Royal Free London NHS
NHS Foundation Trust

# Update on progress made to achieve the quality account priorities: Mid-year report

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| **Report to:** | **Barnet Health and Overview Scrutiny Committee** |
| **Meeting date:** | **December 2018** |
| **Report from:** | **Dr Chris Streather: Chief medical officer** |
| **Author/s:** | **Dawn Atkinson: Deputy director of clinical governance and performance** |
| | **Karen Gordon: Head of clinical governance and performance** |

world class expertise local care

This report provides an update on progress made to achieve the quality account priorities for 2018/19 and feedback on the points raised in the statement issued by Barnet HOSC.

## Part One: Update on progress to achieve the Update on quality account priorities during quarter two (July to September 2018)

The eight chosen priorities remain within the three domains of quality (patient experience, clinical effectiveness and patient safety) and continue to have an executive sponsor, a designated lead and an associated committee where progress is monitored and assurance provided. Five out of the eight priorities were carried forward from 2017/18 and the remaining three priorities were new areas that were identified for improvement across the trust as outlined in table 1 below.

**Table 1: Overview of priorities for 2018/19 and associated committees.**

| Quality domain | | Priorities for 2018/19 | Continued from 2017/18 | Associated committees |
|---|---|---|---|---|
| **Patient experience** | 1 | To achieve certification for The Information Standard. | ✓ | Clinical Standards and Innovation Committee (CSIC) |
| | 2 | To further enhance and support dementia care. | ✓ | |
| | 3 | To improve our involvement with our patients and carers. | ✘ new priority | |
| **Clinical effectiveness/ quality improvement** | 4 | To build capability in the workforce and have an online project tracker tool. | ✓ | People and Population Health Committee (PPHC) |
| | 5 | To develop a superior change-management capability putting clinicians in charge of their clinical pathway. | ✓ | |
| **Patient safety** | 6 | To improve safer surgery and invasive procedures | ✓ | Clinical Standards and Innovation Committee (CSIC) |
| | 7 | To improve our learning from deaths | ✘ new priority | |
| | 8 | To improve infection prevention and control | ✘ new priority | |

The key below is used to summarise the level of progress made during quarter two.

**Key:**

| | | |
|---|---|---|
| **Status** | Progress as expected for mid-year point | ★ |
| | Progress below expectation for mid-year point | ★ |

## Priority one: Improving patient experience:

As a major provider of healthcare services in London, the trust aims to put the patient, carer and our staff at the heart of all we do in delivering excellent experiences.

### 1. Achieving 'The Information Standard'

| **Executive Sponsor: Emma Kearney, director for public affairs and communications. Trust Lead: Yovna Lachanan, patient information manager** | | | |
|---|---|---|---|
| **Priority for 2018/19** | **Key measures for success** | **Update for mid-year point** | **Status** |
| To achieve trust certification for 'The Information Standard'. | To work with Clinical Pathway Groups (CPGs) to embed the patient information approval process and ensure information produced via these channels are in line with the Information Standard requirements. | Progress includes meeting with CPG programme manager for women's and children's division to ensure the trust's patient information approval process is embedded. Support is also provided to all staff producing patient information relating to other CPG pathways in development, for example Acute Kidney Injury (AKI) information.<br><br>Next steps are to meet with the full CPG team to ensure understanding of patient information requirements, the approval process and to identify KPIs to support this.<br><br>Progress is on-going and CPG teams continue to be supported in the production of their patient information. | ★ |
| | 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. | Application process has been scoped out and amendments to patient information policy to be made based on a self-gap analysis before application is made.<br><br>Work with key stakeholders within the radiotherapy department already established and the next steps will include working with the new quality and assurance manager for radiotherapy to undertake a scoping exercise for the department. This will ensure effective communication to the wider team of the plans to apply for the Information Standard for the department.<br><br>Radiotherapy patient information is all currently up to date, but will need to be reviewed in the next quarter in line with their review date. | ★ |

## 2. Enhancing dementia care

| **Executive sponsor: Debbie Sanders, group chief nurse.** | | **Trust Lead: Danielle Wilde, group dementia lead** | |
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| **Priority for 2018/19** | **Key measures for success** | **Update for mid-year point** | **Status** |
| To further enhance and support dementia care initiatives across the trust through the delivery of the dementia strategy | Improve dementia services for patients admitted to RFL and their carers | Action plan for the national audit of dementia has been completed. Audit currently in progress on the 3 reporting sites (8 West, 10 North and 6 South). Data collection closed on September 21 with results available in July 2019.<br><br>Dementia key worker scheme implemented on 4 wards, providing specialist input and support for patients and families.<br><br>Publication of RFL Guide to Dementia now available on all wards across the trust. Regular carer support sessions held on Hampstead and Barnet sites and 5 new "Sundown Sessions" currently in production. | ★ |
| | Improve staff experience in caring for people with dementia | 8 important things about me document updated and new process implemented.<br><br>"High Bay" project to launch in 2019 with an emphasis on resourcing and training NAs to facilitate group activities sessions for patients who are being cared for in an enhanced bay.<br><br>Innovative ChickenShed theatre training to take place on January 30 for CAPER Anchors looking to further their training in communication and care for patients living with dementia.<br><br>Music therapy training planned for interested staff complemented by an improved roster of musicians visiting the organisation under the RF Charity.<br><br>Delirium pathway documentation continues to be piloted across the trust and the Dementia Implementation Group (DIG) will now be reviewing all PALS / incidents reported that relate to dementia or delirium which will help us to identify hotspots. | ★ |
| | To design new dementia strategy for 2019 – 21 period | Strategic event planned for end of the year inviting the public, carers, patients and interested staff to feed into our new strategy. | ★ |

## 3. Improving involvement with our patients and carers

| Executive sponsor: Debbie Sanders, group chief nurse. Trust Lead: Richard Chester, deputy director for patient experience | | | |
|---|---|---|---|
| **Priority for 2018/19** | **Key measures for success** | **Update for mid-year point** | **Status** |
| To improve our involvement with our patients and carers | Following feedback from staff and patients a broader approach is being taken to ensure that we improve our involvement with our patients and carers.<br><br>Building on previous involvement with our patient partners in CPGs, QI projects, hospital based committees/ groups and with task and finish groups | The trust continues its approach to embedding experience and involvement in its services and development.<br><br>The trust has adopted the patient experience framework published by NHS England.<br><br>The framework brings together the characteristics of organisations that consistently improve patient experience and enables boards to carry out an organisational diagnostic against a set of indicators<br>Key themes for rating organisations as outstanding or inadequate were found to be: Leadership, Organisational Culture, Compassionate Care, Safe Staffing Levels, Consistent incident reporting and learning lessons. There are 23 areas to assess against, with each one being broken down into various sub-categories.<br><br>The patient experience has a role to play in a number of questions and the collation as a whole, and the document has been reviewed by the patient experience team. However, information will be required from quality improvement, HR, organisational development, Group, boards, medical directors and directors of nursing. Therefore the suggestion is that the document be taken to each Local Executive Committee (LEC) who can delegate across the hospital site ownership of parts of the assessment and from there we could collate to a group level score.<br><br>In addition the patient experience team have strengthened their relationship with CPG team so that they can become more involved with the CPG work streams.<br><br>Patient representatives have been appointed to the patient experience committees at both Barnet and Royal Free sites. Work has begun on updating and improving the information on the patient experience section of the website for both patients and staff. | ★ |

## Priority two: 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.

## Quality Improvement (QI) priority:

### 4. Building capability within our workforce

| **Executive sponsor: Chris Streather, Chief medical officer.** | | **Trust Lead: James Mountford, director for quality** | |
|---|---|---|---|
| **Priority for 2018/19** | **Key measures for success** | **Update for mid-year point** | **Status** |
| To build capability in the workforce and have an online project tracker tool. | Ability to prioritise QI projects based on local/Group need.<br><br>Local ownership, at service, divisional and hospital unit level.<br><br>To provide access to site-based QI help and support, site-based learning and access to expert QI knowledge.<br><br>To create opportunities to share learning across the site and Group. | A key element of developing our infrastructure is creating an integrated quality improvement management system by which we can register, track and report on QI activity.<br><br>A working group has been set up and a service specification has been developed to reflect the organisations and progress has been made with the introduction of *Leading for Improvement* with our senior leaders being trained as QI sponsors.<br><br>In order to support local ownership we need to provide transparency of Quality Improvement projects through having an online system to register, track and report on QI progress. Life QI has been chosen as the system to do this and we aim to launch this in Q4 2018-19.<br><br>Together with the leadership team we continue to look for effective ways to share learning across each site and the group.<br><br>In November we hosted a QI showcasing event where 34 posters were displayed and presented, over 100 staff attended this event. Additionally, on Royal Free Hospital site we are including a QI presentation at the chief executives briefing. Next steps are to introduce similar events and learning opportunities at each site. | ★ |

## Clinical Pathway Group (CPG) priority:

Variation in clinical practice and process leads to worse patient outcomes and these results in higher costs. Therefore the goal of the program is to reduce unwarranted variation in clinical practice and process. Clinical pathway groups are clinically-led ways of working across several hospital sites aimed at reducing variation and ensuring patients receive the best standard of care, wherever they are treated.

## 5. Digitise clinical pathways

| **Executive sponsor: Chris Streather, Chief medical officer.** **Trust lead: John Connolly, CPG program director** | | | |
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| **Priority for 2018/19** | **Key measures for success** | **Update for mid-year point** | **Status** |
| 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. | 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 roll out of Millennium Model Content and opening of the new Chase Farm Hospital**.**<br><br>Our measure for success for 2018/19 is to have seven digitised clinical pathways. | Work has remained in support of the digital transformation at the RFL. The trust has embarked on a journey which to become one of the most digitally advanced trust in the UK by 2020.<br><br>Multidisciplinary teams are working together to design the clinical pathways; ensuring that the diagnostic and treatment decisions are consistent and based on the latest evidence to deliver the best possible outcome. All the pathways are being co-designed with patients; their experiences are being taken into account, which will in turn improve outcomes.<br><br>The new Chase Farm Hospital has opened and likewise six pathways have been fully digitised. These include:<br><br>1. Preoperative Assessment<br>2. Elective Hip<br>3. Elective Knee<br>4. Right Upper Quadrant Pain (RUQP)<br>5. Induction of Labour<br>6. Admissions to Neonatal Unit (‘Keeping mothers and babies together) | ★ |

## Priority three: Patient safety priorities

For 2018/19 we chose to focus on safer surgery, learning from deaths and infection prevention and control.

## 6. Safer surgery

<table>
<tr><th colspan="4">Executive sponsor: Debbie Sanders, group chief nurse  Trust lead: Hester Wain, deputy director for patient experience</th></tr>
<tr><th>Priority for 2018/19</th><th>Key measures for success</th><th>Update for mid-year point</th><th>Status</th></tr>
<tr><td rowspan="2">Safer surgery and invasive procedures</td><td>To achieve zero Never Events by the end of March 2019</td><td>We have reported a total nine never events during 2018/19 (6 in Q1 and 3 in Q2). The never events were in the following descriptions:
<table>
<tr><th></th><th>Description of never event</th><th>number</th></tr>
<tr><td>Q1</td><td>• unintentional connections of a patient requiring oxygen to an air flow meter,<br>• wrong site procedures which resulted in no/low harm to the patient.<br>• wrong eye injection<br>• retained swab</td><td>2<br>2<br>1<br>1</td></tr>
<tr><td>Q2</td><td>• wrong knee prosthesis<br>• retained needle post episiotomy,<br>• wrong side transforaminal epidural injection</td><td>1<br>1<br>1</td></tr>
</table></td><td>★</td></tr>
<tr><td>To increase by 75% the number of Local Safety Standards for Invasive Procedures (LocSSIPs) in place by the end of March 2019</td><td>The Patient Safety CPG was established on 1 April 2018 and has prioritised the ‘Invasive Procedures Pathway’ as the first initiative to deliver eighteen Local Safety Standards for Invasive Procedures (LocSSIPs) across the trust.<br><br>The Patient Safety CPG is initially focusing on three pathways: cardiology, radiology and endoscopy and meetings have been held with these services. The emphasis has been on redesigning and testing LoCCSIPs within these services. A Gantt chart had been complied to track progress.</td><td>★</td></tr>
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## 7. Learning from deaths

| Executive sponsor: Debbie Sanders, group chief nurse. Trust lead: Hester Wain, deputy director for patient experience | | | |
|---|---|---|---|
| **Priority for 2018/19** | **Key measures for success** | **Update for mid-year point** | **Status** |
| To improve our Learning from deaths (LfD) | To increase by 10% the percentage of reviews of patient deaths recorded centrally by the end of March 2019 | 11% patient deaths were recorded centrally for review in 2017/18.<br><br>Therefore, the aim is to increase this to 21%. Data on the numbers of patient deaths reviewed during 2018/19 will be available from October 2018.<br><br>We have increased the numbers of deaths reviewed in 2018/19 Q1 to 15%. | ★ |
| | 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 | The 2017 NHS staff Survey showed that 68% of RFL staff agreed/strongly agreed that "When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again."<br><br>We are working to use more dynamic survey data to show how we improve this metric.<br><br>We are now publishing: Safety needs and incident learning (SNAIL), weekly update on key areas of learning from incidents and near misses using SBAR.<br><br>Plus, Free Way to Safety (FWTS) monthly newsletter (key safety learning from serious incidents, emailed to incident managers); and Health and safety monthly newsletter (key Health and safety information, emailed to Health and safety champions); | ★ |

## 8. Improving infection control

| **Executive sponsor: Debbie Sanders, group chief nurse**<br><br>**Trust lead: Yvonne Carter, head of infection prevention and control nursing** | | | |
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| **Priority for 2018/19** | **Key measures for success** | **Update for mid-year point** | **Status** |
| To improve infection prevention and control | To achieve 10% reduction by year of meticillin-resistant Staphylococcus aureus (MRSA). | MRSA bacteraemias – currently two attributed cases, one attributed to RFH and one to BH. Reduction in Gram negative bacteraemias remains on going – 10% reduction achieved last year.<br><br>The current rate fluctuates but remains within process limits. Measures for reduction are driven through the monthly IPC Divisional Leads group. | ★ |
| | To achieve Trust-attributed zero *Clostridium difficile* (C.diff) infections due to lapses in care by end of March 2019 | Currently no lapses in care for C.diff cases. Total cases are two above threshold.<br><br>All cases have an RCA, with learning fed back through the monthly IPC Divisional Leads group | ★ |

## Conclusion

It was disappointing to report further never events, however the trust is ensuring that we learn from our never events. Weekly executive-led cross-site safety meetings are held to share immediate learning and identified risks.

During the next reporting period, the trust will carry on building on measures to achieve the set quality account priorities in support of our commitment to provide our patients with world class expertise and local care.

## Part two: Feedback on points raised in the quality account 2017/18

The second part of this report provides feedback on the comments raised by Barnet HOSC as recorded in the quality account 2017/18.

| | Comment from committee | Response from Trust |
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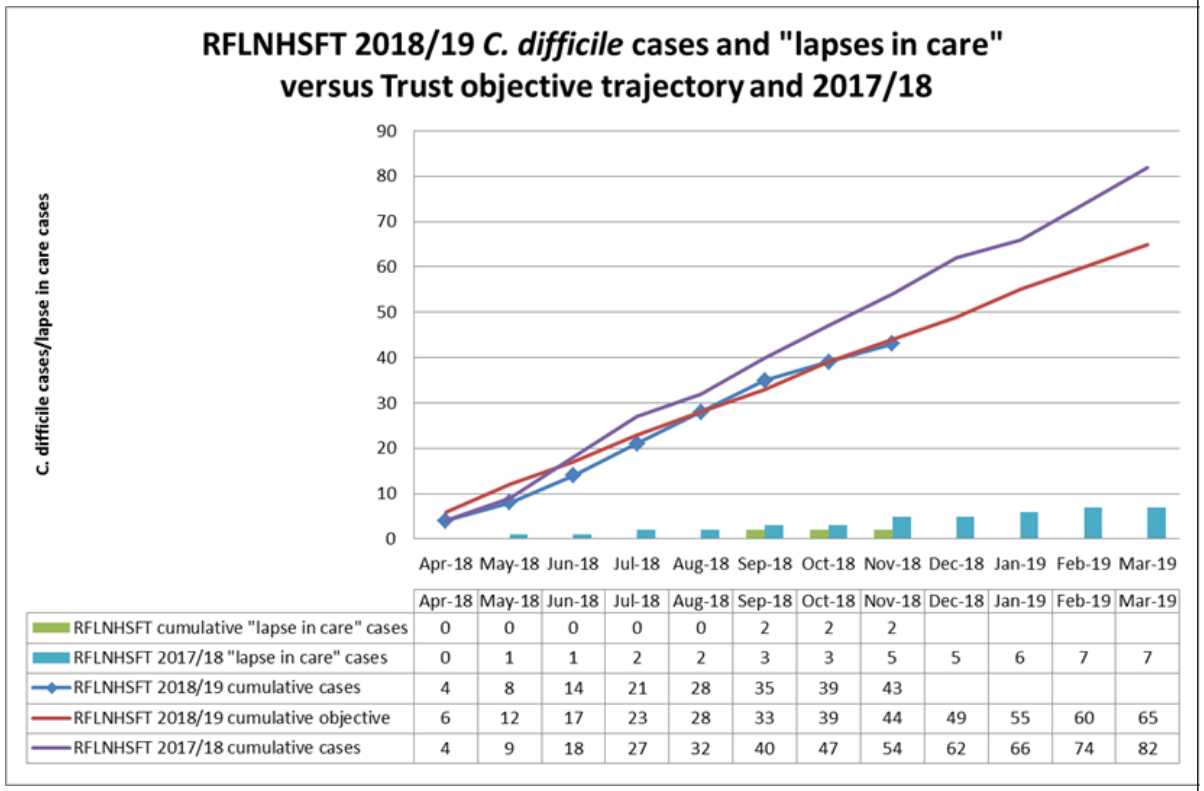
| 1 | The Committee asked the Trust to clarify the total number of C.Diff cases, as it was noted they did not meet their target last year.<br><br>The Committee commented that the tables in the Quality Account were not particularly clear and asked that the target for the year be included.<br><br>The Trust explained that the two graphs explaining C.Diff were measuring different things, which is why the numbers were different. | The trust continues to report on the number of C.difficile cases and the attributable reason (lapse in care) as well as the C.difficile infection rate per 100,00 occupied bed days (which provides a national benchmark for the trust).<br><br>For 2018/19 the C.difficile target is 65 and at the end of November the trust had reported 43 cases.<br><br>  <br><br>| | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |<br>|---|---|---|---|---|---|---|---|---|---|---|---|---|<br>| RFLNHSFT cumulative "lapse in care" cases | 0 | 0 | 0 | 0 | 0 | 2 | 2 | 2 | | | | |<br>| RFLNHSFT 2017/18 "lapse in care" cases | 0 | 1 | 1 | 2 | 2 | 3 | 3 | 5 | 5 | 6 | 7 | 7 |<br>| RFLNHSFT 2018/19 cumulative cases | 4 | 8 | 14 | 21 | 28 | 35 | 39 | 43 | | | | |<br>| RFLNHSFT 2018/19 cumulative objective | 6 | 12 | 17 | 23 | 28 | 33 | 39 | 44 | 49 | 55 | 60 | 65 |<br>| RFLNHSFT 2017/18 cumulative cases | 4 | 9 | 18 | 27 | 32 | 40 | 47 | 54 | 62 | 66 | 74 | 82 |

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| 2 | The Committee noted A&E targets had not been met. The Trust said Barnet Hospital was improving having hit 90% last week, but there had been a big variation during the winter which had been particularly challenging.<br><br>The Trust said that currently the Royal Free was around 85% and that a big focus was being put into increasing this to 90% by September 2018 and 95% by February 2019.<br><br>The Trust said the Emergency Department (ED) at the Royal Free was now fully open and colleagues were working towards improving performance targets. | The Royal Free Hospital has been above year on year performance since April 2018 and is currently on trajectory. Barnet Hospital has been above both trajectory and year on year performance until October 2018.<br><br>There are a number of improvements planned and in progress. Full details will be presented in the quality account 2018/19.<br><br>Improvement initiatives at Barnet Hospital includes:<br><br>1. Workforce profile is being reviewed. Performance of attendance avoidance schemes flagged to the CCG<br>2. Focus on full capacity protocol and supporting flow of patients out of ED<br>3. Daily and weekly reviews. ECIST to provide additional support to long stay patient work<br>4. Workforce plan in place and reviewed weekly by the divisional team.<br><br>Improvement initiatives at Royal Free Hospital:<br><br>Reducing Length of Stay (LoS):<br><br>1. Implement a system-wide weekly escalation meeting<br>2. Account manage the top 8 longest staying patients in the trust (2 per Exec)<br>3. Continue with divisional weekly stranded patient review meetings<br><br>Discharge to access:<br><br>4. Establish non-weight bearing Pathway 1/2<br>5. Increase utilisation of existing pathways<br><br>Increasing ambulatory emergency care:<br><br>6. Set up additional hot clinics for specialties<br>7. Set up a hot clinic for dressing changes & suture removal<br>8. Move chiropody out of AAU<br>9. Embed OT in RAT to ensure a 'home first' culture<br>10. Create a blocked catheter ambulatory care pathway |

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| 3 | The Committee was concerned that the issues surrounding parking at Barnet Hospital which had been raised for many years, were still outstanding. The Committee stressed that patients had raised concerns about the lack of parking and that this often led to them missing appointments. The Committee stressed that the car park was inadequate and that this issue urgently needs addressing. | Detailed separate report sent to the committee. Highlights include:<br><br>• Car parking survey (August 2018) to engage and understand issues. Nearly 800 responses in total with around 600 from Barnet Hospital staff.<br>• Survey information used to inform a new Parking Policy, recently shared with Group Joint Negotiating and Consultative Committee and Group Policy Committee for approval and adoption.<br>• Incentives for car sharing, out of hours permits, simplified qualification criteria.<br>• New permit batches will be released during December to maximise utilisation of current staff parking.<br>• Additional short-term parking capacity options are being considered, these include;<br>  • Modular car park (as used in supermarkets and railway stations)<br>  • Rental of local offsite car parking facility (within walking distance)<br>  • Discussions with Barnet Council are planned to try to delay the extension of Controlled Parking Zone until one of the above solutions can be implemented. |
| 4 | The Committee was concerned that the targets for Referral to Treatment (RTT) had not been met and that the Trust's performance in February 2018 was only 83.4.%, compared to the national target of 92% waiting 18 weeks or less for access to Consultant-led services. The Trust said this was a concern and that it was a big focus for improvement. The Trust said they investigated all cases where patients had waited longer than the target for care to ensure no harm had been caused. The Trust also said the figures were partly a result of improvements to the way in which it tracks patient pathways. | Current focus is on finalising the validation approach to the new Patient Tracking List (PTL) now that this has been released by MBI. A paper has been submitted to the December Trust board for a decision on how to proceed. Additional validators have already been recruited and we are also offering overtime for existing staff.<br><br>However, we are maintaining a small amount of business as usual validation as operations are still using the current PTL and we are using it to report as a trust. We are maintaining a large operational focus on reducing the number of tip-ins to the >52 week backlog including man-marking patients and reporting via weekly sitreps.<br><br>We do have two strands of Clinical Harm Review (CHR) assessment for patients waiting longer than 52 weeks. There is clinical harm component in the RCA form completed when the patient breaches 52 weeks which requires the clinician to identify if harm has been caused or will be caused if the patient continues to wait. There is then a full and formal central clinical harm review that is undertaken for all patients treated after 52 weeks (whether this is an active RTT pathway or not). |
| 5 | The Committee was also concerned with the delay in first definitive treatment with only 83.1% of patients receiving treatment within the 62 days. | The trust continues to identify methods to make improvements to our 62 week cancer target. This has included the roll out an expanded STT service for Lower GI patients on the Barnet and Chase Farm sites in mid-September and the trust now consistently see ~75% of patients enter this |

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| | Although this figure was an improvement on last year, it still is below the 92% standard. The Trust said currently the 62 week target was not being met due to the large volume of referrals of patients with low GI cancer, which was an increasing issue. The Trust assured the Committee that work was being done to make the necessary improvements. | pathway.<br><br>Since implementation, the trust has also seen the overall backlog and number of tip-ins to the backlog reduce |
| 6 | The Committee enquired as to how the Trust dealt with mental health patients that turn up at the A&E. The Trust said it was working on better engagement with service providers to place them into the right care. The Trust acknowledge A&E was not the right environment for many of them, but was sometimes the only safe place the police could bring them. The Committee were also informed that the police do receive training on how to deal with mental health incidents. | Barnet CCG presented a review of mental health provision at the October BH UEC Transformation Board and the following milestones have been incorporated into the Transformation programme plan:<br><br>• NELCSU Smart System to be utilised to capture mental health capacity across NCL and demonstrate where capacity is available for emergency patients<br>• BCCG review of MHLS against core 24 standards<br>• New NEL CSU MH escalation protocol to be implemented and actioned by Trust<br>• Roll-out further training to improve capability of RFH staff in managing mental health patients. |
| 7 | The Committee queried how the Trust was working with other service providers to encourage people to use alternative services rather than A&E, where appropriate. TheTrust said it was working to improve the communication around Out of Hours Services. The Trust is holding conversations about having an Out of Hours Hub at the front of the hospital to assess whether patients can be treated away from A&E. The Trust acknowledged that there was confusion among people about what services are available and this required improvement. The Trust said it would bring a report to a future meeting on how this was progressing. | Streaming guidance has been developed and implemented along with piloting a GP streaming model to review opportunities to redirect patients from ED. Streaming to AAL and AEC increased from October. Joint nursing and primary/ secondary care streaming currently being explored and working with CCGs to increase MiDOS utilisation. |