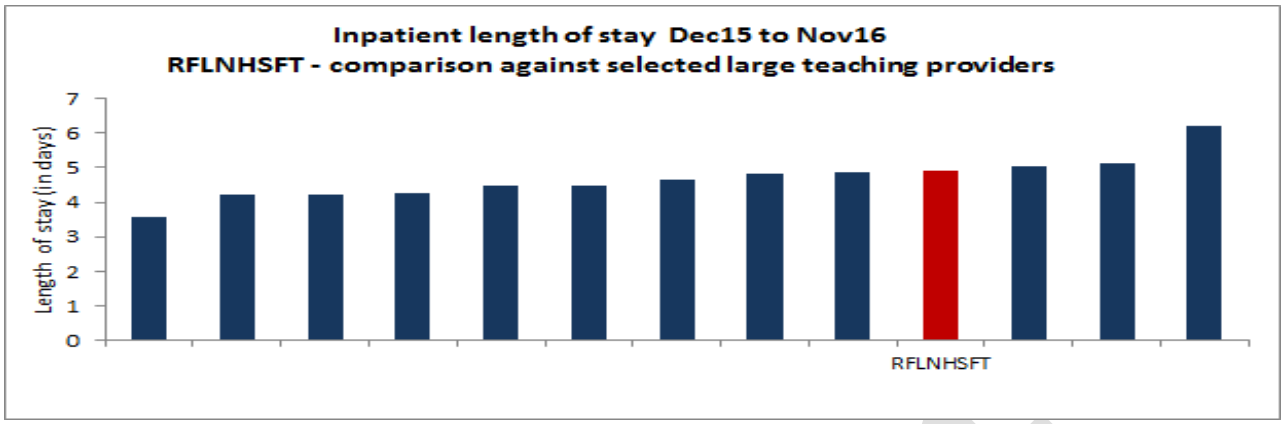
Day case rate



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

During the period covering December 2015 to November 2016, the trust treated 84.7% of elective admissions as day cases, which was the highest proportion across the group of large teaching providers. (Data source: Dr Foster Intelligence Ltd).

In-patient length of stay

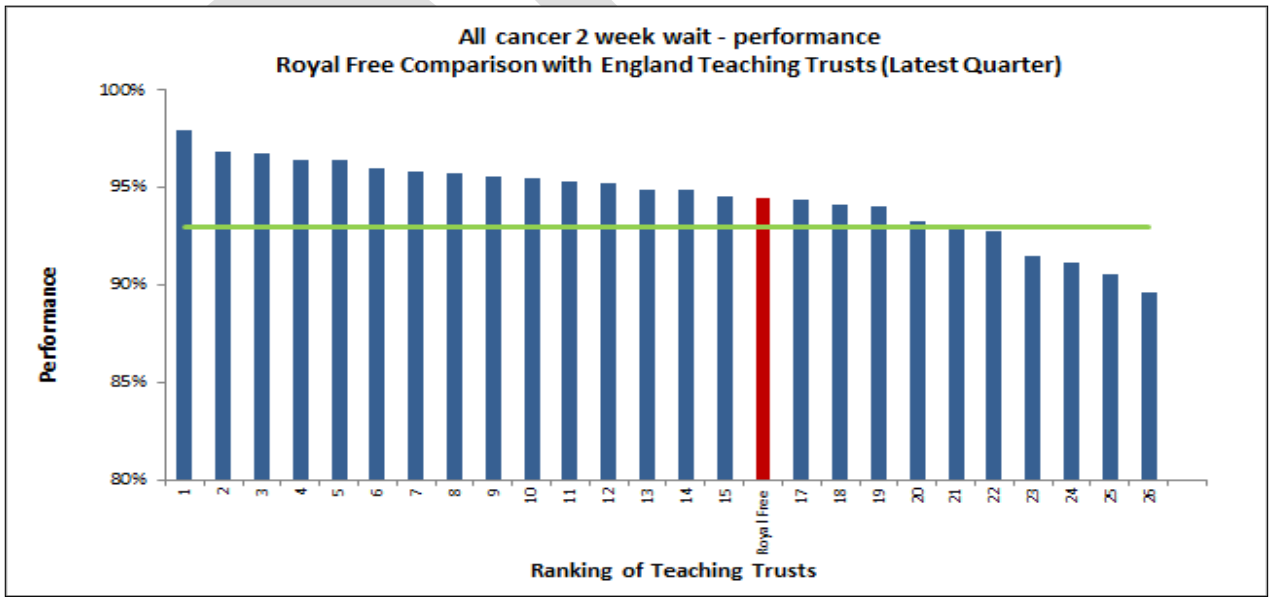


Length of stay is also an important efficiency indicator with, in most cases, a shorter length of stay being indicative of well-organised and effective care. A shorter length of stay can also result in better outcomes with a reduced infection risk. Between December 2015 and November 2016, the trust reported the 10th lowest average length of stay across the group of large teaching providers.

We can analyse our actual length of stay against an expected value once our acuity and patient demographic are taken into account. Our length of stay for this period was 4.9 days against an expected 5.5 days. (Data source: Dr Foster Intelligence Ltd).

Cancer waits

All cancer 2 week waits



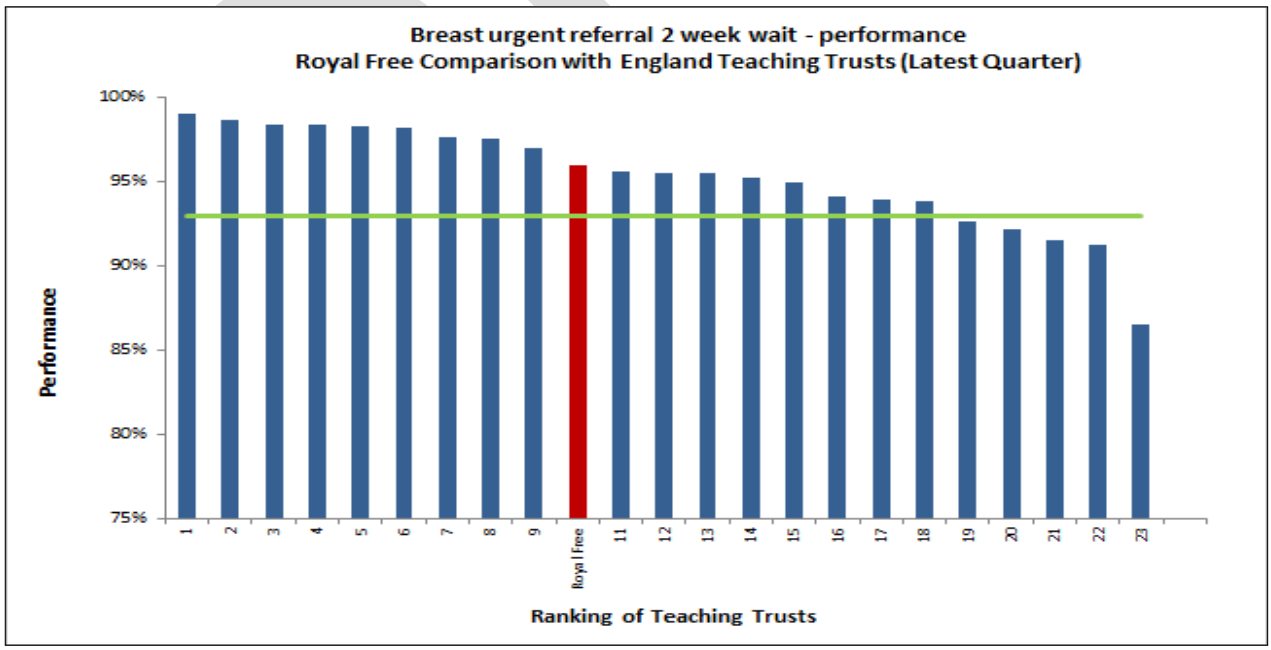
Clinical evidence demonstrates that the sooner patients urgently referred with cancer symptoms are assessed diagnosed and treated the better the clinical outcomes and survival rates.

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

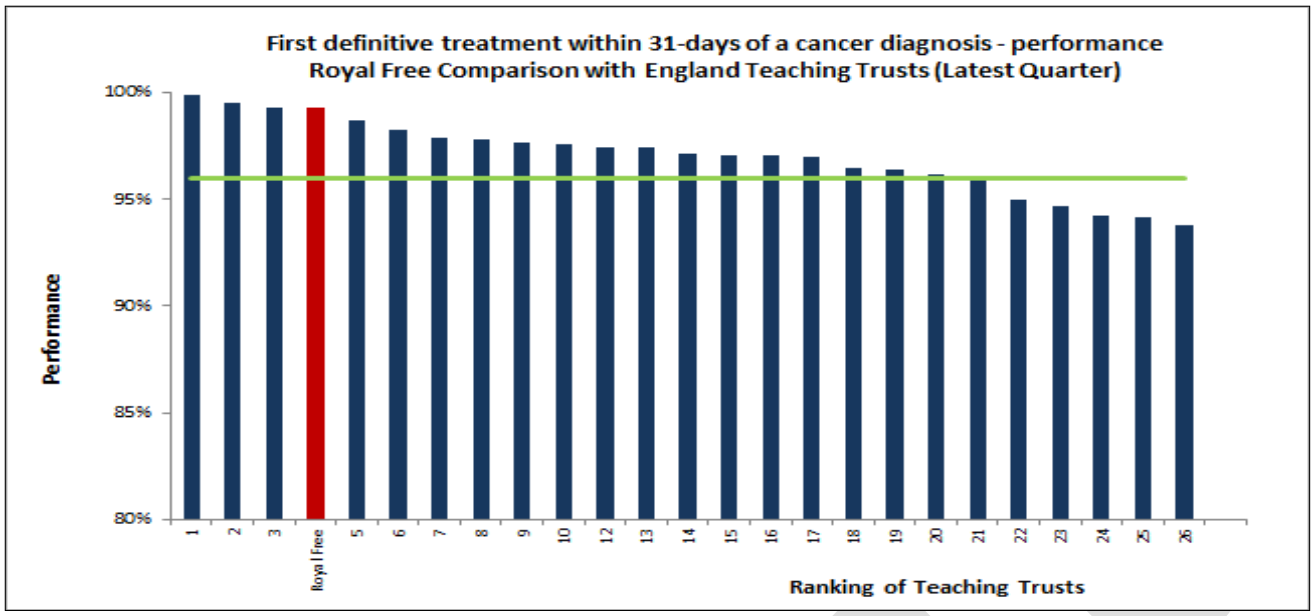
National data is provided for the period October 2015 to December 2015, which is the most recent available.

The trust performed better than the national targets in relation to the two-week wait and 31 day standards in this time period.

Breast Urgent referral two week waits



First definitive treatment within 31 days



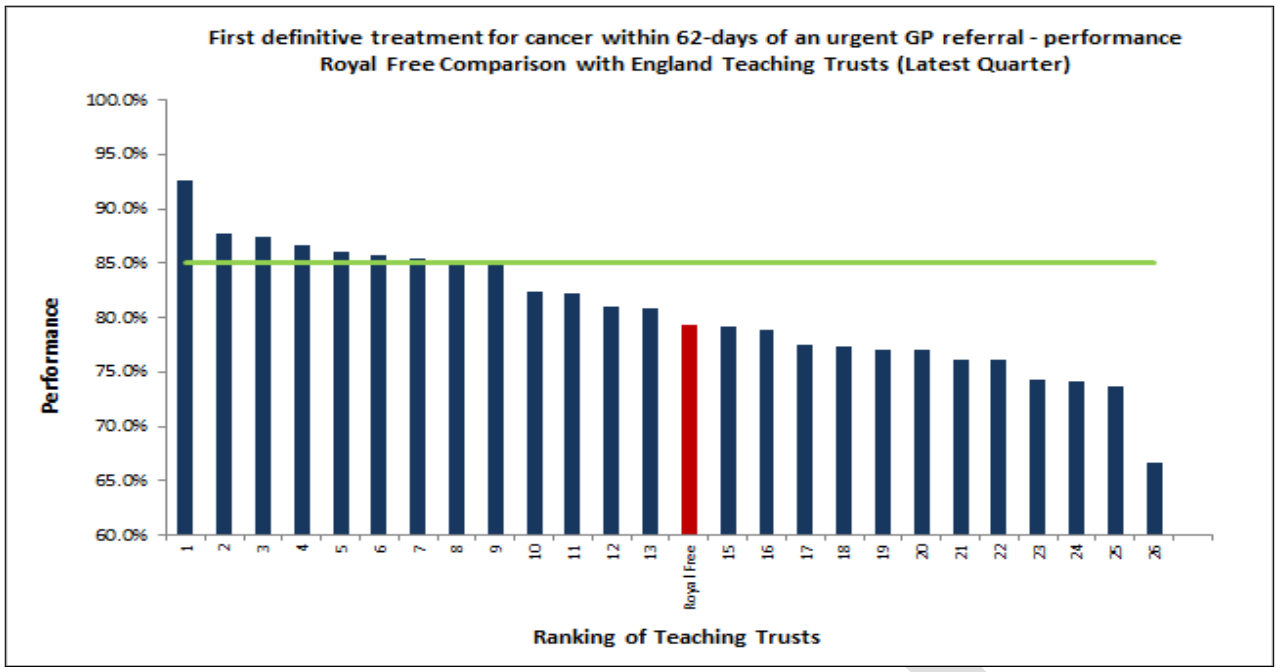
The trust underperformed against the 62 day standard.

Underperformance is being driven by a backlog across a number of tumour sites, most notably urology where there has been significant capacity issues in the diagnostic and tertiary centre surgical stages of treatment. Specific issues in both the urology and skin pathway, such as imaging and biopsy diagnostic clinics, have been addressed, as have extended waiting times at tertiary treatment centres. Waiting times for initial referral to first appointment two-week waits and waits for diagnosis are improving as a result. However the trust is still working through a considerable backlog, which built up prior to the implementation of the improvement programmes.

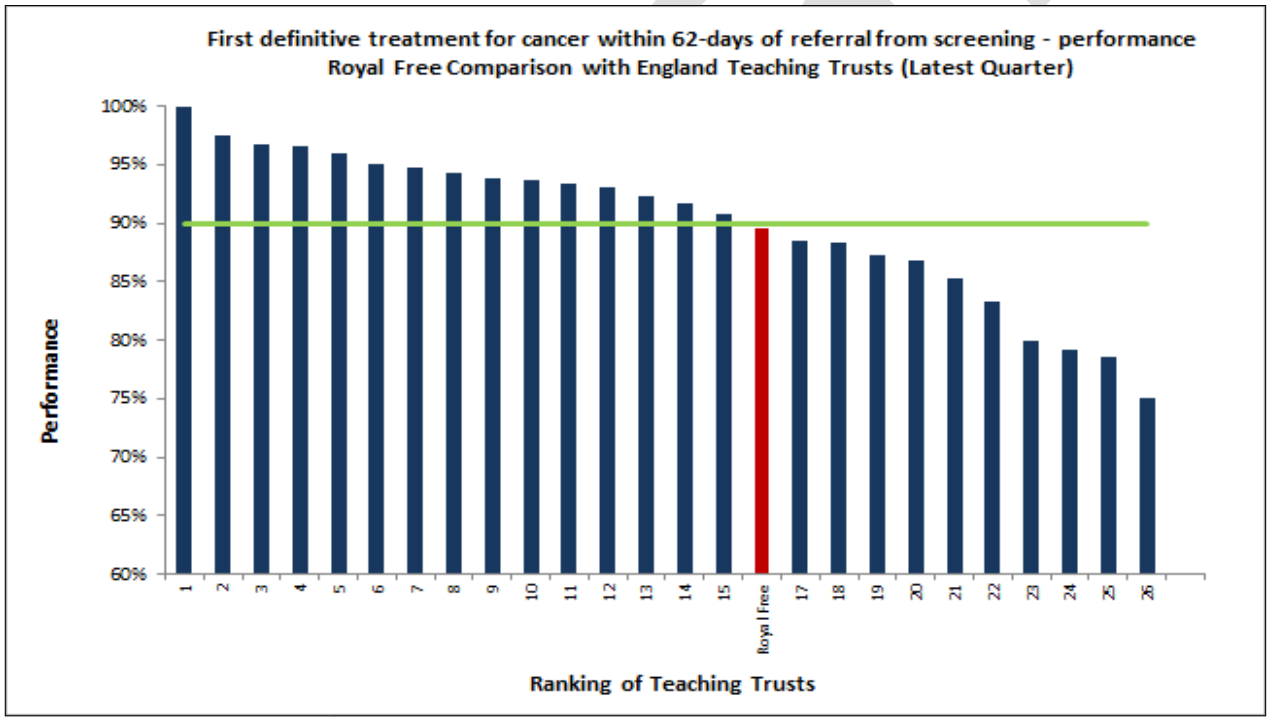
In response the trust has set out a detailed recovery plan to deliver a sustainable waiting list by the end of March 2016 and a return to national target compliance from April 2016.

The graphs present the trust performance compared to English teaching trusts and the relevant national target (Data source: National Health Service England).

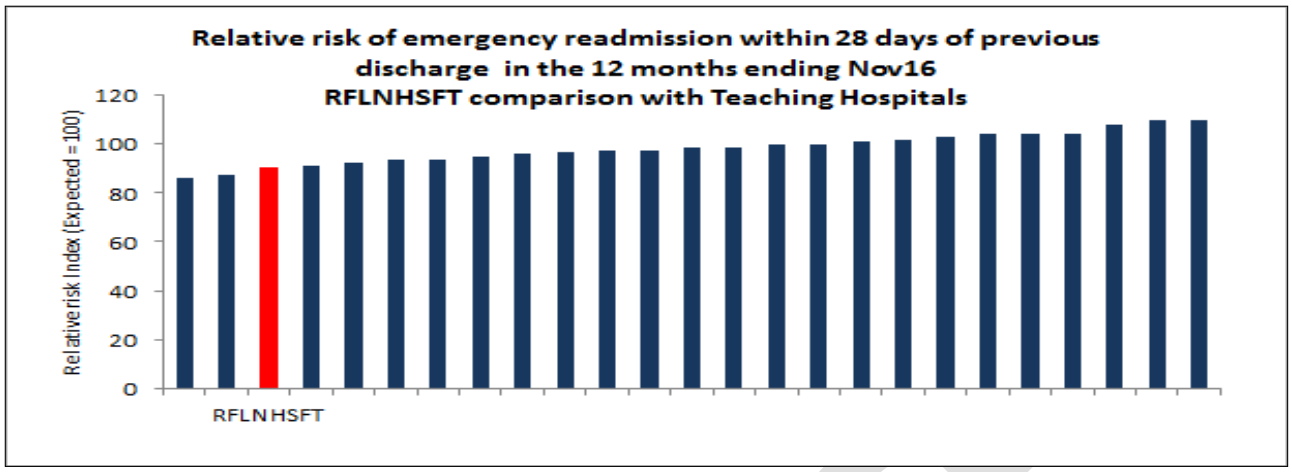
First definitive treatment within 62 days of an urgent GP referral



First definitive treatment within 62 days of referral from screening



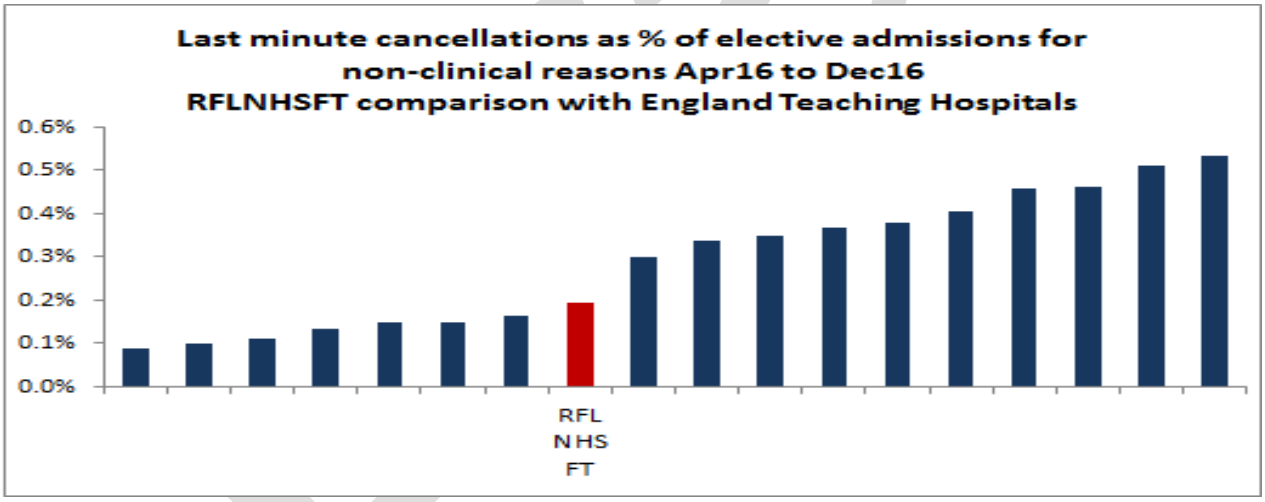
Readmissions



The trust carefully monitors the rate of emergency readmissions as a measure for quality of care and the appropriateness of discharge. The hospital is working with commissioners, GPs and local authorities to provide post discharge support in order to reduce the rate of readmissions.
A low, or reducing, rate of readmission is seen as evidence of good quality care.
The chart presents the rate over the 12-month period shown where the trust had the third lowest relative risk of readmission across the group of 25 English teaching hospitals (Data source: Dr Foster Ltd).

Patient experience indicators

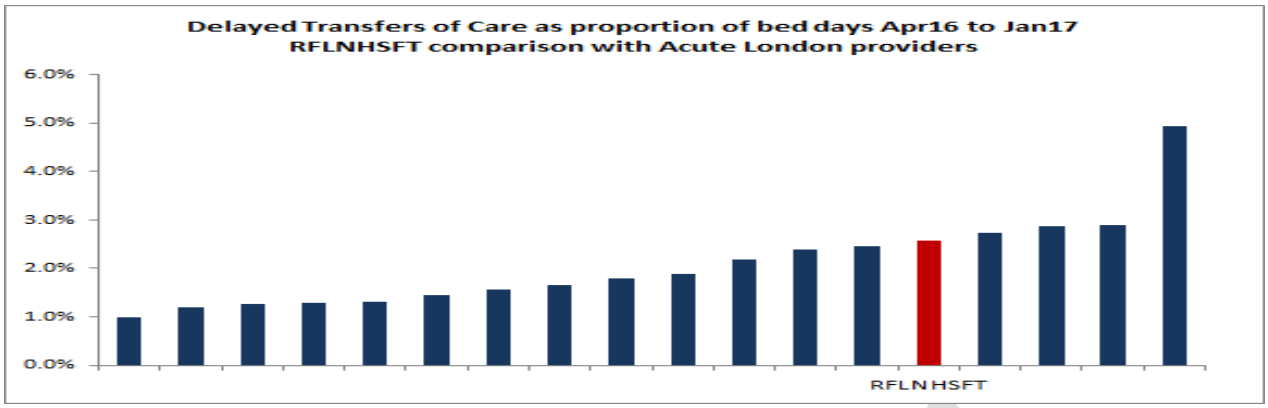
Last minute cancellations



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

From April 2016 to December 2016, the trust cancelled admission for 294 patients at the last minute for non-clinical reasons. This translates into a rate of 1.9 cancellations per 1,000 admissions. The trust rate of 0.2% is the eighth lowest rate of cancellations across the English teaching hospitals peer group (Data source: NHS England).

Delayed transfer of care



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

This causes a waste of hospital resources and inappropriate care for the patient. The aim, therefore, is to reduce the rate of delayed transfers. 30% of the delayed transfers of care observed across the trust were attributable to social care delays (Data source: NHS England).

Friends and family test (patients)

The Friends and Family Test (FFT) was introduced in April 2013. Its purpose is to track and improve patient experience of care. Across England the survey covers 4,500 NHS wards and 144 Accident and Emergency services.

We are not commissioned to provide community services under the auspices of a community services contract or any of those services that are associated with a community provider. However we do provide services in the community, largely out-patient and ambulatory, based across Camden, Barnet and Enfield.

(Data to follow)

3.3 Our local improvement plans

This section contains additional areas of our local improvement plans and data on our performance with our cancer targets.

This also includes:

- Chase Farm redevelopment
- Care Quality Commission (CQC)
- Patient safety
- NHS staff survey (KF21 and KF26)
- Complaints

Throughout 2016/17 we have undertaken additional measures to support our delivery of world class expertise and local care and plans are in place to drive this.

Chase Farm redevelopment - health and wellbeing programme

The acquisition of the Chase Farm Hospital site by the trust gave us an opportunity to help promote the health and wellbeing of the patients using our services, the staff working on the site and the local community.

The Public Health White Paper (2010) stressed the importance of joined up services and tackling the major causes of health and disability in our community. The Royal Free London is committed to working with partners not only to treat people in poor health, but to look at ways in which we can prevent ill health and improve outcomes for people.

We have developed a health and wellbeing plan for Chase Farm setting out our approach to improving the health and wellbeing of the population using Chase Farm Hospital and the community living around it.

To help deliver the plan we set up a multi-agency group with the following aim:

To oversee implementation and delivery of the health and wellbeing programme including joint working with partner agencies.

This includes the following:

1) The trust has a role to promote the health of the local population, its patients and staff.
2) A healthier environment is good for patients, staff and communities.
3) Working in partnership with the local council, NHS and third sector partners to ensure our programme of work reflects and supports local health need.

This group has membership from Chase Farm staff, the London Borough of Enfield public health team, a local councillor, and local charity groups including the London Borough of Enfield carers group, Health Watch Enfield and Macmillan cancer charity.

Outcomes achieved in 2016:

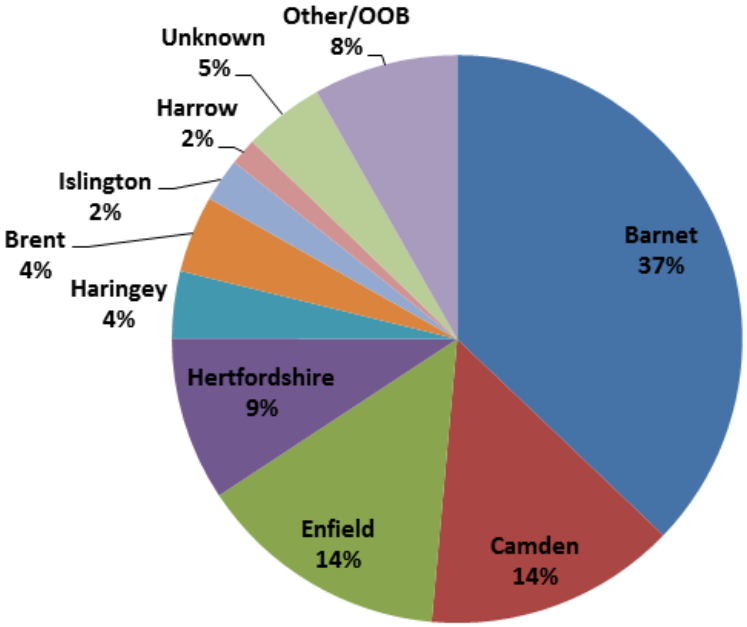
For patients:

- A stop smoking advisor for patients, staff and construction workers is in place. So far they have seen 288 referrals - 83 were Enfield residents and seven members of staff (three of whom are also Enfield residents).

- An Independent Domestic and Sexual Violence Advisor (IDSVA) is in place and training is taking place with staff to encourage them to ask about domestic abuse and refer patients. The service for Chase Farm has been in place since October 2016. Since then there has been 15 referrals from Chase Farm Hospital directly but in total 14% (525) of the service referrals are Enfield residents.

- The highest proportion of referrals comes from the trust's main catchment areas: Barnet, Camden, Enfield and Hertfordshire. Three in four of all referrals (75%) reside in one of these areas. 37% of referrals were from Barnet, 14% from Camden, 14% from Enfield and 9% from Hertfordshire.

Graph: Proportion of DV referrals by borough of residence: Q2 2015/16 to Q3 2016/17 (Source: Royal Free London)



Staff health initiatives:

- Initial discussions have begun on training staff on 'making every contact count' and introducing a social prescribing pilot at Chase Farm where people are linked up with support within the community.
- Weekly walk now in place for staff organised by Tottenham Hotspur Football Club and Macmillan (free piece of fruit for all walkers!).
- Weekly on site discounted yoga classes for staff – average of 14 participants per class.
- Weekly discounted pilates class now on site.
- Health checks for staff – 85 participants seen so far for checks on BMI, cholesterol, glucose and blood pressure. A health trainer who is present every Thursday has set a programme in place for 12 staff.
- New Year event to be held on 31 January where staff can sign up for a boot camp, Shape Up with Spurs, Slimming World vouchers, a free health check, the Royal Free Step Challenge and a walking trip to Mount Snowden.
- Healthy café offering free fruit if you spend £4 or more.

In September, as part of NHS Healthy Living Week, an outdoor green gym and café was opened at Chase Farm for patients, staff and visitors.

Service moves and improvements

Through working with Health Watch we have significantly improved disabled access for patients and carers at Chase Farm. In addition we have moved cardiology and echo services so they are now side by side. Our preoperative assessment area has been moved from a building in a poor state of repair to the Highlands building which is within the main body of the hospital.

Our very busy phlebotomy service has not only moved to much better facilities but has started an appointment service. For patients attending, waiting times are now much reduced leading to a far more responsive service, which in turn has reduced complaints.

The endoscopy service has moved to a brand new building in order to be able take on the additional demands created by the implementation of new screening programmes.

We have been limited in our improvements within the constraints of an old hospital site, but the new hospital build will enable care to be provided within first class facilities by 2018.

Community involvement

Throughout the year we have continued to liaise with community groups across Enfield and Hertfordshire, in particular to provide information about the developments at Chase Farm. We have engaged with Love Your Doorstep Enfield who connect with thousands of local residents through social media, updated twitter feeds, gone out to community patient groups, held Chase Farm stakeholder events, ensured the communication hub on site is well manned and produced a quarterly newsletter. In September we were represented at the Enfield show and many local residents visited our stand to find out more about the new hospital and the improvements underway at Chase Farm.

In addition the Royal Free Charity has engaged with us to increase the number of volunteers on site and has been successful in fundraising to provide a dementia garden and rehab garden facilities for patients. The mayor of Enfield took a particular interest and gave support to this work.

Our contractor, IHP, responsible for the new building is working with local schools regarding art projects connected with the new build. In addition we are involved with the open doors construction scheme where young people who are considering a career in the construction industry are able to register an interest to visit the site to learn more about opportunities available.

Lastly we have been working with a small local social enterprise company to promote communication further and to capture a record of the facilities provided on site and the progress of the new build throughout the seasons.

Care Quality Commission

The Care Quality Commission undertook a full comprehensive hospital inspection during the week 1-5 February 2016. The trust is rated good overall as a provider and good at each hospital site, and for each core service at all sites, which is an unprecedented rating for a London trust.

Royal Free London NHS Foundation Trust

Quality Report

Royal Free Hospital
Pond Street, London NW3 2QG
Tel: 020 7794 0500
Website: www.royalfree.nhs.uk

Date of inspection visit: 2 - 5 February 2016
Date of publication: 15/08/2016

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Good
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Good
Are services at this trust well-led?	Good

The trust was found to require improvement for the safety domain and for specialist community mental health services for children and young people (CAMHS) in the safe and responsive domain.

Our ratings for Royal Free Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Good	Good
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Requires improvement	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Our ratings for Barnet Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Our ratings for Chase Farm

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

The trust has developed and submitted a responsive action plan in relation to the regulatory breaches concerning the suitability of the premises from which the current CAMHS are provided and for issues regarding privacy and dignity, notably inadequate soundproofing of consultation rooms.

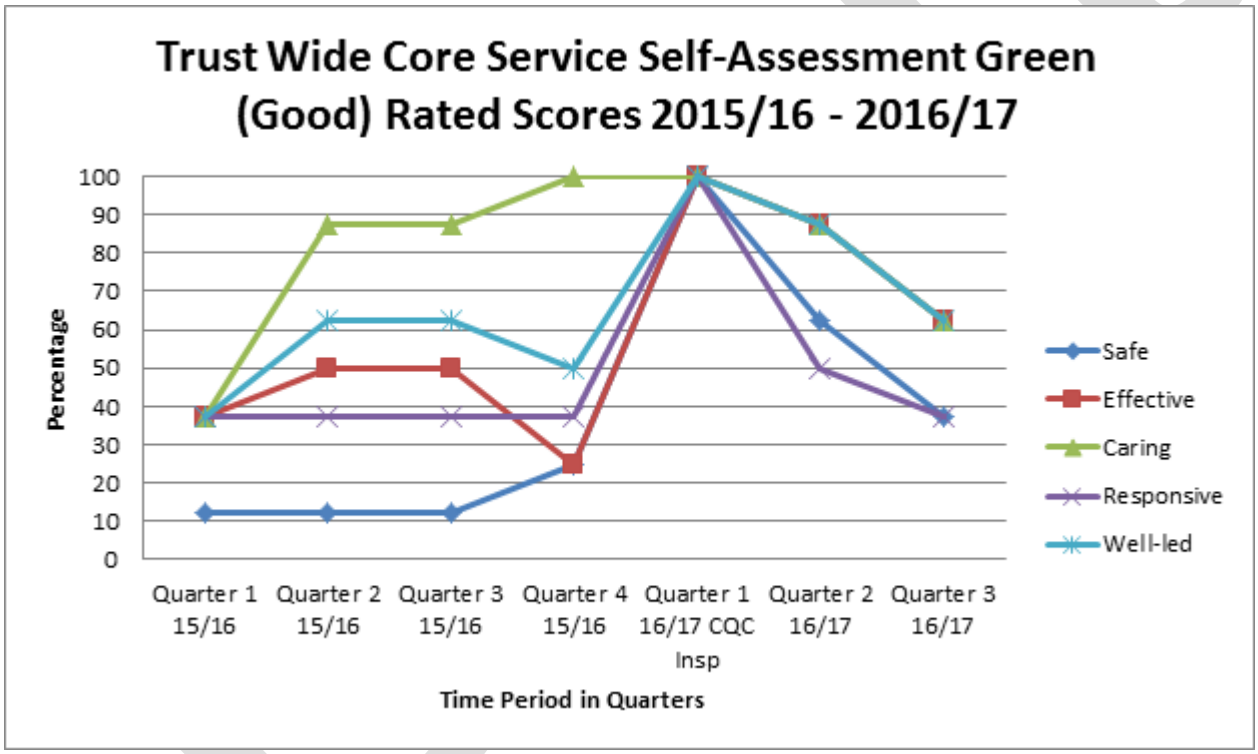
NHS Improvement is responsible for overseeing our improvement actions and will monitor the implementation through a quarterly forum. The responsive action plan is reported and monitored at the trust's patient safety committee.

To improve our services for children and young people within CAMHS, we intend to move this service to an alternative site within Hampstead, which will enable the provision of care to meet the needs of our users and provide appropriate privacy and dignity during their consultation. The new service will be located at Queen Mary House from May 2017.

Action planning for improvement:

The trust historical Care Quality Commission self-assessment process, initially introduced in 2010, has been a key driver earlier in the year in raising awareness of the trust comprehensive hospital inspection and was instrumental in the preparation for inspection as well as connecting the core service teams with their identified areas of improvement across services.

The quarterly self –assessment process is informed by the new model of inspection and is designed to encourage services to assess themselves and understand their compliance for their services. These arrangements require each clinical division to lead and embed assessing compliance for their core services across all trust locations. It also provided the opportunity for the core services to lead and develop responsive quality improvement initiatives across sites to further spread and share knowledge in areas of best practice amongst services in response to quality and safety outcomes.



Percentage scores are derived from the number of green scores identified for each of the eight core services reported throughout the 2015/16 and 2016/17 quarterly self-assessment executive panel review meetings.

Improving Patient safety

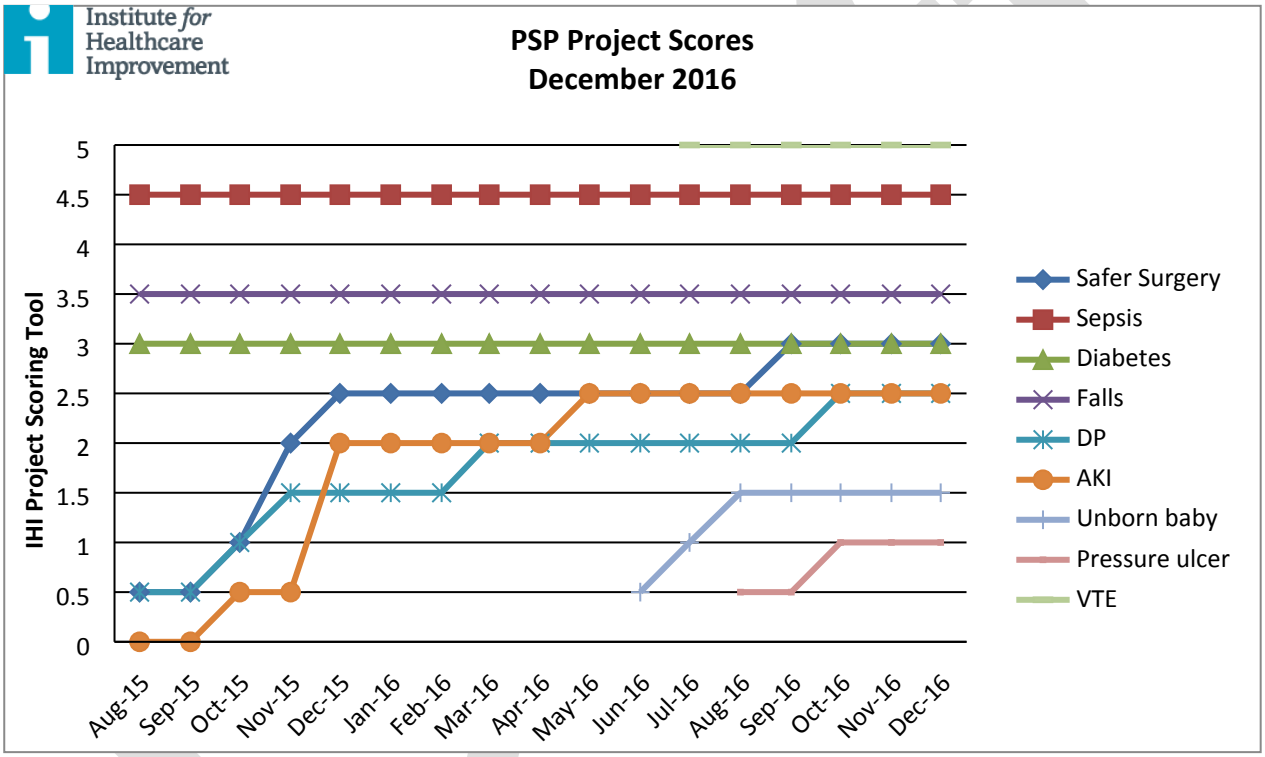
Patient safety programme

As shown through our quality account priorities, patient safety remains integral to the delivery of safe and effective care for our patients. The quality accounts patient safety priorities are based on phase 1 and 2 of the clinical patient safety programme workstreams. Our patient safety programme sets out actions that we will undertake in response to the five sign up to safety pledges via our local safety improvement plan.

Patient Safety Programme

The patient safety programme includes the development of improving patient safety capability, capacity and culture across the trust over three years from April 2015 to March 2018.

We have identified new pilot wards/areas for improvement work on falls, sepsis, deteriorating patient, diabetes, acute kidney injury, safer surgery and pressure ulcer prevention. Alongside this the trust is starting to implement the quality strategy to develop capacity and capability in quality improvement training for frontline staff. We know that in the recent staff survey on quality (Dec-16), patient safety was identified as a key area to enable quality improvement.
With investment in staff and training via the quality strategy, we expect there to be a significant improvement in this area over the next few years.



Implementing the duty of candour (DoC)

We have implemented the 'being open' policy across the trust for many years, and approved our duty of candour policy in November 2014, to clarify the updated processes for staff. We have developed a monthly training package aimed at all staff that has been delivered across all sites.

We have set up our incident reporting system (Datix) to enable us to monitor duty of candour compliance for those incidents that have resulted in moderate harm or above. We provide monthly reports to the patient safety committee and our commissioners detailing our compliance with duty of candour.

All incidents which meet the duty of candour criteria are reviewed at our serious incident review panel, where assurance is provided that this duty has been met. For serious incidents, the duty of candour compliance is reported as part of the monthly quality report that is shared with our commissioners. This includes details as to the reason compliance with DoC is sometimes not possible, such as for a deceased patient with no next of kin.

For non-serious incidents (those graded moderate or above harm) we record whether DoC was met within 10 days, was not breached (i.e. it was not possible to meet DoC in 10 days due to a patient being unconscious), or was possibly breached. This information is available on Datix and reviewed each month, where assurance is sought from our divisional quality managers.

Patient safety improvement plan as part of the 'sign up to safety' campaign

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

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

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

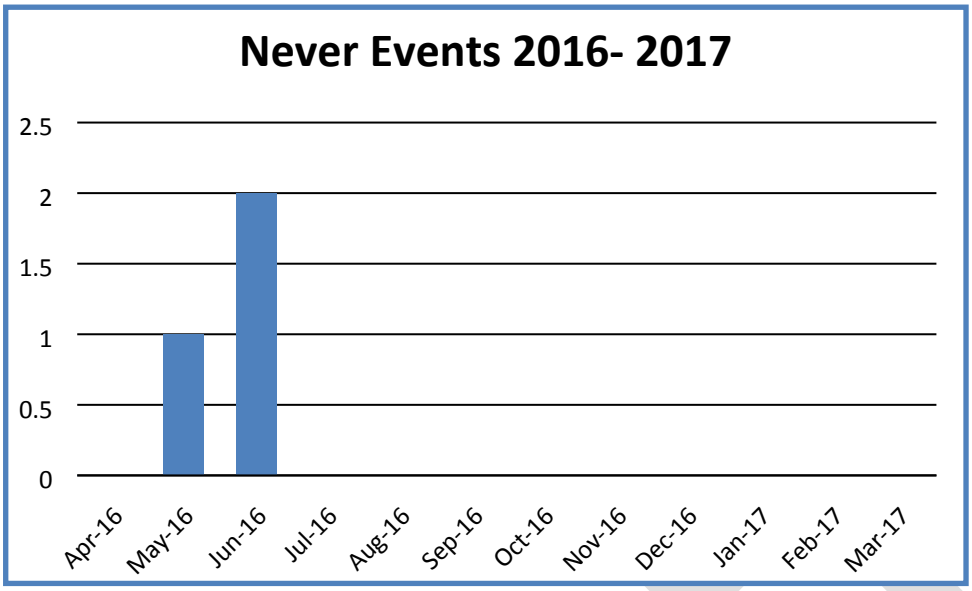
Never events

Never events are extremely serious and largely preventable patient safety incidents that should not occur if the relevant preventative measures had been put in place. The trust takes never events seriously and a full investigation is undertaken with the final report discussed at the serious incident review panel where final actions are agreed.

Unfortunately, we reported 10 never events during 2015/16, nine of which relate to surgery. During this reporting period (April 2016 - March 2017) we have reported three never events which occurred in May and June 2016.

In May 2016, the trust-wide never event; never again symposium was held. With over 70 participants, teams shared local never event stories and lessons learnt, through presentations, story boards, case studies and personal accounts.

By incorporating the findings of root cause analysis of previous never events and conducting a literature search of the relevant evidence base, the team has commenced observational data collection of distractions and interruptions. We are having active collaborative discussions with Loughborough University Human Factors team about the participation in the study of the processes that influence distractions and interruptions.



NHS staff survey results 2016

This section outlines the most recent NHS staff survey results for indicators KF21 and KF26 as requested by NHS England (medical directorate).

- KF21 (percentage believing that the trust provides equal opportunities for career progression or promotion)
- KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months).

The 2016 survey also outlines the trust's Workforce Race Equality Standard (WRES) position compared with other acute trusts and differences from the previous year as below:

			Your Trust in 2016	Average (median) for acute trusts	Your Trust in 2015
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	30%	24%	32%
		BME	35%	27%	36%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	85%	88%	84%
		BME	66%	76%	65%

The patient and staff experience committee (being replaced by the Leadership for Quality Improvement Committee) reviewed the staff survey results in January (pre-publication of the national picture) and a programme of engagement with staff, trade unions and others is underway that will inform changes to the trust's Staff Experience and Retention Plan (SERP).

Complaints

The trust recognises that in the majority of instances it is best to resolve issues as soon as possible. Our patient information leaflets and posters encourage concerns to be raised immediately with the person in charge of a patient's care. Alternatively, contact details are provided for the Patient Advice and Liaison Service (PALS) and complaints teams.

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

- The divisional monthly quality and safety boards.
- The quarterly report taken to the patient and staff experience committee.
- An annual complaints report taken to the July trust board.

The quarterly CLIPS (complaints, litigation, incidents, PALS and safety) report taken to the patient safety committee.

Annexes

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

This will be completed in the final version of this report.

Annex 2: Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare quality accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2016 to May 2017
    - papers relating to quality reported to the board over the period April 2016 to May 2017
    - feedback from commissioners dated ..
    - feedback from governors dated …
    - feedback from local Healthwatch organisations dated …
    - feedback from overview and scrutiny committee dated …
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated ….
    - the latest published Care Quality Commission (CGC) national adult in-patient survey dated …
    - the latest national staff survey dated…..
- the head of internal audit's annual opinion over the trust's control environment dated …
    - CQC Intelligent Monitoring report dated May 2015

- the Quality Report presents a balanced picture of the trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions and is subject to appropriate scrutiny and review and

- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

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

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

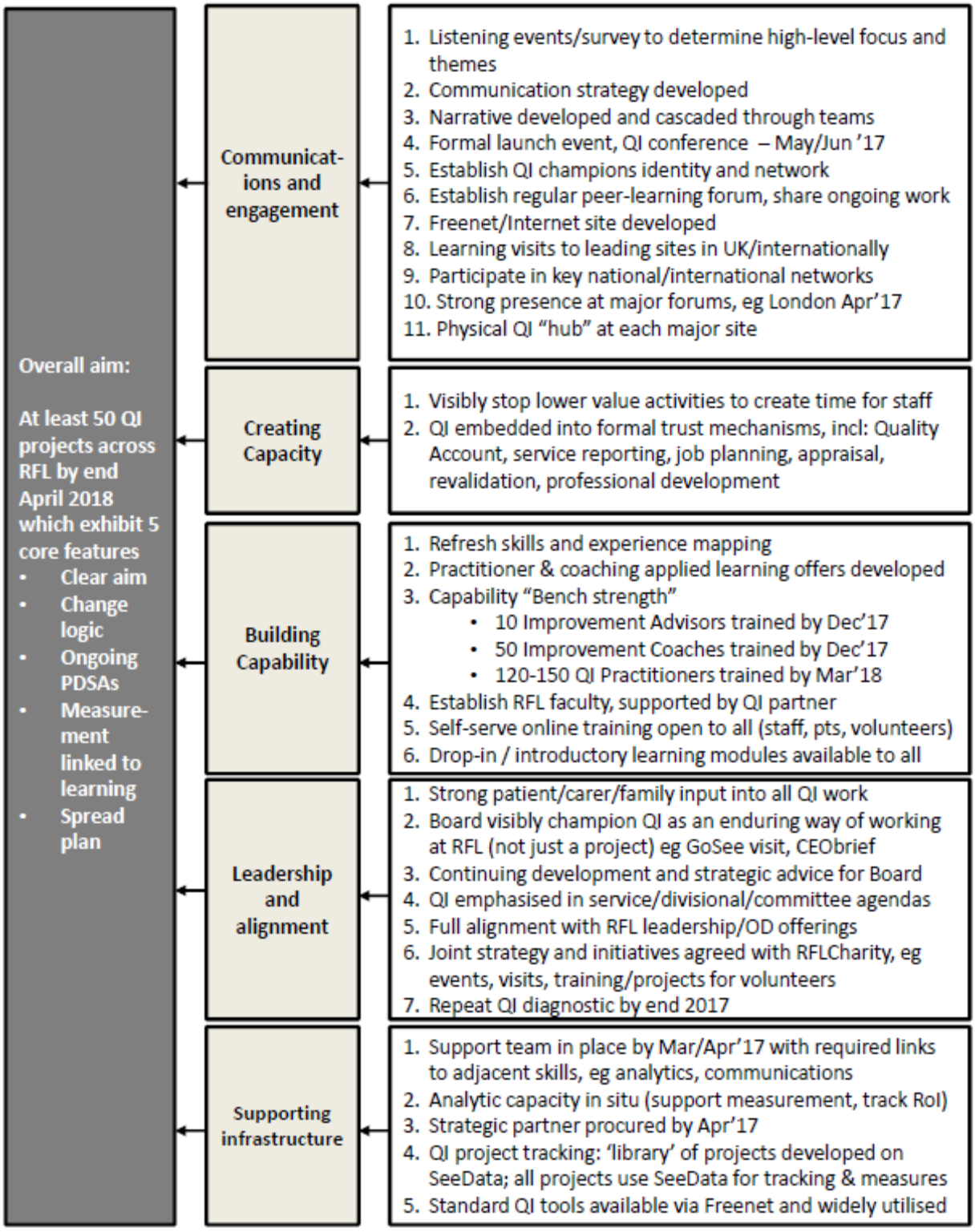
This will be completed in the final version of this report.

Annex 3. Limited assurance statement from external auditors

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

Appendices

Appendix a: Royal Free London Quality Improvement Driver Diagram: toward 50 initiatives by end April 2018



Appendix b: responses to stakeholder comments

In response to comments received from commissioners, local healthwatch organisations and overview and scrutiny committees, we have outlined our responses in the following

This will be added to the final version of this report

Appendix c: glossary of definitions and terms used in the report

Five steps to safer surgery

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

Glossary of Terms

Term	Explanation
CQC: Care Quality Commission	The independent regulator of all health and social care services in England
C-diff: Clostridium difficile	A type of bacterial infection that can affect the digestive system
Clinical Practice Group (CPG)	Permanent structures which the trust is developing to address unwarranted variation in care.
CQUIN: Commissioning for Quality and Innovation	CQUIN is a payment framework that allows commissioners to agree payments to hospitals based on agreed improvement work
MDT: multi-disciplinary team	A team consisting of staff from various professional groups i.e. nurses, therapist, doctors etc.
NHS NCL	NHS north central London clinical network
NICE: National Institute of Clinical Excellence	An independent organisation that produces clinical guidelines and quality standards on specific diseases and the recommended treatment for our patients. The guidelines are based on evidence and support our drive to provide effective care.
Patient at Risk & Resuscitation Team (PARRT)	The Patient at Risk & Resuscitation Team (PARRT) is a combined nursing service to provide 24/7 care to patients at risk, including attending medical emergency calls (2222) and reviewing all patients post discharge from intensive care. The team members provide education, training and support to manage life-threatening situations, including in-hospital resuscitation, care of the patient with a tracheostomy and CPAP.
PEWS: paediatric early warning score	A scoring system allocated to a patient's (child's) physiological measurement. There are six simple physiological parameters: respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness.
SBAR: situation, background, assessment, recommendation	SBAR is a structured method for communicating critical information that requires immediate attention and action contributing to effective escalation and increased patient safety. It can also be used to enhance handovers between shifts or between staff in the same or different clinical areas.
SHMI: summary hospital-level mortality Indicator	The SHMI is an indicator which reports on mortality at trust level across the NHS in England using a defined methodology. It compares the expected mortality of patients against actual mortality.
UCLP: University College London Partners	UCLP is organised around a partnership approach. It develops solutions with a wide range of partners including universities, NHS trusts, community care organisations, commissioners, patient groups, industry and government. (http://www.uclpartners.com/).

VTE: venous thromboembolism	A blood clot that occurs in the vein