Quality report 2017/18

This report will be proof-read and all corrections and additions will be made to the final version.

world class expertise local care

Quality report 2017/18

Part one: Embedding quality

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

Part three: review of quality performance

Annexes

Appendices

Part one: Embedding quality

1.1 Statement on quality from the chief executive

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

1.2 Our trust: Implementing a Group model to deliver world class expertise with local care for a larger population.

Our journey- July 2014 to June 2017

July 2014

- Barnet and Chase Farm Hospitals NHS Trust became part of the Royal Free London Hospital Foundation Trust.

January 2015

- The Royal Free London submitted an application to become a 'vanguard site' for a new care models programme. The purpose of the vanguard was to develop new arrangements for hospitals to improve quality and the experience of care to our patients.

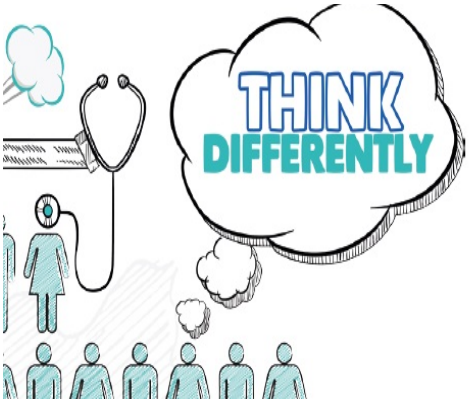
August 2016

- The trust received a 'good'rating from the Care Quality Commission and based on our performance and progress in designing the group model, the trust was accredited to become a vanguard site (leading a group (or chain) of NHS providers

June 2017

- The senior leadership team at each hospital site (Barnet, Chase Farm and the Royal Free) was in place. The teams were responsible for providing local support, leadership and operational oversight for services on a day-to-day basis.

Our Group structure: Collaboration and partnership working



Across the group structure there is a common vision to make the RFL the best place to work and to be treated in the NHS and to become the best hospital group in Europe.

Our staff are doing a fantastic job under growing pressure - treating more people than ever before. To manage this increasing demand we had **to think differently about the way we delivered our services.**

We had the opportunity of a generation to improve the care we deliver to our patients through the NHS vanguard programme.

For far too long, hospitals and other healthcare services have worked independently - **collaboration and partnership working had to be the way forward**

We were chosen to **set up and lead a group of NHS providers** who will share services and resources in order to improve the experience of our staff and patients.

As a result of this, during 2017 we moved to a group model structure. Working side-by-side with other healthcare experts we can share ways of working which we know deliver the best outcomes. By working collectively we can reduce variations in patient care and the cost of treatment that we see across the group, **increasing our purchasing power**.

by doing things differently… We have a new operational structure with:

- local hospital management teams in place
- a group board and group executive team
- new divisional structures

Our plan was to bring together a range of acute providers to create a 'group' of hospitals, connected by a single group centre – similar to models seen internationally, such as Intermountain Healthcare in Utah, USA. Individual trusts will be able to join the group under a range of membership options, from full membership to arrangements such as buddying.

To improve the experience of our staff and patients … By working as a group, we can bring together larger numbers of clinicians to share their knowledge about the very best ways to treat patients in line with the very best care available across the globe.

Under the group model, there would be one consistent approach, based on the shared experiences of clinical practice groups.

Barnet Hospital

Our senior management team:

From left to right

Sally Dootson, director of operations

Dr Steve Shaw, chief executive

Dr Mike Greenberg, medical director

Julie Meddings, director of nursing

During 2017-18 we are particularly delighted with the progress that we have made in improving our ambulance waiting times, Developing a back pain service in primary care, our performance in the national stroke audit and the work undertaken within our maternity and paediatric clinical pathway groups.

Improving our emergency pathway: improving ambulance waiting times.

What was the issue?

- Consistent underperformance with London Ambulance Service (LAS) turnaround times
- Multiple ambulances waiting to off load patients
- Potential delays in patient care
- Delay in ambulance crew being able to respond to 999 calls

What did we do?

- Implemented the national 'fit to sit' initiative which supports patients being admitted to hospital by the most appropriate method
- We questioned if the patient was ambulant and capable of mobilising independently?
- We promoted the use of a wheelchair first, rather than a stretcher or trolley (as often patients are conveyed on ambulance stretcher for safety).
- Challenge ambulance staff about transporting patients to the Emergency Department

What was the outcome?

- We made improvements in the patient's journey
- We are now in the top 5 performing London hospitals for LAS times.

A specialist-led back pain service in primary care

Advanced Practice Physiotherapists working as first contact practitioners

Overview

A team of spinal specialist Advanced Practice Physiotherapists (APPs) worked within a GP practice to introduce a new back pain service to manage the whole patient pathway.

The challenge

There is increasing pressure on GPs due to a national shortage and 30% of their workload is musculoskeletal. Of these patients a large proportion will present with back pain. The service sought to improve patient experience, decrease wait time and reduce pressure on GP colleagues.

Intervention

The team of APPs managed the whole patient pathway, including investigations, prescribing, referrals to secondary care and listing for spinal injections. Innovative aspects included self-referral to a first contact APP, and links to secondary care directly listing patients for injections or surgery.

Staff and patient feedback

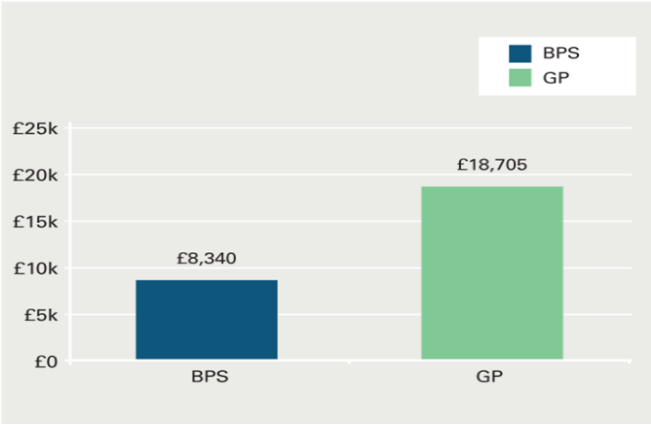
"It is a great service for our patients. Brilliant feedback and problem solving. Saved on referral and patient waiting in pain." – Staff

"I feel reassured regarding my back issues and have come away with lots of helpful advice. Very impressed!"
– Patient

Results

The service ran for 12 months and saw 474 new patients with a total of 611 contacts. It received a 100% friends and family recommendation while helping to reduce demand. 80% of patients weredischarged after their first appointment,3.5% were referred to secondary care and less than 1% of patients were referred back to the GP. The pilot delivered a reduction in secondary care referrals and investigations that translated to cost savings of over £10,000 (65% saving on 500 patients). In addition, patients had to wait an average of nine weeks from initial consultation to injection, compared to 31 weeks on the previous pathway.

Cost of investigations and secondary care referrals. GP vs BPS for 500 patients.



Lessons learned

Robust data collection is essential to compare data across the new and previous pathways. Experienced clinicians are vital to successfully run this service.

Next steps

This pilot shows that APPs can successfully manage back pain patients in primary care with 100% patient satisfaction and with reduced costs. This new model of care is being used to inform how future musculoskeletal services will be delivered in Barnet and Enfield.

Key achievements made within National Clinical Audits.

Top marks for our stroke unit

The stroke unit at Barnet hospital has been awarded an A, in the recent stroke national audit.

Several factors which contributed to the achievement included:

- the work of therapists
- early identification of stroke patients in emergency areas
- strict adherence to the London Stroke pathway

Our physio, speech and occupational therapists have to work under incredible pressure to ensure that each one of our 24 patients gets the appropriate level of therapy. We only score well in the stroke audit if our patients receive the mandated amount of therapy.

Our stroke co-ordinator is incredibly proactive in visiting the acute admission areas in the morning to ensure that stroke patients have been identified and referred to the hyper-acute stroke unit (HASU).

Barnet Hospital is part of the pan-London stroke network, which includes eight HASUs where immediate care is given to stroke patients by expert specialist staff. Patients are then transferred to their local acute stroke unit (ASU), such as Barnet Hospital, for ongoing acute management and rehabilitation. The Sentinel Stroke National Audit Programme (SSNAP) is the single source of stroke data in England, Wales and Northern Ireland. The audit is carried out three times a year.

Chase Farm Hospital

Our senior management team:

"We aim to have zero avoidable harm"

Dr Alan McGlennan
Medical Director

From left to right

Dr Alan McGlennan, medical director
Natalie Forrest, chief executive and director of nursing

During 2017-18, the redevelopment of Chase Farm Hospital has remained a priority, as we aim to prepare for the opening of the new building and clinical moves in June 2018. The new hospital will provide out-patient services including:

- Diagnostics,
- Musculoskeletal therapies
- Women's services,
- Urgent care centre (with paediatrics and an older persons' assessment unit),
- Day surgery,
- Endoscopy
- Medical day cases including a chemotherapy unit.

We plan to integrate the work undertaken within the relevant CPG programs and using of a HIMSS level 6 a digital platform (See glossary for information on HIMSS) which will further provide the best care for our patients.

In line with the overall trust objective, we also aim to have zero avoidable harm in the six months that following the clinical moves.

Royal Free Hospital

Our senior management team

Kate Slemeck, Chief executive

"There is something very special about this hospital, mainly thanks to its committed staff who are focused on doing everything they can to ensure that every patient who walks through our doors gets the best possible care. My ambition is to take this hospital from being rated 'good' to one that is rated 'outstanding' in the eyes of our patients, staff and regulators."

Kate Slemeck
Chief executive

From left to right

Dr Robin Woolfson, medical director

Sarah Dobbing, director of operations

Dr Chris Streather, Group medical director

Rebecca Longmate, director of nursing

During 2017-18, we have made several key achievements that we are proud off.

These include:

- Teamwork to achieve a trio of transplants
- Robot-doc to the rescue!
- Tackling the quiet cancer

Teamwork delivers a trio of transplants

Three life-saving operations were carried out in the space of 18 hours at the RFH – a record for the liver transplant team. Off-duty surgical staff showed their dedication and compassion by coming to work to make sure that the patients had the eight to 12 hour procedures quickly after donors became available.

Two of the cases were emergencies and designated as 'super urgent' which meant it was essential that the patients received the new livers immediately before their condition deteriorated further. The other transplant was for a patient who had been on the list for some time and the team had to operate quickly when a suitable match was identified. Time, in all cases, was of the essence.

Professor Joerg-Matthias Pollok, clinical lead for hepato-pancreato-biliary (HPB) surgery and liver transplantation at the RFH, and the consultant surgeon for the second operation, said: "I would like to express my pride in what we achieved for our patients and their families, who put their trust in us. "Many have given their best and joined the team, even though they weren't on call.

This has truly been a team effort from all disciplines involved in transplantation; coordinators, hepatology, theatre, anaesthetic, surgical and intensive care teams. It feels good to be part of a team with such tremendous spirit."

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Professor Joerg-Matthias Pollok, Clinical lead for hepato-pancreato-biliary (HPB) surgery and liver transplantation.

Dinesh Sharma, the consultant who carried out the first transplant, said: "To do three liver transplants in 18 hours – two of them in sick super-urgent listed patients – is to my mind a heroic and unprecedented effort. A sincere and big thanks for everyone who made this possible. It's teamwork like this that has helped us become being the fastest growing liver transplant programme in the country."

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Dinesh Sharma, Consultant HPB, Hepatology, Gastroenterology and Liver Transplantation.

Dr Doug Thorburn, clinical director for liver transplantation, HPB and hepatology, said: "Our achievements have been reached through demonstrable cohesion across the whole transplant multi-disciplinary team. Enormous credit for this goes to the whole team. "Our contribution to UK transplantation has not gone unnoticed. To me it is an honour to work with such an enthusiastic and committed team who put the patient at the centre of what we do and consistently exhibit world class values."

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Dr Doug Thorburn, clinical director for liver transplantation, HPB and hepatology

Robot-doc to the rescue!

An ambitious team of seven at the specialist centre for kidney cancer, led by urology consultant Ravi Barod, carried out three nephrectomy (surgical removal of a kidney) operations on a single Saturday, as opposed to the usual two, with the help of the da Vinci Xi robot.

Ravi said: “We had no extra resources but we selected relatively straightforward cases and ensured the team was briefed and motivated. Performing three operations can effectively increase theatre efficiency by 50 per cent. “The plan is to perform three cases on all of our Saturday lists from now on, with the aim of doing an extra 52 cases a year, and see how we can make this work for weekday lists, when the operating department is much busier.”

Instead of the surgeon using standard tools via keyhole surgery they use a console to control the robot which carries out the operation with a greater range of movement than the human hand.

The RFH purchased the robot 18 months ago to offer the best possible treatment for patients and help meet the increase in demand as it is a specialist centre for kidney cancer, with five surgeons who solely operate on the disease.

Using the robot results in a quicker recovery time for the patients, as there is less bleeding and less pain. This, coupled with the enhanced recovery after surgery programme, which gets patients moving and avoids strong pain killers, meant that two of the three patients went home the next day and the third patient left less than 48 hours after their surgery. Prior to this, patients stayed in hospital for four to five days after this operation.

Using the robot results in a quicker recovery time for the patients, as there is less bleeding and less pain.

This coupled with the enhanced recovery after surgery programme, which gets patients moving and avoids strong pain-killers.

The operations, from first incision to last stitch, took an average of 90 minutes with actual operation time of less than an hour. Usually patients need only this surgery as their treatment for kidney cancer.

Ravi added: “The key thing is case selection. We carefully selected non-complex patients – they’d had no previous surgeries and required the whole kidney to be removed. It’s also important to build an effective working team so people remain motivated.”

The RFL is the specialist treatment centre for kidney cancer across north central London, north east London and west Essex. It’s the highest volume kidney cancer centre in the UK and last year it saw 360 patients for nephrectomy.

Celebrating the 20th anniversary of the neuroendocrine tumour (NET) unit at Royal Free Hospital

In February 2018, Patients and staff celebrated the 20th anniversary of the neuroendocrine tumour (NET) unit at the Royal Free Hospital, which is helping tackle a rare condition known as neuroendocrine (carcinoid) tumour, sometimes referred to as the 'quiet cancer'.

To mark the anniversary, patients have contributed to a series of films discussing their experiences of this rare cancer, as well as the NET unit. In addition 250 patients and their carers, as well as more than 100 physicians, nurses and researchers attended a special 20th anniversary event, at the Royal College of Physicians.

The Royal Free Hospital NET unit receives approximately 20 new referrals each month, from across the UK and abroad. Since it was established in 1998, the service has grown from 30 to more than 1,800 patients.

NETs are rare and is referred to by some as the 'quiet cancer' as it can often take years for patients to be diagnosed. NETs develop from cells of the neuroendocrine system, which are found in organs including the stomach, bowel and lungs. Symptoms can include tummy pain, changes in bowel habits, flushing, and shortness of breath, loss of appetite and weight loss.

John Sullivan, 75, from Edgware, London, who took part in filming, said: "I was diagnosed with irritable bowel syndrome (IBS) and treated for IBS for 10 years but in fact I had a NET on the outside of my bowel. I won the lottery when I walked into the Royal Free Hospital because for the first time in years I was speaking to someone who knew what the matter was. You have to 'own' your illness. I feedback to the team about the drugs I'm taking because, with respect, I'm the one who knows how it feels and I always attend the patient forums when I can as you learn something every single time."

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

This section describes the following:

- Priorities for improvement: progress made against our priorities during 2017/18.
- Outline on our quality priorities for improvement chosen for 2018/19
- Feedback on key quality measures as identified within the mandatory statements of assurance from the board.

2.1 Priorities for improvement

Following consultation with our key stakeholders, the trust agreed that during 2017/18 we would continue to focus on three areas of quality; patient experience, clinical effectiveness and patient safety. During the year, progress to achieve our quality priorities have been led by a designated senior executive lead and monitored at our board level committees. Further reporting were held with our Group Executive Committee (GEC) and council of governors with overall approval given by our trust board. Overall the results presented relate to the period April 2017 to March 2018 or the most recent available period.

Priority one: Improving patient experience: delivering excellent experiences

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. We chose the following priorities as they were linked to specific strands of ongoing work within the trust, in support of our vision to have strong positive patient experience leaders so we can effectively serve our communities.

Our quality priorities for 2017/18 were:

1	**What did we aim to do?**
	To achieve trust certification for the 'Information Standard' by 2018
	What did we achieve?
	During 2017-1 the following measures were gained towards achieving the Information Standard accreditation: • Since the implementation of the patient information policy in 2016, we now have over 100 patient information resources approved in line with the policy. We also have over 250 leaflets which have been submitted for review and are at various stages of the processes outlined in the policy. • We have worked with our radiotherapy, imaging and ophthalmology departments to embed the practice of evidence based information production, a key requirement of The Information Standard. • We are also in the process of updating our patient information policy based on feedback from staff and to incorporate changes and new requirements of The Information Standard in readiness for an application which is expected in late 2018.

2

What did we aim to do?

To improve how patients, carers and families can provide feedback to the trust.

What did we achieve?

The trust has identified three ways of gaining feedback from our patients regarding their experience. These include:

- **The National Department of Health funded approaches -** The uptake of patients using NHS Choices has increased and is regularly used as an engagement tool.
- **Social Media** - the trust frequently uses Twitter and Facebook as ways of allowing patients to feed back on their experience of care
- **Patient Advice Liaison Service (PALS) –** the trust is seeking to move from a static PALS approach to one of flexibility around patients and increased response times for email and phone queries.

3

What did we aim to do?

To systematically analyse the experience of bereaved families and friends.

What did we achieve?

During 2017-18, the trust chose to explore how the experience of bereaved families and friends could be improved.

A bereavement survey is given to all persons who collect a Medical Certificate Cause of Death from the hospital. It is recognised that there may not be an easy time to ask for feedback as the return rates on the survey have been low. Therefore a web based survey is being launched which may be easier for providing feedback.

The surveys continue to be distributed and returns collated for analysis. The results of the survey and response rates will be discussed at the *Acute Hospital End of Life Care Community of Practice,* which brings together those involved in and those who can influence End of Life Care (EOLC) education in acute hospital trusts across London, Essex, Hertfordshire and Bedfordshire.

(A further update will be presented in the final report)

4

What did we aim to do?

To further enhance and support dementia care initiatives across the trust through the delivery of the dementia strategy by 2018.

What did we achieve?

During 2017-18, the trust has continued to focus on improving the experience for our patients with dementia and their carers. Through the dementia strategy (2017-2019) several key initiatives have been identified and steady progress has been made. This has been monitored through the Dementia Implementation Group (DIG).

These included:

- **Flexible visiting times for carers in line with the principle of John's Campaign**. In 2016/17 71% of our in-patients wards were compliant. In December 2017, all our in-patients wards (100%) are now compliant with John's Campaign.

- **Improving the environment**- Dementia-friendly refurbishment of 10N (in-patient ward at our Royal Free site) commenced in September 2017.

- **Joint working-** The DIG is partnering with associated Clinical Practice Group (CPG) to produce a world class dementia care pathway across organisation (currently in process-mapping phase).

5

What did we aim to do?

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 patent or family member
- Partners with hospital staff on how to improve the patient and family experience through short and/or long-term projects and volunteers his or her time.

What did we achieve?

Recruitment remains underway across the trust and is further supported by Camden Clinical Commissioning Group (CCG).

(A further update will be presented in the final report)

Through the Patient and Staff Experience Committee (PSEC) and the by the Quality Improvement and Leadership Committee (QI&LC) we have monitored, measured and reported progress to achieving our priorities.

A trip down memory lane: Improving care for our patients with dementia

The refurbishment on 10N ward (at our Royal Free Hospital site) has transformed the clinical area into a therapeutic and reminiscence space for elderly patients. This renovation is the first of its kind at the RFH. Patients can be transported back to Hampstead High Street in the 1970s thanks to the refurbishment.

The corridor walls, which show headlines from the past, will be used to stimulate conversation and memories. The patient day room has also been transformed into a living dining room complete with a fireplace, dining tables and a TV playing hit films from the 60s and 70s.

The refurbishment of the ward was made possible by the generosity of the Community Infrastructure Levy fund and the support of the Royal Free Charity and the clinical and executive teams at the RFL.

Our main challenge is to build a world in which we can communicate with them and build a relationship. “This new ward environment is almost like a set – it creates the perfect space to perform those interactions and form the connections that are essential in the care of dementia patients.”

> For a person with dementia, their main priority when in hospital is about establishing where they are, who we are and what we are going to do.
>
> Our main challenge is to build a world in which we can communicate with them and build a relationship. “
>
> **Danielle Wilde, trust dementia lead**

The ward is also equipped with a post box, bus stop and a working hair salon, so patients can experience familiar settings during their recovery.

Eduarda Rodrigues, ward matron, said: “The designs were all chosen by our patients and the multi-disciplinary team on 10N.” Stacey Brown, healthcare assistant on 10N said: “It’s brilliant. It makes our working environment much brighter as well – particularly with the flower-themed bays and the nurse’s station

Priority two: improving clinical effectiveness: delivering excellent outcomes

These priorities were chosen because they directly aligned to our trust wide plans to focus on the reduction

of unwarranted clinical variation. This will strengthen the delivery of the local and national effectiveness agenda and support the delivery of significant improvements in the quality of patient care. Our clinical effectiveness priority had two strands 1. Creating Clinical Pathway Groups (CPGs) 2. Driving quality improvement.

During 2017/18 the trust commenced the deployment of a trust-wide methodology to manage unwarranted variation in clinical care, through the creation of Clinical Practice Groups (CPGs).

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

We will redesign care pathways using evidence based principles and current best practice to deliver the best possible outcomes for our patients.

John Connolly
CPG Programme director

An example from one of our CPGs

Title:	**The Child aged 2-15 years admitted with a wheeze**
Aim:	**To improve the care of children that present with wheeze aged 2-15 years of age**

This cohort of children accounted for the majority of admissions into Accident and Emergency and was subject to large amounts of unwarranted variation in the care they received. The CPG easily identified where the variation in care was and planned a future state pathway based on best local and national evidence.

The children are now categorised on admission within 15 minutes into one of three categories and a plan of care for that category ensues. Subsequent to that, the child will also receive reassessment at 20 minute intervals. It is anticipated that this CPG will reduce the amount of children admitted onto the ward and reduce the amount of readmissions at 7 days following discharge from A&E.

The CPG have tested the pathway and undertaken PDSA cycles to test the proforma and changes have been made to improve the process. The CPG also designed a discharge leaflet to improve the education that the child and parents go home with. Throughout the redesign of this pathway the views of both staff and patients have been sought.

Our quality priorities for 2017/18 were:

Clinical Pathway Groups (CPGs)

1	**What did we aim to do?**
	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 Clinical Practice Groups.
	What did we achieve?
	The trust has made progress in developing the clinical pathways and at present there are over 30 pathways spanning across the four clinical divisions. Each CPG programme is an example of an integrated quality improvement methodology. The Clinical Pathway Groups (CPGs) have been developed through a series of workshops occurring from May 2017 to April 2018. From the workshops we have further achieved the following: • Excellent engagement by North Middlesex clinicians at the workshops • Development of a detailed measurement plan for all pathways • Ongoing analysis of patient pathways using random sampling techniques. • Development of proposed future state pathway and timetable for testing • Engaged heads of finance on all hospital sites who attended the workshops for all CPGs in November • UCL evaluation researcher introduced at all the CPG workshops to the teams • Engaged Cerner for real time study of Emergency workflow and Firstnet upgrade

Further examples from our Women's and Children's Clinical Pathway Groups (CPGs).

Title:	**Keeping mothers and babies together**
Aim:	**To prevent avoidable term admissions by improving care after birth from delivery suite and post-natal ward.**

Nationally between 2011 and 2015 there had been a 30% increase in term babies admitted to levels 1, 2 and 3 neonatal units. The Royal Free London NHS Foundation Trust is committed to reducing avoidable admissions to the neonatal unit and improving the care that mothers and babies receive while on the delivery suite and post-natal ward.

The Service undertook a current state process mapping exercise and used the learning from this process to re-design the pathway with the main focus being on improving improve neonatal care within the first hour following delivery. The data collected supported this decision in highlighting the number of babies that were admitted to the neonatal unit with respiratory distress syndrome and associated co-morbidities such as hypothermia and hypoglycaemia.

A new New-born Early Warning Score (NEWS) observation sheet has been designed to improve the recording of observations both for low risk and high risk babies and observations required for high risk babies have been standardised. PDSA cycles were completed in order to understand how effective the new NEWS chart was and how it was received by staff in practice. Similarly, Nudge Theory has been applied and an amber coloured hat is in use for all the "at risk babies" who have been renamed "Hat Risk Babies". PDSA cycles are underway to test this change idea, which will reflect how staff and families feel about this process. This CPG is a priority pathway and it is planned that it will be digitised by September 2018.

Title:	**Ladies who are admitted to the Early Pregnancy Unit (EPU) with Per Vaginal (PV) bleeding and abdominal pain.**
Aim:	**To introduce a one stop clinic for women who are admitted with PV bleeding and pain in pregnancy.**

There are large numbers of women that visit the Trust's Early Pregnancy Unit with both vaginal bleeding and abdominal pain. The Royal Free London NHS Foundation Trust is committed to the Royal College of Gynaecologists and Obstetricians guidelines and recommendations. Indeed baseline data collected as part of the project showed that women were waiting far longer that the recommended time to have an ultra-sound and subsequent review and plan of care.

The evidence suggests that the women`s experience is greatly improved if they are seen in a "One Stop" environment. In real terms this would require a woman to be reviewed on admission, scanned and counselled by the same clinician. The team undertook patient co-design and asked the women what would be their preference and they supported the introduction of a 'One Stop' EPU.

The CPG project team have designed a Self-assessment form that women complete on admission, ultra-sonographers are being trained and supported to provide counselling to the women and nurses are accompanying ultra-sonographers into the scan room, to provide counselling when the ultra-sonographers feel they are not able to. The project has led to women being seen in a 'One Stop' environment which has resulted in their time to scan and time from admission to the Early Pregnancy Unit and plan of care being greatly reduced. A survey of the women using the service indicated that these women have high levels of satisfaction with the new service and they report feeling cared for throughout their visit.

Title	Induction of labour with a Cook's balloon
Aim:	To improve the clinical outcome for women who undergo an Induction of Labour.

The induction of labour was chosen as a CPG mainly because it was a large volume pathway that had a vast amount of variation in the care delivery. Following the evidence from a randomised control trial in 2016 it was decided that the default method of induction of labour would be a Cook`s Balloon.

The evidence demonstrated that there was improved satisfaction for the women alongside improved clinical outcomes. The maternity service undertook a small pilot which supported the research findings. Women had grater satisfaction with the induction process as it meant that they could remain at home and return when it was time to commence the next stage of their induction. Uterine hyper stimulation was greatly reduced in the pilot group compared to those women who received Propess for induction.

The CPG project group developed a pathway for women undergoing outpatient induction of labour with the Cook's cervical ripening balloon and tested the pathway. The project team are currently looking to improve the care pathway for women who have had their Cook`s Balloon removed and are ready to advance to the next stage of their induction by introducing admission directly to Labour ward for an artificial rupture of membranes for women who have previously had a baby in order to further streamline the pathway and reduce long waiting times for induction of labour.

Title:	Better births pathway
Aim:	To provide continuity of carer to 20% of women delivering at the Trust by 2019 and for all women to take part in a choice conversation of place of birth with their midwife during their 16 week appointment. This is part of the national Maternity Transformation Strategy

Following the National Maternity Review there was a national drive to promote choice of place of birth to all women and to provide a package of care that was more personalised. The choices include both Barnet and the Royal Free Hospital, or the alongside midwifery led units at Barnet and the Royal Free Hospitals or the stand-alone unit at Edgware Hospital.

The evidence to support the place of birth was based upon the Birth Place Study (2011) and a decision tool was designed to facilitate these conversations between the midwife and the woman. The CPG's work continues to support this process and staff co-design has taken place to find out how this can be improved.

The Maternity Transformation Board has stipulated that by March 2019, 20% of women booking into maternity services will receive continuity of carer for their antenatal, intrapartum and postnatal care. The CPG has supported the process whereby two of the vulnerable women's teams are now providing continuity of carer during the ante-natal, post-natal and intra partum period to a significant number of their women with a view to extending this over time.

Similarly the Edgware birth team are providing continuity of carer throughout the pregnancy journey to all women who book to deliver their baby at Edgware Birth Centre. Work is underway with all community midwives to encourage them to promote all choices to their women and to actively promote Edgware Birth Centre as an option.

Driving Quality Improvement

2

What did we aim to do?

To have at least 50 active Quality Improvement (QI) projects in place across the Group. The projects should exhibit the core features which we want to see in all our QI work including: a clear, patient-relevant aim, change logic, ongoing PDSA and measurement linked to learning.

What did we achieve?

During 17/18 we formed a small QI support team and entered a strategic partnership with the Institute for Healthcare Improvement (IHI). Together, these are significant enablers to embed QI across the Royal Free Group. The QI programme for 17/18 focused on building QI capability in our workforce. This has taken place through four main training programmes, summarised below:

- ***QI for all*** – QI for all encompasses resources available to all staff at RFL, this includes Intranet learning resources such as IHI's Open School e-learning and the LifeQI project management tool. 25 members of staff have completed 30% of IHI open school
- ***QI practitioners*** – Staff members become QI practitioners through attending Improvement Science in Action (ISIA), a five day, team-based programme pairing learning QI methodology with application to a real-life project relevant to their work. We now have 123 QI practitioners across the organisation.
- ***QI team coaches*** – Our Quality Improvement Team Coach Development Programme (QITCDP) trains staff to become QI team coaches. QI team coaches have greater knowledge of QI methodology and work to support teams who are doing a QI project. We currently have 33 QI team coaches across the organisation.
- ***Improvement Advisors (IA)*** – Improvement advisors have expert QI knowledge form the core of our QI support faculty. We currently have 3 trained IAs.

Through building increased skills and knowledge of the science of improvement and by leaders reinforcing the importance of QI, more teams are running QI projects as part of their normal work.

We now have over 80 known QI projects in place which have made differing levels of progress. Most of these projects have been set up through the ISIA QI training programmes, our Clinical Practice Group work and the Patient Safety Programme. We assess the maturity of QI projects on a 0-5 scale, where 5 is the most mature. Currently:

- 23 QI projects are at level 3-5 across RFL, this means they have demonstrated modest to significant improvement through successful PDSA cycles
- 14 QI projects are at level 2-2.5 maturity, meaning the team has started to test changes but sustainable improvements have not yet been evidenced
- 47 QI projects are at level 0.5 -1.5 maturity: these teams are largely setting up their project through establishing their aims and deciding on change ideas.

In order to support increased quality improvement activity it is important we build a strong infrastructure to ensure support is available to teams.

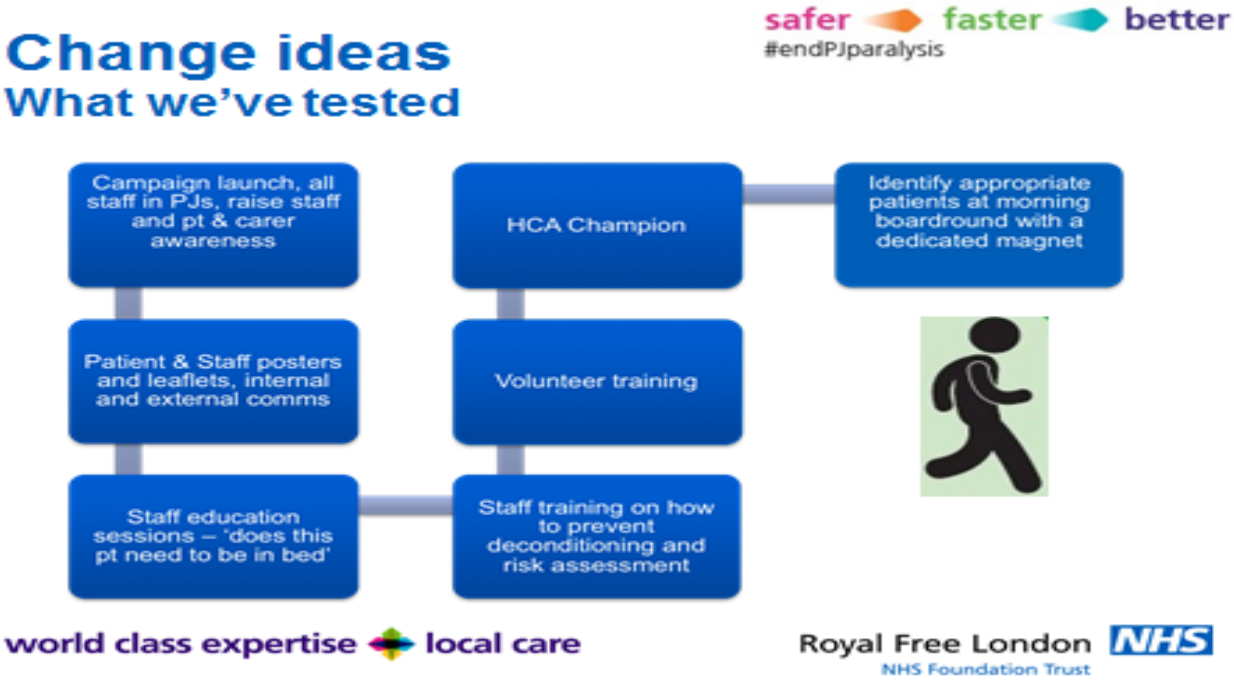
During 2017/2018 we started work to create local learning systems. Initial achievements include:

- QI clinics now run on each major site providing as an opportunity for staff to ask questions and problem solve QI queries with experienced QI faculty

- QI forums run monthly on each major site, open to all staff. At each forum, examples of work are shared and we focus learning on a particular QI tool or technique, using a combination of discussion, video and exercises to support learning.

The trust continues to work in partnership with the Institute for Health improvement (IHI) as QI partner. In September 2017, 29 teams started their Improvement practitioner training each with a QI project as central to their work. Through the Quality Improvement and Leadership Committee we have monitored, measured and reported progress to achieving our priorities.

Positive outcomes achieved from a QI project



Our staff promoting the end to PJ paralysis as part of the national initiative

Priority 3: Our focus for Safety

Our over-arching aim is to become a zero avoidable harm organisation by 2020, initially by reducing the level of avoidable harm at the trust through discrete pieces of work. Our targets were set out in our three year Patient Safety Programme (PSP) improvement plan (2015-2018) and we will be delivering key milestones along the way.

While the quality report'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. Through the Patient Safety Committee (PSC), and more recently, the Clinical Standards and Innovation Committee we have monitored, measured and reported progress made during 2017-18 to achieve the set priorities. The committee reports to the trust board.

Our quality priorities for 2017/18 were:

Falls

- To decrease by 25% the rate of falls incidents per 1000 occupied bed days (OBDs) from a mean of 4.9 in 2014/15 to a mean of 3.7 in 2017/18
- To reduce by 20% the proportion of patients that experience moderate harm or above from falls from a mean of 0.134 in 2014/15 to a mean of 0.107 in 2017/18

Our milestones for 2017-18 were:	What did we achieve?
To evaluate phase 1 of the 24/7 Falls Free Care.	We completed the evaluation on phase 1 of the 24/7 Falls Free Care.
To initiate phase 2 of the programme by recruiting 6-7 wards	A 'buddying system' has been used to join two to three wards together to increase collaborative working across all hospitals. In total we recruited a further 9 wards to phase 2 of the programme, which meant that in total 17 wards were recruited.
Implementation and spread of new falls prevention plan and bedrail assessment tool across the trust	The new falls prevention plan and bedrail assessment tool has been implemented across the trust, which includes our inpatient wards at our hospital sites.
To harmonise the bedrail policy	Our bedrail policy has been harmonised across our hospital sites.

Acute Kidney Injury (AKI)

- To increase by 25% the survival for inpatients with AKI, by increasing from a mean of 73% to 80% by 2018.
- To increase by 25% the proportion of patients who recover renal function from 68% to 85% by 2018.
- To reduce by 25% length of stay of AKI patients from 5 days to 3.5 days by 2018.
- To measure and improve patient experience and wellness scores by the end of March 2018.

Our milestones for 2017-18 were:	What did we achieve?
Through testing the new AKI app at RFH, we will develop an implementation plan for the trust	We completed the implementation plan for the trust.
Through PDSA cycles, we will co-design the AKI proforma to support the local clinical teams to deliver interventions specific to AKI pathology.	We successfully completed the AKI proforma to support our local renal, The Patient at Risk & Resuscitation Team (PARRT) and renal pharmacy teams.
Identify high prevalence areas and co-design an educational package to increase recognition and treatment of AKI.	We identified high prevalence areas which are now prioritised for blood sampling through phlebotomy services.
Develop methods for patient involvement with the programme.	Previous co-designing and testing of the AKI patient experience survey has been adopted with randomly selected AKI patients. This survey has evolved through collaborative working with AKI patients and the Trust's Patient experience Team.

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

Our milestones for 2017-18 were:	What did we achieve?
Spread and Implementation of tested methods to deliver robust processes of care at steps 1 & 5 (brief & debrief)	All theatres have been participating in using the WHO Safer Surgery checklist and its key components and in the introduction of a new policy and procedure Swab, instruments, sharps and disposable items count. A total of 10 theatres have tested the running debrief tool (currently on version 17) and cumulatively this has been used and observed >2,240 times.
By scaling up our plan-do-study-act (PDSA) cycles, we will develop locally driven methods to robustly embed the quality of step 4(counting swabs, needles and instruments)	Active PDSA cycles include: running debrief, count boards, escalation ladder, thematic analysis of incidents, counting bags, distraction & interruptions, white boards and emoji feedback.
To help co-ordinate the development of theatre team human factors skills and knowledge. This will include a framework for theatre etiquette and WCC behaviours	Where unnecessary distractions and interruptions occur, teams responsible for surgical invasive procedures will be asked to consider the severity of these distraction/ interruptions; local common causes of distractions and interruptions within their context and to identify the opportunities to build resilience in system to reduce potential adverse impact from frequent and severe the episodes.

Deteriorating Patient

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

Our milestones for 2017-18 were:	What did we achieve?
We will use one primary pilot ward to test continual PDSA cycles to improve processes & mechanisms to enhance timely communication within and between teams through the use of SBAR handover tools and enhanced ward rounds, board rounds and safety huddles.	We used 10W ward for piloting tests such as whiteboard communication and our safety huddles have been used.
We will use ward-based metrics such as cardiac arrest rates, PARRT referral and numbers of Multidisciplinary team meetings triggered to track progress.	This is happening monthly on our cardiology ward at our RF hospital site.
We will develop the 'champion' role further in this pilot area to enable long term sustainability.	Staff have continued to change and new champions recruited to enable long term sustainability.
Implementation and spread of tested communication mechanisms and processes to other areas in the organisation.	Data collection is underway to identify new area

Deteriorating unborn baby

- To reduce by 50%, the number of claims relating to deterioration of the unborn baby from a mean of 2 per year to a mean of 1 per year, during 3 years.

Our milestones for 2017-18 were:	What did we achieve?
To scope current processes around Elective caesarean sections performed before 39 weeks gestation and identify areas that could be improved to reduce preventable C Sections.	This work stream has merged into 'Keeping mum and babies together CPG' . This will; ensure that areas of good practice are embedded across the trust.
We will improve team communications of potential expected admission to NICU – through adopting PDSA cycles to implement team huddles and SBAR handovers.	We have successfully introduced daily cross-site huddles (see following example on safety huddles).
To undertake staff confidence survey associated with CTG interpretation; using this information to co-design teaching and skills package to improve CTG confidence in staff.	This was completed.
Using PDSA cycles we will plan methods of standardising the administration of Oxytocin infusion.	The administration of oxytocin infusion is now standardised across business units.

Safety huddles: An example of excellent practice.

Delivering world class care at the right time in the right place by the right team'.

The huddle is probably the single most effective meeting teams can have.

The maternity and neonatal departments from Royal Free and Barnet hospitals have been holding daily ten minute cross-site safety huddles during the week to help staff from both sites share critical information on mothers and babies who are at risk as well as highlight other safety issues.

The huddles, which started in June 2017, have proved a great way to engage with staff.

A survey on staff satisfaction showed that nearly 70 per cent of those involved found the huddles either very useful or extremely useful in reducing risks to patients.

Over 80 per cent of staff also said they wanted the huddles to take place seven days a week, 365 days a year and are themselves driving the roll out of the maternity safety huddles over the weekend.

"The huddle is a vital element of forward planning to minimise the risk of increased activity having a detrimental effect on safety levels." Karen Griffin, Delivery suite coordinator.

Dr Shanthi Shanmugalingam, neonatal consultant said the huddles were a "fabulous example of truly collaborative cross site working. Since introducing huddles, we have seen a reduction in ex-utero transfers of preterm babies.

"We are making huge strides to achieve our aim of 'delivering world class care at the right time in the right place by the right team'.

Sepsis

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

Our milestones for 2017-18 were:	What did we achieve?
We will be further consolidating sustained improvement in existing pilot areas.	The sepsis improvement work is underway in the following pilot areas: • **Royal Free Hospital** : Emergency department (ED), Paediatric ED, 10S, 10E, 8N, 6E, 7W and labour ward (see the table 1: clinical specialities) • **Barnet Hospital** : ED and labour ward, Paediatric ED • **Chase Farm Hospital** : Urgent Care Centre (UCC)
We will be planning and implementing a sepsis work stream plan of spread across the organisation with all key stakeholders, including establishing mechanisms to continue monitoring progress beyond the formal life of the work stream.	We have co-designed and developed local sepsis pathways with multidisciplinary teams using PDSA cycles specific to each of the new pilot areas due to their local and unique environments
We will be sharing the learning from the 10 pilot sites in the work stream with everyone involved and impacted by this spread, including further expansion of the 'champion' role to support long term sustainability	Sepsis capability is also being developed through e-Learning packages and tools appropriate to each clinical area

Table 1: Wards involved in our sepsis work and their clinical specialist area

	Our wards at Royal Free hospital	Specialist area
	6 East (6E)	Medical assessment unit
	7 West (7W)	Vascular surgery
	8 North (8N)	General medicine
	10 East (10E)	Renal
	10 South (10S)	Renal

Our Priorities for improvement (2018/19)

This section of the quality report 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 strategic committees and our trust board as illustrated in figure 1.

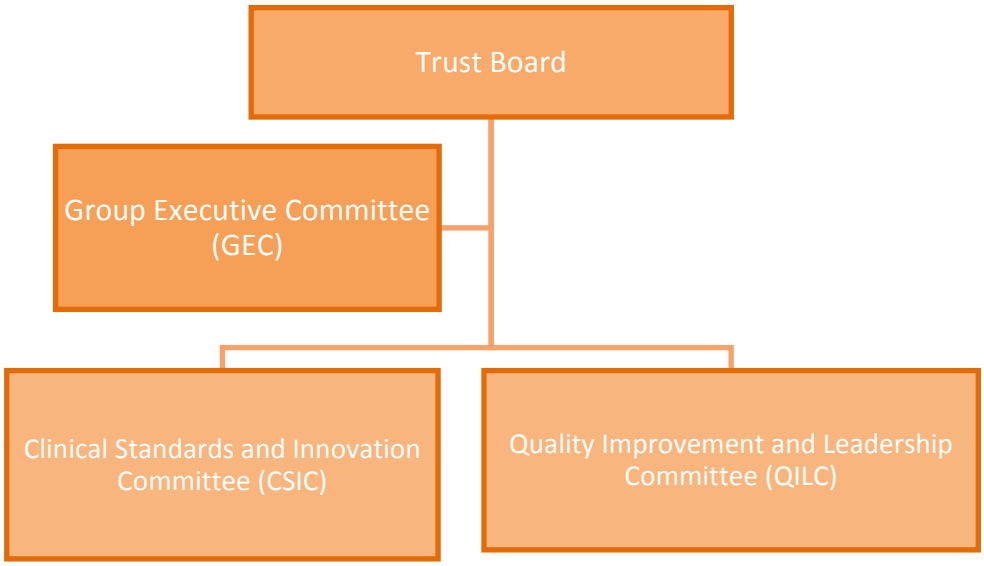


Figure 1: Strategic committees and trust board

Our consultation process

As part of our consultation process, the trust held various consultation events and our key stakeholders were invited to attend. The main stakeholder's engagement event **(Showcasing Clinical Excellence)** was held on the 2 February 2018. Attendees included staff, commissioners, governors and members from healthwatch.

In addition, an online survey was conducted with our council of governors and ran from the 20 – 27 February 2018. The governors were asked to provide feedback on the proposed priorities and to indicate if there was anything else that we should be prioritised for 2018/19. On the whole, the respondents were in agreement with our proposed priorities.

Priority 1: Improving patient experience: Delivering world class experience

We aim to put the patient, carers and our staff at the heart of all we do in delivering excellent experiences. Building on our strategy we will continue to make improvements for those who use our services.

Progress reports will be sent to the Dementia Implementation Group , Quality Improvement and Leadership Committee (QILC) and updates to our commissioners via Clinical Quality Review Group

Priorities for 2018/19	Continuation from 2017/18	Key measures for success
To achieve trust certification for 'The Information Standard'.	✓ (previous performance shown in section 1.1)	• To work with CPGs to embed the patient information approval process and ensure information produced via these channels are in line with the Information Standard requirements. • To submit an application for to The Information Standard for information produced by the radiotherapy department - the department will act as our exemplar for further rolling out the standard.

Priorities for 2018/19	Continuation from 2017/18	Key measures for success
To further enhance and support dementia care initiatives across the trust through the delivery of the dementia strategy	✓ (previous performance shown in section 1.1)	• To fully implement the National Audit of dementia action plan. • To embed the updated "8 things about me" document and filing information in the notes. • To continue to work on the delirium pathway as part of the Frailty Clinical Pathway Group.

Priorities for 2018/19	Continuation from 2017/18	Key measures for success
To improve our involvement with our stakeholders	✗ (new priority for the trust)	Specific measures will be confirmed and included in the final version of this report

Priority 2: Improving clinical effectiveness

The over-arching plan for 2018/19 is to continue to further dovetail our clinical effectiveness priorities with our quality improvement initiatives; thus facilitating the alignment of our trust wide plans to focus on the reduction of unwarranted clinical variation through Clinical Pathway Groups (CPGs).

Progress reports will be sent to the Group Executive Committee (GEC) and updates presented to commissioners via Clinical Quality Review Group meetings.

Quality Improvement priority:

RFL has a strategic objective to embed continuous quality improvement (QI) into daily work. For maximum benefit, QI needs to be reinforced by our management systems. During the coming year we will build on the foundations laid in 2017/18.

Priorities for 2018/19	Continuation from 2017/18	Key measures for success
Our priorities for 2018/19 include continuing to build capability in the workforce and developing our infrastructure. In order to develop a strong infrastructure that supports our QI programme we require an online QI project tracker tool. This will provide real-time intelligence on the status of QI projects across the trust, as well as providing vital project information including project maturity.	✓ (previous performance shown in section 1.1)	We will also continue to build local learning systems, characterised by the following: • Ability to prioritise QI projects based on local/Group need • Local ownership, at service, divisional and hospital unit level • Provide access to site-based QI help and support, site-based learning and access to expert QI knowledge • Create opportunities to share learning across the site and Group.

Clinical Pathway Group priority:

Variation in clinical practice and process leads to worse patient outcomes these results in higher costs. Therefore the goal of the program is to reduce unwarranted variation in clinical practice and process.

As part of the Global Digital Excellence Programme 20 pathways will be digitised over the next 2 years, prioritisation for pathway digitisation has been agreed with the goal of seven pathways digitised at the time of roll out of Millennium Model Content and opening of the new Chase Farm Hospital**.**

The intervention at the heart of the program is implementation of evidence based standardised clinical practice and processes as core operating standards across the trust.

Priorities for 2018/19	**Continuation from 2017/18**	**Key measures for success**
To develop a superior change-management capability this puts clinicians in charge of their clinical pathway to deliver high quality care to their patients across the RFL group.	✓ (previous performance shown in section 1.1)	To have 7 pathways prioritised for digitation which are as follows: 1. Preoperative Assessment 2. Elective Hip 3. Elective Knee 4. Right Upper Quadrant Pain 5. Induction of Labour 6. Pneumonia 7. Admissions to Neonatal Unit ('Keeping Mothers and Babies together')

Patient safety priorities

The RFL Group safety priorities are: zero Never Events, reducing avoidable deaths and zero avoidable hospital-acquired infections. In line with these, for 2018/19, the patient safety priorities in the quality accounts will be:

- Safer surgery
- Learning from deaths
- Infection prevention and control.

Data and information on these patient safety aims will be reported to the Clinical Innovations and Standards Committee (CSIC). Updates will be presented to commissioners via Clinical Quality Review Group meetings

Priorities for 2018/19	Continuation from 2017/18	Key measures for success
Safer surgery and invasive procedures	✓ (previous performance shown in section 1.1)	• To achieve zero Never Events by the end of March 2019 • To increase by 75% the number of Local Safety Standards for Invasive Procedures (LocSSIPs) in place by the end of March 2019

Priorities for 2018/19	Continuation from 2017/18	Key measures for success
Learning from deaths (LfD)	✘ (new priority for the trust)	• To increase by 10% the percentage of reviews of patient deaths recorded centrally by the end of March 2019 • To improve by 5% the sharing of the learning from serious incidents and patient deaths considered likely to be avoidable; as measured by staff survey data, by the end of March 2019

Priorities for 2018/19	Continuation from 2017/18	Key measures for success
To improve infection prevention and control	✘ (new priority for the trust)	• To achieve 10% reduction by year of E.coli bacteraemias. • To achieve Trust-attributed zero *Clostridium difficile* (C.diff) infections due to lapses in care by end of March 2019

Reports to be sent to trust level infection prevention and control committee (Chaired by Director for Infection Prevention and Control (DIPC) and the site level clinical performance and patient safety committees.

Statements of assurance from the board

During 2017/18, the Royal Free London NHS Foundation Trust (RFL) provided and/or sub-contracted 40 relevant health services.

The RFL has reviewed all the data available on the quality of care in 40 of these relevant health services.

The income generated by the relevant health services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by the Royal Free London NHS Foundation Trust for 2017/18.
(final number to be confirmed)

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 that we have evidence of improvements made to practice.

During 2017/2018 44 national clinical audits and 9 national confidential enqu
health services that the Royal Free London NHS Foundation Trust provides.

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

The national clinical audits and national confidential enquiries that the Royal Free London NHS Foundation Trust was eligible to participate in, during 2017/18 are listed in table 2:

The national clinical audits and national confidential enquiries that the Royal Free London NHS Foundation Trust participated in, during 2017/18 are also listed in table 2:

The national clinical audits and national confidential enquiries that RFL Trust participated in, and for which data collection was completed during 2017/18, 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, including case ascertainment rates in 2017/18.

Case ascertainment relates to the proportion of all eligible patients captured by the audit during the sampling period compared to the number expected according to other data source, usually Hospital Episode Statistics (HES) data. HES is a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England.

Key:

Yes = data submitted during 2017/18 and relates to 2017/18

* = timeframe for data collection

Name of Audit	Data collection completed in 2017/18	Trust Eligibility to participate	Participation 2017/18	Case ascertainment
British Association of Urological Surgeons (BAUS): Female stress urinary incontinence audit	Yes	Yes	RFH BH and CFH service not available	121.4% *2014/16
BAUS: Nephrectomy audit	Yes	Yes	RFH and BH CFH service not available	134%*2014/16
BAUS: Percutaneous nephrolithotomy (PCNL)	Yes	Yes	RFH BH and CFH service not available	152%*2014/16
Cancer: National bowel cancer audit	Yes	Yes	RFH and BH CFH service not available	290 (109%)*2015/16
Cancer: National lung cancer audit	Yes	Yes	RFH and BH CFH service not available	N=381
Cancer: National oesophago-gastric cancer audit	Yes	Yes	RFH and BH CFH service not available	N=202 (81-90%) *2015/16
Cancer: National prostate cancer audit	Yes	Yes	RFH, BH and CFH	N=428 *2015/16
Chronic obstructive pulmonary disease (COPD) audit programme: Secondary care	Yes	Yes	RFH and BH CFH service not available	60%
COPD audit programme: Pulmonary rehabilitation	Yes	Yes	RFH BH and CFH service not available	N=1 (100%)
Diabetes: National foot care in diabetes audit	Yes	Yes	RFH BH and CFH service not available	N=59 (100%)
Diabetes: National diabetes in-patient audit (NaDIA)	Yes	Yes	RFH and BH CFH service not available	BH=32 RF=66
Diabetes: National pregnancy in diabetes (NPID)	Yes	Yes	RFH and BH CFH service not available	BH = 65 *2014/16 RF = 54 *2014/16
Diabetes: National diabetes audit (NDA)	Yes	Yes	RFH BH and CFH	Awaiting figures
Diabetes: National diabetes transition audit	Yes	Yes	RFH and BH CFH service not available	Audit extracts data from NDA and NPDA submission. Data reported at national-level only

Diabetes: National paediatric diabetes audit (NPDA)	Yes	Yes	RFH BH and CFH	BH = 112 *2016/17 CFH = 60 *2016/17 RFH= 51 *2016/17
Elective surgery (National PROMs programme)	Yes	Yes	RFH BH and CFH	Pre-operative questionnaires n=1033 [42.5%]*2015/2016 Post operative questionnaires n=589 [65.9% *2015/2016]
Endocrine and thyroid national audit	Yes	Yes	RFH and CFH BH service not available	n = 432 *2011/15
Falls and fragility fractures audit programme (FFFAP): Fracture liaison service database	Yes	Yes	BH RFH and CFH service not available	n=156 *2016
FFFAP: Inpatient falls	Yes	Yes	RFH and BH CFH service not available	n = 30 (100%)
FFFAP: National hip fracture database	Yes	Yes	RFH and BH CFH service not available	BH = 391 (98.7%) *2016 RFH= 201 (102.9%)
Heart: Cardiac rhythm management	Yes	Yes	RFH and BH CFH service not available	BH= 304 *2015/16 RFH = 167 *2015/16
Heart: Myocardial infarction national audit project (MINAP)	Yes	Yes	RFH and BH CFH service not available	BH = 297 *2015/16 RFH = 268 *2015
Heart: National audit of percutaneous coronary interventions	Yes	Yes	RFH BH and CFH service not available	n = 867 *2015
Heart: National heart failure audit	Yes	Yes	RFH and BH CFH service not available	BH = 470 *2015/16 RFH = 303 *2015/16
Intensive Care National Audit and Research Centre (ICNARC): Case mix programme: Adult critical care	Yes	Yes	RFH and BH CFH service not available	BH = 1021 *2016/17 RFH = 1793 *2016/17
ICNARC: National cardiac arrest audit (NCAA)	Yes	Yes	RFH and BH CFH service not available	BH = 141 *2016/17 RFH = 359 *2016/17
Inflammatory bowel disease (IBD) registry: Biological therapies audit (Adult)	Yes	Yes	RFH and BH CFH service not available	Audit due for completion 2018/19
IBD registry: Biological therapies audit (Paediatric)	Yes	Yes	RFH BH and CFH service not available	Audit due for completion 2018/19
National audit of breast cancer in older people	Yes	Yes	RFH BH and CFH service not available	n = 600* 2015
National audit of dementia	Yes	Yes	RFH and BH CFH service not available	Audit did not collect data in 2017/18
National audit of dementia - Delirium spotlight audit	Yes	Yes	RFH and BH CFH service not available	BH = 25 (100%) RFH = 25 (100%)
National audit of pulmonary hypertension audit	Yes	Yes	RFH BH and CFH service not available	719 *2016/17
National audit of seizures and epilepsies in children and young people	Yes	Yes	RFH and BH CFH service not available	Audit did not collect data in 2017/18
National clinical audit of care at the end of life (NACEL)	Yes	Yes	RFH and BH CFH service not available	Audit did not collect data in 2017/18
National clinical audit for rheumatoid and early inflammatory arthritis (NCAREIA)	Yes	Yes	RFH and BH CFH service not available	Audit did not collect data in 2017/18

National comparative audit of blood transfusion programme: Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients	Yes	Yes	RFH BH and CFH	
National comparative audit of blood transfusion programme: 2017 National comparative audit of transfusion associated circulatory overload (TACO)	Yes	Yes	RFH BH and CFH	
National comparative audit of blood transfusion programme: Audit of patient blood management in scheduled surgery	Yes	Yes	RFH BH and CFH	Audit did not collect data in 2017/18
National comparative audit of blood transfusion programme: Audit of the use of blood in lower GI bleeding	Yes	Yes	RFH BH and CFH	Audit did not collect data in 2017/18
National emergency laparotomy audit (NELA)	Yes	Yes	RFH and BH CFH service not available	BH = 83 *2015/16 RFH = 118 *2015/16
National joint registry (NJR)	Yes	Yes	RFH BH and CFH	BH= 37 CFH = 586 RFH = 384
National maternity and perinatal audit (NMPA)	Yes	Yes	RFH and BH CFH service not available	BH = 100% *2015/16 RFH= 100% *2015/16
National neonatal audit programme (NNAP)	Yes	Yes	RFH and BH CFH service not available	BH = 100% *2016 RFH= 100% *2016
National ophthalmology audit: Adult cataract surgery	Yes	Yes	RFH BH and CFH	552 *2015/16
National vascular registry	Yes	Yes	RFH BH and CFH service not available	368 *2014/16
Royal College of Emergency Medicine (RCEM): Fractured neck of femur	Yes	Yes	RFH and BH CFH service not available	BH= 52 (100%) RFH=75(100%)
RCEM: Pain in children	Yes	Yes	RFH and BH CFH service not available	BH=51 RFH= 99
RCEM: Procedural sedation in adults	Yes	Yes	RFH and BH CFH service not available	BH = 50 RFH =21
Sentinel stroke national audit programme (SSNAP)	Yes	Yes	RFH and BH CFH service not available	BH= Clinical Audit: 90+% (Level A) RFH= Clinical Audit: 90+% (Level A)
Serious hazards of transfusion (SHOT): UK national haemovigilance scheme	Yes	Yes		
Trauma audit research network (TARN)	Yes	Yes	RFH and BH CFH service not available	BH = 34% RFH = 90%
UK Parkinson's Audit	Yes	Yes	RFH BH and CFH	100%

During 2017/18, the Trust did not participate in the below national audit as service is not provided by the organisation.

National audit title
Adult cardiac surgery
BAUS: Radical prostatectomy audit
BAUS: Cystectomy
BAUS: Urethroplasty audit
Head and neck cancer audit (DAHNO)
Mental health clinical outcome review programme
National audit of anxiety and depression
National audit of intermediate care (NAIC)
National bariatric surgery registry (NBSR)
COPD audit programme: Primary care
National clinical audit of psychosis
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)
National congenital heart disease (CHD)
National lung cancer audit: Consultant-level data
National neurosurgical audit programme - Consultant-level data
National oesophago-gastric cancer audit (NOGCA) - Consultant-level data
Paediatric intensive care (PICANet)
Prescribing observatory for mental health

The Royal Free London NHS Foundation Trust also participated in the following national audits by submitting data 2017/18:

During 2017/18, the trust participated in several other national audits which were not in the HQIP 'Quality accounts' list, published in December 2017. These included the following:

National audit title
7-day service audit
Health records audit
National audit of cardiac rehabilitation
National benchmarking pharmacy technician audit
NHSBT: kidney transplantation
NHSBT: liver transplantation
Potential donor
Renal registry
Royal College of Anaesthetists: National of perioperative anaphylaxis
Society for Acute Medicine Benchmarking Audit (SAMBA) study
The iBRA-2 study: a national prospective multi-centre audit of the impact of immediate breast reconstruction on the delivery of adjuvant therapy

The reports of 44 national clinical audits were reviewed by the provider in 2017/18 and the Royal Free London NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Actions to improve the quality of healthcare provided:

- 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.

(specific actions to improve quality are presented in table 3)

Table 3: Specific actions to improve quality

Specific actions to improve quality as the result of a national audit	
	The Royal Free Hospital has successfully bid for funding from the NHSE Diabetes Transformation Fund for Multidisciplinary Foot Teams which will soon enable us to provide a 7 day Hot Clinic, improving service delivery, patient pathways and outcomes as well as compliance with the National Footcare Diabetes Audit at the Royal Free Hospital.
	The Royal Free Hospital remains one of the leading participants and one of the best hospitals nationally to achieve case ascertainment, presenting mortality rates below the national average. We have now implemented a new operating theatre booking form that requires the stratification of the risk of death calculated prior to surgery which will improve our compliance in documenting the risk of death. We have also appointed a geriatric surgical specialist making sure all of our elderly patients are reviewed post-surgery. As a service we continuously monitor and review every unplanned admission to critical care addressing any issues arisen.
	More multidisciplinary team (MDT) input to ensure the 4AT (a tool for assessing delirium) is completed. Discussion with physiotherapy to try and have a Sunday service to mobilise patients first day post-op. On-going attempt to reduce time to theatre.

Summary of our key achievements relating to national audits

A **top** 'green' **rating** was achieved by **Barnet Hospital, Chase Farm Hospital** and Royal Free Hospital for **90 day mortality and revision rates** for both **elective hip and knee surgery**	Our **stroke patients receive a world class stroke service** with **Royal Free Hospital** amongst the **top 23% of teams** nationally	**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
Royal Free Hospital is in the **best 25% of hospitals** nationally for **diabetes care in pregnant women** for **blood glucose control in the first trimester and third trimester**	The Trust participated in **53** national audits and confidential enquiries	**Pregnant women** delivering at **Barnet and Royal Free Hospitals** are **achieving outcomes** that are **lower than expected** for **induction of labour, instrumental births and 3rd and 4th degree tears**
Royal Free Hospital intensive care unit • Achieved a **green rating (good to excellent) for all RAG-rated quality measures** • **Improved compared to previous for 4 out of 7 re-audited measures.**	**Barnet Hospital** achieved the **top 'green' rating** for **6 out of 10 RAG rated quality indicators for emergency laparotomies**: •	Compared to other hospitals nationally **more people with type 1 diabetes** treated at the **Royal Free Hospital** are receiving best practice care by: • **Receiving insulin pump therapy** • **Receiving all 8 recommended key care processes** • **Meeting all 3 treatment targets**
Barnet Hospital: • Is in the **best 25% of hospitals** nationally **for 8 best practice care processes and outcomes** for **hip fracture** patients • Achieved the **lowest rate in London** for **hip fractures sustained as an in-patient** and is amongst the best 25% of hospitals nationally	**Royal Free Hospital** emergency department Is in the **best 25% of hospitals** nationally for **6 out of 13 best practice criteria relating to the timely treatment of severe sepsis and septic shock**	**Barnet Hospital** is in the **best 25% of hospitals** nationally for the care of **patients with dementia** for 5 out of 7 key domains – **governance, nutrition, staff rating of communication, carer rating of communication and carer rating of patient care**

The National COPD Audit Programme

COPD Secondary Care Audit Programme

During 2017-18 the trust participated in the COPD Secondary Care Audit Programme. The programme is in two parts. Part one is a continuous audit of patients that have been admitted to hospital with exacerbations, and a part two is a snapshot audit of the organisation and resourcing of care.

The programme is also linked to a 'Best Practice Tariff'- (BPT), which is a national price that is designed to incentivise quality and cost effective care.

Since the start of the tariff in April 2017, the trust has met all the standards required, which is a notable achievement, as only 58 out of 137 acute trusts have managed this.

National confidential enquiries for inclusion in quality report 2017/18

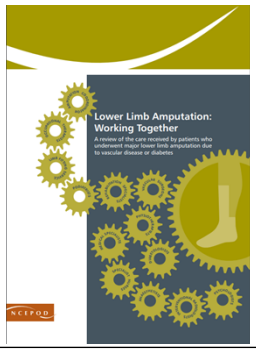
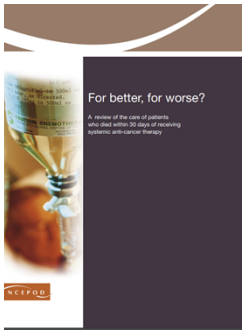
Name of Audit	Data collection completed in 2017/18	Trust Eligibility to participate	Participation 2017/18	Case ascertainment
Child health clinical outcomes review programme: Young people's mental health	Yes	Yes	RFH BH and CFH	BH = Clinical Questionnaire: n = 6/9 (67%) CFH = Casenotes: n = 5/9 (56%) Organisational Audit: n = 2/2 (100%)
Child health clinical outcomes review programme: Chronic neurodisability	Yes	Yes	RFH and BH CFH service not available	BH = Clinical Questionnaire: n = 14/16 (87.5%) Casenotes: n = 12/16 (75%)
Child health clinical outcomes review programme: Chronic neurodisability	Yes	Yes	RFH and BH CFH service not available	9/9
Child health clinical outcomes review programme: Long-term ventilation in children, young people and young adults	Yes	Yes	RFH BH and CFH	Enquiry in development
LeDer: Learning disability review programme	Yes	Yes	RFH BH and CFH	Enquiry due for completion 2018/19
Medical and surgical clinical outcomes review	Yes	Yes	RFH and BH	Clinical Questionnaire: n = 10/10 (100%)

programme: Acute heart failure			CFH service not available	Casenotes: n = 9/10 (100%) Organisational Audit: n= 2/2 (100%)
Medical and surgical clinical outcomes review programme: Pulmonary hypertension	Yes	Yes	RFH and BH CFH service not available	Enquiry in development
Medical and surgical clinical outcomes review programme: Non invasive ventilation	Yes	Yes	RFH and BH CFH service not available	Clinical Questionnaire: n = 5/5 (100%) Casenotes: n = 5/5 (100%) Organisational Audit: n = 2/2 (100%)
Medical and surgical clinical outcomes review programme: Perioperative diabetes	Yes	Yes	RFH BH and CFH	Enquiry due for completion 2018/19
Medical and surgical clinical outcomes review programme: Cancer in children, teens and young adults	Yes	Yes	RFH and BH CFH service not available	Clinical Questionnaire: n = 10/10 (100%) Casenotes: N/A Organisational Audit: N/A
Maternal, newborn and infant: Maternal programme 2015 data	Yes	Yes	RFH and BH CFH service not available	100%
Maternal, newborn and infant: Perinatal programme 2015 data	Yes	Yes	RFH and BH CFH service not available	100%

The trust continues to review National Confidential Enquiries into Patient Outcomes and Death (NCEPODs) on an annual basis until they are fully implemented. Progress is reported at both divisional and corporate levels.

Table 4: Specific actions to improve quality

Specific actions undertaken to improve quality	
NCEPOD Surgery in Children: Are we there yet? (SIC) **R**eviewed and updated: August 2017 	All hospitals that undertake surgery in children must hold regular multidisciplinary audit and morbidity and mortality meetings that include children and should collect information on clinical outcomes related to the surgical care of children. We are in the process of setting up a joint MDT meeting for General Surgery with RFL and GOSH.
NCEPOD Peri-operative Care: Knowing the risk (POC)	Mortality risk is assessed by using risk stratification score by the consultant surgeons and anaesthetists. Mortality risk is communicated to the patient in the consent procedure but not

Reviewed and updated: August 2017	documented on the consent form. However we are compliant with the legal requirements which are reflected in the Trusts consent policy.
NCEPOD Lower Limb Amputation: Working together. Reviewed and updated: December 2017 	We are in the process of establishing formal pathways for access to medical specialists pre- and post-amputation. There is an ongoing business case for additional physiotherapists to improve care.
Subarachnoid Haemorrhage: Managing the flow	Guidance for Subarachnoid haemorrhage is currently being drawn up.
NCEPOD Systemic Anti-Cancer Therapy: For better, for worse? Published: Nov-08 	The Oncology department has undertaken repeat audits 2009, 2013, 2014, 2016 and planned for 2018 (5th repeat). The audit studies the treatment and management of all patients who died within 30 days of receiving SACT, Outcomes measured are : treatment initiated and prescribed appropriately, and complication of treatment managed appropriately. All death cases are reviewed at mortality and morbidity meetings, and learning shared.
NCEPOD Acute Kidney Injury (AKI): Adding Insult to Injury. Published: Jun-09	The recommendations from this report was embedded as part of our Patient Safety Programme work stream until autumn 2017. It is now part of the AKI Clinical Pathway Groups.

Clinical audit remains a key component of improving the quality and effectiveness of clinical care, ensuring that safe and effective clinical practice is based on nationally agreed standards of good practice and evidence-based care. The Trust remains committed to delivering safe and effective high quality patient centred services, based on the latest evidence and clinical research. Through our four clinical divisions, work is in progress to dovetail our clinical audits and quality improvement initiatives which will provide better outcomes for our patients.

The reports of 23 local clinical audits* were reviewed by the provider in 2017/18 and RFL intends to take the following actions to improve the quality of healthcare provided.

- (* the local audits undertaken relate to the quality improvement projects previously described om page 22 which demonstrated modest to significant improvement through successful PDSA cycles)

Actions to improve the quality of healthcare provided:

- To ensure that all local audits/ quality improvement projects are monitored effectively throughout our clinical divisions, with an increased focus on identifying the outcomes and embedding recommendations

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 active participation in research leads to better patient outcomes.

Our reputation attracts outstanding staff and researchers from many different countries. The close collaboration between staff and the research department of the medical school is one of our unique strengths - 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 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was **10, 985**

The figure includes **4140** patients recruited into studies on the National Institute for Health Research (NIHR) portfolio and **6845** patients recruited into studies that are not on the NIHR portfolio. This figure is l**ower** than that reported last year.

The Trust is supporting a large research portfolio of over 700 studies, including both commercial and academic research**. 159** new studies were approved in 2017/18. The breadth of research taking place within the Trust is far reaching and includes clinical and medical device trials, research involving human tissue and quantitative and qualitative research, as well as observational research.

Celebrating research success

Research is of huge strategic importance to the trust and to help us achieve even greater success in the future. In July 2017 the trust launched a new three-year strategy. Its aim is to advance clinical outcomes, quality and experience through access to world-leading clinical research for all our patients and staff, across all of our healthcare sites.

Our vision is that by 2020, clinical research will be part of our core business and that we'll be ranked in the top ten nationally for clinical research outputs and performance.

Adele Fielding, director of research and development, states:

'This inaugural clinical research and development strategy is a crucial step towards the trust securing its rightful position as a top-ten ranked NHS provider of nationally adopted high quality clinical research.

Its delivery will ensure that all of our patients and staff have the same opportunity to participate in clinical research, regardless of the site they are treated or work at. This in turn will contribute to improved patient outcomes and enhance the experience of being a patient or member of staff at the trust. As R&D director and an active clinical researcher, I am very excited about implementing the strategy and the opportunity it will bring to advance clinical research at the trust.'

CQUIN Payment framework

A proportion of the Royal Free London NHS Foundation Trust income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between the Royal Free London NHS Foundation Trust and any person or body they 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 2017/18 and for the following 12-month period will be presented in the final report).

CQUIN scheme priorities 2017/2018	**Objective rationale**
Staff health & well being	This national initiative made up of three areas of improvement: 1) Improvement of health and wellbeing of NHS staff with a focus on MSK and stress 2) Healthy food for NHS staff, visitors and patients 3) Improving the uptake in 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 a empiric review of antibiotic prescriptions. Antimicrobial resistance has risen alarmingly over the last forty years and inappropriate plus overuse of antimicrobials is a key driver.
Mental health in A&E	Reducing the number of frequent attenders who would benefit from mental health and psychosocial interventions The Trust has worked closely with mental health providers and other partners (including police, ambulance, substance misuse, social care and the voluntary sector) to ensure that people presenting at A&E with primary or secondary mental health requirements have these needs met by an improved integrated service.
Advice & Guidance	Scheme requires the Trust to set up and operate Advice & Guidance services for non-urgent GP referrals allowing GP's to access consultant advice prior to referring patients in to secondary care.
e-Referral	CQUIN designed to encourage a move away from any paper based processes so that all referrals to first outpatient services are available electronically by April 2018.
Supporting proactive & safe discharge	Unnecessary delays in discharging patients from hospital is a systemic problem and a rising trend. In particular with older patients longer stays in hospital can lead to worse health outcomes and an increase in long term care needs. CQUIN supports systems to streamline discharge pathways, embed and strengthen discharge to assess pathway to maximum effect and to understand the capacity

	within community services to support improved discharge.
Hep C Virus – Improving pathways	The Trust is a lead provider in reducing harm from Hepatitis C. This is a continuing CQUIN that forms part of a long term project with the end goal being the elimination of Hepatitis C as a major health concern by 2030.
Medicines optimisation	This CQUIN supports the optimisation and use of medicines commissioned by specialised services in identified priority areas.
Cancer dose banding	Supporting the implementation of nationally standardised doses of SACT across England using dose banding principles and dosage tables published by NHS England.
Optimising palliative chemotherapy decision making	To support optimal care by ensuring that, in specific groups of patients, decisions to start and continue further treatment are made in direct consultation with peers and then as a shared decision with the patient.
Complex device optimisation	To ensure that complex implantable cardiac device selection for patients remains consistent with the commissioning policy, service specification, and relevant NICE guidance and that contractual requirement are in place for providers while new national procurement and supply chain arrangements are embedded.
Multisystem Autoimmune Rheumatic Disease	This CQUIN oversees 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).
Breast screening	Increasing uptake of screening programmes through MECC (making every contact count) in both clinical service and admin hub.
Dental	Collection and submission of data on priority pathways procedures by Tier using the CQUIN dashboard. Participation in the Acute Dental Systems Resilience Group (SRG), including supporting data requests to contribute to a Pan London approach to demand and capacity modelling. Active participation in consultant led MCN with collaborative oversight of appraisal of performers.

In 2017/18 the Clinical Commissioning Group (CCG) monetary total was xxxxx and the NHS England (NHSE) monetary total was xxxx conditional upon achieving quality improvement and innovation goals.

(The final monetary total will be presented in the final report).

Registration with the Care Quality Commission (CQC)

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

The Care Quality Commission has not taken enforcement action against the Royal Free London NHS Foundation Trust during 2017/18.

The Royal free London NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 19 February 2018 review of services for looked after children and safeguarding in Barnet (details are presented below).

The Royal Free London NHS Foundation trust has not yet received the final report conclusions of this review.

The CQC undertook the following unannounced responsive and announced inspections during 2017 at the Royal Free Hospital Hampstead site (Further details are provided on page 69).

Information on the quality of data

Good quality information ensures that 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 ethnicity and other equality data 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 2017/18 to the Secondary Uses service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

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

% of records	2014/15	2015/16	2016/17	2017/18 (April to September)
For admitted patient care	98.8%	98.6%	98.15%	

				98.7%
For out-patient care	99.2%	98.6%	98.65%	99.1%
For accident & emergency care	92.6%	94.4%	94.89%	95.6%

General Medical Practice Code

In order to transfer clinical information from the trust to our patient's GP, It is essential that the information sent is accurate. Data which included the patients' valid General Medical Practice Code was:

% of records	2014/15	2015/16	2016/17	2017/18 (April to September
For admitted patient care	99.8%	99.95%	99.92%	99.8%
For out-patient care	99.9%	99.96%	100%	99.9%
For accident & emergency care	99.9%	99.94%	100%	100%

Information Governance (IG)

The Royal Free London NHS Foundation Trust Information Governance Assessment Report overall score for 2017/18 was 68% and was graded satisfactory (green)

	2015/16	2016/17	2017/18
Information governance assessment score	**68%**	**66%**	**68%**
Overall grading	**green**	**green**	**green**

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 for 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:

- Implementing a new Trust wide data quality dashboard on Qlikview during Q1 2018/19 which will provide access to a range of KPIs that cover the main datasets and will ensure visibility and standardisation throughout the Group model. Specialities that are performing poorly against the targets set will be reviewed by the Data Quality team and action plans will be put in place to resolve the issues.

- An external partner will be used to implement a Data Assurance Framework. The Data Assurance Framework will assess current data quality, provide KPIs to internally measure data quality and develop a programme of regular audit to continually assess progress.

Learning from deaths

Learning from deaths

Hundreds of patients come through our doors on a daily basis. Most patients receive treatment, get better and are able to return home or go to other care settings. Sadly and inevitably, some patients will die here.

While most deaths are unavoidable and would be considered to be "expected", there will be cases where sub-optimal care in hospital may have contributed to the death. The Trust is keen to take every opportunity to learn lessons to improve the quality of care for other patients and families.

A Care Quality Commission review in December 2016, "Learning, Candour and Accountability" found that some providers were not giving learning from deaths sufficient priority and so were missing valuable opportunities to identify and make improvements in quality of care. In March 2017, the National Quality Board (NQB) introduced new guidance for NHS providers on how they should learn from the deaths of people in their care.

The Trust is committed to fully implementing the national guidance and has published a "Learning from Deaths" policy which outlines its processes for identifying, reviewing and learning from deaths and the roles and responsibilities for staff involved in that process.

Details to follow.

2.3 Reporting against core indicators

Details to follow.

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 2017/18 against indicators and national priorities selected by the board in consultation with our stakeholders.

Performance against key national indicators

The charts and commentary contained in this report represents the performance for all three of our hospital sites. This approach has been taken to ensure consistency with the indicators the trust is required to report on by the NHS Improvement Single Oversight Framework.

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.

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 Infections
Clinical effectiveness	• referral to treatment (RTT) • A&E performance • cancer waits
Patient experience	• friends and family test

Definitions

The following table sets out the definition for each performance measure. These are, to the best of our knowledge, consistent with standard national NHS data definitions. There has been no change in the basis for calculation for any of these measures since 2015/16.

Indicator / Metric	Description / Methodology
Accident and Emergency – 4hr standard	Percentage of A & E attendances where the patient was admitted transferred or discharged within 4 hours of their arrival at an A & E department.
Summary Hospital Mortality Indicator (SHMI) and Hospital Standard Mortality Ratio (HSMR)	These measures uses routinely collected data to calculate an overall "expected" number of deaths if the trust matched the national average performance. The result is a ratio (calculated by dividing the observed number of deaths by the expected deaths). The main differences between these measures are found in the data coverage: (a) while HSMR only considers around 80% of deaths the SHMI metric ostensibly covers all hospital spells, (b) definition of death in HSMR includes in-hospital mortality only whilst SHMI captures any death occurring 30 days post discharge), and (c) adjustments are made for palliative care in HSMR only.
Average length of stay	Measured in days, the average length of stay is the result of calculating the difference between the admission date and the discharge date for each patient treated as an Inpatient over the period.
Day-case rate	The proportion of elective admissions that are treated on a day case basis with no overnight stay.
Readmission rate	The relative risk of a patient being readmitted as an emergency within 28 days of a previous discharge. The result is a ratio (calculated by dividing the observed number of emergency readmissions by the expected volume emergency readmissions).
RTT Incomplete Performance - % waiting less than 18 weeks	Percentage of patients on the incomplete RTT patient tracking list who are waiting 18 weeks or less for treatment or discharge from Referral.
2 Week Wait - All Cancer	Percentage of patients referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment or diagnostic.
2 Week Wait -symptomatic breast	Percentage of patients referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for their first outpatient appointment.
31 day wait diagnosis to	Percentage of patients waiting no more than one month (31 days)

treatment	from diagnosis to first definitive treatment for all cancers.
31 day wait - subsequent surgery	Percentage of patients waiting no more than 31 days for subsequent treatment where that treatment is surgery.
31 day wait - subsequent drug treatment	Percentage of patients waiting no more than 31 days for subsequent treatment where that treatment is a drug regimen.
31 day wait - subsequent radiotherapy	Percentage of patients waiting no more than 31 days for subsequent treatment where the treatment is a course of radiotherapy.
62 day wait - from urgent GP referral	Percentage of patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer.
62 day wait - from screening service referral	Percentage of patients waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for cancer.
C. Difficile Lapses in care	Number of Clostridium Difficile infections due to lapses in patient care
Friends and Family IP & AE Score	The number of responses that scored likely and extremely likely as a percentage of the total number of responses to the IP & AE friends and family tests. (Neither Likely or not likely excluded from responses)

Notes on the charts

This year the presentation of the data has changed to ensure that it is in line with Healthcare Statistics best practice[1]. Two chart types are now used: control charts and funnel plots.

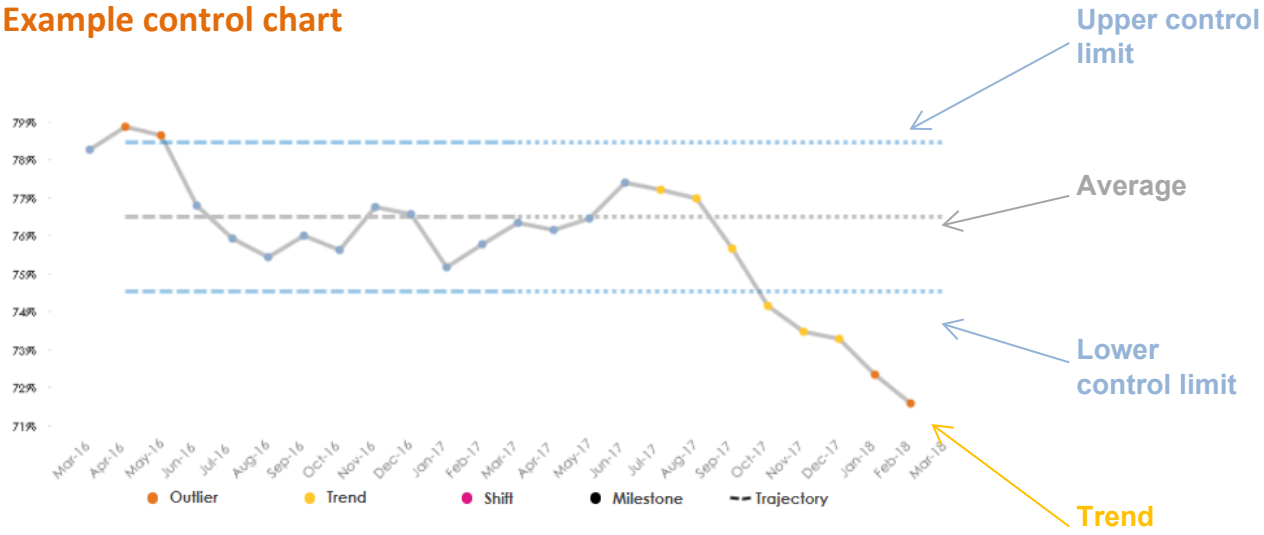
Control charts

The control chart is a graph used to study how a process changes over time. Data are plotted in time order. A control chart always has a central line for the average, an upper line for the upper control limit and a lower line for the lower control limit. These lines are determined from historical data. By comparing current data to these lines, you can draw conclusions about whether the process variation is consistent (in control) or is unpredictable (out of control, affected by special causes of variation).[2]

Where there has been variation that signals a change in the underlying process, this is marked on the chart as:

- Outlier - data points either above the upper control limit or below the lower control limit
- Trend - 6 or more points either all ascending or all descending
- Shift - 8 or more points either all above or all below the average line

Example control chart



[1] See, for example, "The Health Care Data Guide", Provost & Murray

[2] http://asq.org/learn-about-quality/data-collection-analysis-tools/overview/control-chart.html

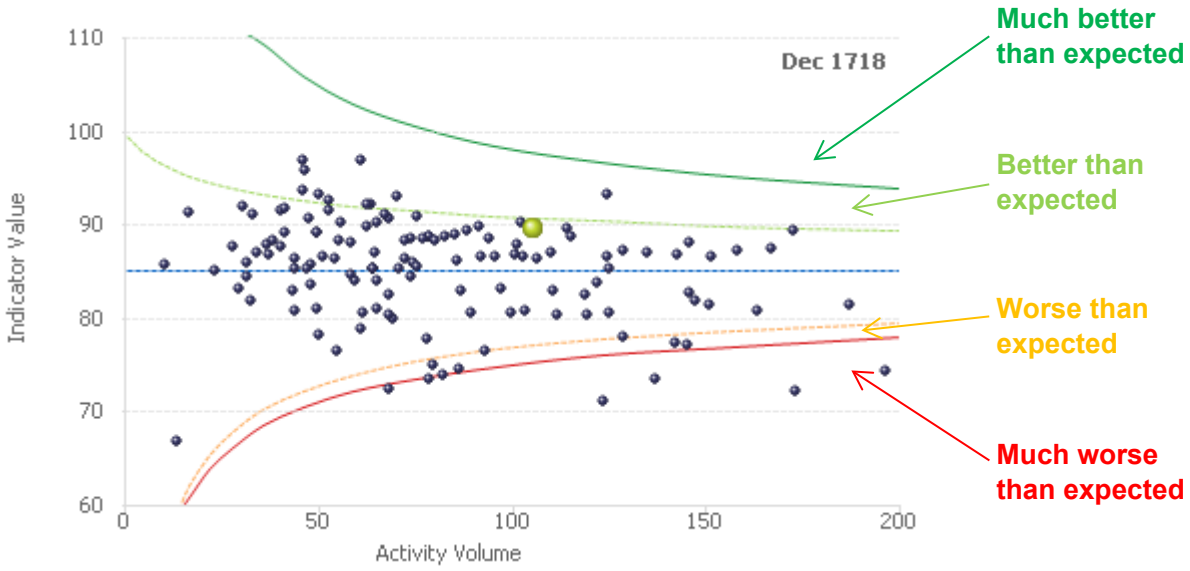
Spine charts

Spine charts are a way of displaying variation data that is derived from a funnel plot. A funnel plot shows data for a range of organisations at a single point in time. The denominator (count of activity, population etc.) is plotted on the X axis and the value of the measure (mortality rate, readmission rate) on the Y axis.[3] The central line represents the mean for all organisations on the chart.

If the trust is within the central portion of the chart, it means that performance on this indicator does not differ from the national mean by more than can be explained by random chance. If the trust is within a coloured region, these can be interpreted as follows:

- Dark green: the rate is much better than expected by chance
- Light green: the rate is better than expected by chance
- Amber: the rate is worse than expected by chance
- Red: the rate is much worse than expected by chance

Example spine chart



Source: Stethoscope benchmarking tool, Methods Analytics 2018

These charts can also be used to display measures that have been adjusted for case mix.

[3] Methods Analytics methodology, 2018

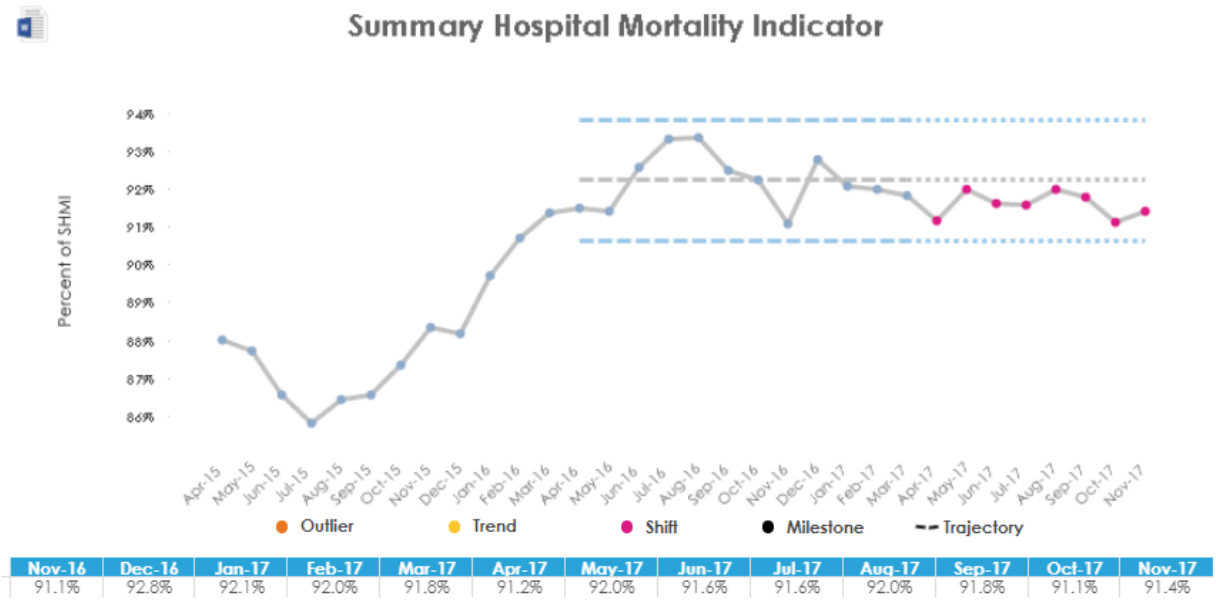
Patient Safety

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 groups 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 below for April 2015 to November 2017. This shows a recent improvement in the trust's score to a mean of 91.7 or 8.3% better than expected over the months April to November 2017.

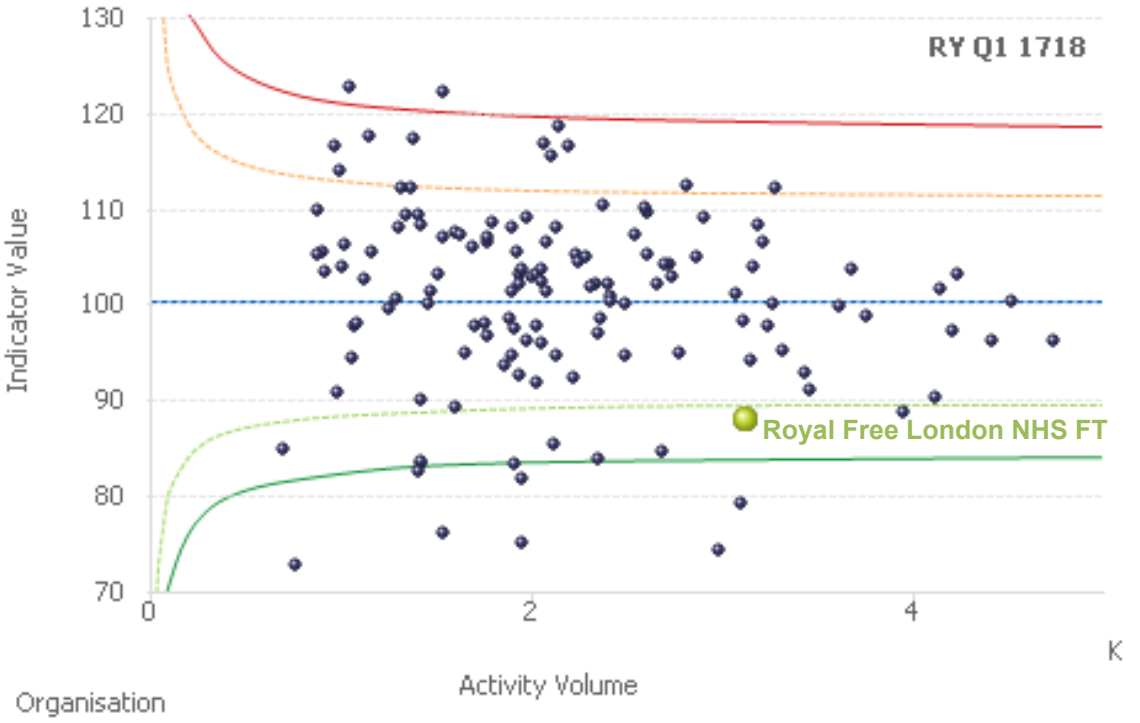


Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
91.1%	92.8%	92.1%	92.0%	91.8%	91.2%	92.0%	91.6%	91.6%	92.0%	91.8%	91.1%	91.4%

Source: Royal Free London NHS Foundation Trust

The chart below shows the Royal Free London SHMI performance compared to all other acute NHS trusts for the rolling year ending Q1 2017/18 (the latest for which information is currently available). The Royal Free SHMI was 15th lowest out of 134 acute trusts and was statistically lower than expected.

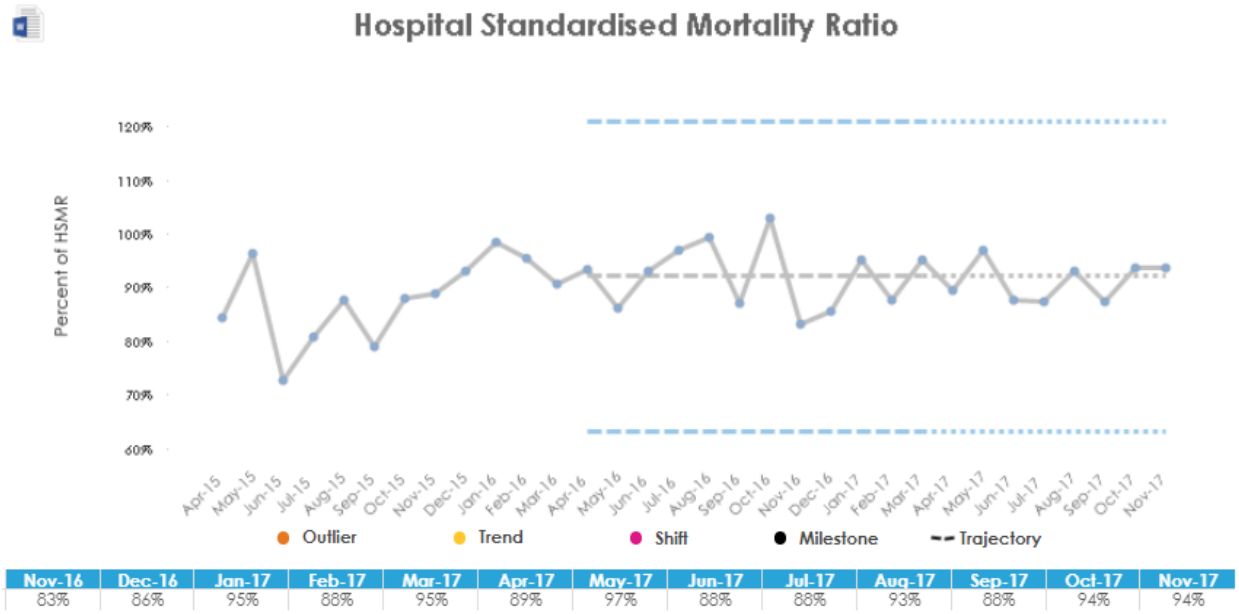
Chart: Summary Hospital-level Mortality Indicator by NHS acute trust



Source: Stethoscope benchmarking tool, Methods Analytics 2018

Hospital Standardised Mortality Ratio (HSMR)

The HSMR (Hospital Standardised Mortality Ratio) includes 56 diagnoses groups responsible for 80% of deaths and only includes in-hospital mortality. Our data shows that there has been no significant change in our HSMR over the year to November 2017; our average over the period has been 92 or 8% better than expected.

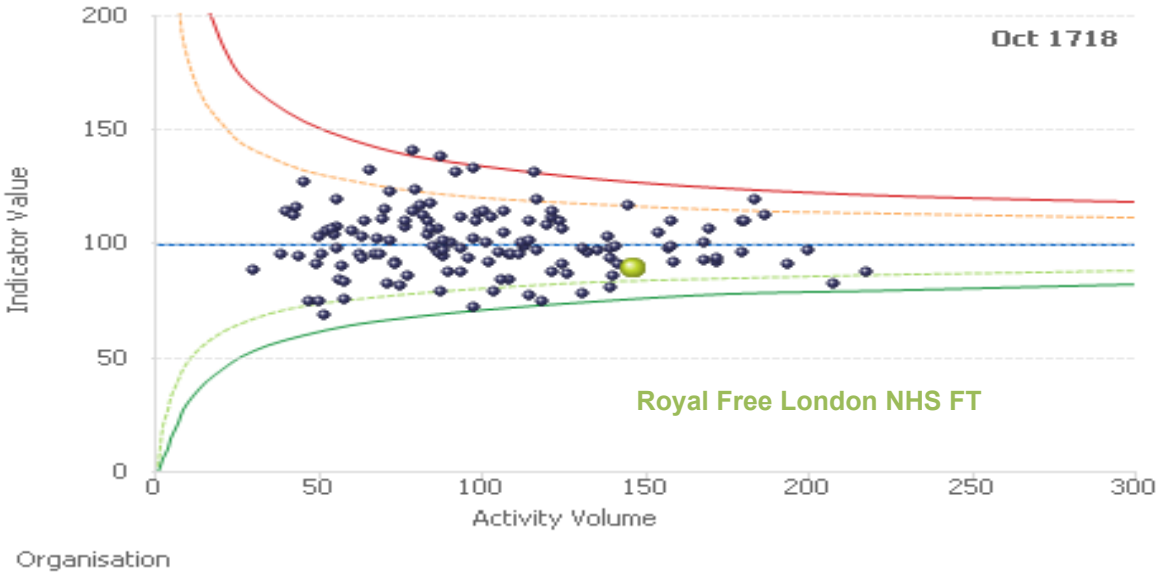


Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
83%	86%	95%	88%	95%	89%	97%	88%	88%	93%	88%	94%	94%

Source: Royal Free London NHS FT

However, benchmarking shows that on this measure the Royal Free London does not differ from the national mean by more than can be explained by random chance. This is consistent with previous performance.

Chart: Hospital Standardised Mortality Ratio by NHS acute trust



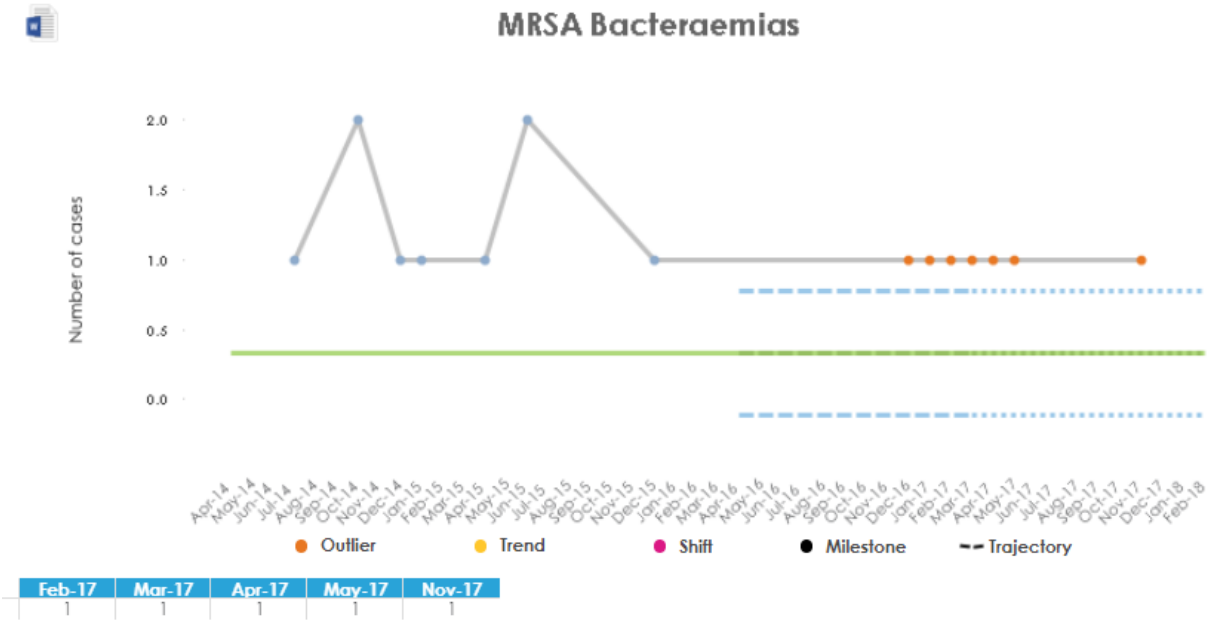
Source: Stethoscope benchmarking tool, Methods Analytics 2018

Data shows that for October 2017 the Royal Free London NHS Foundation Trust recorded the 27th lowest relative risk of mortality of any English Teaching Trust with a relative risk of mortality of 89.0 which is 11% below (statistically significantly better than expected) (Data source: Methods Analytics).

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.

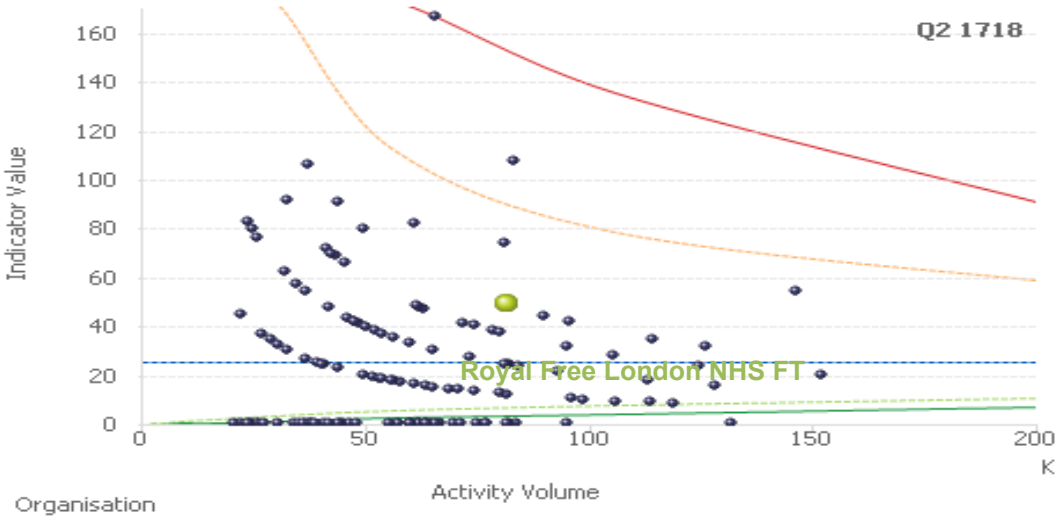
Reducing the rate of MRSA infections is vital to ensure patient safety and is indicative of the degree to which our hospitals prevent the risk of infection by ensuring cleanliness of their facilities and good infection control compliance by their staff.



Source: Royal Free London NHS FT

In the twelve months to the end of February 2018 the Royal Free reported 4 MRSA bacteraemias, with none reported since November 2017. The chart below shows the Royal Free London Q2 2017/18 MRSA rate per 1,000,000 occupied bed days benchmarked against all other NHS trusts. This shows that our MRSA rate does not differ from the national mean by more than can be explained by random chance.

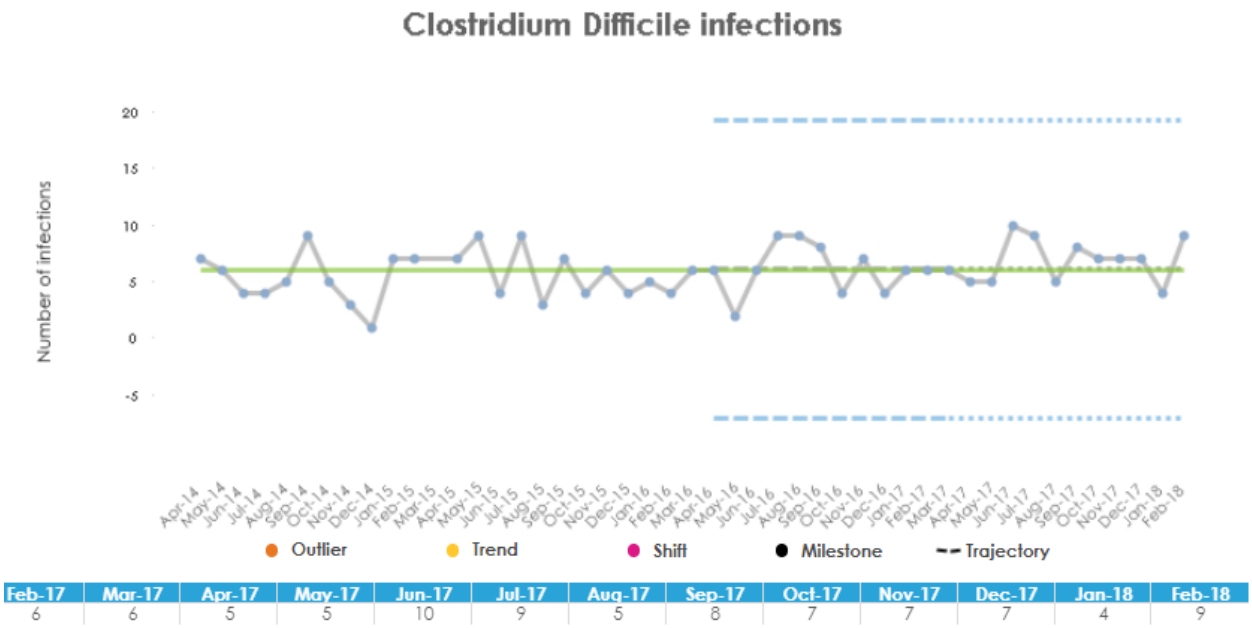
Chart: MRSA bacteraemia, rate per 1,000,000 occupied bed days by NHS acute trust Q2 2017/18



Source: Stethoscope benchmarking tool, Methods Analytics 2018

C. difficile

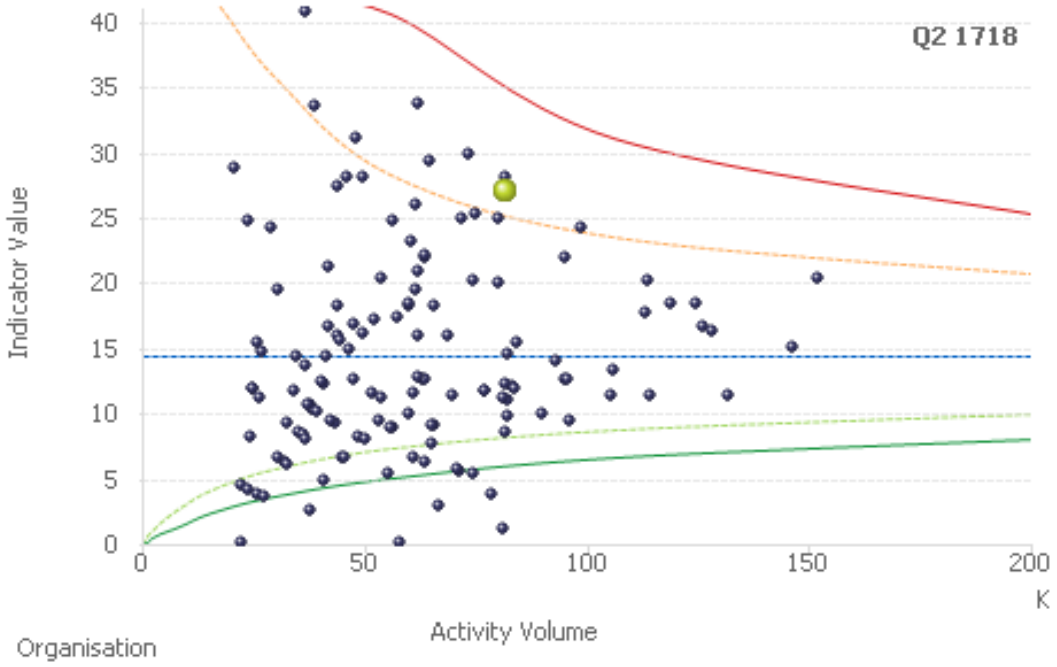
In relation to C. difficile the trust saw no change in 2017/18 from 2016/17 in terms of the rate of infections, with an average of 6 per month.



Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
6	6	5	5	10	9	5	8	7	7	7	4	9

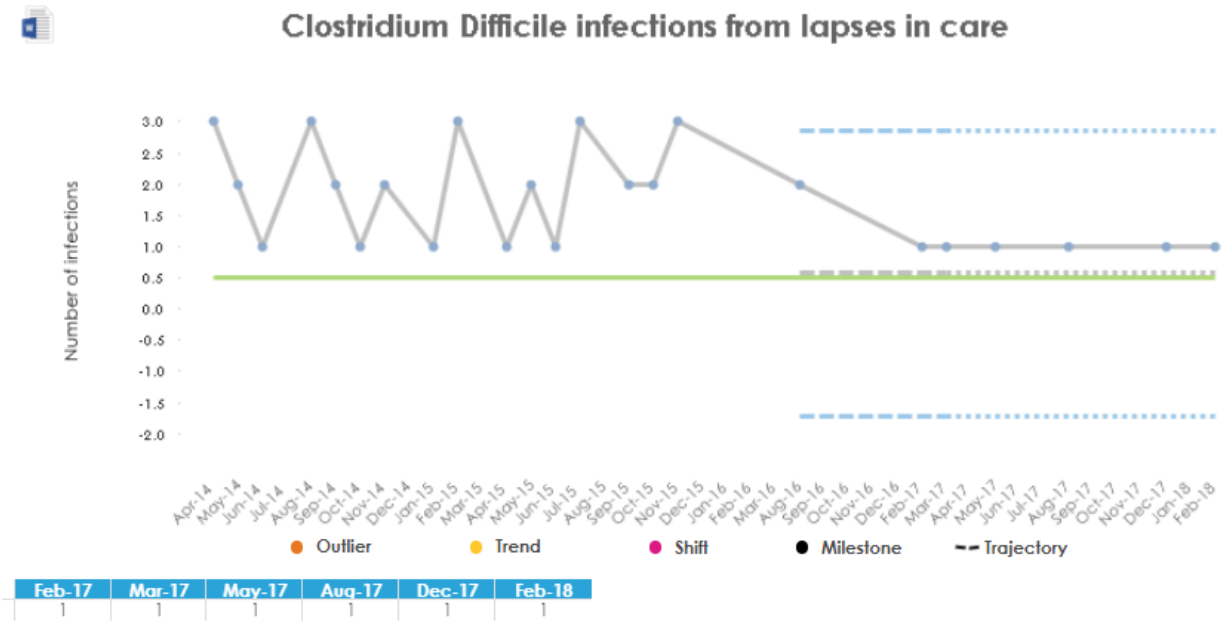
According to our benchmark information for Q2 2017/18, this indicates that our infection rate per 100,000 occupied bed days is higher than would be expected by chance.

Chart: C. Difficile infection rate per 100,000 occupied bed days by NHS acute trust Q2 2017/18



Source: Stethoscope benchmarking tool, Methods Analytics 2018

However, our C. Difficile volumes that can be attributed to "lapses in case" by the trust are significantly lower. Against this measure of performance the trust has seen 5 incidents in the 12 months to February 2018.



Source: Royal Free London NHS FT

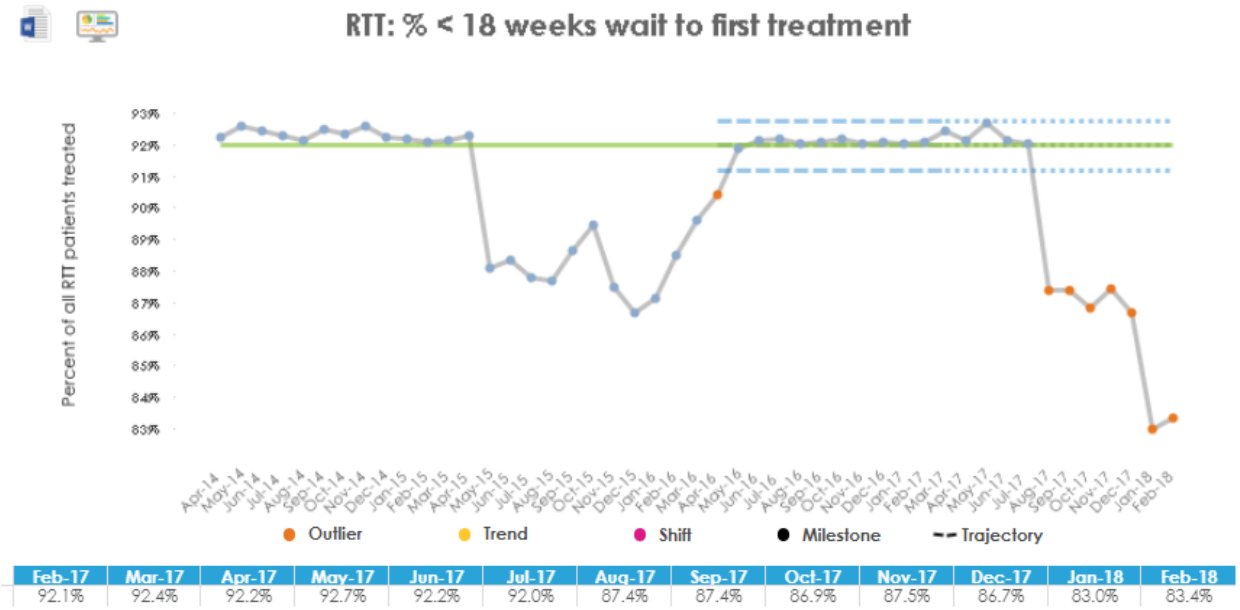
Clinical Effectiveness

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.

From September 2015, NHS England has used as the single measure of compliance with the NHS Constitution, the proportion of pathways where the patient has yet to receive treatment and is actively waiting. For these pathways the national standard requires that no more than 8% of patients should be waiting longer than 18 weeks for treatment i.e. 92% should be waiting 18 weeks or less.

As shown in the chart below, the trust returned to compliance against the incomplete pathway standard in June 2016. However, since August 2017, the trust has failed the standard. Performance in February 2018 was 83.4%.



Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
92.1%	92.4%	92.2%	92.7%	92.2%	92.0%	87.4%	87.4%	86.9%	87.5%	86.7%	83.0%	83.4%

Source: Royal Free London NHS FT 2014-2018

This was primarily a result of improvements the trust made to the way in which it tracks patient pathways using a Patient Tracking List (PTL). During 2017/18 the Trust worked on improving the PTL for two main reasons:

1. In order to better link patient encounters together to identify whole pathways
2. To eliminate the need for the number of exclusion rules that were in place in the original PTL

The new PTL was also designed to ensure that we no longer need to repeatedly validate the same patients, whose validation was being lost by the old logic.

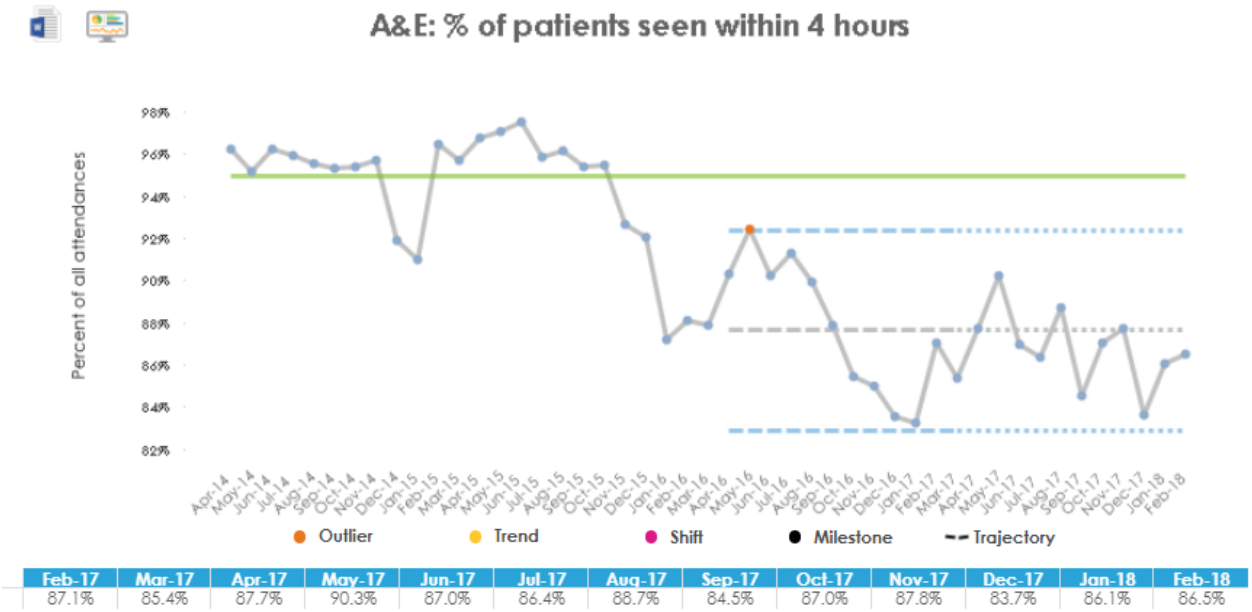
This revised PTL was originally planned for delivery in December 2016 but due to a number of technical issues it was released on 1st August 2017. Upon release, the volume of breaches across the trust increased significantly and 35 patients waiting over 52 weeks were identified. This was expected as it identified the whole set of patients whose past validation had been lost by the old logic as well as patients that had been suppressed.

[To include: updated chart with comparative data from Stethoscope once Methods have amended methodology]

A&E performance

The Accident and Emergency Department is often the patient's point of arrival. The graph summarises the Royal Free London's performance in relation to meeting the 4-hour maximum wait time standard set against the performance of London A&E departments. The national waiting time standard requires trusts to treat, transfer, admit or discharge 95% of patients within 4-hours of arrival.

During the period April 2017 to February 2018, the Royal Free London NHS FT achieved an average monthly performance of 86.8%. This was not significantly different from average performance in 2016/17.



Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
87.1%	85.4%	87.7%	90.3%	87.0%	86.4%	88.7%	84.5%	87.0%	87.8%	83.7%	86.1%	86.5%

Source: Royal Free London NHS FT 2014-2018

[To include: updated chart with comparative data from Stethoscope once Methods have amended methodology]

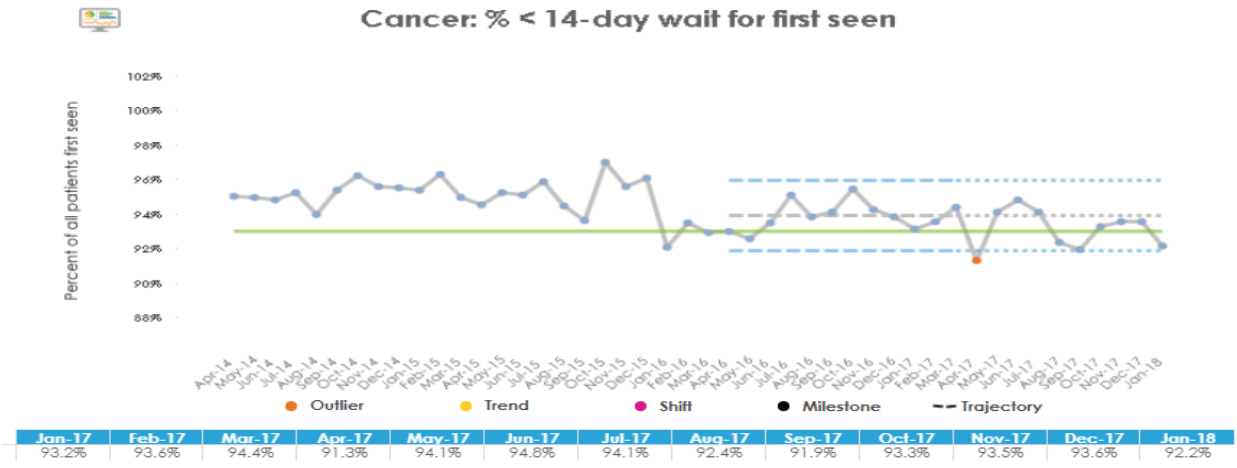
Pressure on A&E's has been increasing with more people than ever before selecting Accident and Emergency as their preferred means of accessing urgent healthcare. In response, the trust has invested in rebuilding the Royal Free hospital site A&E department, the last elements of which will open early in 2018/19. In addition, the trust has been working closely with system colleagues to improve flow of patients through the hospital.

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 for an outpatient or diagnostic appointment 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.

For 2017/18 to January, the trust met the standard to see at least 93% within 2 weeks from GP referral in 7 out of 10 months. The main factors influencing this were the holiday periods for Easter, summer and Christmas. The trust has been improving its holiday planning processes to ensure that no capacity is lost and that patients are brought in as quickly as possible following the end of the holiday period.

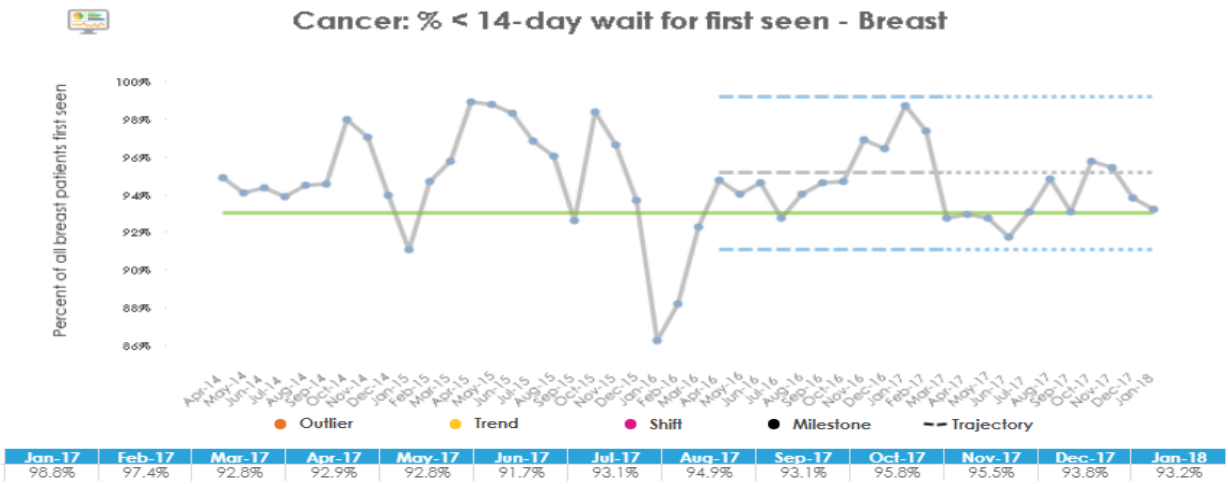


Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
93.2%	93.6%	94.4%	91.3%	94.1%	94.8%	94.1%	92.4%	91.9%	93.3%	93.5%	93.6%	92.2%

Source: Royal Free London NHS FT 2014-2018

Breast Urgent referral 2 week waits

In 2016/17, the trust on average each month saw 93.8% of patients on an urgent breast referral pathway within 2 weeks, meeting the national standard.



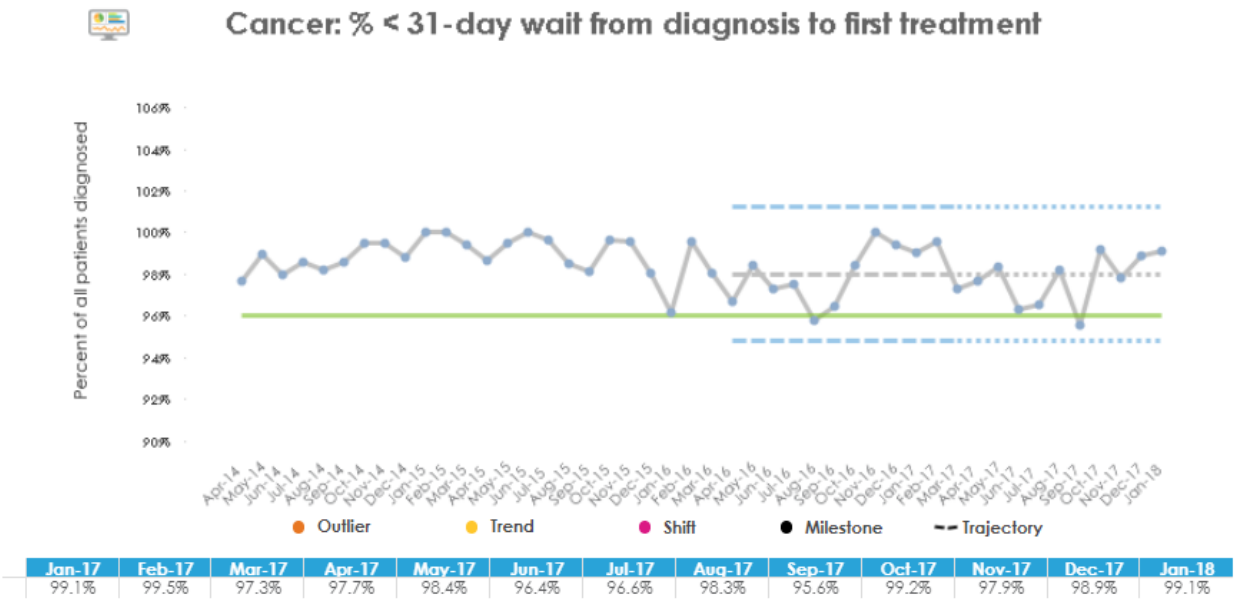
Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
98.8%	97.4%	92.8%	92.9%	92.8%	91.7%	93.1%	94.9%	93.1%	95.8%	95.5%	93.8%	93.2%

Source: Royal Free London NHS FT 2014-2018

This was not significantly different from 2016/17 when we also met the standard.

First definitive treatment within 31 days

In 2017/18, the trust met the standard to see 96% of patients within 31 days for their first definitive treatment for cancer, in every month except September 2017, meeting the national standard for the year overall.



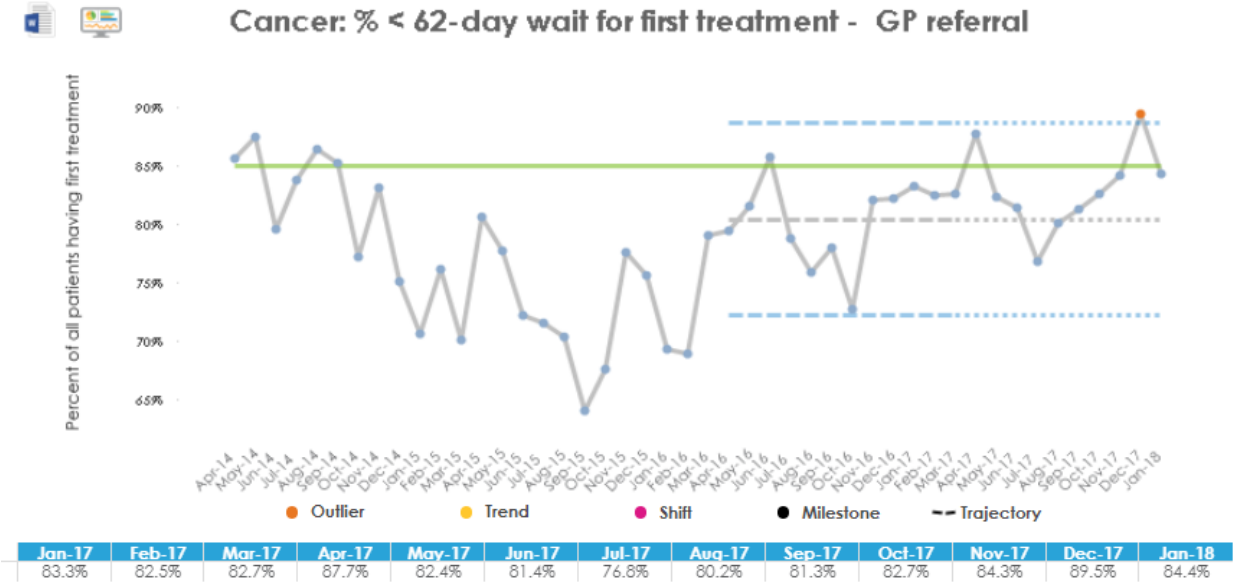
Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
99.1%	99.5%	97.3%	97.7%	98.4%	96.4%	96.6%	98.3%	95.6%	99.2%	97.9%	98.9%	99.1%

Source: Royal Free London NHS FT 2014-2018

This is similar performance to 2016/17 when we also met the standard.

First definitive treatment within 62 days of an urgent GP referral

The trust did not meet the 62 day standard in 2017/18, with 83.1% of patients receiving first treatment within 62 days of a GP referral. This represents an improvement on 2016/17 where 80.5% of patients met the standard and on 2015/16 when 72.7% of patients met the standard.



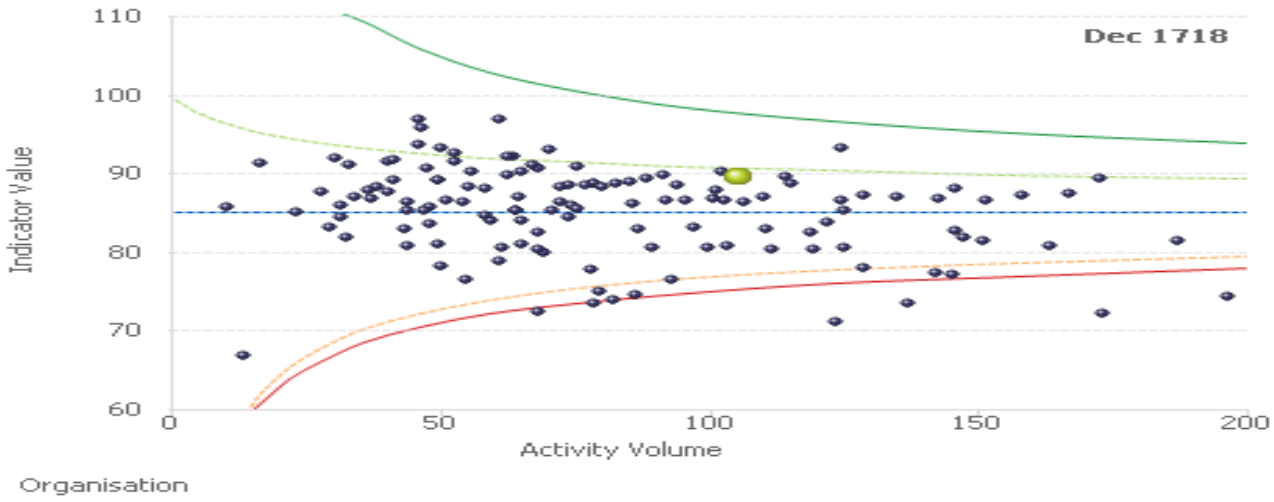
Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
83.3%	82.5%	82.7%	87.7%	82.4%	81.4%	76.8%	80.2%	81.3%	82.7%	84.3%	89.5%	84.4%

Source: Royal Free London NHS FT 2014-2018

The trust has had a recovery plan in place for cancer since July 2016 which has been working through improvement actions across all tumour sites. Q3 2017/18 was the first quarter of compliance since 2014. In 2018/19 the trust plans to strengthen the improvements already made and aim to deliver compliance across the year.

When comparing Royal Free London to benchmarks in December 2017, this suggests that performance did not differ from the national mean by more than can be explained by random chance. This is an improvement on previous years where performance has been worse than expected when compared to other trusts' performance.

Chart: Cancer 62 day wait for first treatment from GP referral, all acute trusts, December 2017



Source: Stethoscope benchmarking tool, Methods Analytics 2018

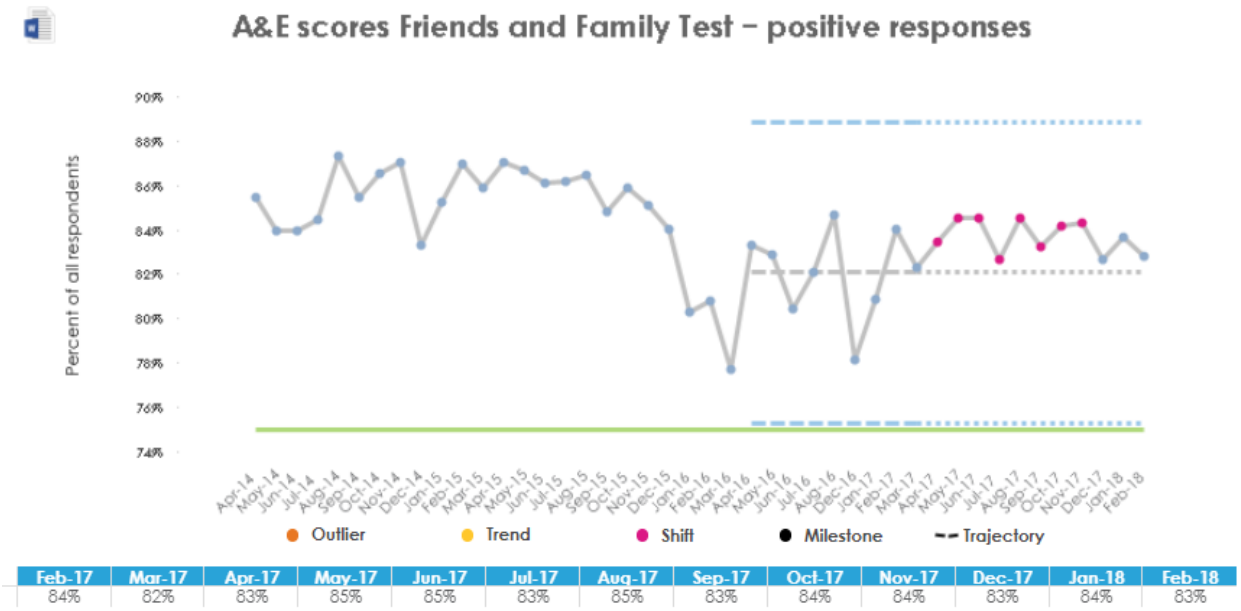
Patient experience indicators

Friends and family test (patients)

The Friends and Family Test (FFT) was introduced in April 2013. Its purpose is to track and therefore improve patient experience of care. FFT aims to provide a simple, headline metric which, when combined with follow-up questions, can be used to drive cultural change and continuous improvements in the quality of care received by NHS patients. Across England the survey covers 4,500 NHS wards and 144 A&E services.

The data below shows our performance from April 2014 to February 2018 with regards to our A&E, Inpatient and Maternity FFT scores.

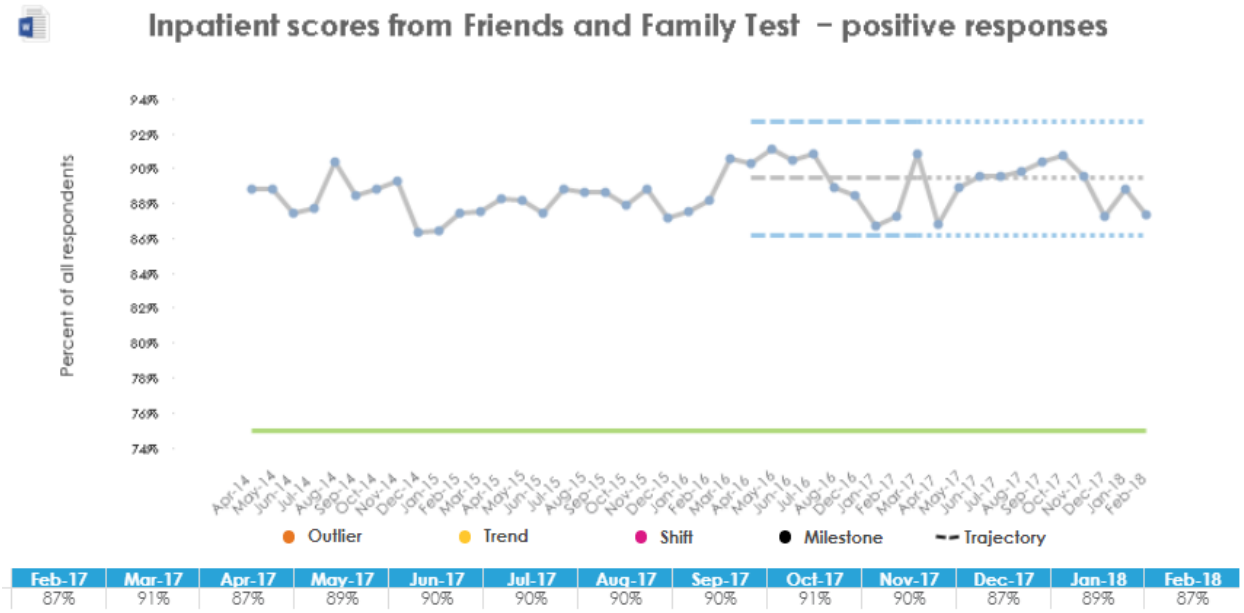
The scores for A&E suggest that there has been a significant improvement in our FFT scores that started in April 2017 and has been maintained since then. This has been driven by an improvement at the Royal Free Hospital site, likely to be linked to the opening of the new Emergency Department in 2017.
For all other areas we have maintained performance over the last year.



Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
84%	82%	83%	85%	85%	83%	85%	83%	84%	84%	83%	84%	83%

Source: Royal Free London NHS FT 2014-2018

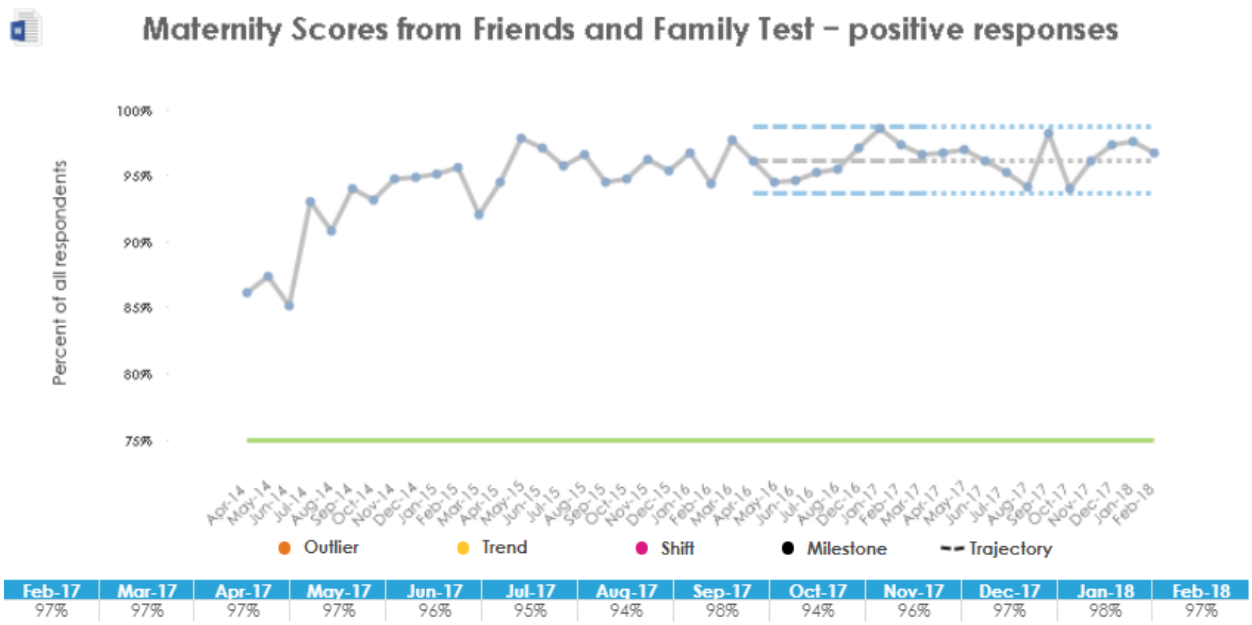
The FFT scores for inpatients have remained stable over 2017/18. Any variation has been within expected limits.



Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
87%	91%	87%	89%	90%	90%	90%	90%	91%	90%	87%	89%	87%

Source: Royal Free London NHS FT 2014-2018

The FFT scores for maternity have remained stable over 2017/18. Any variation has been within expected limits.



Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
97%	97%	97%	97%	96%	95%	94%	98%	94%	96%	97%	98%	97%

Source: Royal Free London NHS FT 2014-2018

[To include: benchmark information from Methods once charts have been updated]

3.2 Performance against key national indicators

The following indicators are reported in accordance with national indicator definitions.

Monitors Indicators of Governance	Target	Q1	Q2	Q3	Q4	2017-18
A&E Maximum waiting time of four hours from arrival to admission/transfer/discharge	>=95%	88.4%	86.5%	86.2%	TBC	TBC
**C difficile number of cases against plan	18/Qtr	20	23	21	TBC	TBC
**Maximum time of 18 weeks from point of referral to treatment in aggregate for patients on an incomplete pathways (reported as proportion of waiting list at end of quarter waiting under 18 weeks)	>=92%	92.3%	87.3%	86.7%	TBC	TBC
**Cancer: two week wait from referral to date first seen						
All cancers	>=93%	93.6%	92.9%	94.0%	TBC	TBC
Symptomatic breast patients	>=93%	92.5%	93.7%	95.1%	TBC	TBC
**All cancers: 31 day wait from diagnosis to first treatment	>=96%	97.5%	96.9%	98.6%	TBC	TBC
**All Cancer 31 day second or subsequent treatment -						
surgery	>=94%	98.4%	96.0%	98.5%	TBC	TBC
drug	>=98%	100%	100%	100%	TBC	TBC
radiotherapy	>=94%	100%	100%	100%	TBC	TBC
**All Cancer 62 days wait for first treatment:						
from urgent GP referrals:	>=85%	83.5%	79.4%	85.1%	TBC	TBC
from a screening service	>=90%	85.7%	96.3%	89.2%	TBC	TBC

Our plans: Details of CQC inspections during 2017/18 and implementing the priority clinical standards for seven day hospital services.

This section contains details on our CQC action plans following both announced and unannounced inspections undertaken at both our Royal Free and Barnet hospital sites and our plans to implement the priority clinical standards for seven day hospital services.

Care Quality Commission (CQC): details of our inspections and action plan

The CQC undertook the following unannounced responsive and announced inspections during 2017 at the Royal Free Hospital Hampstead site.

11 July 2017

Further to the initial raised concerns in December 2016, the CQC has received further raised concerns for the services at Mary Rankin Dialysis Unit and in response to this, undertook an unannounced inspection to the unit on 11 July 2017. The inspectors found that patients had been left for short periods of time during staff breaks but there was no evidence that patients had been harmed to the inspection but it was considered to be an unnecessary risk.

The CQC did not provide a rating of the unit and identified 6 specific areas of practice that the trust should consider making improvements relating to personal protective equipment (PPE) , sharps bin labelling, storage of cleaning solutions, fire evacuation instructions, recording of patient competence and the supervision and support of staff by managers.

The trust has developed a responsive action plan in relation to the improvements identified. The Royal Free Hospital Executive committee monitors the implementation of the improvement actions and receives the updates from the clinical service leads for the Mary Rankin Dialysis Unit.

18 July 2017

The CQC undertook an unannounced inspection of the Royal Free hospital critical care unit on 18 July. The inspection was undertaken because the CQC had received anonymous information that the implementation of a new patient record IT system had meant that patients had been harmed and was creating an ongoing risk to patient safety.

During the inspection the CQC found no evidence that patients had been harmed or were at a higher risk of harm as a result of the implementation and use of the new IT system. The CQC did not provide a rating of the unit and found evidence of significant and persistent disagreement and conflict between staff at different levels of responsibility. The senior leadership team had not demonstrably addressed this nor implemented timely strategies to reduce pressure on affected staff.

In response to the inspection the trust undertook targeted work with NHS Elect regarding staff in ITU at the Royal Free site to deliver a listening/engagement exercise with all staff groups to support the development of the ICU strategy. The aim is to build consensus on the aspirations, goals, and ambitions for the unit.

The Royal Free Hospital Executive committee monitors the implementation of the ICU strategy and receives the update of the improvement actions from the clinical service leads for Intensive care.

1 September 2017 and 7 December 2017

The CQC carried out a focussed inspection of Camden and Islington NHS Foundation Trust's psychiatric liaison service 30 August to 1 September 2017 Across Three acute trusts:

• The Whittington Health NHS Trust
• University College London Hospitals NHS
• The Royal Free London NHS Foundation Trust (1 September and 7 December 2017)

In response to a serious incident that took place at The Whittington Hospital in November 2016 that resulted in a patient death.

The CQC did not provide a rating as this was a focussed inspection and identified six specific areas of practice that the Camden and Islington trust should consider. These included:

- making improvements relating to observations of mental health patients that these are carried out effectively by suitably trained staff.
- Ensure they update the environment of the assessment rooms as planned and complete risk assessments of the furniture.
- Reduce the number of patients leaving the ED before being assessed, especially at the Whittington.
- Ensure it provides patients with all relevant information about their care in a suitable format.
- Continue to recruit to the liaison teams across all three sites and complete full and detailed care records, including the time and full detail of assessments.

The Royal Free London NHS FT alongside the other two acute trusts has engaged with Camden and Islington to develop a joint action plan following the serious incident involving the death of a patient.

The trust receives from Camden and Islington liaison staff regular training sessions delivered to acute staff working in ED to develop their knowledge of mental health patients.

The trusts assessment rooms in the ED offered appropriate levels of privacy and provided an environment where patients could wait in comfort, however these will be further improved on the completion of the Royal Free Hospital emergency department refurbishment plans.

The Royal Free Hospital Executive committee monitors the implementation of the emergency department refurbishment and receives the update of the improvement actions from the clinical service leads for emergency care.

19 February 2018

The CQC undertook a review of services for looked after children and safeguarding in Barnet. The inspection focussed on the quality of health services for looked after children, and the effectiveness of safeguarding arrangements for all children in the area.

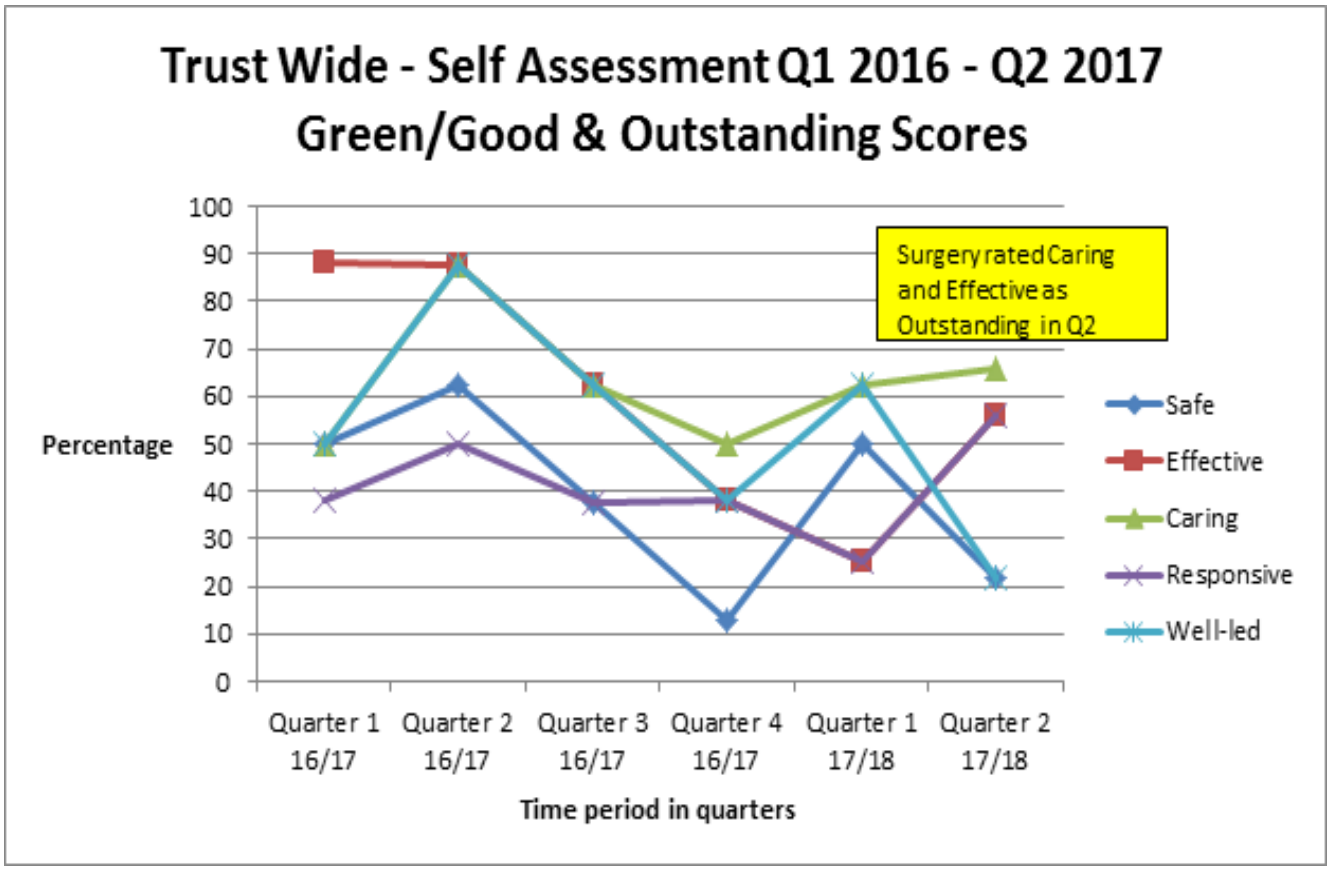
The inspection included paediatric and maternity services at Barnet Hospital. The trust is awaiting the final outcome report of this inspection although initial verbal feedback given to the trust in February was very positive.

Action planning for improvement:

The quarterly CQC 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 developed responsive quality improvement initiatives across sites which further spreads and shared knowledge in areas of best practice amongst services in response to quality and safety outcomes.

Action planning following self-assessment enables the opportunities for teams to work collaboratively between operational and clinical intentions in order to drive the implementation of quality improvements as well as share ideas and best practice particularly amongst cross site clinical teams.



Percentage scores are derived from the number of green scores identified for each of the eight core services reported throughout the 2016/17 and 17/18 quarterly self-assessment executive panel review meetings.

NB: The chart above will be updated with Q3 and Q4 scores by final submission.

In line with the Trusts Quality Goals all sites are aiming to be the top 10% at self-assessing core services as CQC Outstanding.

Further to the trust comprehensive inspection in 2016, a list of improvement actions have been undertaken in response in addition to the following improvement work.

Summary of key achievements (Trust CQC Inspection and Must / Should Do Actions)

The Royal Free London NHS Foundation Trust should review and ratify the Safer Surgery Policy. In September 2016 the policy was ratified and has been aligned to the Safer Surgery Quality Improvement Work-stream across the organisation.	Barnet Hospital **should** successfully complete a **15 Steps Challenge audit** and was undertaken on a paediatric ward. Results from the audit were **good** and from the patient feedback further **improvements are now underway.**	**10 North** at the Royal Free Hospital officially **opened an activity day** on the 5th December 2017 room adapted specifically for dementia and elderly patients. Since the opening 10 North have increased **discharge rates, patient experience** and **reduced length of stay.**
The Trust should ensure that Referral to Treatment Time is met in accordance to national standards and in June 2016 the Outpatient services successfully met the 90% target.	**Critical Care services should** be regularly collecting and submitting data to ICNARC and since the last CQC inspection the Trust has been **consistently contributing** to the ICNARC report and benchmarking performance against other similar hospitals.	**Endoscopy services** were **awarded a JAG accreditation** in 2017, an award that is only awarded to **high quality** gastrointestinal endoscopy services. Endoscopy services have met the competence to deliver against the set criteria set out in the JAG standards.
Theatre recovery staff must receive PILS training which has begun at Barnet Hospital. PILS training is now mandatory and along with the PARR Team, up to ??% of staff have been trained at Barnet.	In January 2018 the Surgical Assessment Unit **(SAU) opened** at Barnet Hospital, freeing up 16 bays for medical patients and **improving patient flow** at the hospital. The surgical team can now accept patients referred directly by GPs or from the emergency department (ED), **reducing ED waiting times** and improving patient experience.	Since February 2018 all clinicians at the Urgent Care Centre **(UCC)** at Chase Farm Hospital are now **successfully recording all patient records on an electronic system**. Patient records are now more secure, current and accessible and Chase Farm Hospital is closer to becoming a **paperless site**.
Urgent and emergency care must and did complete removing all emergency drugs such as Sodium Bicarbonate and Adrenaline from Resuscitaires.		

Implementing the priority clinical standards for seven day hospital services

The trust is part of a regional support group for the 7 day services implementation and audit (North Central London 7-day service Network Group). The purpose of the group is to discuss the audit process, share ideas on how to approach it and provide a safe space for open discussion. The group includes representatives from University College London Hospital (UCLH), Royal Free, North Middlesex hospital and the Whittington hospital and NHS England.

The RFL Group's performance on the NHSE 7 day services audit in October 2017 showed that for Standard 2, 63% of patients were seen by a consultant within 14 hours of the decision to admit against a national average performance of 73%. Barnet Hospital and Royal Free hospital each carried out an internal audit in February 2018 in order to obtain a snapshot to further understand the issues related to our performance against standard 2.

We are now preparing for the fifth round of audit and are focusing on the need to embed standardised audit processes within divisions and our hospital sites. In the longer term, this lends itself to a quality improvement project and this will be considered by our working group on seven day services when this first convenes in 2018-19.

The following steps will be undertaken to support the implementation of the priority clinical standards for seven day hospital services.

Seven Day Services Review Board

- Development at group level with site based ownership to help drive improvement work, alongside Clinical Practice Groups
- Review provision of services outside of standard working hours
- Ensure consistent quality of services for acutely unwell patients on a 24/7 basis
- Achieve compliance with National Seven Day Service standards (priority Standard 2)
- Review evidence base and audit data to inform improvements in care provision and support the trust efforts to manage flow.

Engagement

- Involvement of junior and senior clinicians in audit process and steering board
- Multi-divisional support for audit process and review of data
- Clear ownership for 7 Day Services Review process to inform business as usual
- Consider small scale QI project to test Standard 2 (such as asking patients to track number of hours to consultant review) as part of trust target of 50 QI projects

Audit process

- Consider the continuation of a prospective approach to ensure high quality data and adequate engagement with clinicians during audit week
- Operational and site based ownership and involvement to help drive audit and data collection
- Enhanced communications to clinical and non-clinical staff
- Embed any lessons learnt from previous audits (including the Health care records audit) and ensure that the results are triangulated and communicated effectively

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, Imagining available	In practice most of this information is discussed before, so this is used as a final check. Surgeons may use this opportunity to check that antibiotics prophylaxis has been administered.
4. Sign out	Before staff leave theatre	**Confirmation of recording of procedure:** • instruments, swabs and sharps correct • specimens correctly labelled. • equipment issues addressed • Post-operative management discussed and handed over
5. Debriefing	At the end of the list	Evaluate list Learn from incidents Remedy problems, e.g. equipment failure Can be used to discuss five–step process

Glossary of Terms

Term	Explanation
ASA	The ASA physical status classification system is a system for assessing the fitness of patients before surgery adopted by the American Society of Anesthesiologists (ASA) in 1963.
Best Practice Tarriff (BPT)	A BPT is a national price that is designed to incentivise quality and cost effective care. The first BPTs were introduced in 2010/11 following Lord Darzi's 2008 review. The aim is to reduce unexplained variation in clinical quality and spread best practice.
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.
DeepMind.	DeepMind is a technology company that is in partnership with the Royal Free London NHS Foundation Trust which has created a new app called Streams. The new app detects early signs of kidney failure and is now being used to improve care for some of the Royal Free's most vulnerable patients by directing clinicians to patients who are at risk of or who have developed a serious condition called acute kidney injury (AKI).
HIMSS	Healthcare Information and Management Systems Society (HIMSS) are a not-for-profit organisation that is based in Chicago with additional offices in North America, Europe, United Kingdom and Asia. Their aim is to be leaders of health transformation through health information and technology with the expertise and capabilities to improve the quality, safety, and efficiency of health, healthcare and care outcomes. HIMSS drives innovative, forward thinking around best uses of information and technology in support of better connected care, improved population health and low cost of care.
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	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

(PARRT).	(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