Quality report 2018/19

Our journey of improvement

Where relevant, data will be updated with the most recent figures. Spelling and grammatical errors will also be corrected prior to final publication

Quality report 2018/19

Part one: Achievements in quality

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

Part three: Our quality performance

Annexes

Appendices

Part one: Embedding quality

1.1 Statement on quality from the chief executive

This will be included in the final report

1.2 Our trust: our journey of improvement

The Royal Free London NHS Foundation Trust is one of the largest hospital trust in the country, employing more than 10,000 staff and serving almost 2 million patients across our three main hospitals and other sites in north London and Hertfordshire.

Our trust attract patients from across the country and beyond to our specialist services in liver and kidney transplantation, haemophilia, HIV, plastic surgery, immunology, neurology, Parkinson's disease, vascular surgery, cardiology, amyloidosis, scleroderma and infectious disease (which can be treated in our high-level isolation unit)

We are also a member of the academic health science partnership UCL Partners, which brings people and organisations together to transform the health and wellbeing of the population.

At the Royal Free London our **vision** is clear: to deliver world class expertise and local care. We combine globally recognised clinical expertise with local and friendly hospital care to represent the NHS at its best.

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Our **mission** is to be world class in terms of healthcare treatment, clinical research and teaching excellence. We aim to deliver and develop leading local healthcare in all three of our hospitals, to improve lives and help people to thrive

Our **governing objectives** set out how we will achieve our mission:

- Excellent outcomes in our clinical services, research and teaching
- Excellent experience for our patients and staff
- Excellent financial performance
- Safe and compliant with our external duties
- Continual development of a strong and highly capable organisation

In 2017, we became a **group,** working alongside other healthcare experts to share ways of working which know deliver the best outcomes.

- By working collectively we can reduce variations in patient care and the cost of treatment across the group.

- 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 the **clinical practice groups** where we can introduce innovation and continuous improvement for the benefit of patients who come into any of the hospitals within our group.

Clinical practice groups

Patients are at the heart of our clinical practice groups and the overall aim is to work in partnership to co-design new pathways of care and define the outcome measures that matter. The central focus of our CPGs is the reduction in unwarranted variation in clinical practice and processes as the variation in care adds no value for our patients and is inefficient is use of health care resources.

Our current CPG pathways
1. Preoperative assessment
2. Elective hip
3. Elective Knee
4. Right Upper Quadrant Pain (RUQP)
5. Induction of Labour
6. Admissions to Neonatal Unit ('Keeping Mothers and Babies together')
7. Dermatology
8. Prostate pathway
9. Lung Cancer pathway
10. Lower GI cancer pathway
11. Haematuria pathway
12. Wheeze Child pathway
13. HPB Cancer
14. Early Pregnancy pathway
15. Anaemia
16. Pneumonia
17. Frailty
18. COPD
19. Heart failure
20. Chest pain/Pulmonary embolism
21. Cataract - Med iSOFT

An example of one of our CPGs where we have worked with our patients is within our paediatrics clinical teams to support the wheezy child.
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The CPG was set up to the aim to ensure that 100% of children presenting with wheeze will receive a standardised severity score and follow a clinical algorithm that will achieve the highest standard of clinical outcomes by July 2019.

The team are seeing early signs of improvement with an overall reduction in admissions and re-attendances at 7 and 30 days and are looking forward to go live of the digitised pathway July 2019.

Members of our ‘wheezy child’ CPG with Dr Chris Streather, chief medical officer and Caroline Clarke, group chief executive

During 2018/19 we have made several key achievements that we are proud of. The following information is a snapshot of some of our key achievements in support of improving patient care and outcomes.

Key achievements

Team celebrates 2,000 liver transplants

Congratulations to our liver transplant team on reaching its landmark 2,000th transplant.

A second chance for 2,000th liver transplant patient

A patient who has become our 2,000th liver recipient since transplantation began at the Royal Free Hospital more than 30 years ago.

David Edgell, from Canning Town, east London, says he is incredibly grateful to the family who granted permission for their loved one's liver to be transplanted, granting him a second chance at life.

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"It's a real landmark that we have reached our 2,000th transplant and I wish David well. I'd also like to pay tribute to our incredible multi-disciplinary team that collaborates to enable this life-saving work to take place."

Silence is golden: Using a ‘silent’ saw at Barnet Hospital to help children and older people to feel less anxious when having their plaster removed.

Our BH orthopaedic practitioners, or ‘plaster techs’, are celebrating the sound of silence after the recent delivery of a special saw.

The ‘silent’ saw helps young children, older people with dementia, as well as people with learning disabilities to feel less anxious when they are having their plaster cast removed. Marlon Ferro, an orthopaedic practitioner at Barnet Hospital, said: “Sometimes when children are having a cast removed they can become quite distressed by the sound of the saw which is very loud.

“This is quieter, and also much lighter and more mobile so we can also use it on the wards.”

Thanks to a donation from Barnet Hospital Charity, patients are able to benefit from the quiet saw as well as an iPad and headphones which help to distract them while their casts are removed.

Steve Shaw, BH chief executive said: “It’s often the small, simple things that make a huge difference to children and other patients.

“This will undoubtedly make it a more pleasant and less frightening experience for them.”

> “This new saw is really great. It can be a very frightening experience for young children having a plaster cast removed; even though it doesn’t hurt, it’s the noise that can scare them,”
>
> Jane Markus, senior orthopaedic practitioner,

Left to right top row: Mark Baker, orthopaedic practitioner, Jody Graber clinical pathway manager orthopaedics, Steve Shaw, BH chief executive

Left to right bottom row: Jenny Randall, senior sister, outpatients, Jane Markus, senior orthopaedic practitioner, Marlon Ferro and Rita Sandhu orthopaedic practitioners, Carla Bispham, community fundraiser, Barnet Hospital Charity

Pathway to better care for haemophilia patients

The RFL is home to the UK's biggest treatment centre for haemophilia and other inherited blood disorders.

People with haemophilia have little or no factor 8 or 9 in their blood – proteins that make the blood clot.

It is an inherited disorder that affects men, which means the centre looks after many generations of family members. In its most severe form haemophilia can cause extremely painful muscle and joint bleeding – usually at the hinge joints of the elbows, knees or ankles.

After many bleeds such as this, patients can develop haemophilic arthritis.
Paul McLaughlin, a haemophilia physiotherapy specialist, has pioneered the establishment of a proactive pathway to support patients in managing the musculoskeletal (MSK) issues associated with haemophilia

Using the pathway helps many people to avoid hospital attendances and admission, have better control over their condition and reduces unnecessary doses of costly medication.

Paul explains: "Many people think haemophiliacs bleed uncontrollably when they get cuts or wounds, but it is rare to see blood – most bleeding takes place internally."

Paul describes his role as a bridge between haemophilia, orthopaedics and MSK physiotherapy. He says: "We have an exceptional multidisciplinary team providing a comprehensive service for people with haemophilia to manage their condition day-to-day, stay well and live as full a life as possible."

Historically haemophiliacs were advised against doing exercise or sport, due to risk of bleeding. But with the excellent medical treatment now available the advice has changed, because strong joints and flexible muscles can reduce the risk of bleeds.

"We often see our haemophilic patients with pain after an activity like football, but it is not necessarily caused by a bleed, it may be an injury that could happen to anyone." says Paul.

"Patients can come directly to our clinic and we will assess the possible reasons for their pain. We might arrange imaging, instigate a rehabilitation plan or see them in our combined orthopaedic clinic – whatever is clinically appropriate."

New-look breast unit

A new-look specialist breast unit at Royal Free Hospital is helping staff to deliver better care and support to patients.

The unit has expanded, allowing the breast service to provide a much improved and more private environment for patients.

There are two new high-tech mammogram machines, offering 3D imagery and the ability to take biopsies. By doubling capacity and upgrading equipment, more patients are able to receive same day images, speeding up both diagnosis and referral to a consultant.

The space has also been improved with the introduction of additional consulting rooms and toilet facilities.

Tina Kelleher, lead nurse for breast services, has worked for the service for more than 40 years and is delighted to see the improvements. She said: “We knew that a better space was something that patients desperately wanted and we did too.

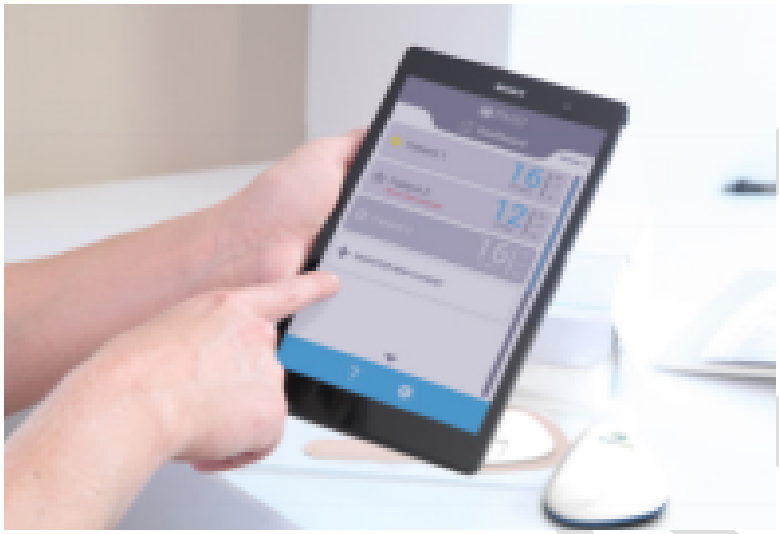
“We even have a dedicated nurses office now so that oncology and surgery cancer nurses can communicate more effectively. It will improve the patient experience, so much and we are already receiving lots of positive feedback.”

Left to right: Azita Moman, senior radiographer and mammographer and Gemma Fenlon, senior radiographer and trainee mammographer

Trial for new smart device

Chase Farm Hospital is trialling an innovative respiratory monitoring device to speed up the identification of patients whose condition is deteriorating.

Respiratory rate is the earliest and most sensitive indicator of a worsening condition, and is a key component of the new National Early Warning Score (NEWS2) which is set to become the standard for identifying patient deterioration in England by April 2019. However, it is not always easy to monitor.



We are one of four trusts selected from a number of applicants to work with UCL Partners on piloting the device.

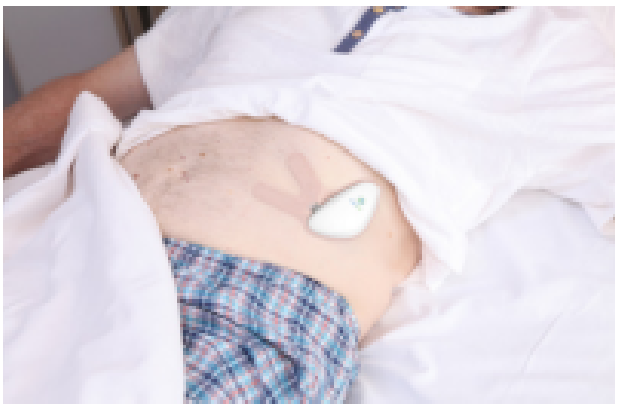
A set-up phase has begun in CFH's surgical ward. If this is successful, the ward will carry out a full pilot, receiving a free six-month supply of the monitors.

RespiraSense has been selected for the trial by NHS England's Innovations Accelerator, which supports the uptake and spread of proven, impactful innovations.

Fiona Morcom, clinical implementation lead, said: "Early identification of deterioration is a challenge for hospitals worldwide. It's vital to improve outcomes, reduce length of stay and avoid transfers to a high dependency unit.

"Our task in the trial is to explore how it can be embedded in our work flows and how best to use the information it provides. We're delighted that we were chosen for the trial as this kind of innovation fits perfectly with our aspiration to be one of the leading digital hospitals in Europe."

It provides clinical teams with highly accurate readings enabling them to spot if a patient's condition is deteriorating up to 12 hours earlier than usual.



Our IBD (Inflammatory Bowel Disease) patient panel

IBD is a long term, chronic condition that causes inflammation in the gastrointestinal tract. It can be divided into two illnesses; Crohn's Disease and Ulcerative Colitis. Often diagnosed at a young age, patients experience periods of relapse and remission. Most are managed with medical treatments but surgery is sometimes required. The Royal Free has a large IBD service and a significant proportion of its patients require care and support over many years

The IBD Patient Panel was set up in February 2018 and consists of a group of enthusiastic volunteers identified through a patient experience questionnaire.

Panel Aims:

- To provide feedback on patient service development.
- To advocate for IBD services in the Trust
- To provide a sounding board for the healthcare team
- To bring a patient's perspective to service development and improvement

Panel Objective:

To improve quality of care, efficiency and patient satisfaction by working with the IBD team in the Clinical Pathway Programme to coproduce care pathways for use across all sites.

IBD Journeys and Panel Values

The panel identified common journeys through the service encountered by patients at different stages of their IBD. These journeys ranged from diagnosis, initial treatment and on-going care, through to management of patients during periods when their symptoms flare.

They also identified underpinning values felt to be fundamental to the delivery of high quality care. These included confidence, efficiency, personalisation, effective communication, access to medicines and services, management of test results, support for patients and clear sign-posting to information and support for carers.

Pathway Review

The Patient Panel worked alongside the clinical team to coproduce a series of pathways that they felt represented excellent care. As a result of the development of these pathways, a number of recommendations were made and these have now been implemented by the IBD team.

Recommendations implemented by the IBD team:

- An improved cancellation management system that avoids recurrent and inappropriate clinic cancellations.
- A review of clinic letters, particularly the timescale for production and the use of attachments, e.g. for flow chart of blood results.
- A review of service information publications for patients and carers.
- The introduction of information for patients and carers about what to do when experiencing a flare of symptoms.
- A review and update of the service's website.
- A review of communication options for the clinical team and patients, including the introduction of video technology.
- A joint venture between NHS England and Crohn's and Colitis UK to produce a video about the role of the Patient Panel.
- Designing an individual patient care plan.
- Designing a patient questionnaire to gather regular feedback about the service.

The panel has proved to be a great success, providing a strong patient voice in service reviews and in bringing patients and clinicians together to really understand each other's priorities and demands.

Members of the panel have expressed their clear commitment to continuing with this work and to striving towards further service improvements and innovations in the future.

Stuart Berliner, Member of the IBD patients panel.

Dawn Atkinson, Deputy director of clinical governance and performance

Kidney Peer Support Work

Over the last year a team of kidney nurses and doctors have worked together with the support of the hospital volunteer team and the kidney patient's association to re-launch the kidney peer support service.

Peer support involves putting a kidney patient in touch with another person with first hand experience of kidney disease for an informal one to one chat. Being a kidney patient can be challenging, having to make difficult decisions about treatments such as kidney transplant or dialysis, together with having to restrict what you eat and drink whilst remembering to take multiple medications.

Whilst kidney patients are offered education and support by nurses, doctors and other health professionals, many people find it helpful to talk to someone who is in a similar position or who has been through the same treatment. Indeed, what has struck me during our peer support training sessions is that all of our volunteers wished that they had had the opportunity to talk to another patient at some stage during their journey through the kidney service.

Since the relaunch of the peer supporter service in September 2017, 21 volunteers have attended one of our kidney peer support training sessions. The training session lasts 2-3 hours and is run by the peer support team; a group of nurses and one of our psychologists who are passionate about providing a peer support service for our patients. During the sessions I have been struck by the motivation and commitment of our volunteers who speak so passionately about their desire to help other patients through difficult times.

We have slowly been receiving referrals for peer support, mostly these come from the nursing and medical team but we are hoping that patients will also contact us directly for support. This is what led us to create posters featuring some of our active supporters and their journeys. We are hoping the posters will be ready in the next month and will be displayed in all of our kidney care centres.

Meet two of our Peer supporters:

Gillian

‘I have been a kidney patient at the Royal Free Hospital for over ten years. My son, who is now 25, was also born there, so it feels like home and the staff feel like family. The medical care for Kidney patients is excellent, but kidney disease can be a huge challenge and just like any other challenge, the journey is made easier if the people who help through it, understand what you are going through, because they’ve been that way before. That’s why I became a peer supporter, to help kidney patients have an easier time through Kidney disease, by sharing my experience and helping patients understand that there is life after Chronic Kidney disease.

Helene

“It all came as a rather nasty shock. I'm sure I did not take in much of what the doctors said at the time.

If only I could have spoken to someone who had been through a similar set of medical events I could have asked more pertinent questions and would have had a greater understanding of what lay ahead instead of muddling through”.

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

Every year all NHS hospitals are required to write a quality report for our stakeholders about the quality of their services. The quality report allows us to be more accountable and helps us to drive improvement in the quality of our services.

Within the quality report we review our performance over the previous year, identify areas for improvement and publish that information. Areas include: patient experience, patient safety and clinical effectiveness

- **Patient safety** – how have we been keeping our patients safe from harm?
- **Clinical effectiveness** – what were the outcomes? how successful is the care provided?
- **Patient experience** - how was the experience for our patients using our services?

This section describes the following:

- Priorities for improvement: progress made against our priorities during 2018/19
- Outline on our quality priorities for improvement chosen for 2019/20
- Feedback on key quality measures as identified within the mandatory statements of assurance from the board.

2.1 Priorities for improvement

A look back at the progress made during 2018/19 to achieve our priorities for improvement.

Following consultation with our key stakeholders, the trust agreed that during 2018/19 we would focus on eight priorities. 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 as outlined in table 1

The eight 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 was monitored and assurance provided.

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

Quality domain	Priorities for 2018/19		Carried forward from 2017/18	Associated committees
Patient experience	1	To achieve certification for *The Information Standard.*	✓	People and Population Health Committee (PPHC)
	2	To further enhance and support dementia care.	✓	
	3	To improve our involvement with our patients and carers.	✘	
Clinical effectiveness/ quality improvement	4	To build capability in the workforce and have an online project tracker tool.	✓	Clinical Standards and Innovation Committee (CSIC)
	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	✘	
	8	To improve infection prevention and control	✘	

Priority one: Improving patient experience: delivering excellent experiences

The trust is committed to working in partnership with our patients to ensure that its services are both relevant and responsive to local needs.

Providing an excellent experience for our patients, staff and service users is central to the trust's governing objectives. Therefore, listening to the views of our patients helps us to better understand what we are doing right and what we need to improve.

Our patient experience team are involved in various works across the trust with the aim of improving practice and changing our patients' experiences for the better. For 2018/19 we chose the following priorities as they were linked to specific strands of work within the trust, in support of our vision to have strong positive patient experience.

Our quality priorities for 2018/19 were:

1. To achieve trust certification for 'The Information Standard'
2. To further enhance and support dementia care.
3. To improve our involvement with our patients and carers.

Improving the information for our patients.

A key objective for the trust has been to improve the consistency of the information available to patients and carers, as the provision of high-quality accessible information is crucial to embed our world class care values.

This priority was carried forward from 2016/17 as the trust identified that there was more to be done to improve the information for our patients.

The appointment of our Patient Information Manager in 2015 supported the trusts aim to improve the information for our patients and carers. Since the introduction of the trust wide patient information policy in 2016 and framework for producing information, the trust has approved over 200 information resources. All resources are available on our website, and teams and departments print their resources locally.

Progress to achieve the priority has been monitored at our People and Population Health Committee (PPHC) as part of our patient experience reporting.

What did we aim to do in 2018/19?

To achieve trust certification for 'The Information Standard'.

What were the key measures for success?

- To work with Clinical Practice Groups (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 The Information Standard for information produced by the radiotherapy department - the department will act as our exemplar for further rolling out the standard.

What did we achieve?

The trust's patient resources approval process has been integrated into clinical pathway group (CPG) work. Information for patients produced as a result of CPG work are reviewed via the trust process, and following approval, published onto the trust website.

We are piloting the use of QR codes on resources produced via the women's and children's CPG to increase accessibility. We will be monitoring downloads to see if this is an effective method to reach our audience.

Following the closure of The Information Standard certification scheme in 2018, this priority has been closed. The trust will continue to follow the principles underpinning the Information Standard, which have been embedded into our framework for producing information and patient information policy.

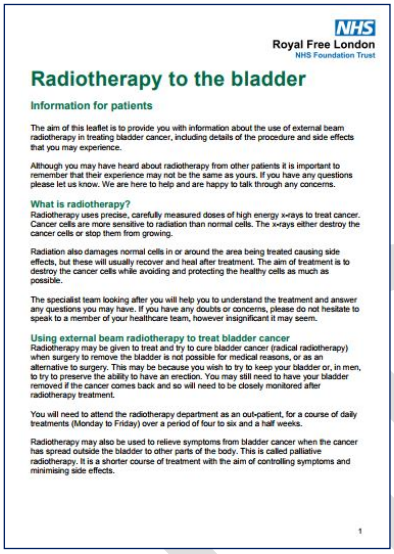
We have also improved the transparency of approval and review dates of our information both in print and online, and have a stringent review process in place to keep resources up to date.

We will continue to strive to produce easy to understand, evidence-based, high quality information for our patients, carers and family members.

Examples of materials produces for our patients.

A

About epidermal harvesting **Service:** Plastic surgery .pdf (280 KB)	Approved: 01/09/2018
About lidocaine/prilocaine cream for micro-pigmentation **Service:** Plastic surgery .pdf (258 KB)	Approved: 08/02/2019
Acute oncology service at Barnet Hospital **Service:** Cancer services .pdf (278 KB)	Approved: 20/03/2019
Acute oncology service at the Royal Free Hospital **Service:** Cancer services .pdf (303 KB)	Approved: 20/03/2019
Advice for kidney patients: Eating with a small appetite **Service:** Kidney services .pdf (449 KB)	Approved: 07/11/2017
All about intermittent claudication **Service:** Vascular surgery .pdf (394 KB)	Approved: 09/08/2017


NHS
Royal Free London
NHS Foundation Trust

Radiotherapy to the bladder

Information for patients

The aim of this leaflet is to provide you with information about the use of external beam radiotherapy in treating bladder cancer, including details of the procedure and side effects that you may experience.

Although you may have heard about radiotherapy from other patients it is important to remember that their experience may not be the same as yours. If you have any questions please let us know. We are here to help and are happy to talk through any concerns.

What is radiotherapy?

Radiotherapy uses precise, carefully measured doses of high energy x-rays to treat cancer. Cancer cells are more sensitive to radiation than normal cells. The x-rays either destroy the cancer cells or stop them from growing.

Radiation also damages normal cells in or around the area being treated causing side effects, but these will usually recover and heal after treatment. The aim of treatment is to destroy the cancer cells while avoiding and protecting the healthy cells as much as possible.

The specialist team looking after you will help you to understand the treatment and answer any questions you may have. If you have any doubts or concerns, please do not hesitate to speak to a member of your healthcare team, however insignificant it may seem.

Using external beam radiotherapy to treat bladder cancer

Radiotherapy may be given to treat and try to cure bladder cancer (radical radiotherapy) when surgery to remove the bladder is not possible for medical reasons, or as an alternative to surgery. This may be because you wish to try to keep your bladder or, in men, to try to preserve the ability to have an erection. You may still need to have your bladder removed if the cancer comes back and so will need to be closely monitored after radiotherapy treatment.

You will need to attend the radiotherapy department as an out-patient, for a course of daily treatments (Monday to Friday) over a period of four to six and a half weeks.

Radiotherapy may also be used to relieve symptoms from bladder cancer when the cancer has spread outside the bladder to other parts of the body. This is called palliative radiotherapy. It is a shorter course of treatment with the aim of controlling symptoms and minimising side effects.

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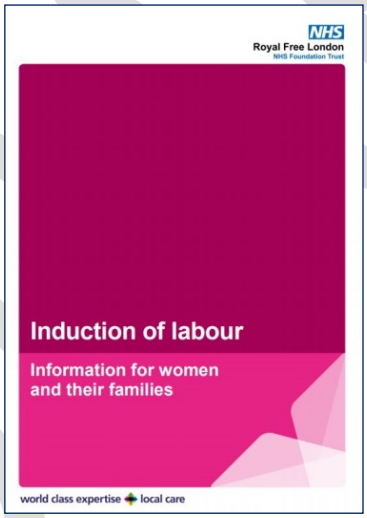



For more information about maternity services at the Royal Free London, please visit our website:
www.royalfree.nhs.uk/services/services-a-z/maternity-services

If you have any feedback on this leaflet or require a list of references for it, please email: rf.communications@nhs.net

This leaflet is also available in large print. If you need it in another format, for example braille, a language other than English or audio, please ask a member of staff.

Version number: 1
Approval date: October 2018
Review date: October 2020
www.royalfree.nhs.uk
world class expertise local care

Anaemia clinic: A patient journey

If you have an anaemia clinic appointment, please watch the information video below before you visit to help you understand more about your condition and what will happen on the day of your appointment.

If you would like further information or to get in touch with us please contact the haematology department on: 020 7830 2301.

Useful downloads

Information about anaemia

Information about intravenous iron therapy treatment

Improving dementia care

People with dementia do not do well in hospital – they have longer lengths of stay, they have higher mortality rates and are less likely to go home after admission. This is thought to be related to the way we care for them in hospital – not because of the dementia itself.

Since 2015/16, the trust has prioritised to improve dementia care and has reported progress in previous quality accounts/reports.

Previous achievements have included:

- the production of a film for staff highlighting the carers perspective
- an increase in the number of dementia awareness trainers
- implementation of the 'John's campaign' (improving visiting rights for carers)
- Development of a 'passport' which entitles the holder to reduction in the staff restaurant, reduced parking costs, free massages
- Implementation of the 'forget-me-not' scheme, which alerts staff to the specific needs of the patient

In 2016/17 we developed a framework called CAPER which was designed to support and upskill staff working with patients experiencing dementia and/ or enhanced care needs.

CAPER stands for:

C	Collateral and Communication	getting the right information from the right people and using specialist communication techniques
A	Assessment	understanding behaviour as a form of communication and understanding reversible causes of distressed behaviour; pain and delirium
P	Partnership	working alongside patients, families and carers
E	Enablement	helping patients maintain the skills and function they came in with
R	Role-modelling	using your own skilled practice to inspire cultural change

Progress to achieve the priority has been monitored at our People and Population Health Committee (PPHC) as part of our patient experience reporting. Specific metrics which includes monitoring the length of stay, place admitted from, discharge destination and readmission within 30 days are also reviewed by the Dementia Implementation Group (DIG).

What did we aim to do in 2018/19?

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

What were the key measures for success?

- Improve dementia services for patients admitted to RFL and their carers
- Improve staff experience in caring for people with dementia
- To design new dementia strategy for 2019 – 21

What did we achieve?

During 2018/19, the trust has continued to prioritise the improvement of dementia care for our patients, carers and staff.

Highlights include the following:

- 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) results will be available in July 2019.

- Dementia key worker scheme implemented on 4 wards, providing specialist input and support for patients and families.

- 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.

- 8 important things about me document updated and new process implemented.

- “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.

- Innovative Chicken Shed theatre training took place in January 2018 and CAPER Anchors are looking to further their training in communication and care for patients living with dementia.

- Music therapy training planned for interested staff complemented by an improved roster of musicians visiting the organisation under the RF Charity.

- 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.

- Strategic event planned inviting the public, carers, patients and interested staff to feed into our new strategy.

Raise the curtain

Patients at the RFH will have the best beds in the house thanks to a refurbishment designed to improve the care of dementia patients.

8 West ward has been decorated to transport patients and visitors to the seaside, and now includes a theatre space for live performances by actors, musicians and poets.

The seaside theme was inspired by feedback from patients and relatives on the ward, and co-designed by Danielle Wilde, RFL dementia lead, Chito Gabutin, 8 West ward manager and the 8 West multi-disciplinary team.

Following months of hard work to bring the idea to life, the new look was met with a tremendous reception from all at its grand unveiling.

The event was held in 'The Royal Free Theatre' – a new day room on the ward.

Previously a patient bay, the area has been converted into theatre space, complete with a red-curtain backdrop.

The theatre will be used to provide patients with a weekly programme of activities while they are in hospital – it will also set the stage for the future of dementia care at the RFL, where art and engagement will be a key focus.

Showcasing how the space will be used, patients and staff were treated to a live musical performance during the opening by 40's swing trio, The Polka Dots.

> "It was fantastic to see all the patients singing along with the music and enjoying themselves. This will be a great place we can bring our patients to."
>
> "The opening ceremony was a great opportunity to showcase the day room, and everything that we will be doing in this space."
>
> **Michelle Cody and Allison Kelleher, therapists on 8 West ward**

The refurbishment, which was funded by the Royal Free Charity, extends into the corridor areas.

Images of iconic British seaside towns line one side of the ward; beach huts signpost patient rooms and bays; and along another corridor, a reminiscent boardwalk mural has been created complete with an ice-cream van and gift shop.

The imagery on the walls will be used to stimulate conversations and help patients, particularly those with dementia, to feel more relaxed during their stay on a busy acute hospital ward.

The work on 8 West ward builds on the trust's commitment to deliver world-class dementia care and follows the refurbishment of 10 North ward at the RFH, Larch ward at BH and the dementia-therapy gardens at CFH.

What did we aim to do?

To improve our involvement with our patients and carers

What were the key measures for success?

- Following feedback from staff and patients a broader approach is being taken to ensure that we improve our involvement with our patients and carers.
- Building on previous involvement with our patient partners in CPGs, QI projects, hospital based committees/ groups and with task and finish groups

What did we achieve?

- The trust continues its approach to embedding experience and involvement in its services and development and has adopted the patient experience framework published by NHS England. 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.
- 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.
- 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.
- Patient representatives have been appointed to the patient experience committees at both Barnet and Royal Free sites and the Mortality Surveillance Group. 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: delivering excellent outcomes

The over-arching plan for 2018/19 was 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.

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. Driving quality improvement.
2. Clinical Pathway Groups (CPGs)

Quality Improvement (QI) priority:

What did we aim to do?

To build capability in the workforce and have an online project tracker tool

What were the key measures for success?

- Ability to prioritise QI projects based on local/Group need.
- Local ownership, at service, divisional and hospital unit level.
- To provide access to site-based QI help and support, site-based learning and access to expert QI knowledge.
- To create opportunities to share learning across the site and Group

What did we achieve?

- 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.

- 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.

- 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.

- Together with the leadership team we continue to look for effective ways to share learning across each site and the group.

- 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 Practice Groups (CPGs)

Patients are at the heart of the CPG process and in partnership with clinical teams co-design new pathways of care and define the outcome measures that matter.

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.

What did we aim to do?

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.

What were the key measures for success?

- Our measure for success for 2018/19 is to have seven digitised clinical pathways.

What did we do?

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.

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.

The new Chase Farm Hospital opened and seven pathways have been fully digitised. These include:

1. Preoperative Assessment
2. Elective Hip
3. Elective Knee
4. Right Upper Quadrant Pain (RUQP)
5. Induction of Labour
6. Admissions to Neonatal Unit (Keeping mothers and babies together)
7. Dermatology

The following information highlights some of the work specifically undertaken within our CPG program.

Pathways to better health: Our patients are having a direct impact on the way their healthcare is delivered, resulting in better care

Our surveys and focus groups told us that women didn't want to see lots of different staff, what they wanted was continuity and a relationship with a named midwife."

Katerina Christodoulou with her son, Jason

Katerina Christodoulou with her son, Jason who had given birth at Edgware Birth Centre,.

She told the audience that being able to have continuous care with a designated midwife had enabled her to have an incredibly positive experience.

She said: "I actually suffer from paranoia about hospitals and was almost convinced I would go private. But being able to have a named midwife with me from the start to the finish means I plan to have all my babies with the NHS! It's restored my trust. I think this new approach will also have other benefits like reducing incidents of post-natal depression."

Cathy Rogers, the BH consultant midwife who is leading on the 'Better birth pathway' explained that listening to their patients was at the core of the new pathway, which included introducing named midwives.

She said: "As midwives we do the job because we care but we also made assumptions about what women wanted. When we talked to mums-to-be and to midwives we actually found out there was a lot of common ground.

Dr Chris Streather, group chief medical officer, told members that the work on new patient pathways – the way a patient is treated for a particular health issue – was based on best practice and the latest clinical evidence.

He said: "We will be looking at 44 pathways in the first three years and we think that we will deliver savings of approximately half a million pounds on each through actually improving the patient experience and removing waste. That's £20 million that we can spend on our patients."

Priority three: Patient safety priorities

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. Actions such as debriefs and safety huddles help our staff to provide quality care to our patients.

For 2018/19, focus was made on safer surgery, learning from deaths and infection prevention and control.

Safer surgery

What did we aim to do?

To improve safer surgery and invasive procedures

What were the key measures for success?

- 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

What did we achieve?

Unfortunately, we reported nine never events during 2018/19. The majority of these incidents have resulted in no or low harm to our patients.

We have continued to work closely with our commissioners, NHSI and NHSE to learn from these never events and put in place robust actions to prevent reoccurrence. This has included undertaking additional risk assessments relating to high risk areas for never events and developing a trust wide action plan to bring together learning from across all the previous never events.

	Site	Date	Type	Harm
1	CFH	18/04/2018	Wrong side hernia	Low
2	CFH	19/04/2018	Wrong side ureteroscopy	None
3	RFH	14/06/2018	Retained swab after a laparoscopic cholecystectomy	Moderate
4	BH	19/06/2018	Air/oxygen mis-connection	None
5	RFH	20/06/2018	Air/oxygen mis-connection	None
6	RFH	27/06/2018	Wrong eye injection	None
7	RFH	04/07/2018	Wrong knee prosthesis	Moderate
8	BH	30/08/2018	Retained needle post episiotomy	None
9	Other	02/10/2018	Wrong side epidural injection	None

The Patient Safety CPG has focussed on developing Local Safety Standards for Invasive Procedures (LocSSIPs) for three pathways identified as those where never events had occurred previously and where the most procedures were undertaken: cardiology, radiology and endoscopy.

- The design and testing of the data collection tool is complete. The tested data collection tool is being incorporated into the 'Perfect Ward' App, with initial testing at RFH in the Cath Lab and Endoscopy unit.

- Clinical areas are collecting compliance data (most areas weekly), in line with their implementation phase audit plan.

- The Statistical Process Charts (SPC) on the quality improvement platform (Life QI) are used to analyse and share the LocSSIPs compliance data dynamically among the clinical, quality governance and senior leadership staff.

All incidents resulting in moderate or severe harm or death are reviewed at our weekly review panels where serious incidents, reports and actions are discussed with all Divisions, so that the information can be shared at divisional quality meetings.

We publish a weekly précis of serious incidents as they are reported and share further general and speciality specific newsletters online and by email.

We also hold learning events, seminars and workshops in order to disseminate lessons learnt.

All serious incidents are reviewed at our board level clinical innovations and standards committee (CSIC), chaired by one of our Non-executive directors where we triangulate serious incidents with incidents, complaints, PALS and litigation to identify themes which might require system-wide work.

learning from deaths

What did we aim to do?

To improve our Learning from deaths (LfD)

What were the key measures for success?

- 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

What did we achieve?

- 11% patient deaths were recorded centrally for review in 2017/18. Therefore, the aim is to increase this to 21%. .

- 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."

- We are working to use more dynamic survey data to show how we improve this metric.

- We have increased the numbers of deaths reviewed in 2018/19 Q1 to 15%.

- We are now communicating more via: Safety needs and incident learning (SNAIL), a weekly blog on key areas of learning from incidents and near misses using SBAR. Plus, we are distributing: Free Way to Safety (FWTS) our monthly newsletter (with key safety learning from serious incidents, emailed to incident managers); and Health and safety monthly newsletter (with key Health and safety information, emailed to Health and safety champions).

- The quarterly in-house staff survey has now been amended to include the question: "When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again."

- The patient safety culture survey, based on a survey tool derived from the Texas Safety Attitudes Questionnaire (Sexton et al 2006), elicits a snapshot of the safety culture from 17 questions. We have been using this since early 2016 to survey over 500 staff during training and development interactions. We will be using the following two questions to generate metrics demonstrate improvement relating to the sharing of the learning across the trust:

- As a team, we discuss learning from errors/incidents

- The culture in my area makes it easy to learn from the mistakes of others.

Infection prevention and control

What did we aim to do?

To improve infection prevention and control

What were the key measures for success?

- To achieve 10% reduction by year of meticillin-resistant Staphylococcus aureus (MRSA).

- To achieve Trust-attributed zero *Clostridium difficile* (C.diff) infections due to lapses in care by end of March 2019

What did we achieve?

MRSA

- MRSA bacteraemias – currently two attributed cases to Barnet and one attributed to RFH.

- Learning from the cases and measures for reduction are driven through the monthly IPC Divisional Leads group.

C.diff

- Currently three lapses in care for C.diff cases. Two at BH related to apparent transmission and one at RFH related to delays in identification, testing and incomplete documentation.

- Total cases for 2018/19 expected to be below threshold. Revised threshold for 2019/20 is 100 cases relating to more detailed definitions of attribution of cases.

- All cases have an Root Cause Analysis, with learning fed back through the monthly IPC Divisional Leads group

Through the Clinical Standards and Innovation Committee we have monitored, measured and reported progress made during 2018/19 to achieve the set priorities. The committee reports to the trust board.

Our Priorities for improvement (2019/20)

Looking forward to what our quality account priorities will be for the year ahead.

The 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 reported to the trust board as illustrated in figure 1.

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.

Progress reports will be sent to the Dementia Implementation Group , Population xxxxx and updates to our commissioners via Clinical Quality Review Group

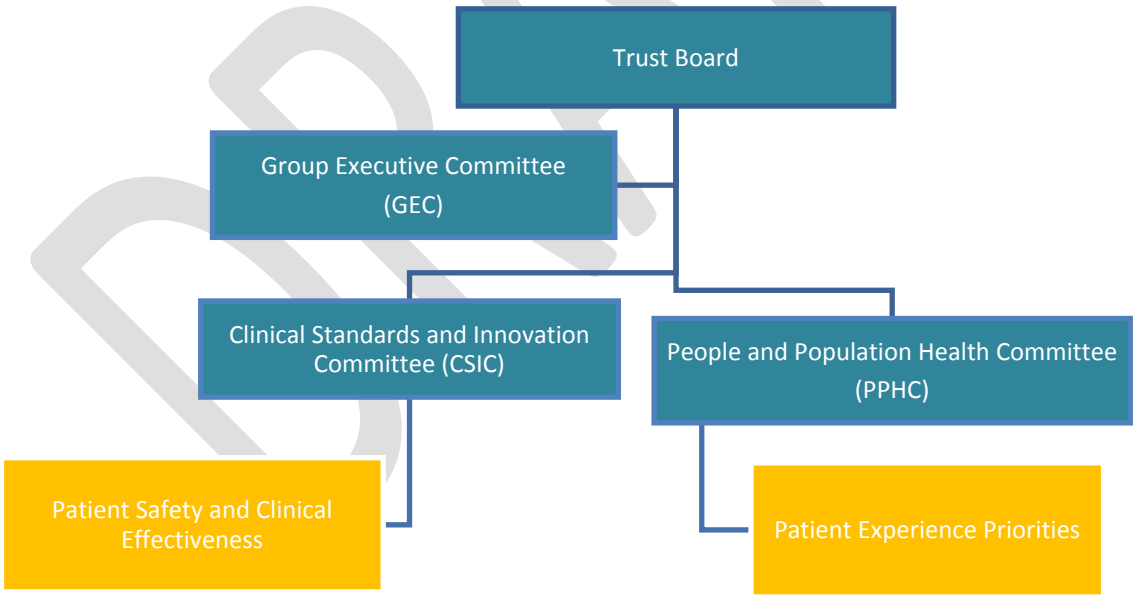


Figure 1: Strategic committees reporting to the trust board

Our consultation process

Our stakeholder's engagement event **Showcasing Clinical Excellence** was held in February 2019. Over seventy people attended which included, commissioners, governors and members from Healthwatch and staff.

To include brief statement

Judy Dewinter, Lead Governor and Afsaneh Motabar, National Clinical Audit lead.

James Mountford, Director of quality

Caroline Clarke, Group chief executive

Priority one: Improving patient experience: Delivering world class experience

We aim to put the patient, carers and our staff at the heart of all we do to deliver excellent experiences.

Priorities for 2019/20	Continuation from 2018/19	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 improve the quality of care being undertaken in high need bays • To develop and build the dementia pathway via Clinical Practice Group work (CPG) • To further develop and roll out innovative communication workshops for staff working with dementia patients • To recruit and train volunteer led activity coordinators to increase use of activity groups in day rooms

Priorities for 2019/20	Continuation from 2018/19	Key measures for success
 To improve our involvement with our patients and carers	✓ (previous performance shown in section 1.1)	• To organise a suite of tools, strategies, and cultural elements into an easy-to-follow framework

Priority two: Improving clinical effectiveness: reducing variation and improving outcomes

The over-arching plan for 2019/20 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:

Priorities for 2019/20	Continuation from 2018/19	Key measures for success
 To build capability in the workforce	✓ (previous performance shown in section 1.1)	• Increase Joy in Work for teams participating in the collaborative by 50% above baseline measures by 31 May 2020 • Be sustainable in delivering core QI training programmes toward our goal that 20% of staff (2,000 staff) have received formal training in QI by end of 2020 • Further incorporate QI into routine operations/processes across RFL, and further establish opportunities to share learning within and across our sites • QI embedded into Divisional Board meetings • QI integral to CEO briefings • QI learning events on major sites and annual RFL-wide event

Clinical Pathway Group (CPG) priority:

Priorities for 2019/20	Continuation from 2018/19	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.	✓ (previous performance shown in section 1.1)	• To have 20 clinical pathways digitised across our CPGs

Priority three: Patient safety priorities: Improving safety- improving care

Each year as we set the overarching quality priorities we recognise that delivery against the most important quality objectives often requires a focus lasting several years. The RFL group safety priorities are: zero Never Events, reducing avoidable deaths and zero avoidable hospital-acquired infections. Therefore for 2018/19 we will focus on:

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

Priorities for 2019/20	Continuation from 2018/19	Key measures for success
5 To improve safer surgery in line with trust aims/goals	✓ (previous performance shown in section 1.1)	• To achieve zero never events by the end of March 2020 • To increase by 75% the number of LocSIPs in place by the end of March 2020

Priorities for 2019/20	Continuation from 2018/19	Key measures for success
6 Learning from deaths (LfD)	✓ (previous performance shown in section 1.1)	• To increase by 10% the percentage of reviews of patient deaths recorded centrally • 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

Priorities for 2019/20	Continuation from 2018/19	Key measures for success
7 To improve infection prevention and control	✓ (previous performance shown in section 1.1)	• To achieve zero trust attributed meticillin-resistant Staphylococcus aureus bacteraemias. (MRSA). • To reduce Gram negative bacteraemias in line with mandated threshold (- 25% reduction by 2021-2022 with the full 50% by 2023-2024) • To remain below mandated threshold for trust-attributed zero *Clostridium difficile* (C.diff) (100 cases 2019/20) To have zero infections due to lapses in care

2.2 Statements of assurance from the board

Review of services

During 2018/19 the Royal Free London NHS Foundation Trust (RFL) provided and/or sub-contracted 40 relevant health services.

The Royal Free London NHS Foundation Trust 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 2018 represents 100% of the total income generated from the provision of relevant health services by the Royal Free London NHS Foundation Trust for 2018/19.

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 2018/19 xx national clinical audits and xx national confidential enquires covered relevant health services that Royal Free London NHS Foundation Trust provides.

During that period Royal Free London NHS Foundation Trust participated in xxx% national clinical audits and xx% national confidential enquires of the national clinical audits and national confidential enquires 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 2018/19 are as follows: (Insert list)

The national clinical audits and national confidential enquiries that the Royal Free London NHS Foundation Trust participated in during 2017/18 are as follows: (insert list)

The national clinical audits and national confidential enquiries that Royal Free London NHS Foundation Trust participated in, and for which data collection was completed during 2018/19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. (inset list and percentages)

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 sources, usually hospital episode statistics (HES) data.

HES is a data warehouse containing details of all admissions, out-patient 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
- RFH = Royal Free Hospital
- BH = Barnet Hospital
- CFH = Chase Farm Hospital

Name of Audit	Data collection completed in 2017/18	Trust Eligibility to participate	Participation 2018/19	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	N =167 total. [RFH-95, BH-72]
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) audit	Yes	Yes	RFH and BH CFH service not available	BH = 46 RF = 16
Diabetes: National diabetes audit (NDA)	Yes	Yes	RFH BH and CFH	Type 1 = 1205, Type 2 = 1675
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: 2017 National comparative audit of transfusion associated circulatory overload (TACO)	Yes	Yes	RFH BH and CFH	BH = 40 CFH = 26 RFH = 40
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)

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 2018/19, 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 2018/19:

During 2018/19, the trust participated in several other national audits which were not in the HQIP 'Quality accounts' list, published in December 2018. 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 2018/19 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:

The reports of 23 local clinical audits* were reviewed by the provider in 2018/19 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:

- 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

* the local audits undertaken relate to the quality improvement projects previously described which demonstrated modest to significant improvement through successful plan, do, study, act cycles

Participating in clinical research

The number of patients receiving relevant health services provided or sub-contracted by the Royal Free London NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee 10,098

The above figure includes 4522 patients recruited into studies on the NIHR portfolio and 5576 patients recruited into studies that are not on the NIHR portfolio. This figure is lower than that reported last year.

The Trust is supporting a large research portfolio of over 800 studies, including both commercial and academic research. 168 new studies were approved in 2018 - 2019. 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.

Patients first to help new eye disease research at Barnet Hospital

Left to right: Dr Dinushni Muthucumarana and Dr Haseena Sadhwani, research doctors; Mr Martin Harris, ophthalmology consultant; Susan Freedman, patient; Dr Sarah Ah-Moye, junior clinical research fellow in ophthalmology; Adaora Udenze, clinic nurse; **Mr Hemal Mehta, ophthalmology consultant;** Gloria Ferenando, research nurse; Steve Paratian, research medical photographer

Barnet Hospital has recruited the first European patient to take part in an international study exploring a potential new treatment for wet age-related macular degeneration (AMD).

Mr Hemal Mehta, consultant ophthalmic surgeon, leads ophthalmology clinical trials at BH. The latest research project aims to establish the effectiveness and safety of a new eye drop to treat the condition. Wet AMD occurs when abnormal blood vessels grow underneath the retina. These unhealthy vessels leak blood and fluid, which can prevent the retina from working properly and lead to permanent loss of central vision. It does not usually cause total blindness but it can make every day activities difficult, such as reading or recognising faces.

We currently use injections to stabilise wet AMD and patients often need to have these every month or two.

"The potential benefits of using eye drops would be that fewer or possibly no injections would be needed, so it would be safer and less unpleasant for the patient.

It is also more convenient for them and their relatives as they would not need to attend hospital so often. We need clinical trials to establish how well these new drops work."

Mr Hemal Mehta, consultant ophthalmic surgeon

The injections contain medicines called anti-vascular endothelial growth factor agents that reduce the growth of new blood vessels.

The molecules in the eye drops are a thousand times smaller than those in the injections, which mean they can enter and penetrate the eye more effectively.

CQUIN Payment framework

A proportion of the Royal Free London NHS Foundation Trust income in 2018/19 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 2018/19 and for the following 12-month period are available electronically at: (provide a weblink)

Table 6: CQUIN scheme priorities 2018/2019

CQUIN scheme priorities 2018/2019	**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.
Preventing ill health by risky behaviours – alcohol & tobacco	To support people to change their behaviour to reduce the risk to their health from alcohol and tobacco
CQUIN scheme priorities	**Objective rationale**

2018/2019	
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).

The Commissioning for Quality and Innovation (CQUIN) payment framework enables commissioners to reward excellence by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. Since the first CQUIN framework in 2009/10, many CQUIN schemes have been developed and agreed.

In **2018/19** a total of **xxxxxxxx** of the trust's income was conditional upon achieving quality improvement and innovation goals. Our CQUIN payment framework was agreed with NHS North East London Commissioning Support Unit and NHS England. The monetary total for 2018/19 was xxxxxxx

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 the following conditions on registration none.

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 not participated in any special reviews or investigations by the CQC during 2018/19.

The trust was subject to an announced core service inspection across our three hospital sites Barnet Hospital, Chase Farm and the Royal Free Hospital during 11 to 13 December 2018 the inspection focussed on the following core services:

Chase Farm :

Urgent and Emergency Care; our Urgent care Unit

Surgery; Our surgical ward and day surgery services

Medical; Our medical ward and outpatient clinics

Barnet Hospital:

Surgery; Our surgical wards, theatres and day surgery services

Urgent and Emergency care; our Urgent and emergency care Unit

Medical; Our medical wards

Critical Care; Our critical care and high dependency Unit.

Royal Free Hospital

Surgery; Our surgical wards, theatres and day surgery services

Urgent and Emergency care

Medical; Our medical wards

Critical Care; Our critical care unit

Maternity; Our maternity wards and midwifery service.

In addition to the December 2018 core services inspection the CQC undertook the Well Led and use of Resources inspection between 8 to 10 January 2019. The trust is awaiting the final report from these inspections. See 'Section 3.4 our plans' for further information.

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 which are included in the latest published data.

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

% of records	2015/16	2016/17	2017/18	2018/19
For admitted patient care	98.6%	98.15%	98.8%	99.1%
For out-patient care	98.6%	98.65%	99.2%	99.5%
For accident & emergency care	94.4%	94.89%	95.7%	96.8%

General Medical Practice Code

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

% of records	2015/16	2016/17	2017/18	2018/19
For admitted patient care	99.95%	99.92%	99.8%	99.8%
For outpatient care	99.96%	100%	99.9%	99.9%
For accident & emergency care	99.94%	100%	100%	100%

Information Governance (IG)

The Royal Free London NHS Foundation Trust Information Governance Assessment Report overall score for 2018/19 was xxxxx and was graded xxxx

	2016/17	2017/18	2018/19
Information governance assessment score	**66%**	**68%**	
Overall grading	**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:

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 (approximately 1.02% of all admissions).

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.

During 2018/19, 2048 of the Royal Free London NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

In 506 cases a death was subjected to both a case record review and an investigation.

506 in the first quarter; 472 in the second quarter; ### in the third quarter; ### in the fourth quarter.

Due to differences in the reporting periods for Learning from deaths (LfD) reviews and the Quality Accounts, for completeness data are included here for 2017/18 quarters 3 and 4, as these were not included in last year's Quality Accounts. Likewise review data for 2018/19 quarters 3 and 4 are not available for inclusion in this year's Quality Accounts.

Table

Reporting period		**Number of deaths**	**Number of reviews**	**Number of serious incident investigations**	**Number** of the patient deaths considered likely to be avoidable	**Percentage** of the patient deaths considered likely to be avoidable
Third quarter	October 2017 to December 2017	549	52	5	4	0.72%
Fourth quarter	January 2018 to March 2018	563	40	12	10	1.91%
First quarter	April 2018 to June 2018	506	52	3	2	0.40%
Second quarter	July 2018 to September 2018	472	19	2	2	0.42%
Third quarter	October 2018 to December 2018	###	Not yet completed	Not yet completed	Not yet completed	Not yet completed
Fourth quarter	January 2019 to March 2019	###	Not yet completed	Not yet completed	Not yet completed	Not yet completed

Reporting Period 2018/19 (Q1 and Q2)

By 31/03/19, 71 case record reviews and 5 serious incident investigations have been carried out in relation to 978 of the deaths included in the information presented in the Table
In 5 cases a death was subjected to both a case record review and a serious incident investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 52 in Q1, 19 in Q2, as shown in the table. Data for Q3 and Q4 are not yet available.

There were 5 patient deaths, representing 0.41% of the patient deaths during the reporting period Q1 and Q2 that were considered likely to be avoidable. These were patient deaths were also identified as incidents prior to the Learning from deaths (LfD) process, and reported as serious incidents.

In relation to each quarter, this consisted of: 3 deaths representing 0.40% for the first quarter; 2 deaths representing 0.42% for the second quarter as shown in the table. Data for Q3 and Q4 are not yet available.

The numbers of deaths considered likely to be avoidable have been estimated using the Likert avoidability scales in line with the Learning from deaths (LfD) policy and the Incident management policy. Scores of 1-3 indicate those deaths considered likely (ie over 50%) to be avoidable.

Likert avoidability Scale:
1 Definitely avoidable
2 Strong evidence of avoidability
3 Probably avoidable, more than 50:50
4 Possibly avoidable, but not very likely, less than 50:50
5 Slight evidence of avoidability
6 Definitely not avoidable (unavoidable)

Previous reporting period 2017/18 (Q3 and Q4)

By 31/03/19, from Quarters 3 and 4 of 2017/18, 92 case record reviews and 17 serious incident investigations have been carried out in relation to 1130 of the deaths included in the information presented in the Table. In 17 cases a death was subjected to both a case record review and a serious incident investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 52 in Q3, 40 in Q4, as shown in the table.

There were 14 patient deaths, representing 1.33 % of the patient deaths during the reporting period Q1 and Q2 that were considered likely to be avoidable. These were patient deaths were also identified as incidents prior to the Learning from deaths (LfD) process, and reported as serious incidents.

In relation to each quarter, this consisted of: 4 deaths representing 0.72% for the Q3; 10 deaths representing 1.91% for Q4 as shown in the table. Data for Q1 and Q2 were presented in last year's Quality Accounts.

The numbers of deaths considered likely to be avoidable have been estimated using the Likert avoidability scales in line with the Learning from deaths (LfD) policy and the Incident management policy. Scores of 1-3 indicate those deaths considered likely (ie over 50%) to be avoidable.

Likert avoidability Scale:
1 Definitely avoidable
2 Strong evidence of avoidability
3 Probably avoidable, more than 50:50
4 Possibly avoidable, but not very likely, less than 50:50
5 Slight evidence of avoidability
6 Definitely not avoidable (unavoidable)

Summary of lessons learnt

The lessons learnt summarised below relate to all patient deaths which were reviewed as part of this process. We have included examples of good practice and areas for improvement; it should be noted that these do show differences in care for our patients and we continue to work to ensure that patient care is consistent and of high quality. During 2018/19, we developed a Learning lessons from near misses, serious incidents and deaths communications plan to help us better define our processes and stakeholders with the objectives:

- Staff use the learning from serious incidents and deaths to improve care and prevent further patient /staff harm
- Staff can describe the learning from a recent near miss, incident, serious incident, or never event.

- Staff know that they can receive practical and emotional support following a serious incident and how they can access this.

Some of our approaches include:

- Newsletters: Patient safety weekly and monthly bulletins, Divisional newsletters, safety alerts, quarterly Complaints, Litigation, Incidents, PALS and Safety report
- Meetings: Clinical innovations and standards committee, Mortality surveillance group, Hospital Mortality review groups, Hospital Clinical performance & patient safety committees, Serious incident review panel (SIRP), Divisional Quality Safety Boards
- Events: Learning from incidents and near misses event, Audit and quality days, trainee doctors, nursing, AHP induction.

Advance Care Planning

The Learning from deaths (LfD) process has helped us to understand where we have areas for improvement, so that we can target these for specific focus. At Barnet Hospital we set up a quality improvement project to improve Advance care planning (ACP), which is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care. The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness.

We have a growing population of frail patients who are frequent users of healthcare services. When discussing their place of death, the majority report that they would like to die at home, although statistically most deaths occur in hospital. Initially we reviewed a cohort of patients over one month to understand where and how we could improve the ACP process. Our interventions included adding ACP to the Board round, increasing training and identifying ACP champions, using ACP stickers to assist recording of the correct information, and enhancing CMC (Co-ordinate my care) training and access. On the pilot ward advanced care planning increased from 39% to ~78%, and this was expanded to 6 further wards. The results showed that six-months later 75% of these patients had remained in the community in their place of discharge. We showed that advanced care planning on the ward leads to more patients ending life in their preferred place of care and with reduced transfers of care.

2017/18 (Q3 and Q4)

<u>Patient care</u>

- Care thoughtful and appropriate
- Develop a clear document for repositioning patients with a raised BMI who have a new tracheostomy.
- Fluid balance charts should be used when monitoring a patient's fluid balance.
- Staff worked well together to gain access as the patient was difficult to cannulate.
- Attention paid to pressure area care.

<u>Communication</u>

- Anticipating early or rapid complications of disease process such as hydration and nutrition, as well as carer support for a dying patient.
- Communication with family not documented in the notes.
- Discussion with next of kin was hampered by the fact that the patient did not want them to know what was going on.
- Documentation of resuscitation drugs and printouts of rhythms and names of clinicians involved in care, clear in notes
- Excellent involvement of medical and surgical teams, appropriate decisions
- Excellent sepsis management
- Excellent repeated attempts and discussions with family.
- Excellent documentation of final discussion and DNAR decision making
- Frequent discussion with family

- Good communication with family
- Good nursing care documentation
- No Documentation of care after death and communication (or attempts to communicate) with relatives and coroners
- Patient's hospital passport was mislaid
- Very clear documentation of numerous conversations with family members.
- When the patient expressed their wish to stop active/life-prolonging treatment, this was respected and acted upon

End of Life care
- Better documentation of events post-death, such as discussions with the family, whether the GP was informed and if any further action was taken.
- Ensuring all involved in the patient's care have been informed of the death.
- Consider earlier referral to Palliative care
- Family involved in end of life discussions.
- Good discussion with family about end of life care.
- Lack of recognition of the importance of obtaining independent interpreting services

Training
- Improve training for emergency management of the deteriorating patient ventilated via tracheostomy
- Improve training on 'red flag' signs in patients ventilated via tracheostomy.
- Update training on the use of capnography
- Increase staff knowledge relating to the management of a child with pyrexia of unknown origin by the provision of formal training.
- There was a lack of adequate staff knowledge of the effects of Amiodarone particularly when administered as a bolus

Treatment pathways
- Create a pathway for all dialysis inpatients at Barnet Hospital
- Deprivation of Liberty Safeguards (DOLs) not in place
- It could have been acknowledged earlier that the patient was deteriorating with a high likelihood of dying and so treatment could have been appropriately limited
- Oral care not well documented in nursing notes and oral care plan not triggered on admission
- Thorough capacity assessment with MDT involvement.

2018/19 (Q1 and Q2)

Patient care
- Excellent management of an aplastic anaemia crisis
- Good care and timely decision making
- Medication should not be given orally to a drowsy patient
- Rapid timely access to very senior clinician input.
- Staff were slow to act on poor oral intake
- The patient was placed appropriately in a high visibility bed on the ward.
- The patient received a weekend medical review and appropriate action was taken.
- The patient's acute deterioration was immediately recognised by nursing staff
- Timely second opinion and legal advice
- Well planned and conducted best interests meeting

Communication
- Excellent documentation of communication with the family
- Good communication regarding nutrition and attempts to maximise oral intake
- Good communication with next of kin following admission to ITU
- Good cooperation between hospital teams
- MDT meeting held to discuss concerns, well documented, all MDT & community involved.

- Post-take ward round documentation could have been more detailed
- Regular review by multi professional team and joined up multi professional approach throughout admission.

End of Life care
- Clarity of visiting hours ie relaxing visiting hours in the case of a terminally dying patient so family can stay with patient in last hours
- Early involvement of palliative care, however this was not communicated well to the whole team involved which caused some confusion
- Excellent palliative care plan providing support to patient and family, with spiritual needs taken into account
- Improve end-of-life care planning for patients with severe long-term conditions
- Need for better community resources to support end of life care at home
- There was poor end of life care in the final hours, as there is little documentation and limited medical review

Treatment pathways
- Clarify the reporting of intraoperative deaths within the incident policy
- VTE management complex but decision making process clearly documented at each point

Description of actions taken during 2017/18 (Q3 and Q4)

The actions summarised below relate to those patient deaths which were considered likely to be avoidable. From October 2017 to March 2018, we identified 15 patient deaths that were considered likely to be avoidable, all of which were identified and reported as serious incidents:

ID	FinYear	Quarter	Likert Avoidability
2017/25733	2017/18	Q3	3. Probably avoidable, more than 50/50
2017/29402	2017/18	Q3	3. Probably avoidable, more than 50/50
2017/29762	2017/18	Q3	3. Probably avoidable, more than 50/50
2017/29969	2017/18	Q3	2. Strong evidence of avoidability
2018/1325	2017/18	Q4	3. Probably avoidable, more than 50/50
2018/4182	2017/18	Q4	3. Probably avoidable, more than 50/50
2018/1569	2017/18	Q4	2. Strong evidence of avoidability
2018/5773	2017/18	Q4	2. Strong evidence of avoidability
2018/11183	2017/18	Q4	2. Strong evidence of avoidability
2018/3607	2017/18	Q4	3. Probably avoidable, more than 50/50
2018/7350	2017/18	Q4	2. Strong evidence of avoidability
2018/6728	2017/18	Q4	2. Strong evidence of avoidability
2018/6737	2017/18	Q4	2. Strong evidence of avoidability
2018/8069	2017/18	Q4	2. Strong evidence of avoidability

Following investigation, each serious incident report contains a detailed action plan that is agreed with our commissioners and shared with the relatives. These actions are reviewed so that we have assurance that they are implemented. We have reworded some of the actions, so that our patients and their families are not identifiable.

- Amend the current ICU guideline for repositioning patients, to include that patients who have a high BMI and a new tracheostomy and who require repositioning should have four staff members involved in the procedure (including the nurse managing the tracheostomy).
- Clarify that the medical FY1 doctor overnight is to be viewed as Supernumerary and must not be asked to review acute or deteriorating patients without support.
- Complete a medication risk assessment for Amiodarone.

- Consider whether all wards should combine nursing and medical notes.
- Develop a business case to seek funding to explore the development of an electronic solution which would aid interpretation of plotted measurements on the GAP/GROW (Foetal development chart) and in turn clinical management is currently being finalised for presentation to the Technology Board.
- Develop a communication decision tool with suggested strategies and contact information for staff to support their decision making and clinical history taking when dealing with patients and families where there are communication difficulties.
- Develop a GAP/GROW (Foetal development chart) workbook of case studies as part of training improvement
- Develop an appointment system to ensure an effective process for following up women who do not attend for planned CTG scans.
- Develop clear criteria identifying the appropriate waiting time for transfer of women following induction with the Cooks' balloon and this information will be incorporated into the Maternity escalation policy as part of the maternity red flag triggers.
- Develop links with the Infectious diseases team in order to produce training for paediatric staff focusing on the following areas:
- Develop Multidisciplinary simulation training specifically relating to care of a child with SVT including the administration of Amiodarone.
- Devise an action template for staff shortages to ensure that patients at risk are prioritised.
- Highlight and escalate displaced patients of concern at the bed meeting, with a list of outliers for daily review.
- Emphasise the importance of communication cancellations of antenatal appointments to the midwife
- Ensure all patients that are reported as having chest pain (regardless of the history) have a new ECG and have this reviewed by an FY2 doctor or registrar.
- Ensure all women booked under midwifery led care have their appointment booked and sent to them by the community midwife. In the event that they do not attend, this will be followed up by the community midwifery team.
- Ensure that if a patient is unpredictable, a behavioural chart will be completed daily.
- Ensure the Enhanced Care Assessment form is available on all wards
- Ensure there is an adequate supply of critical drug stickers with the prescriptions charts and with the critical drugs poster clearly visible for all prescribers to see with the correct process of identifying critical drugs.
- Explore a solution for accessing ice or a suitable alternative in the Emergency Department.
- Explore the possibility of increasing the referral rate from Barnet hospital to the Fetal Medicine Unit at Royal Free hospital, focusing particularly on women who require increased surveillance.
- Have a permanent medical FY2 rotated in on the weekends who will conduct a daily Ward Round.
- Highlight the availability of interpreting services within the Trust
- Identify patients at handover and safety huddles that are at risk and who will be responsible for the patient safety that day.
- Implement weekend consultant-led ward rounds on the Ward
- Incorporate the learning from this death into training
- Introduce a consistent 24 hour cover, which will help provide a better point of contact, particularly for outlier medical patients, and also ensure the on take FY1 doctor continues with clerking rather than being pulled to see ward patients.
- Offer to share a copy of the final report and a face to face meeting with the patient/carer/ relative to feedback the findings of the investigation at a 'being open' meeting.
- Organise the schedule for ICU doctors to receive training on how to use the new ICU ultrasound machines.
- Place a safety alert regarding critical medications on to the Trust screensaver.
- Prepare a continuous programme for staff to simulate the scenario of management of the deteriorating patient.
- Present the case at the governance meeting to share learning
- Provide a clear process when access to the CCTV room is required out of hours.
- Reiterate the importance of safeguarding patient information during the safety briefing.

- Remind all staff of the importance of using capnography monitoring for tracheostomy patients
- Remind staff about speaking up at safety huddles when patients have a triggering PAR/NEWS score.
- Remind staff about the need for comprehensive documentation and consideration of the use of a scribe to record events.
- Review and update the guidance on ultrasound scan to include clearer guidance for sonographers as to what to report on the scan report if a scan falls within the extremes of normal limits for fetal growth measurement parameters.
- Review and update the Transfer Checklist to ensure there is an escalation prompt/ process for nursing staff to follow to ensure patients get a medical review prior to transfer if they have a PAR score of 3 and above.
- Review ICU discharge policy to reflect that complex ICU patients should not be stepped down to wards at night.
- Review safeguarding processes
- Review the feasibility of implementing weekend safety huddles as part of the current Quality Improvement work on the Safety Huddles initiative of the NHS Improvement Maternal and Neonatal health safety Collaborative
- Review the guideline for women who fail to attend antenatal visits in the community or in hospital and include additional actions for the follow-up of women who are having on-going blood pressure profile assessments in the Day assessment unit.
- Review the medical rota to ensure there are adequate medical staff covering the medical wards on the weekend.
- Set up a working group to review the pathway for escalating for a clinical review and the criteria for triggering the emergency bleep calls.
- Share a copy of the report with staff involved and ensure they reflect on what could have could have been done differently and include this in their appraisals.
- Share learning via CLIPS report (Complaints, Litigation, Incidents, PALS and Safety)
- Submit an ICU business case recommending the purchase of three new multi-modal ultrasound machines.
- Triage calls made to Hospital at Night Coordinators as routine or urgent by asking the caller. All urgent calls to record SBAR (Situation / Background / Assessment / Recommendation) on a separate sheet and record outcomes based on a doctor's feedback.
- Undertake an audit on the use of MEOWS (mother's early warning score) charts.
- Update guideline for the Induction of labour including pre-labour rupture of membranes at term guideline
- Update the risk relating to Nursing Shortages
- Ward Manager to liaise with PARRT and organise a learning session for nursing team about deteriorating patients and escalation processes.
- Write the protocol recommending use of ultrasound imaging for all invasive procedures carried out on ICU. This should incorporate the radiology LocSSIPs (Local Safety Standards for Invasive Procedures) for invasive procedures.

Description of actions taken during 2018/19 (Q1 and Q2)

The actions summarised below relate to those patient deaths which were considered likely to be avoidable. From April 2018 to September 2018, we identified 4 patient deaths that were considered likely to be avoidable, all of which were identified and reported as serious incidents:

ID	FinYear	Quarter	Likert Avoidability
2018/11594	2018/19	Q1	2. Strong evidence of avoidability
2018/15356	2018/19	Q1	3. Probably avoidable, more than 50/50
2018/18956	2018/19	Q2	3. Probably avoidable, more than 50/50
2018/21527	2018/19	Q2	2. Strong evidence of avoidability

Following investigation, each serious incident report contains a detailed action plan that is agreed with our commissioners and shared with the relatives. These actions are reviewed so that we have

assurance that they are implemented. We have grouped the actions into broader themes here, so that our patients and their families are not identifiable.

- Arrange simulation of adult emergency call situations in ward areas (including scenarios with patients displaying confusion)
- Develop guidance on the use of bed and chair alarms and the checks to undertake to ensure the equipment is safe for use.
- Develop a protocol for safe transfer of confused patient after 8pm
- Ensure and document attendance of ward nursing staff at escalation and use of the SBAR (Situation, Background, Assessment, Recommendation) training
- Ensure staff attend refresher training on how to take lying and standing blood pressures
- Ensure that monthly audits are undertaken to determine the accuracy of documentation on the NEWS 2 observation chart.
- Establish a 12 midnight huddle where Registered Nurses (RN) go through each patient's notes and documentation with HCAs and also discuss patients at risk of deterioration or/ and patients who require escalation.
- Facilitate discussion and training about the use of CPAPs in ED
- Offer to share a copy of the final report and a face to face meeting with the patient/carer/relative to feedback the findings of the investigation at a 'being open' meeting.
- Present the case at the governance meeting to share learning
- Remind staff about using the "P" function on ECGs and audit to check understanding
- Share a copy of the report with staff involved and ensure they reflect on what could have could have been done differently and include this in their appraisals.
- Share the learning via CLIPS report (Complaints, Litigation, Incidents, PALS and Safety)
- Update ECG audit template to include signatures and monitor results.

Description of proposed actions to take during 2018/19

Actions from quarter 3 and 4 reviews when they are completed will be taken forward during 2018/19 and reported on in next year's Quality Accounts.

Assessment of the impact of the actions taken

For each patient death that was considered likely to be avoidable, an investigation was undertaken and the actions to prevent recurrence of the incident were recorded (these actions have been detailed above). These actions are logged on our Risk Management system Datix, and are monitored by the hospital Clinical performance & patient safety committee and Clinical standards and innovations committee (CSIC) to ensure completion and compliance.

In addition, a number of actions are also reviewed by our commissioners, providing external assurance of our processes. This ongoing external review has been completed to the satisfaction of our commissioners. This will include a review of audits undertaken that provide evidence that the action continues to be implemented.

2.3 Reporting against core indicators

This section of the report presents our performance against 8 core indicators, using data made available to the trust by NHS Digital. Indicators included in this report, shows the national average and the performance of the highest and lowest NHS trust.

Areas covered will include:

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

This information is based on the most recent data that we have access to from NHS Digital and the format is presented in line with our previous annual reports. In future annual reports we will look to standardise the information produced, including time period examined.

Summary hospital-level mortality (SHMI)

Indicator:

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

Royal Free Performance Jul 14 - Jun 15	Royal Free Performance Jul 15 - Jun 16	Royal Free Performance Jul 16 - Jun 17	Royal Free Performance Jul 17 - Jun 18	National Average Performance Jul 17 - Jun 18	Highest Performing NHS Trust Performance Jul 17 - Jun 18	Lowest Performing NHS Trust Performance Jul 17 - Jun 18
0.853 (Lower than expected)	0.9053 (as expected)	0.8777 (lower than expected)	**0.8351 (lower than expected)**	1.0 (as expected)	0.6982 (lower than expected)	1.2572 (higher than expected)

The SHMI score published in this report has been calculated by NHS Digital and uses finalised HES data for the financial years 2014-15, 2015-16, 2016-17 and 2017-18. NHS Digital have indicated that they believe there is a shortfall in the number of records in the HES data for discharges in the reporting period October 2015 – September 2016 for Royal Free London NHS Foundation Trust (provider code RAL). This has the potential to either under or over represent performance against this indicator and as such the report should be viewed with caution, however it should be noted that the Royal Free London NHS Foundation Trust participates in the HSCIC NHS Choices / Clinical Indicator sign off programme whereby data quality is reviewed and assessed on a monthly and quarterly basis.

No significant variance between the data held within Trust systems and data submitted externally has been observed.

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

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

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

The latest data available covers the 12 months to June 2018. During this period the Royal Free had a mortality risk score of 0.8351, which represents a risk of mortality lower than expected for our case mix. This represents a mortality risk statistically significantly below (better than) expected with the Royal Free ranked 9th out of 131 non-specialist acute trusts.

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

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

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

Patient deaths with palliative care code

Indicator:

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

Royal Free Performance Jul 14 - Jun 15	Royal Free Performance Jul 15 - Jun 16	Royal Free Performance Jul 16 - Jun 17	Royal Free Performance Jul 17 - Jun 18	National Average Performance Jul 16 - Jun 17	Highest Performing NHS Trust Performance Jul 16 - Jun 17	Lowest Performing NHS Trust Performance Jul 16 - Jun 17
25.4%	25.6%	34.2%	**40.8%**	33.8%	59.5%	14.3%

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from NHS Digital.

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

Last year the Royal Free London NHS Foundation Trust intended to take the following actions to improve this percentage, and so the quality of its services, by:

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

This year there has been an increase in the percentage of deaths with palliative care coding so that it is now above the national average performance, with the Royal Free London NHS Foundation Trust ranking 36th out of 132 non-specialist acute trusts.

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

Patient reported outcome measures scores (PROMS)

Indicator:

The NHS asks patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards. PROMs measure health gain in

patients undergoing hip replacement, knee replacement and up to September 2017, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.

This provides an indication of the outcomes or quality of care delivered to NHS patients and has been collected by all providers of NHS-funded care since April 2009. The table below shows the scores for the adjusted average health gain, which is the casemix-adjusted average gain in health from pre- to post-operative.

Royal Free Performance 2014/15	Royal Free Performance 2015/16	Royal Free Performance 2016/17	Royal Free Performance 2017/18	National Average Performance 2017/18	Highest Performing NHS Trust Performance 2017/18	Lowest Performing NHS Trust Performance 2017/18
Indicator: Groin hernia surgery IS THIS STILL INCLUDED? NOT IN ONLINE DATASET						
Low Number rule Applies	Low Number rule Applies	0.05				
Indicator: Varicose vein surgery – IS THIS STILL INCLUDED? NOT IN ONLINE DATASET						
Low Number rule Applies	0.12	0.11				
Indicator: Total hip replacement (EQ-5D Index)						
0.74	0.43	0.42	**0.41**	0.46	0.55	0.36
Indicator: Knee replacement surgery (EQ-5D index)						
0.68	0.31	0.32	**0.299**	0.34	0.40	0.25

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

This data has been reviewed and when we compare our clinical data with the data produced by the National Joint Registry (NJR) and National Hip Fracture Database (NHFD) there are no concerns regarding our performance which shows good care and above average performance. Therefore it appears that the data is related to patient's mismatched expectations regarding their condition post-operative. To address this we have a Joint School, where patients are informed of what to expect post-surgery and can manage their expectations of pain and mobility.

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

- obtaining data of actual number of procedures undertaken to compare with figures
- reviewing where pre-operative questionnaires are completed

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

Emergency readmissions within 28 days

Indicator:

The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.

Please note that this indicator is currently suspended by NHS Digital with the intention that they will produce it again from summer 2018 onwards. As a result the trust has provided the latest available data to 2016/17. Internally the trust review it's 30-day emergency readmission rates for elective patients as part of its board key performance indicators.

Royal Free Performance 2014/2015	Royal Free Performance 2015/2016	Royal Free Performance 2016/2017	National Average Performance 2016/2017	Highest Performing NHS Trust Performance 2016/2017	Lowest Performing NHS Trust Performance 2016/2017
Patients aged 0 to 15 years old					
9.93%	10.1%	**5.2%**	**6.4%**	3.3%z	10.5%
Patients aged 16 years old or over					
9.5%	8.5%	**8.3%**	**10.6%**	5.5%	10.6%

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

The Royal Free carefully monitors the rate of emergency readmissions as a measure for quality of care and the appropriateness of discharge. A low, or reducing, rate of readmission is seen as evidence of good quality care. The table above demonstrates that the 28 day readmission rate at Royal Free London NHS Foundation Trust compares favourably with the rate amongst the 136 non-specialist providers in England; with a lower than average readmission rate observed at Royal Free London Foundation NHS Trust in both paediatric and adult cohorts.

The relative risk of emergency readmission within 28 days of previous discharge provides further evidence that the Royal Free London Foundation NHS Trust performs better than expected given its casemix and patient profile; the relative risk is 9.8% below (better than) expected. Standardised for both casemix and patient demographics this is the 8th lowest relative risk of any non-specialist English provider.

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

- carefully monitoring the rate of emergency readmissions as a measure for quality of care and the appropriateness of discharge. A low or reducing rate of readmission is seen as evidence of good quality care. (In relation to adults the re-admission rate is lower (better) than the peer group average)
- undertaking detailed enquiries into patients classified as readmissions with our public health doctors, working with GP's and identifying the underlying causes of readmissions

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

Responsiveness to the personal needs of our patients

Indicator:

The trust's responsiveness to the personal needs of its patients during the reporting period. This is the weighted average score of 5 questions relating to responsiveness to inpatient personal needs from the national inpatient survey (score out of 100).

Royal Free Performance 2014/2015	Royal Free Performance 2015/2016	Royal Free Performance 2016/17	Royal Free Performance 2017/18	National Average Performance 2017/18	Highest Performing NHS Trust Performance 2017/18	Lowest Performing NHS Trust Performance 2017/18
68.6	69.9	68.3	**67.1**	68.1	85.0	60.5

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

The NHS has prioritised, through its commissioning strategy, an improvement in hospitals responsiveness to the personal needs of its patients. Information is gathered through patient surveys. A higher score suggests better performance. Trust performance is just below the national average and 2016/17 performance.

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

- Developing site-based experience strategies that identify local issues for patients
- Continuing to deliver and monitor the patient experience strategy goals of cancer and dementia:
    - Cancer experience
        - Commenced the cancer clinical practice group across all tumour types where cancer patient experience will be a key focus
        - Established a cancer CNS community of practice for all cancer nurses
        - Piloting a new app which will gather real-time patient experience metrics split by tumour site
    - Dementia experience
        - 2 elderly care wards (8 West and 10 North) have undergone dementia friendly refurbishment
        - Publication of RFL Dementia Handbook for carers
        - 100 members of staff joined Chickenshed theatre company to complete an innovative study day in advanced comms for dementia
        - Over 600 members of staff have completed specialist CAPER Anchor training

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

Friends and Family test (Staff)

Indicator:

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

Royal Free Performance 2015	Royal Free Performance 2016	Royal Free Performance 2017	Royal Free Performance 2018	National Average Performance 2017	Highest Performing NHS Trust Performance 2017	Lowest Performing NHS Trust Performance 2017
72%	75%	74%				

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

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

The Royal Free London NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

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

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

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

Venous thromboembolism (VTE)

Indicator:

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

NHS Digital publish the VTE rate in quarters and this is presented in the table below.

Royal Free Performance Oct 15 - Dec 15	Royal Free Performance Oct 16 - Dec 16	Royal Free Performance Oct 17 - Dec 17	Royal Free Performance Oct 18 - Dec 18	National Average Performance Oct 17 - Dec 17	Highest Performing NHS Trust Performance Oct 17 - Dec 17	Lowest Performing NHS Trust Performance Oct 17 - Dec 17
97.1%	96.6%	95.9%	**95.9%**	95.3%	100.0%	76.08%

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from NHS Improvement data collection.

The Venous Thromboembolism (VTE) data presented in this report is for the period October 2018 to December 2018.

Venous Thromboembolism (VTE) results in many hospital deaths whichare potentially preventable. The government has therefore set hospitals a target requiring 90% of patients to be assessed for risk of VTE.

The Royal Free performed better than the 95% national target, achieving 95.9%, the same as Q3 in 2016/17.

The Royal Free London NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- The trust reports its rate of hospital acquired thromboembolism (HAT) to the monthly meeting of the trust board and the quarterly meeting of the clinical performance committee. Any significant variations in the incidence of HAT are subject to investigation with a feedback report provided to the trust board and clinical performance committee at their next meetings.

- The Thrombosis Unit conduct a detailed clinical audit into each reported case of HAT with finding shared with the wider clinical community.

https://improvement.nhs.uk/resources/vte-risk-assessment-data-q3-201718/

C difficile

Indicator:

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

Royal Free Performance 2014/2015	Royal Free Performance 2015/2016	Royal Free Performance 2016/2017	Royal Free Performance 2017/2018	National Average Performance 2016/2017	Highest Performing NHS Trust Performance 2016/2017	Lowest Performing NHS Trust Performance 2016/2017
17.8	21.0	21.3	**66.1**	37.6	0	157.5

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

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

Royal Free London NHS Foundation Trust performance was worse than the national average during 2017/18. However, very few of these infections have been attributed to lapses in care by the trust.

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

- The trust is ensuring that all staff adhere to the trust's infection control policies, including hand hygiene and dress code. Delivery of educational programmes, comprehensive antibiotic policies, good bed management with early isolation of symptomatic patients and enhanced environmental cleaning.

- The microbiology, infection, prevention and control and pharmacy teams continue to perform Clostridium difficile ward rounds to ensure that all elements of the care and treatment of patients with C. difficile are being appropriately managed.

- The trust C.difficile 'action log' incorporates activity across the trust and is driven through the fortnightly divisional lead/C.diff action group.

- Learning from antimicrobial audits has provided evidence for a revised patient prescription chart with enhanced antimicrobial section. This has now been rolled-out across the trust and elements are being audited to focus on embedding as best practice.

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

Patient safety incidents

Indicator:

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

	Royal Free Performance Oct 14 - Mar 15	Royal Free Performance Oct 15 - Mar 16	Royal Free Performance Oct 16 - Mar 17	Royal Free Performance Oct 17 - Mar 18	National Average Performance Oct 17 - Mar 18	Highest Performing NHS Trust Performance Oct 17 - Mar 18	Lowest Performing NHS Trust Performance Oct 17 - Mar 18
(a)	5,734 (34.7)	5,915 (36.5)	6,549 (39.1)	**6,527 (38.8)**	4,713 (40.9)	1,828 (14.9)	2,100 (158.3)
(b)	43 (0.75)	26 (0.44)	33 (0.20)	**24 (0.14)**	17 (0.15)	0 (0.0)	4 (4.34)

Every six months, NHS Improvement publishes official statistics on the incidents reported to the National Reporting and Learning System NRLS. These reports give NHS providers an easy-to-use summary of their current position on patient safety incidents reported to the NRLS, in terms of patient safety incident reporting and the characteristics of their incidents. The information in these reports should be used alongside other local patient safety intelligence and expertise, and supports the NHS to deliver improvements in patient safety.

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the NRLS.

NHS Improvement regards the identification and reporting of incidents as a sign of good governance with organisations reporting more incidents potentially having a better and more effective safety culture. The trust reported a similar volume of incidents per 1,000 bed days between Oct 2017 and Mar 2018 (38.8) compared to the national average (40.9).

The Royal Free London NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

1) Launching our Patient safety Clinical Practice Group (CPG) , which is initially focussed on embedding Local Safety Standards for Invasive Procedures (LocSSIPs). The LocSSIPs are safety checklists for procedures that are undertaken outside theatres eg biopsies and some injections.

2) Developing its patient safety culture, supporting the Trust goals of: zero never events, reducing avoidable deaths and zero avoidable hospital-acquired infections. We have focussed on improving our risk assessment processes for those most serious incidents and continue encouraging staff to report incidents. We have developed our safety learning and communications plan, that supports us

providing timely feedback to staff on the outcomes and learning resulting from incident investigations. This is underpinned by safety events, newsletters, blogs and visits to ward areas.

We have robust processes in place to capture incidents, and increase our reporting by an average of 9% year on year. However there are risks at every trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on every incident being reported. Whilst we have provided training to staff and policies in place relating to incident reporting, this does not provide full assurance that all incidents are reported. We believe this is in line with all other trusts.

All incidents resulting in severe harm or death undergo additional scrutiny at our weekly, site-based Serious incident review panels (SIRP). These multi-disciplinary panels are led by each hospital's medical director and they review all moderate harm or above incidents to determine level of harm, level of avoidability and level of investigation required. They also provide scrutiny of the final reports to ensure that the actions address the root causes identified in the investigations.

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

Part three: review of quality performance

3.1 Overview of the quality of care in 2018/19

This section of the quality report presents an overview of the quality of care offered by the trust based on performance in 2018/19 against indicators and national priorities selected by the board in consultation with our stakeholders.

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 and to show key performance indicators that are requested by the Royal Free London NHS FT Board.

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
Section 1: Patient safety	• Summary hospital mortality indicator (SHMI) • Hospital standardised mortality ratio (HSMR) • Methicillin-resistant staphylococcus aureus (MRSA) • C. difficile Infections
Section 2: Clinical effectiveness	• Referral to treatment (RTT) • A&E performance • Cancer waits • Average length of stay (elective and non-elective) • 30-day emergency readmission rates for elective patients
Section 3: Patient experience	• Friends and family test • Volume of delayed transfers of care (DTOCs) • Cancelled operations not readmitted within 28 days

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	Source
Summary Hospital Mortality Indicator (SHMI)	These measures use routinely collected data to calculate an overall “expected” number of deaths if the trust matched the national average performance. The result is a ratio	Stethoscope, Methods Analytics

and Hospital Standard Mortality Ratio (HSMR)	(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.	
MRSA	The count of meticillin resistant Staphylococcus aureus (MRSA) bacteraemias attributed to the trust.	Datix system
C. Difficile infections	Number of Clostridium Difficile infections reported at the trust	Datix system
C. Difficile Lapses in care	Number of Clostridium Difficile infections due to lapses in patient care	Datix system
RTT Incomplete Performance - % waiting less than 18 weeks	Percentage of patients on the incomplete RTT patient tracking list waiting 18 weeks or less for treatment or discharge from referral.	Cerner system
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.	Cerner system
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.	Infoflex system
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.	Infoflex system
31 day wait diagnosis to treatment	Percentage of patients waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers.	Infoflex system
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.	Infoflex system
Average length of stay (non-elective and elective)	Mean length of stay for all inpatients based on whether their mode of admission was elective or non-elective. This includes patients with a 0-day length of stay.	Stethoscope, Methods Analytics
30-day re-admission rate following elective or non-elective spell	Number of emergency re-admissions within 30 days of discharge as proportion of total discharges following an elective admission And	Stethoscope, Methods Analytics

	Number of emergency re-admissions within 30 days of discharge as a proportion of number of discharges following an elective admission	
Friends and Family IP, A&E and maternity scores	The number of responses that scored likely and extremely likely as a percentage of the total number of responses to the IP, A&E and maternity friends and family tests. (Neither Likely or not likely excluded from responses)	To be confirmed
Volume of delayed transfer of care (DTOCs)	This is the number of bed days lost in a month to patients who are awaiting a transfer of care to social or NHS community care.	Cerner system
Cancelled operations	Volume of last minute (on the day of surgery or following admission) cancellations for non-clinical reasons as a proportion of all elective inpatient and day-case operations.	Cerner system

Notes on the charts

This year the presentation of the data is the same as the previous Quality Account. Two chart types are now used: control charts and funnel plots. Only where appropriate funnel plots are unavailable have we used a standard bar chart to show Royal Free London performance benchmarked against other providers.

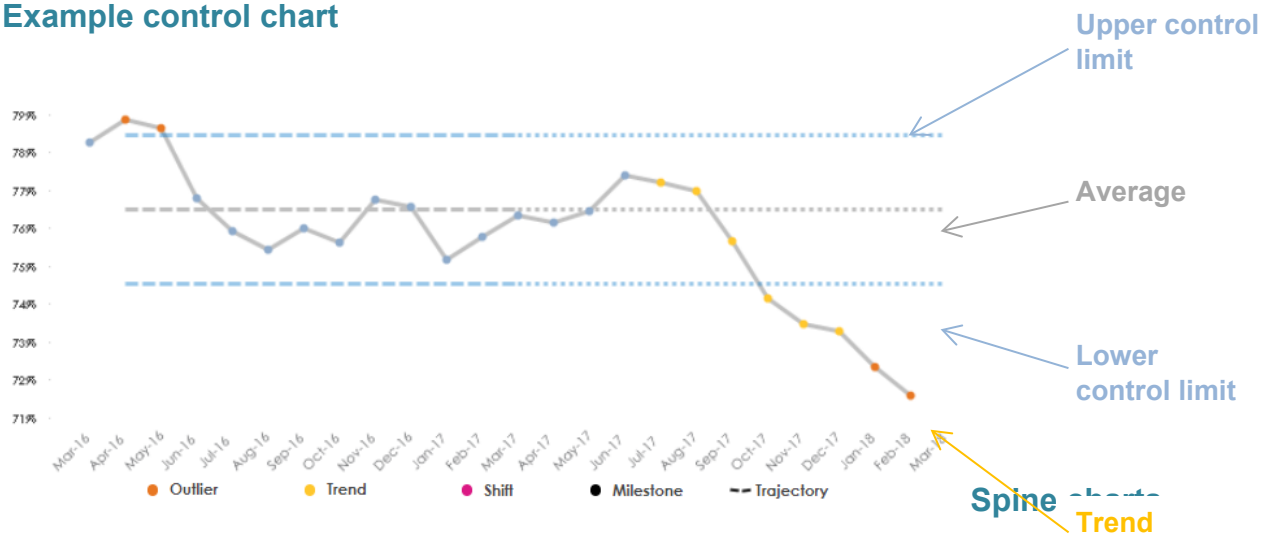
Control charts

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).[1]

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



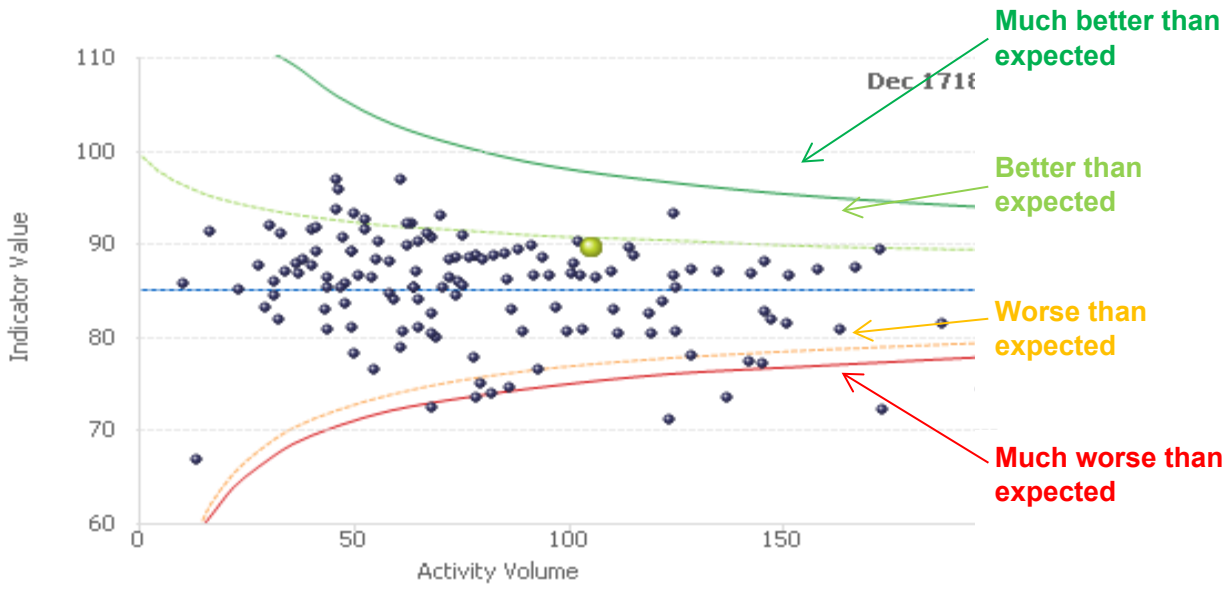
[1] http://asq.org/learn-about-quality/data-collection-analysis-tools/overview/control-chart.html

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.[2] 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.

[2] Methods Analytics methodology, 2018

Performance against key national indicators

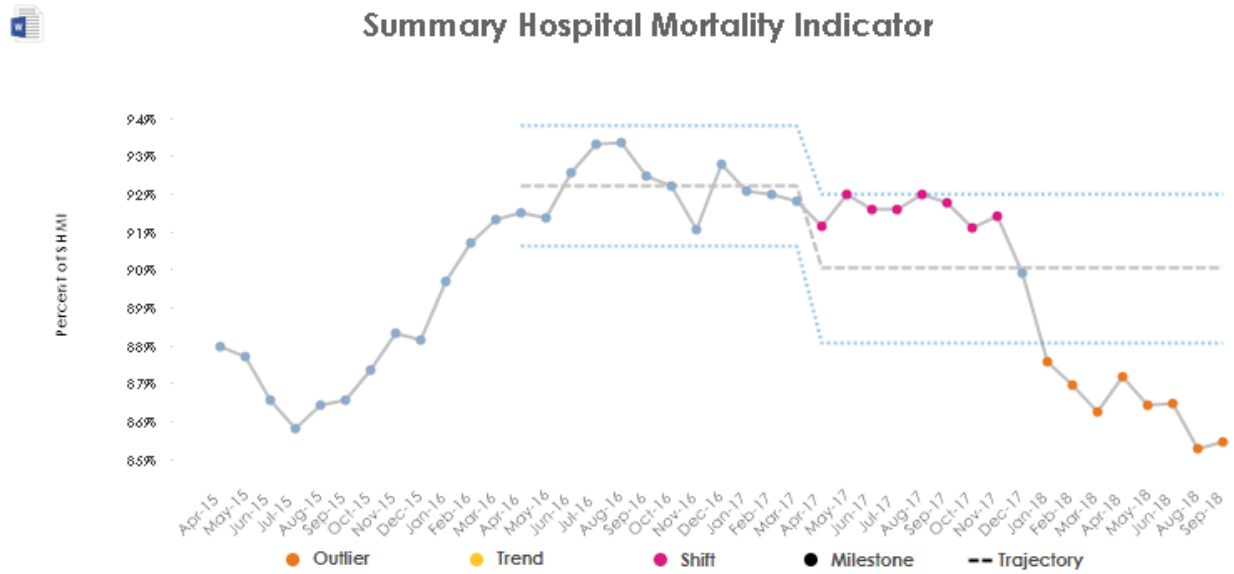
Section 1: Patient Safety

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

SHMI data is presented below for April 2015 to September 2018. This shows a recent improvement in the trust's score to a mean of 86.2 or 13.8% better than expected over the months April to September 2018.

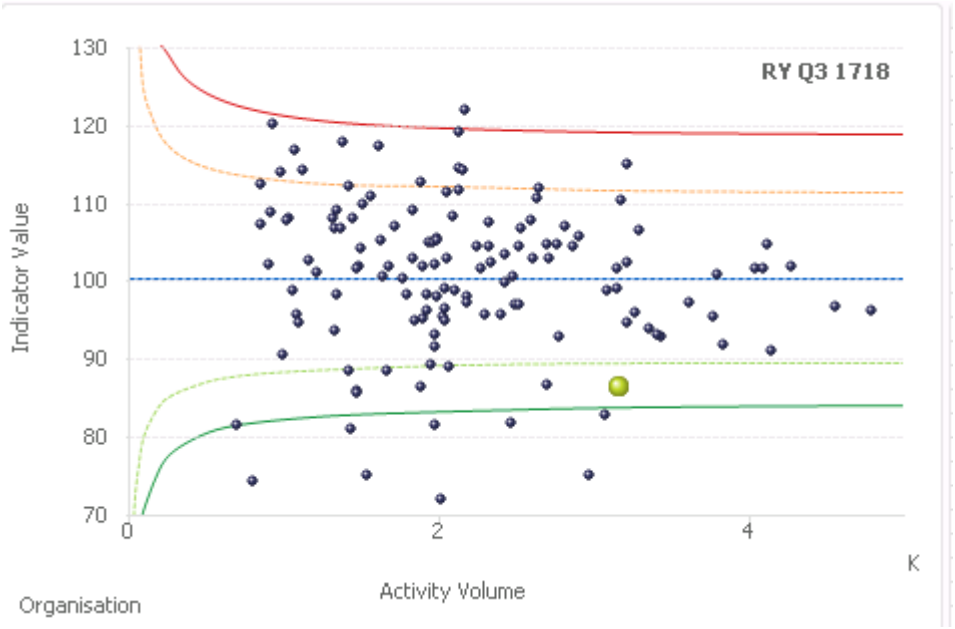


Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Aug-18	Sep-18
91.78%	91.12%	91.42%	89.94%	87.60%	86.99%	86.29%	87.20%	86.46%	86.50%	85.31%	85.47%

Source: Royal Free London NHS Foundation Trust 2015-2018

The chart below shows the Royal Free London SHMI performance compared to all other acute NHS trusts for the rolling year ending Q2 2018/19 (the latest for which information is currently available). The Royal Free SHMI was 9th lowest out of 134 acute trusts and was statistically lower than expected.

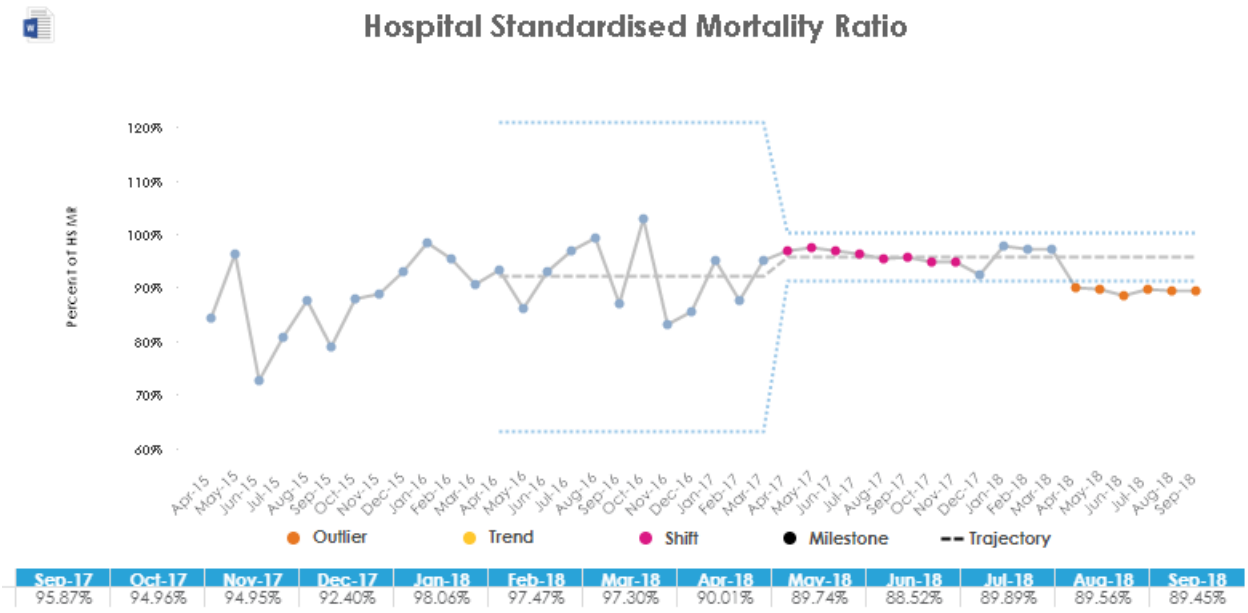
Chart: Summary Hospital-level Mortality Indicator by NHS acute trust



Source: Stethoscope benchmarking tool, Methods Analytics 2019

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 September 2018; our average over the period has been 89 or 9% better than expected.



Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
95.87%	94.96%	94.95%	92.40%	98.06%	97.47%	97.30%	90.01%	89.74%	88.52%	89.89%	89.56%	89.45%

Source: Royal Free London NHS FT 2015-2018

However, benchmarking shows that on this measure the Royal Free London is significantly below (better than) the national mean. Previously, we fell within expected limits.

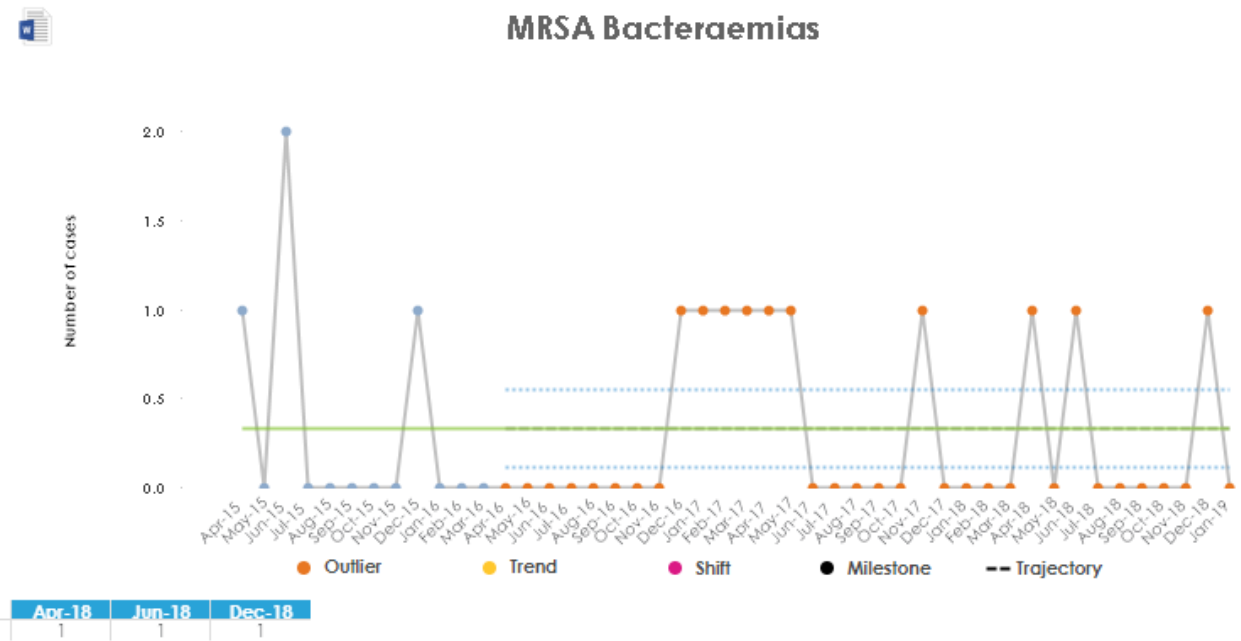
Chart: Hospital Standardised Mortality Ratio by NHS acute trust

Source: Stethoscope benchmarking tool, Methods Analytics 2019

The charts describe the standardised mortality ratio for the 12 months ending 30th September 2018, and shows that the Royal Free London NHS Foundation Trust recorded the 23rd lowest relative risk of mortality of any English Teaching Trust with a relative risk of mortality of 89.46 (where a risk of 100 would indicate mortality exactly as expected for this casemix across England), the reported risk signposts that our mortality risk is 9% below (better than) expected, and that this is statistically significant, in other words unlikely to have occurred by random chance.

Methicillin-resistant staphylococcus aureus (MRSA)

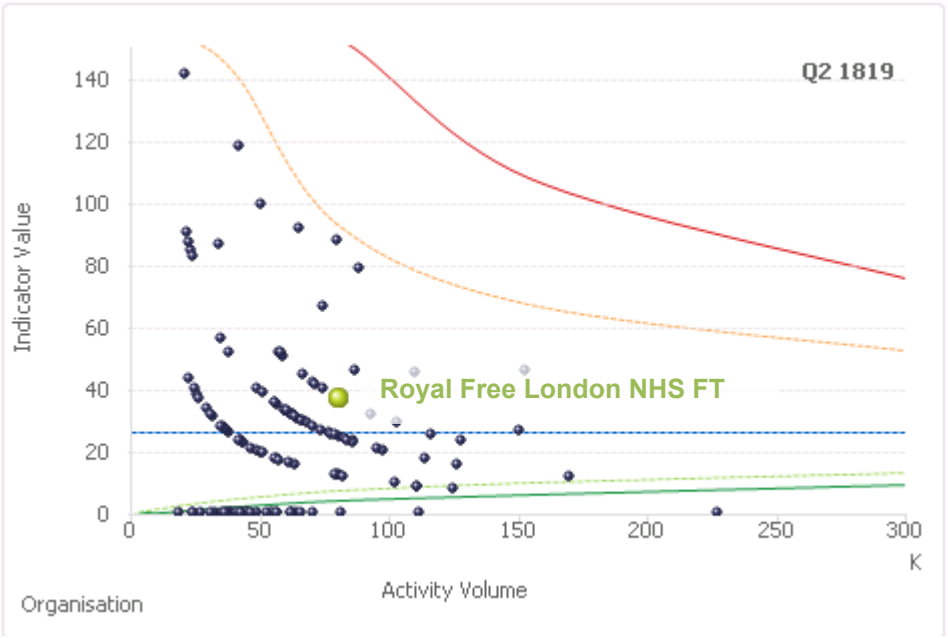
MRSA is an antibiotic resistant infection associated with admission to hospital. The infection can cause an acute illness, particularly when a patient's immune system may be compromised due to an underlying illness. Reducing the rate of MRSA infections is vital to ensure patient safety and is indicative 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 2015-2019

In the twelve months to the end of January 2019 the Royal Free reported 3 MRSA bacteraemias. The chart below shows the Royal Free London Q2 2018/19 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.

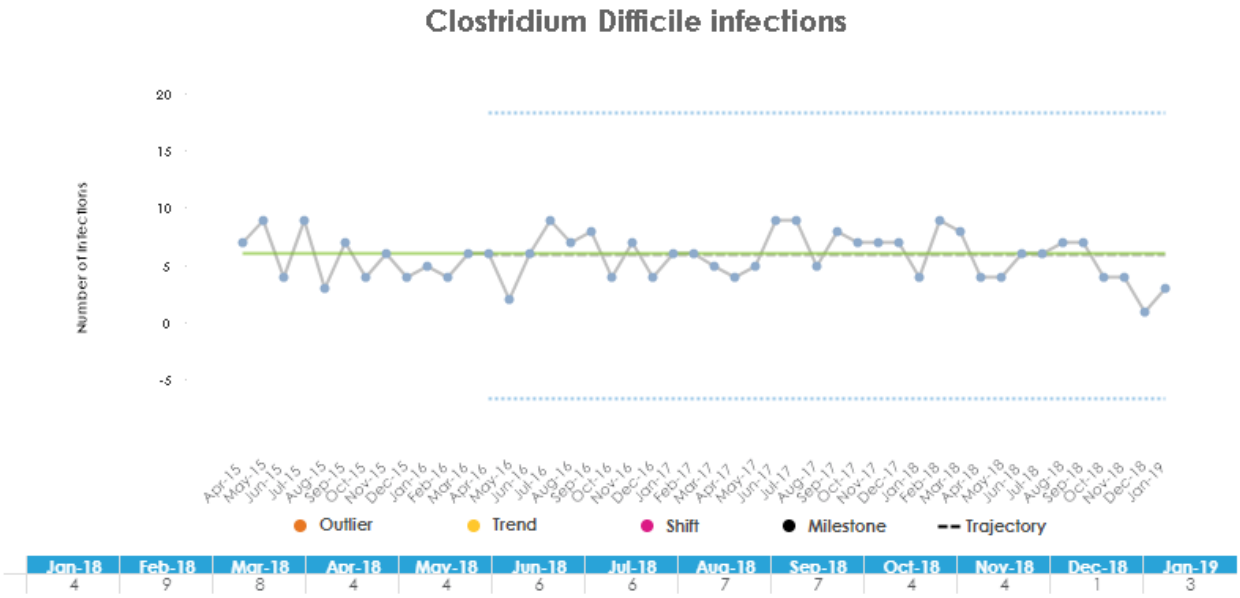
Chart: MRSA bacteraemia, rate per 1,000,000 occupied bed days by NHS acute trust



Source: Stethoscope benchmarking tool, Methods Analytics 2019

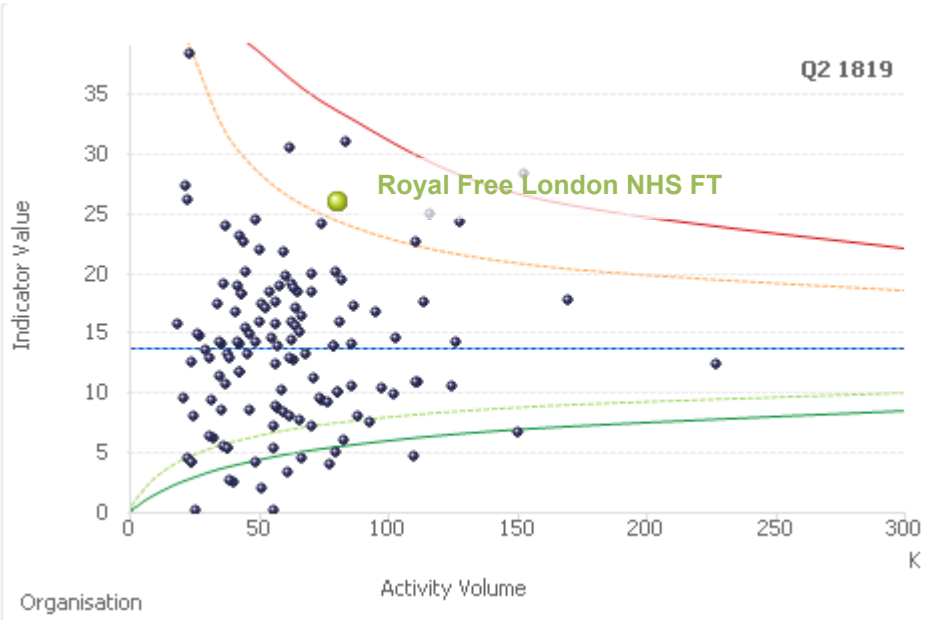
C. difficile

In relation to C. difficile the trust saw little change in 2018/19 from 2017/18 in terms of the rate of infections, with an average of ~5 per month in the 12 months prior to February 2019.



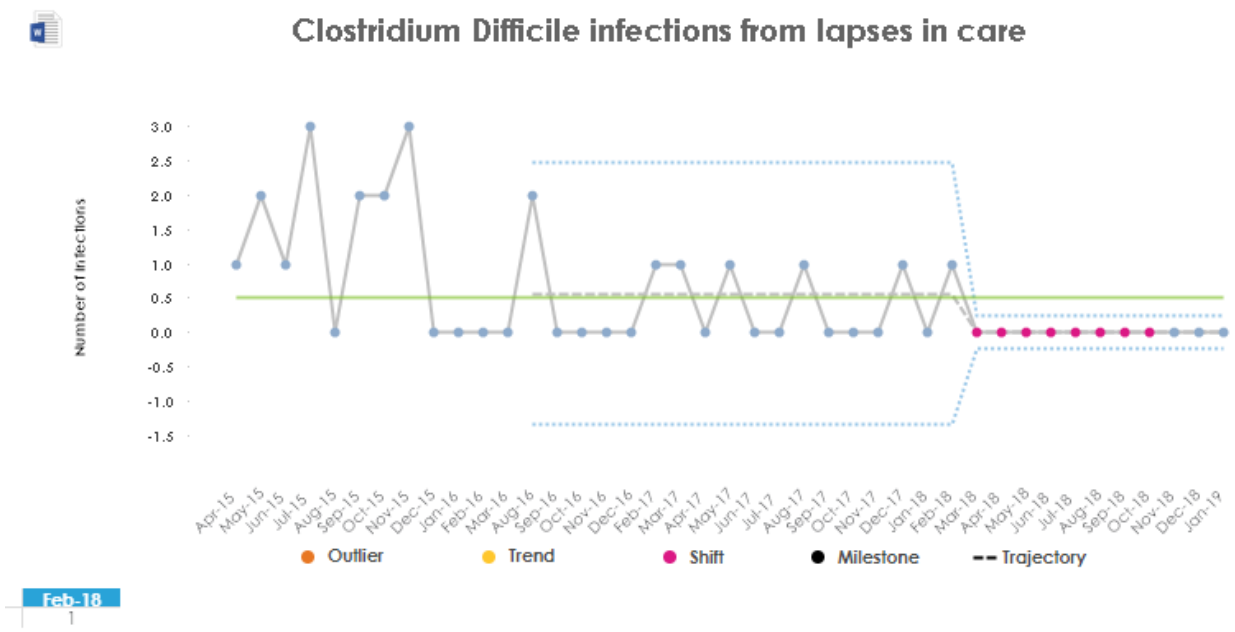
According to our benchmark information for Q2 2017/18, this indicates that our infection rate per 100,000 occupied bed days is higher than would be expected by chance. This is consistent with previous performance.

Chart: C. Difficile infection rate per 100,000 occupied bed days by NHS acute trust Q2 2018/19



Source: Stethoscope benchmarking tool, Methods Analytics 2019

However, of the 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 1 incident in the 12 months prior to February 2019.



Source: Royal Free London NHS FT 2015-2019

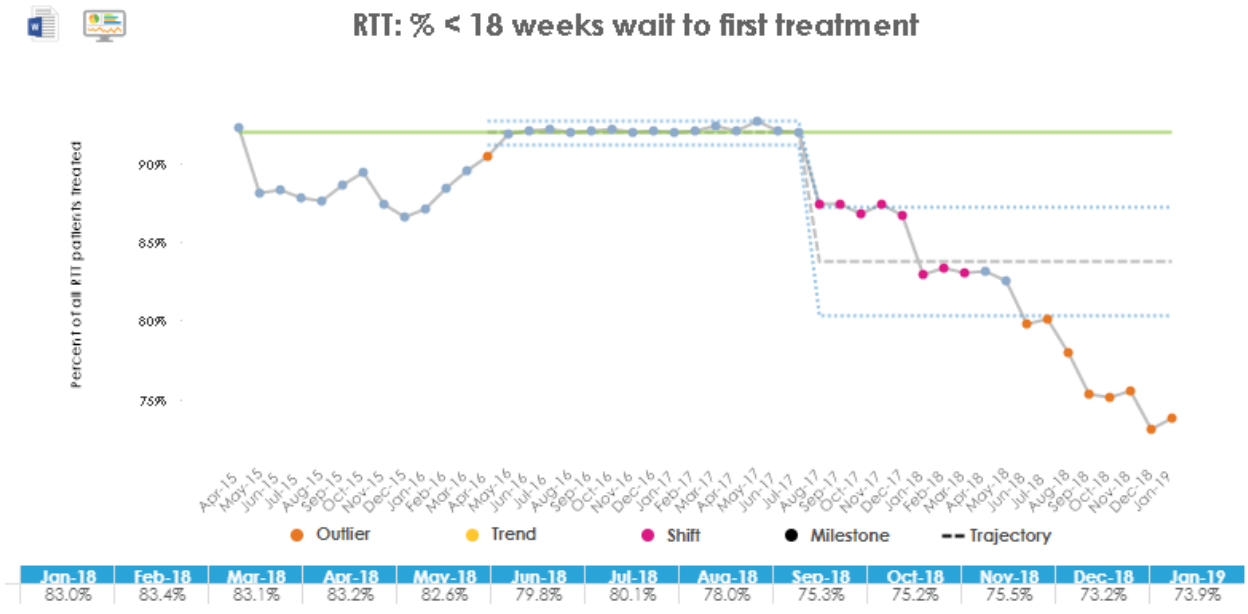
Section 2: Clinical Effectiveness

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 92% should be waiting 18 weeks or less to start treatment. This is the 'incompletes' standard.

As shown in the chart below, However, since August 2017, the trust has failed the standard. Performance in January 2019 was 73.9%.



Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
83.0%	83.4%	83.1%	83.2%	82.6%	79.8%	80.1%	78.0%	75.3%	75.2%	75.5%	73.2%	73.9%

Source: Royal Free London NHS FT 2015-2019

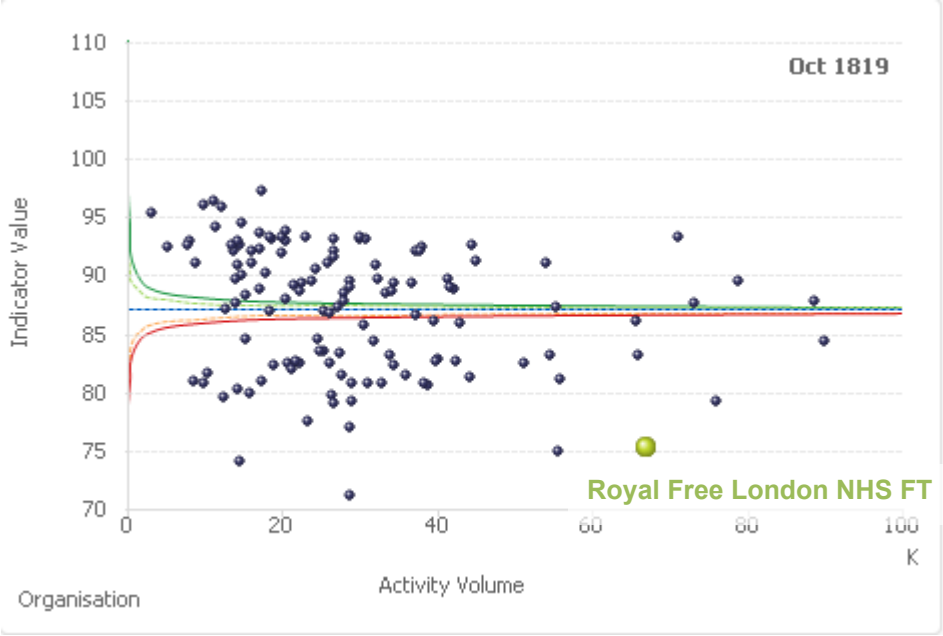
This was primarily a result of improvements the trust made to the way in which it tracks patient pathways using a Patient Tracking List (PTL). During 2018/19 the trust worked on improving the PTL for two main reasons:

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 logic which will be used to construct the new PTL has been written and agreed and we are in the process of agreeing timescales for validation of pathways that will become visible once implemented. It is expected that this exercise will take 12 months, after which we will have an accurate and complete list of the status of RTT pathways.

The chart below shows the Royal Free London October 2018 performance (the latest available data) compared to other NHS acute trusts in England. This shows that our performance was 4th lowest in England.

Chart: RTT % waiting <18 weeks for first treament by NHS acute trust October 2018/19

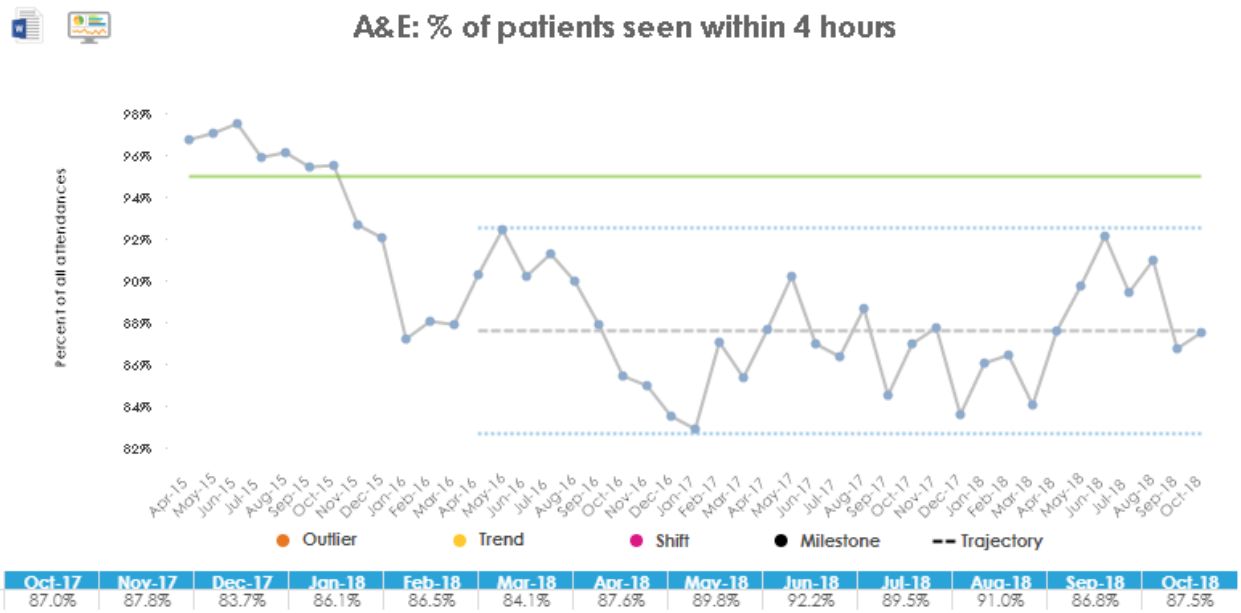


Source: Stethoscope benchmarking tool, Methods Analytics 2019

Accident and Emergency performance

The Accident and Emergency Department is often the patient's point of arrival. The graph below summarises the Royal Free London's performance in relation to meeting the 4-hour maximum wait time standard set against the performance of 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 December 2018 to January 2019, the Royal Free London NHS FT achieved an average monthly performance of 87.4%. This was not significantly different from average performance in 2017/18.



Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
87.0%	87.8%	83.7%	86.1%	86.5%	84.1%	87.6%	89.8%	92.2%	89.5%	91.0%	86.8%	87.5%

Source: Royal Free London NHS FT 2015-2019

Pressure on A&Es 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.

The chart below shows the Royal Free London November 2018 performance (the latest available data) compared to other NHS acute trusts in England. This shows that our performance was within expected control limits when compared to other Type 1 A&E providers in England.

Chart: Performance against 4 hour A&E standard in November 2018 by NHS acute trust

Source: Stethoscope benchmarking tool, Methods Analytics 2019

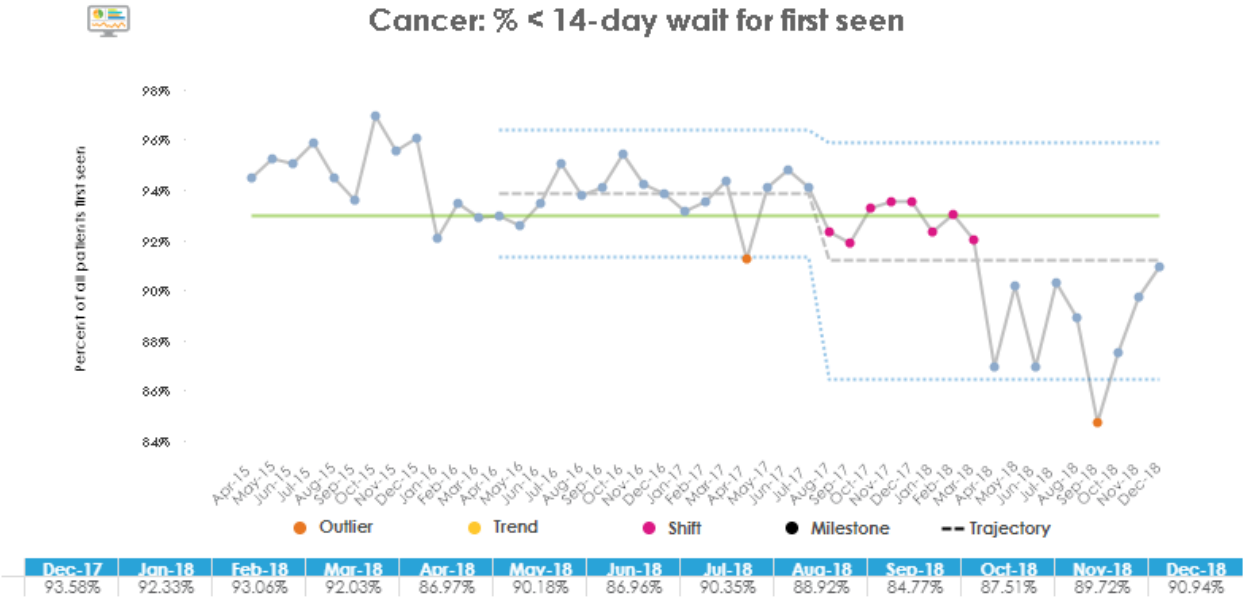
Cancer waits:

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 have begun first definitive treatment within 31 days of the decision to treat and 85% of patients to have begun first definitive treatment within 62 days of referral.

For 2018/19, trust performance has declined against the standard to see at least 93% within 2 weeks from GP referral, achieving an average performance of 89.47%. The main factors influencing below standard performance have been the holiday periods for Easter and summer as well as significant unexpected increases in referral rates in some tumour sites. The trust continues with robust seasonal 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.

In addition, we have seen performance decline in conjunction with roll-out of the national "paperless" referral system (ERS) which means patients book and can reschedule their appointments without speaking to a member of staff and this limits our ability to encourage patient to attend sooner.

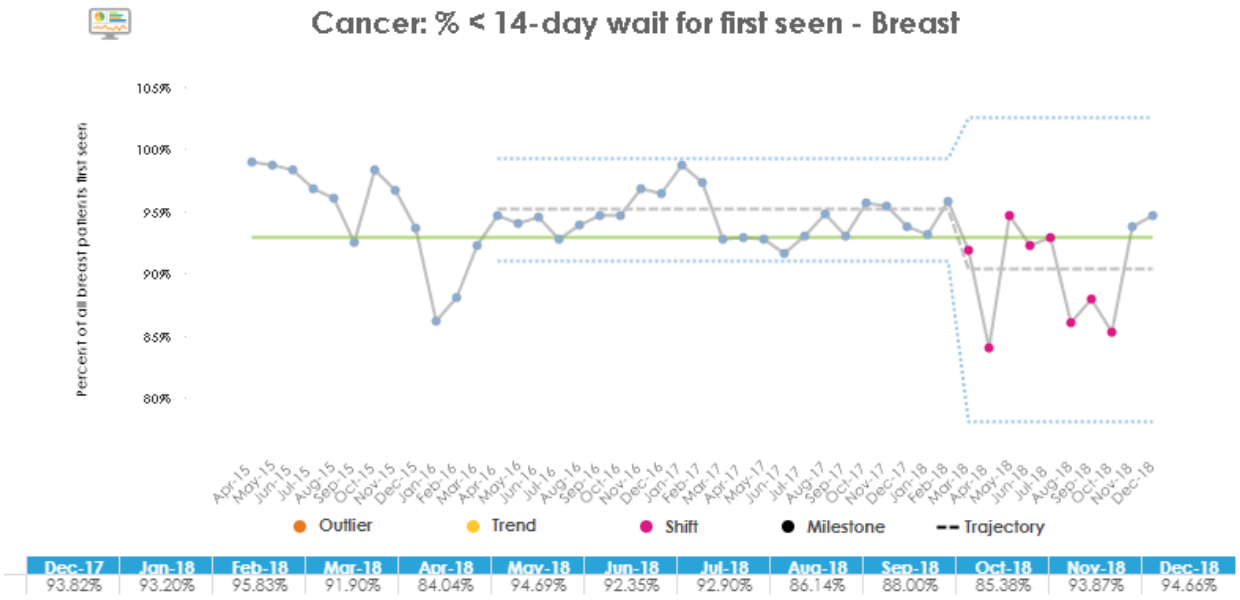


Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
93.58%	92.33%	93.06%	92.03%	86.97%	90.18%	86.96%	90.35%	88.92%	84.77%	87.51%	89.72%	90.94%

Source: Royal Free London NHS FT 2015-2018

Breast Urgent referral 2 week waits

In 2018/19, the trust saw 81.2% of patients on an urgent (symptomatic) breast referral pathway within 2 weeks, below the national standard.



Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
93.82%	93.20%	95.83%	91.90%	84.04%	94.69%	92.35%	92.90%	86.14%	88.00%	85.38%	93.87%	94.66%

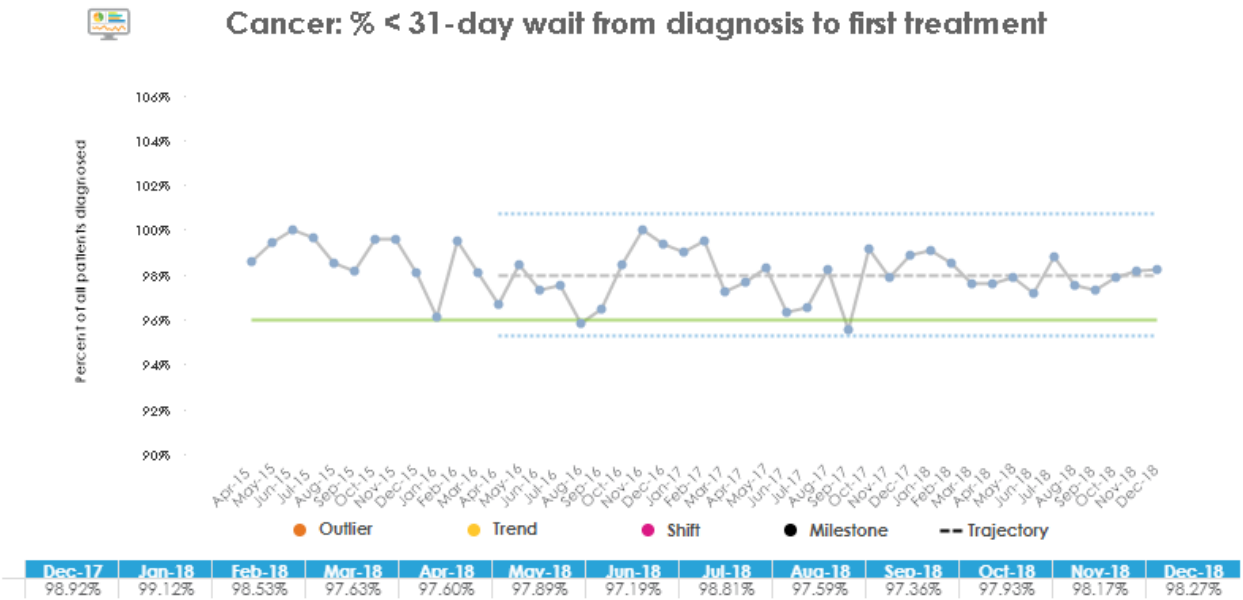
Source: Royal Free London NHS FT 2015-2018

This is discrepant to previous years where we met the standard. The service had undertaken an audit of patients who do not accept an appointment within two weeks and have found many patients are not informed about the urgency prior to referral. The service will now work with CCGs to improve communication with patients prior to referral.

We have also seen performance decline in conjunction with roll-out of the national “paperless” referral system (ERS) which means patients book and can reschedule their appointments without speaking to a member of staff and this limits our ability to encourage patient to attend sooner.

First definitive treatment within 31 days

In 2018/19, the trust met the standard to see 96% of patients within 31 days for their first definitive treatment for cancer, meeting the national standard for the year overall.



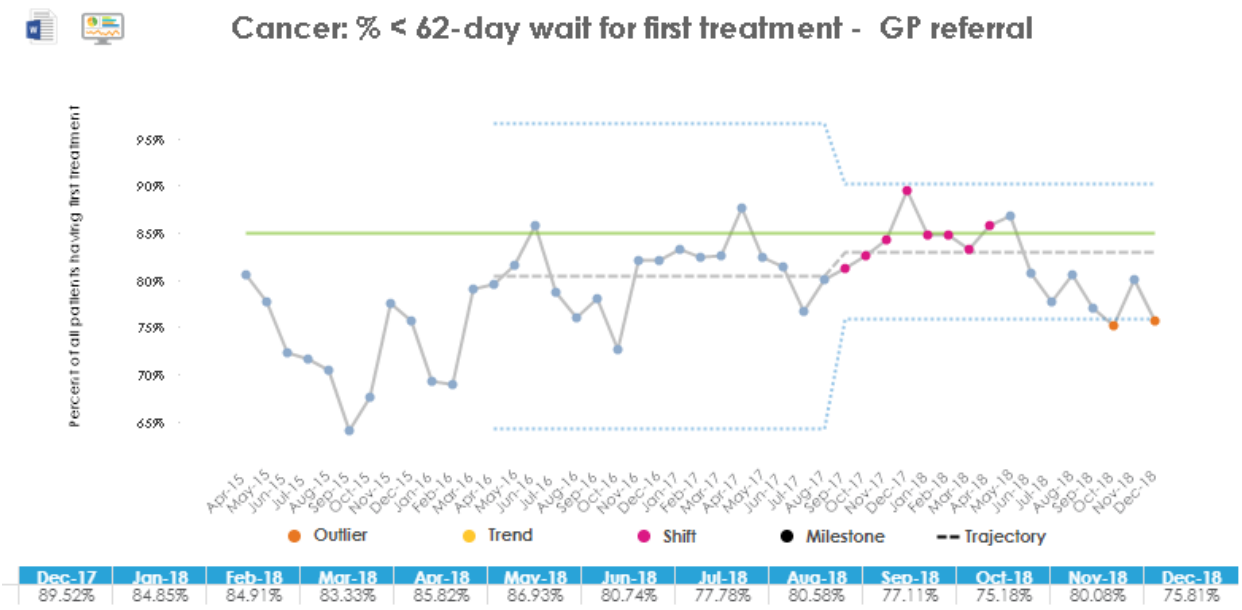
Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
98.92%	99.12%	98.53%	97.63%	97.60%	97.89%	97.19%	98.81%	97.59%	97.36%	97.93%	98.17%	98.27%

Source: Royal Free London NHS FT 2015-2018

This is similar performance to 2017/18 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 2018/19, with 80% of patients receiving first treatment within 62 days of a GP referral. This represents a slight deterioration on 2017/18 where 82.9% of patients were treated within the standard.



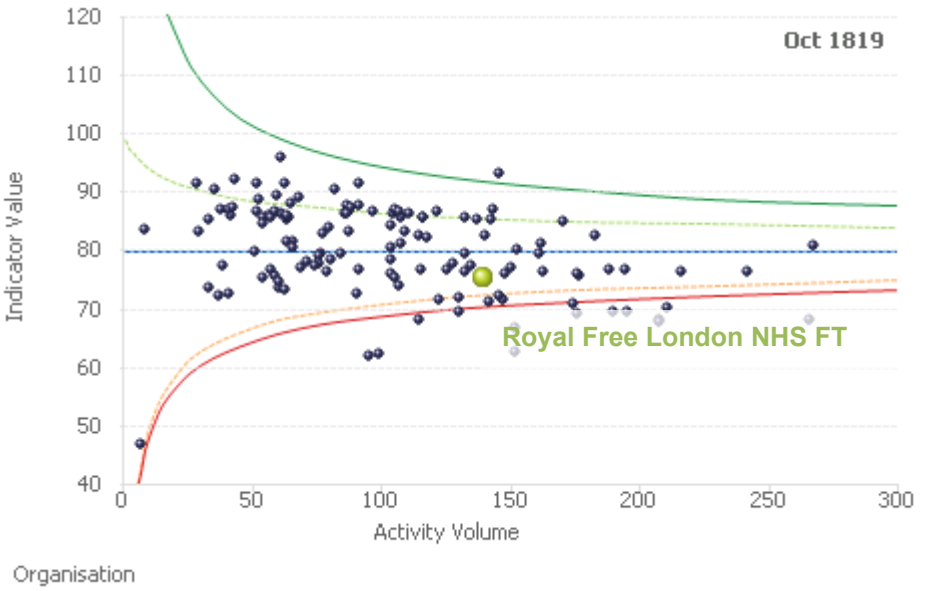
Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
89.52%	84.85%	84.91%	83.33%	85.82%	86.93%	80.74%	77.78%	80.58%	77.11%	75.18%	80.08%	75.81%

Source: Royal Free London NHS FT 2015-2018

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 2019/20 the trust plans to launch a Clinical Pathway Group dedicated to cancer. This will be a large, clinically-led, programme of improvement work using methodology that has been tested and proven in other areas within the trust (e.g. “keeping mothers and babies together”).

When comparing Royal Free London to benchmarks in October 2018 (the latest available data), this suggests that performance did not differ from the national mean by more than can be explained by random chance.

Chart: Cancer 62 day wait for first treatment from GP referral, all acute trusts, October 2018

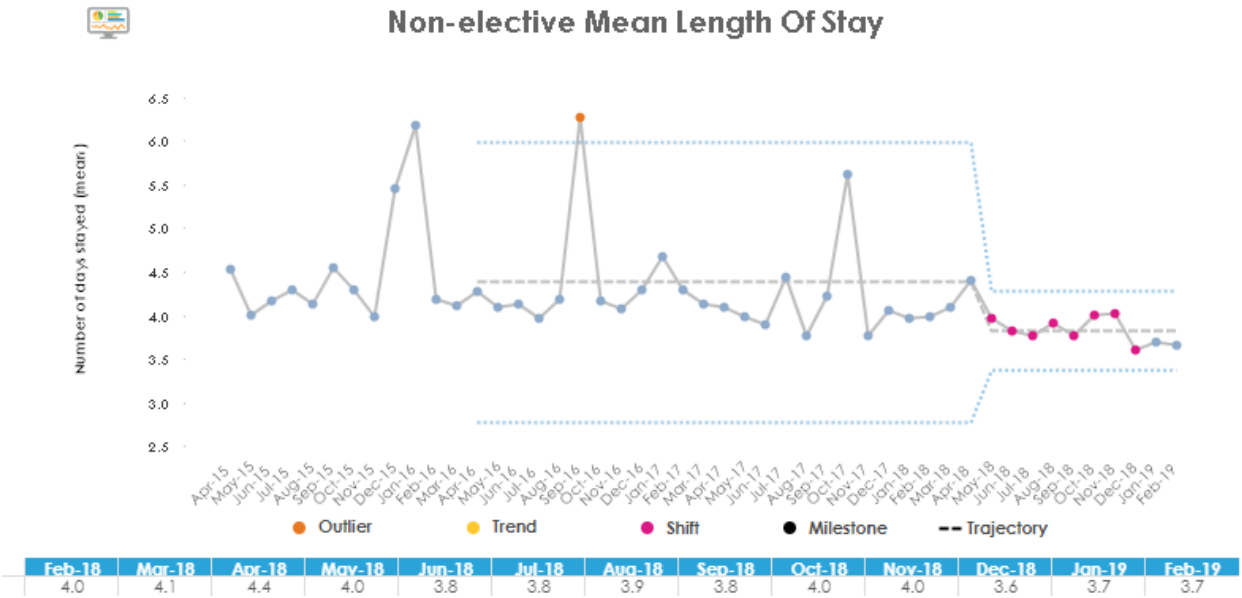


Source: Stethoscope benchmarking tool, Methods Analytics 2019

Average length of stay:

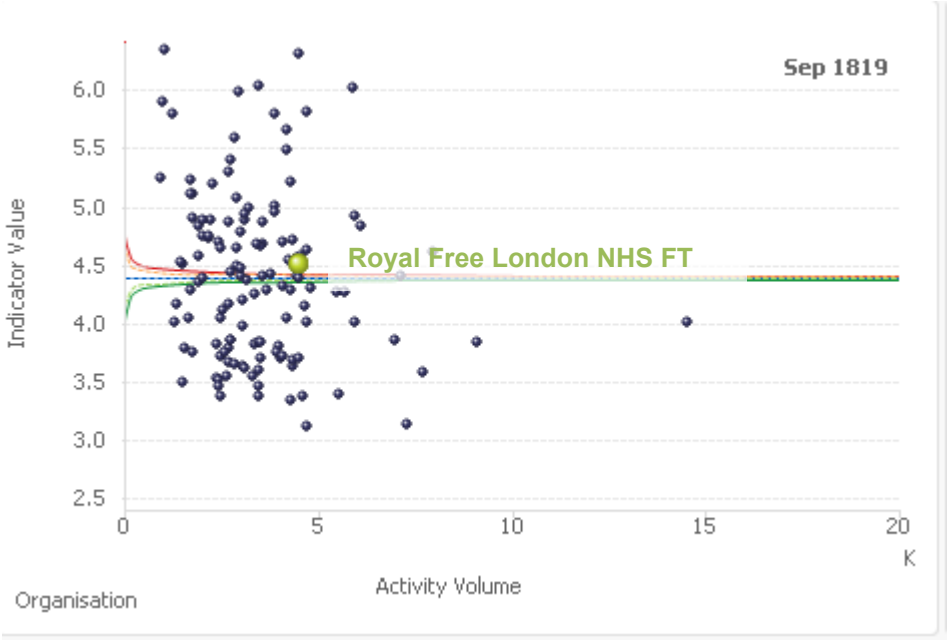
Non-elective mean length of stay

The trust average inpatient length of stay for patients admitted as non-elective from April 2018 to February 2019 (the latest available data) shows that the trust average length of stay in the period April to December 2017 was 3.9 days. This is significantly improved from the average length of stay reported in 2017/18 at 5.1 days and you can see from the chart below we had a positive shift in performance in December 2018.



Source: Royal Free London NHS FT 2015-2019

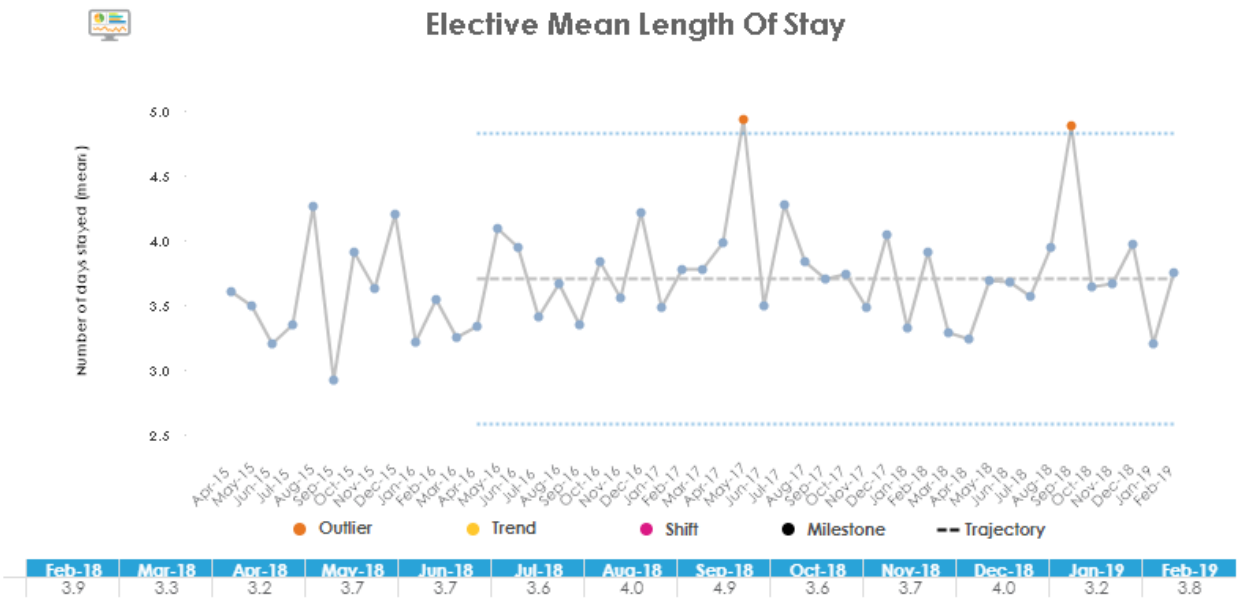
When comparing Royal Free London to benchmarks in September 2018 (the latest available data), this suggests that length of stay was higher (worse) than the national mean by more than can be explained by random chance.



Source: Stethoscope benchmarking tool, Methods Analytics 2019

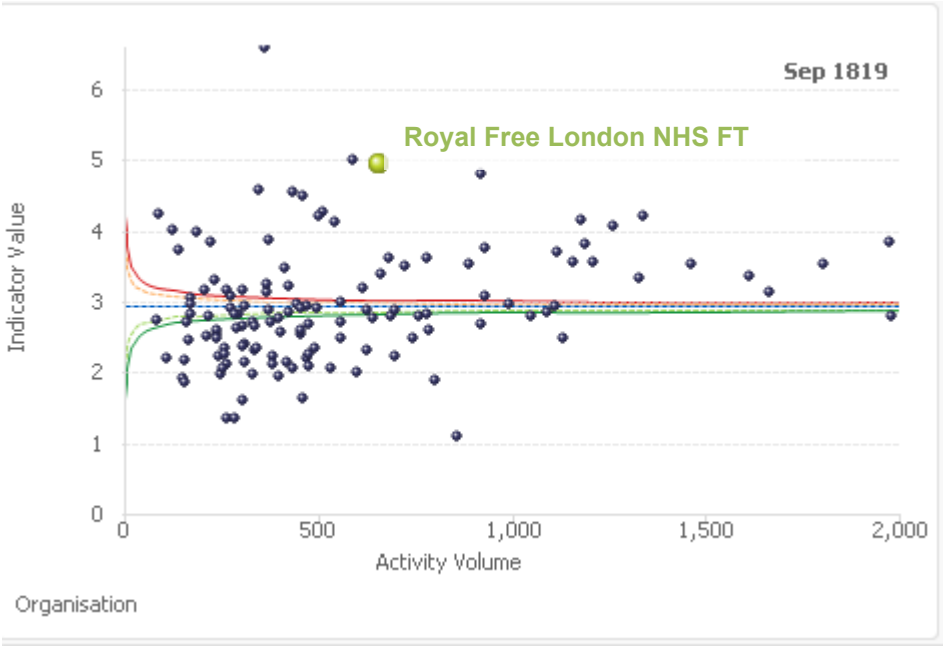
Elective mean length of stay

The trust average inpatient length of stay for patients admitted as non-elective to February 2019 (the latest available data) shows that the trust average length of stay in the period April 2018 to February 2019 was 3.8 days. This is an improvement on the average length of stay from 2017/18 which was reported at 4.6 days.



Source: Royal Free London NHS FT 2015-2019

When comparing Royal Free London to benchmarks in September 2018 (the latest available data), this suggests that average length of stay was significantly higher (worse) than the national mean by more than can be explained by random chance.

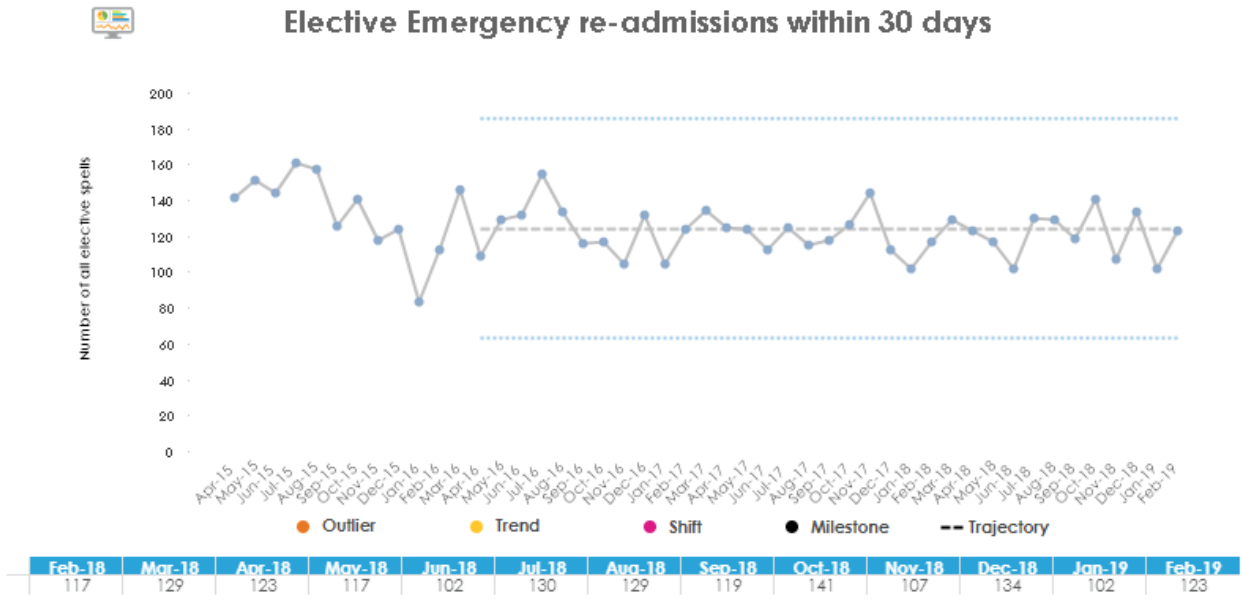


Source: Stethoscope benchmarking tool, Methods Analytics 2019

Emergency re-admissions:

30 day emergency re-admissions following an elective admission

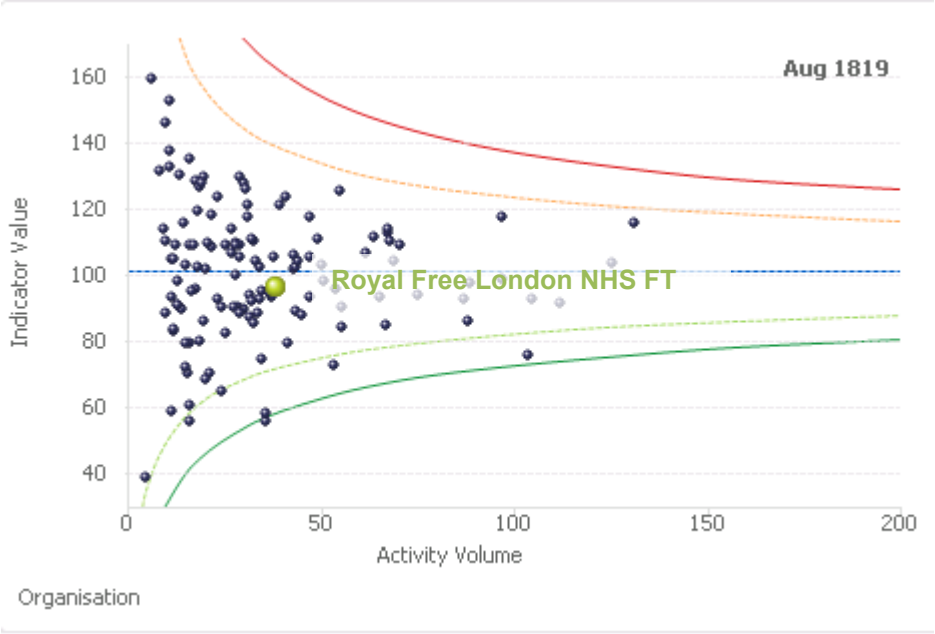
The chart below shows the proportion of patients re-admitted as an emergency following an elective admission in the previous 30 days between April 2015 and February 2019 (the latest available data). The average for April 2018 to February 2019 was ! 6.5%. This shows that there has been no significant change during this period.



Source: Stethoscope benchmarking tool, Methods Analytics 2018

When comparing Royal Free London to benchmarks in August 2018 (the latest available data), this suggests that average length of stay did not differ from than the national mean by more than can be explained by random chance.

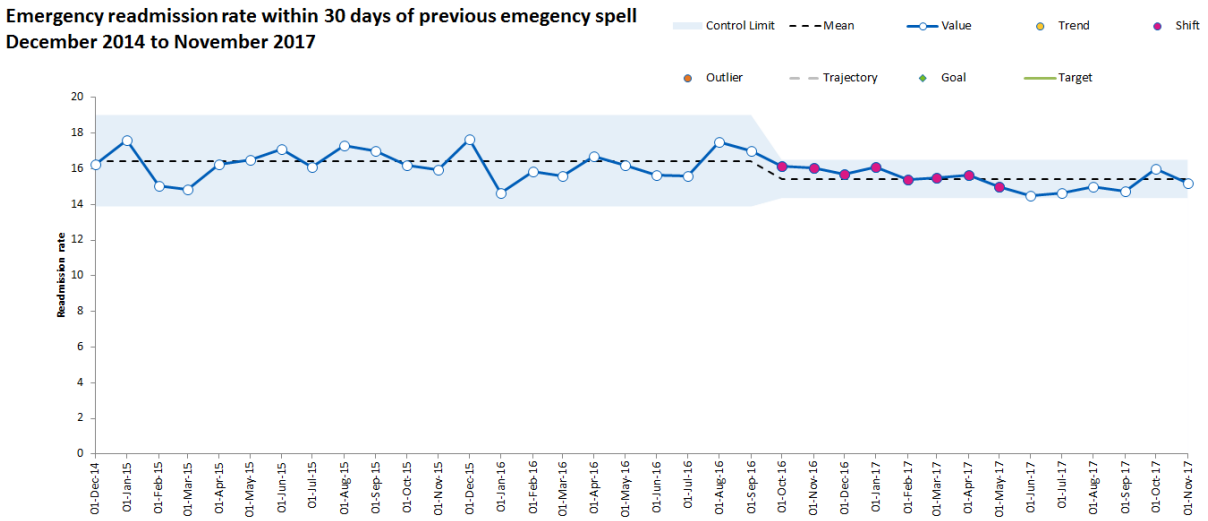
Chart: Emergency re-admissions, percentage within 30 days of an elective admission August 2018



Source: Stethoscope benchmarking tool, Methods Analytics 2019

30 day emergency re-admissions following a non-elective admission

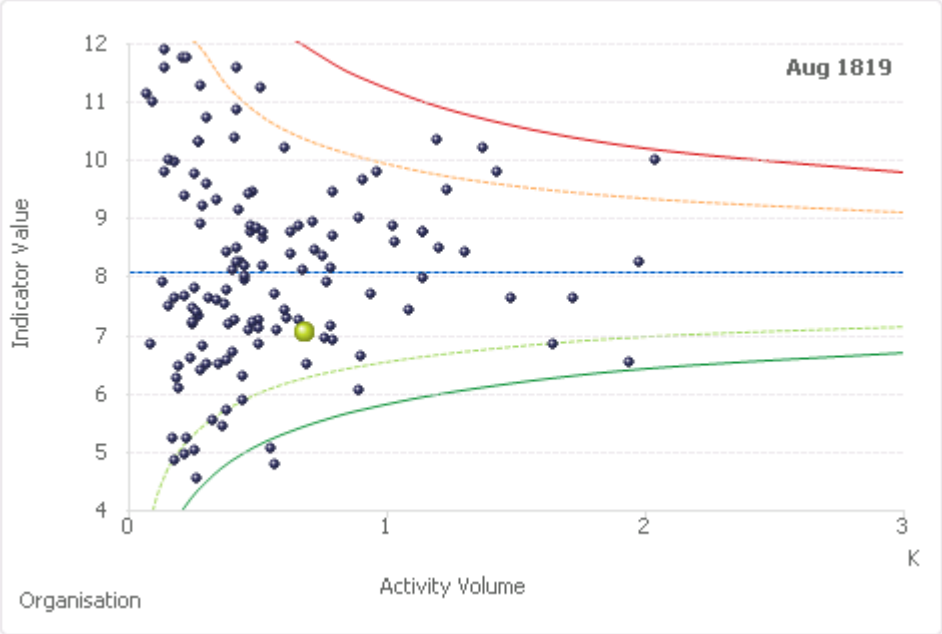
The chart below shows the proportion of patients re-admitted as an emergency following a non-elective admission in the previous 30 days between January 2015 and November 2017 (the latest available data). The average for April 2017 to November 2017 was 15.1%. This shows that there has been no significant change since a reduction that started in October 2016.



Source: Stethoscope benchmarking tool, Methods Analytics 2018

When comparing Royal Free London to benchmarks in August 2018 (the latest available data), this suggests that average length of stay did not differ from than the national mean by more than can be explained by random chance.

Chart: Emergency re-admissions, percentage within 30 days of a non-elective admission Apr-Nov 2017



Source: Stethoscope benchmarking tool, Methods Analytics 2018

Section 3: Patient experience indicators

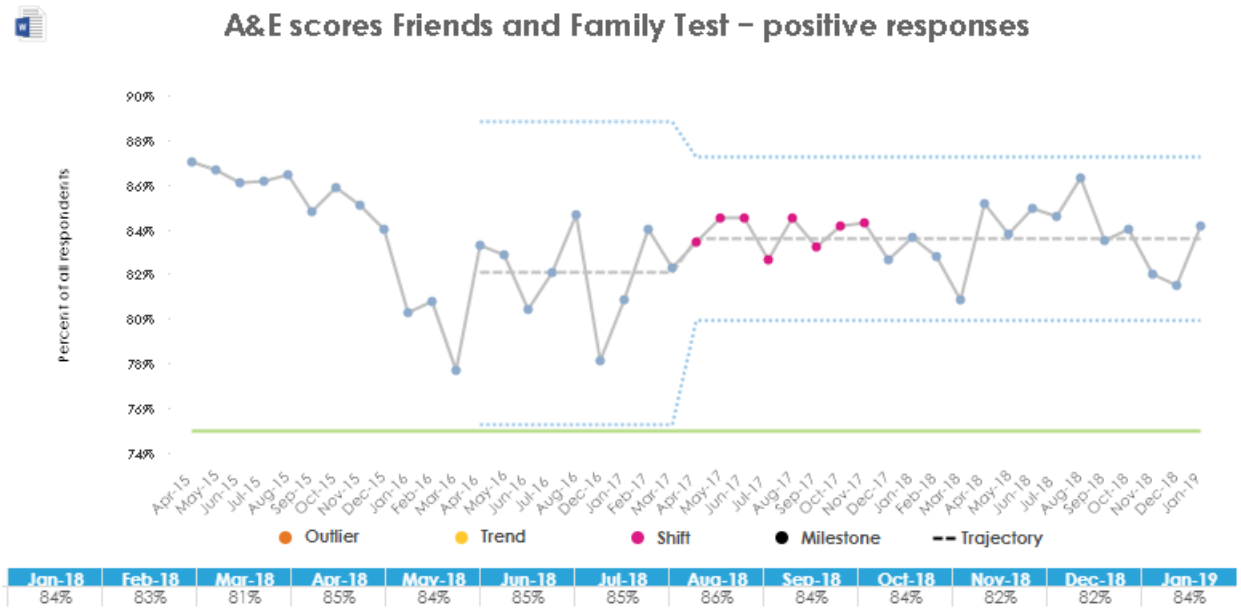
Friends and family test (patients)

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 2015 to January 2019 with regards to our A&E, Inpatient and Maternity FFT scores.

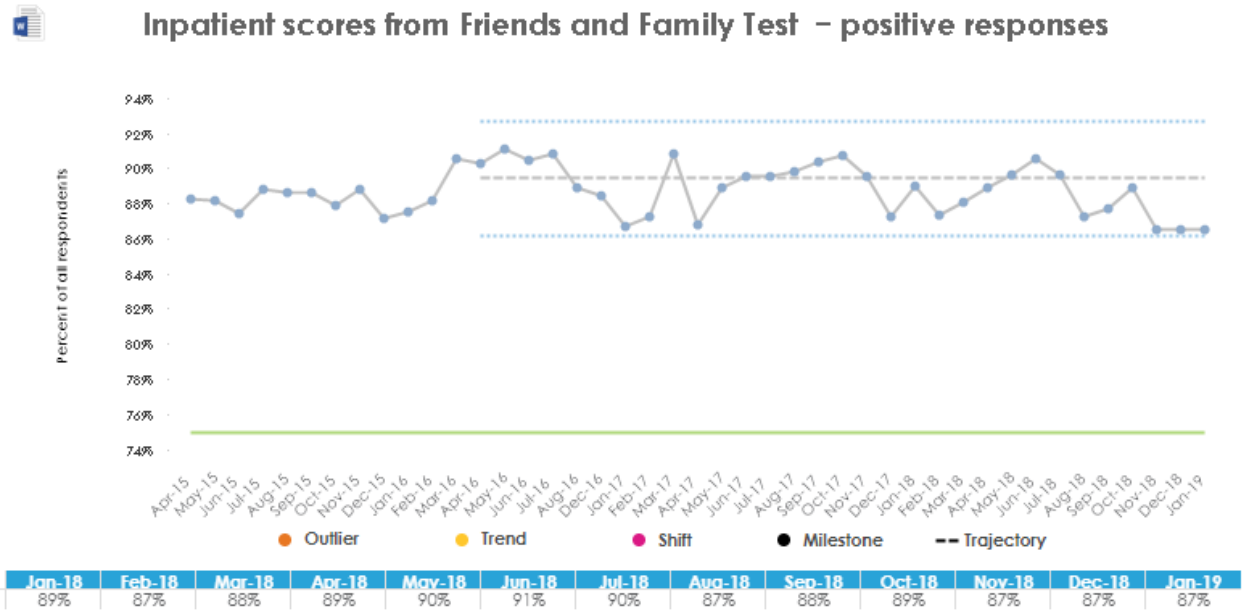
The scores for A&E suggest that there has been a significant improvement in our FFT scores that started in April 2017 and has been largely maintained since then. The positive shift in performance was driven by improvement at the Royal Free Hospital site, likely to be linked to the opening of the new Emergency Department in 2017.

For all areas we have maintained performance over the last year. Whilst we previously did include benchmarking charts for these measures, NHSE recommends that benchmarking is not used to compare providers due to the flexibility of local data collection methods and variation in local population.



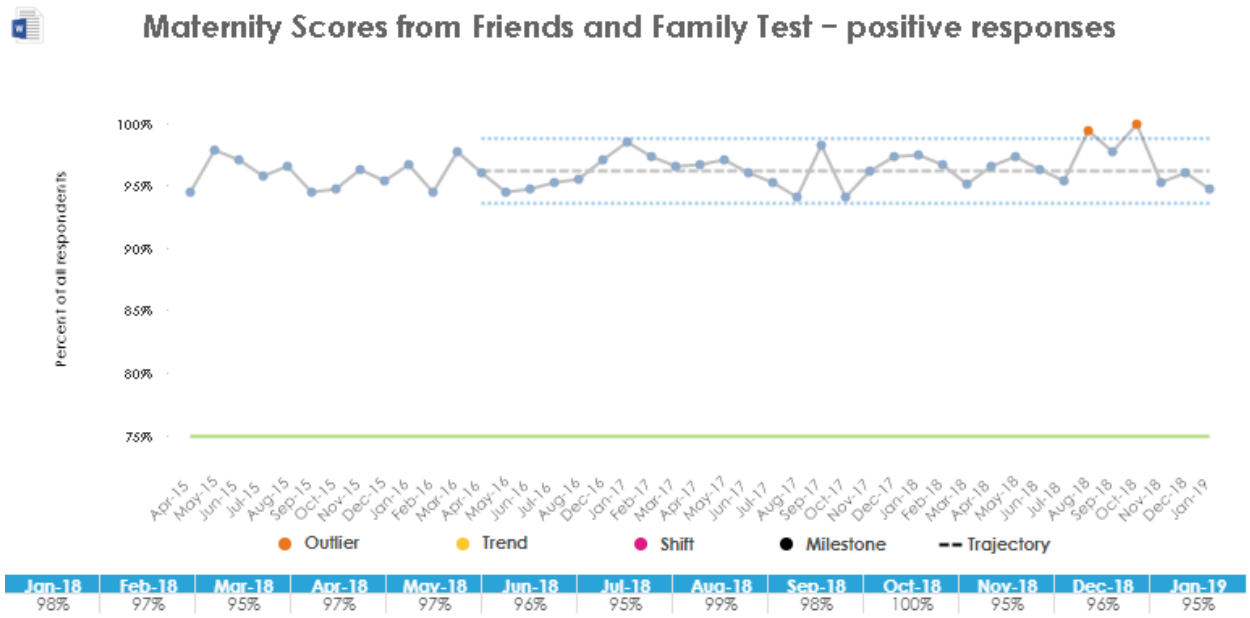
Source: Royal Free London NHS FT 2015-2019

The FFT scores for inpatients have remained compliant and stable over 2018/19. Any variation has been within expected limits.



Source: Royal Free London NHS FT 2015-2019

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

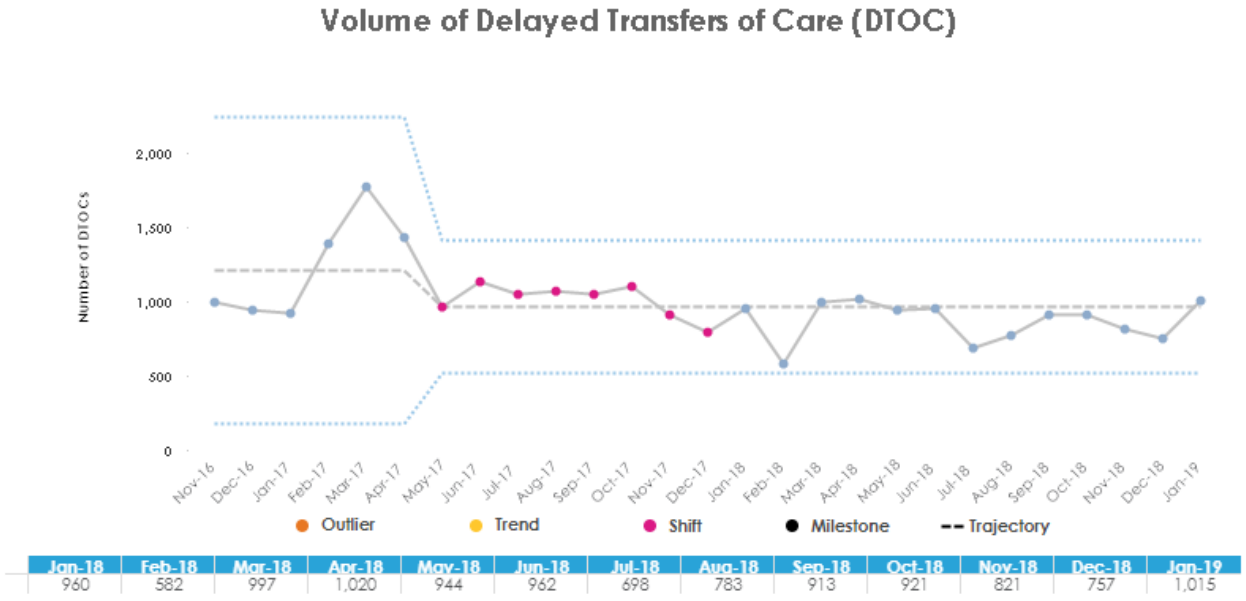


Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
98%	97%	95%	97%	97%	96%	95%	99%	98%	100%	95%	96%	95%

Source: Royal Free London NHS FT 2015-2019

Volumes of delayed transfers of care

This is the number of bed days per month that the trust lost to patients who were waiting for a transfer to social or NHS community care. Over the course of 2018/19, we have seen this number stabilise following a positive shift in performance from April 2017. We have been working closely with our local commissioners and social and community care providers to reduce this rate.



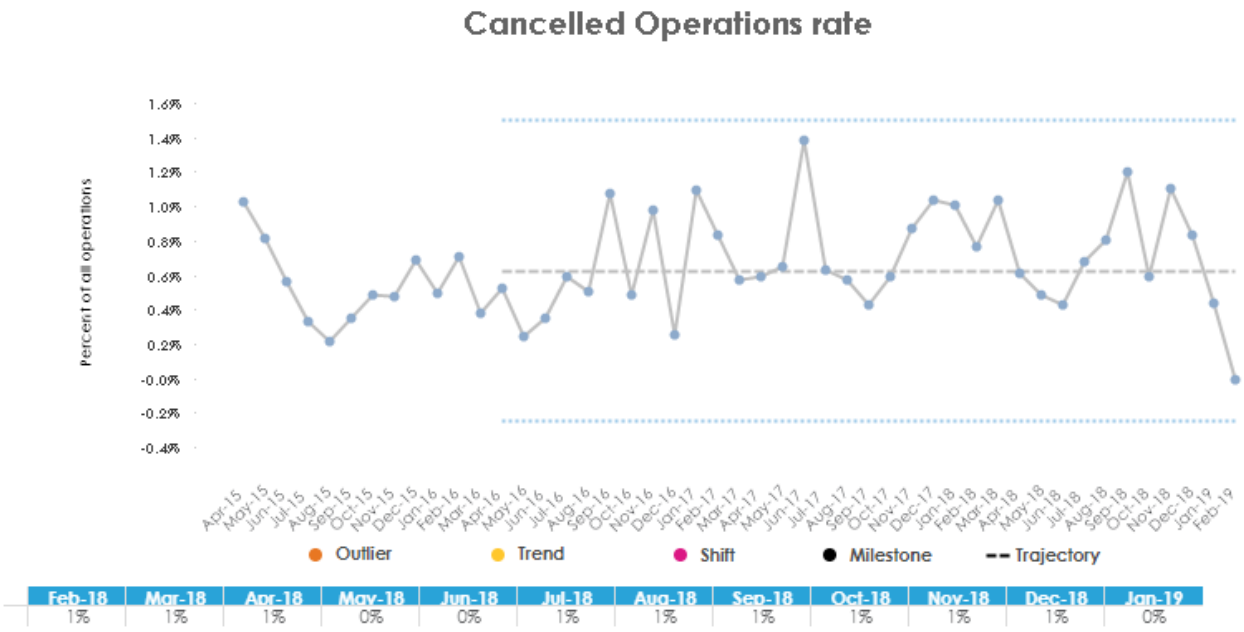
Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
960	582	997	1,020	944	962	698	783	913	921	821	757	1,015

Source: Royal Free London NHS FT 2016-2019

Benchmark information is not available for this measure.

Cancelled operations rate

This is the volume of last minute (on the day of surgery or following admission) cancellations for non-clinical reasons as a proportion of all elective inpatient and daycase operations. Over the course of 2018/19, this rate has remained within expected control limits.



Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
1%	1%	1%	0%	0%	1%	1%	1%	1%	1%	1%	0%

Source: Royal Free London NHS FT 2015-2019

Benchmark information is not available for this measure.

3.2 Performance against key national indicators

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

Indicators of Governance	Target	Q1	Q2	Q3	Q4	
Summary Hospital Mortality Indicator (rolling year average to end of quarter, Q3 and Q4 are unavailable)	**<100**	**87.8**	**86.8**	**unavailable**	**unavailable**	
A&E Maximum waiting time of four hours from arrival to admission/transfer/discharge	**>=95%**	**88.2 %**	**86.4%**	**86.2%**	**85.4%**	
**C difficile number of cases against plan	**18/Qtr**	**16**	**22**	**21**	**21**	
**Maximum time of 18 weeks from point of referral to treatment in aggregate for patients on an incomplete pathways (reported as arithmetic average of months in quarter/year waiting under 18 weeks)	**>=92%**	**92.3 %**	**88.9%**	**87.0%**	**83.1%**	
Maximum 6 week wait for diagnostic procedures	**>=99%**	**99.5 %**	**98.8%**	**98.9%**	**99.5%**	
****Cancer: two week wait from referral to date first seen**						
All cancers	**>=93%**	**93.6 %**	**92.9%**	**94.0%**	**92.4%**	
Symptomatic breast patients	**>=93%**	**92.5 %**	**93.7%**	**95.1%**	**93.7%**	
**All cancers: 31 day wait from diagnosis to first treatment	**>=96%**	**97.5 %**	**96.9%**	**98.6%**	**98.4%**	
****All Cancer 31 day second or subsequent treatment -**						
surgery	**>=94%**	**98.4 %**	**96.0%**	**98.5%**	**95.2%**	
drug	**>=98%**	**100 %**	**100%**	**100%**	**100%**	
radiotherapy	**>=94%**	**100 %**	**100%**	**100%**	**99.1%**	
****All Cancer 62 days wait for first treatment:**						
from urgent GP referrals:	**>=85%**	**83.5**	**79.2%**	**85.1%**	**84.4%**	

		%				
from a screening service	**>=90%**	**90.3 %**	**96.3%**	**89.2%**	**94.2%**	
Venous thromboembolism risk assessments	**95%**	**96.6 %**	**95.7%**	**95.9%**	**96.4%**	

Section 3.4 Our Plans

This section contains an overview on our plans in regards to:

- Implementing seven day services
- Speaking up
- The Care Quality Commission

Seven day 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 Trust showed an improvement in its performance against the standards of the 7 Day services survey in 2018 compared with 2017. The key findings particularly for standards 2 and 8 were as follows:

Standard 2:

- The overall proportion of RFL patients seen and assessed by a suitable consultant within 14 hours of admission was 80% (March 2017 - 56%).
- The overall proportion of Barnet Hospital patients seen and assessed by a suitable consultant within 14 hours of admission was 88%.
- The overall proportion of Royal Free Hospital site patients seen and assessed by a suitable consultant within 14 hours of admission was 73%.

Standard 8:

For RFL Trust as a whole, the overall proportion of once daily consultant or delegated reviews where the patient required a once daily review and received this was 85% on a weekday and 82% on a weekend. Equally, for RFL Trust as a whole where the patient required twice daily reviews and received these was 83% on a weekday and 83% on a weekend.

- 57% of the once daily reviews were undertaken directly by a consultant on a weekday and 36% of these reviews on a weekend.
- 72% of the twice daily reviews were undertaken directly by a consultant on a weekday and 53% of these reviews on a weekend.

In April 2019 the Royal Free London will be undertaking a limited audit of specific specialties in order to meet the Board Assurance requirements for the 7 Day Audit Services. The specialities which will be audited will include those which did not meet the 90% standard for

consultant review within 14 hours of admission (Standard 2). For standard 8 patients on ICU/HDU under the above specialties will be audited as to whether they have had twice daily reviews. The following specialties will be surveyed:

Barnet Hospital	Royal Free Hospital
• Cardiology • Emergency Medicine • General Surgery • Paediatric Medicine • Trauma and Orthopaedics	• Acute Internal Medicine • Cardiology • General Surgery • Geriatric Medicine • Infectious Diseases • Oncology • Trauma and Orthopaedics • Vascular Surgery

The audit will cover a sample of emergency patients admitted between 02/04 /2019 and 08/04 /2019.

The completed data will be validated by the Medical Director for the site.

Speaking up

Sir Robert Francis's 'Freedom to Speak Up' review in February 2015 highlighted the need for the creation of the National Guardian and Freedom to Speak up (FTSU) Guardians at every Trust in England as a 'vital step towards developing the right culture and environment for speaking up'.

This strategy sets out the trust's vision for an open and effective speaking up culture and how the outcomes will be measured to ensure that all of our staff feel safe to speak up. Having a healthy speaking up culture is an indicator of a well-led trust.We are committed to promoting an open and transparent culture across the organisation to ensure that all members of staff feel safe and confident to speak out. Our Board, Group Executive Committee and Local Executive Committees will support this agenda by:

- Role-modelling our world class care values and behaviours to promote a positive culture

- Providing the resources required to deliver an effective Freedom to Speak Up function; and
- Having oversight to ensure the policy and procedures are being effectively implemented.

Our Freedom to Speak up Guardian and other champions have a key role in:

- Helping to raise the profile of raising concerns in our organisation
- Providing confidential advice and support to staff in relation to concerns they have about patient safety
- Providing confidential advice and support in staff in relation to the way their concern has been handled.

Representatives of the trust are fully engaged with the National Guardian's office and the local network of Freedom to Speak Up Guardians in our region to learn and share best practice.

Our Strategy

The Trust will take the following actions to deliver this vision:

- Increase the level of awareness for all staff so they are clear about what concerns they can raised and how to raise them using the appropriate pathways;
- Ensure managers are clear about their roles and responsibilities when handling concerns and are supported to do so effectively;
- Ensure the FtSU Guardian and local speaking up champions are clear about their roles and responsibilities when supporting staff to raise concerns;
- Continue to increase the number of local speaking up champions across all sites, staff groups and backgrounds, so they are representative of the workforce.
- Provide regular communications to all staff (including those permanently employed on a full / part time basis, temporary workers and volunteers) to raise the profile and understanding of how to raise speaking up concerns;
- Communicate key findings to staff about the level and type of concerns raised and any resultant actions taken, as is appropriate under the scope of confidentiality;
- Share good practice and learning from concerns raised, through a variety of mediums, with the key aim of fostering openness and transparency such as staff briefings, team meetings, intranet, social media; and
- Actively seek the opinion of staff to assess that they are aware of and are confident in using local processes and use this feedback to ensure our arrangements are improved based on staff experiences and learning.

Outcome and measures

1. Annual staff survey results
2. Feedback from ‘go see’ visits and Board and Executive walk rounds
3. Feedback from structure walk rounds undertaken by FtSU Guardian and local champions
4. Regular review of speaking up issues being raised through other routes e.g. Datix, counter fraud etc
5. Number of channels available for staff to raise concerns including champions and other internal and external routes e.g. staff side, staff networks, national guardian office, CQC etc
6. Feedback from staff on the speaking up process once the complaint has been investigated
7. Quarterly FtSU updates for all staff via various methods e.g. staff briefings, social media, freepress, intranet etc.
8. Evidence that investigations are factually based and led by someone suitably independent in the organisation, producing a report which focuses on learning lessons and improving care
9. High level findings of cases provided to the Audit Committee on a bi-monthly basis
10. Speaking up policy reviewed annually.

Monitoring

A Freedom to Speak Up Annual Report will be presented to the Board each year by the Freedom to Speak Up Guardian and the Executive Lead for Speaking up which will include:

- An overview of the cases reported and the themes identified;
- Action taken within the last 12 month period;
- Planned action to be taken within the following 12 month period

Care Quality Commission:

In addition to the December 2018 core services inspection, the CQC undertook the Well Led and use of Resources inspection between 8 to 10 January 2019. The trust is awaiting the final report of these inspection.

We anticipate the most recent inspection report for 2018/19 and we continue to improve on areas identified from the previous CQC inspection in February 2016 and have achieved the following improvements in response to the 2016 report during 2018/19. ‘should do and Must do’ information as used in the current draft.

Completed actions from CQC 2016 Report

Should dos:

Trust wide, arrangements around equipment storage should be reviewed so that shower rooms are not used. At Chase Farm Hospital, this was included in the development of the new building.

Royal Free and Barnet Hospitals should improve the termination of pregnancy pathway; the service was reconfigured with a new clinical guideline and pathway.

The trust should address the compliance with the National Emergency Laparotomy Audit (NELA) at Barnet Hospital; compliance for NELA has now improved.

The trust should introduce the use of POSSUM scoring. We routinely use P-POSSUM scoring in our emergency general surgery and it is a mandatory part of the booking process. However, we don't use CR-POSSUM for elective colorectal surgery and there are no plans or national guidelines for colorectal cancer recommending its use.

At Royal Free Hospital should identify a dedicated bereavement facility for women and families to use in or near the labour ward. A room within the Heath Birth Centre was identified; The Royal Free Hospital charity provided funding for the refurbishment.

Royal Free and Barnet hospital sites should ensure all staff interacting with children have an appropriate level of Safe guarding training. Compliance is >90%

Must dos

Chase Farm Hospital must review the selection criteria for cases at the Chase Farm hospital site; strict selection criteria was reviewed and agreed and is being reviewed periodically.

Nursing staffing levels on the children's ward on the Royal Free site must be improved; additional nursing staff recruited.

Barnet Hospital must address the inconsistencies in mandatory training records for clinical staff in Medicine. Data on MAST training is now only taken from one source.

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A summary of CQC "Must and should dos"

Annexes

Annex 1. Statements from commissioners, local Healthwatch organisations, Overview and Scrutiny Committees and council of governors

- **Commissioners:**
- **Healthwatch**
- **Overview and Scrutiny Committees**
- **Council of governors**

Appendices

Appendix a: Changes made to the quality report

The views of our stakeholders and partners are essential in developing our quality report.

Our report has changed in response to comments received following the distribution of the draft as follows:

This information will be included in the final report.

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 Tariff (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.
Cardiotocography (CTG)	Cardiotocography (CTG) is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy. The machine used to perform the monitoring is called a cardiotocograph.
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
Never event	Never events are extremely serious and largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place.

NICE: National Institute of Clinical Excellence.	An independent organisation that produces clinical guidelines and quality standards on specific diseases and the recommended treatment for our patients. The guidelines are based on evidence and support our drive to provide effective care.
Patient at Risk & Resuscitation Team (PARRT).	The Patient at Risk & Resuscitation Team (PARRT) is a combined nursing service to provide 24/7 care to patients at risk, including attending medical emergency calls (2222) and reviewing all patients post discharge from intensive care. The team members provide education, training and support to manage life-threatening situations, including in-hospital resuscitation, care of the patient with a tracheostomy and CPAP.
PEWS: paediatric early warning score.	A scoring system allocated to a patient's (child's) physiological measurement. There are six simple physiological parameters: respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness.
SBAR: situation, background, assessment, recommendation.	SBAR is a structured method for communicating critical information that requires immediate attention and action contributing to effective escalation and increased patient safety. It can also be used to enhance handovers between shifts or between staff in the same or different clinical areas.
SHMI: summary hospital-level mortality Indicator.	The SHMI is an indicator which reports on mortality at trust level across the NHS in England using a defined methodology. It compares the expected mortality of patients against actual mortality.
UCLP: University College London Partners .	UCLP is organised around a partnership approach. It develops solutions with a wide range of partners including universities, NHS trusts, community care organisations, commissioners, patient groups, industry and government. (http://www.uclpartners.com/).
VTE: venous thromboembolism.	A blood clot that occurs in the vein