Royal Free London
NHS Foundation Trust

Update on 2019/20 quality account.

Introduction

This report presents an update to Barnet Health Overview and Scrutiny Committee (HOSC) on the actions that the trust has taken since the publication of their quality account 2019/20 in May and June 2019.

The report is divided into two sections:

- Part one: feedback on the points raised by Barnet HOSC (May 2019)
- Part two: update on progress to meet the quality account priorities (2019/20)

Part One: Feedback from points raised by Barnet HOSC

In May 2019, the Barnet Health Overview and Scrutiny Committee (HOSC) reviewed the draft quality account 2018/19 and following comments were recorded. A response from RFL is as follows:

Comment from BHOSC	RFL Trust response.
The Committee commented that as the Quality Account was a document intended for use by the public, it should be clearly set out and easy to navigate: this was not felt to be the case. The draft report had no page numbers, the language was vague in places and it was suggested that SMART be used as a methodology (Specific, Measurable, Agreed upon, Realistic and Time-based). The overall presentation should be reviewed to make the report easier to assimilate and scrutinise.	The trust addressed this point in the final version of the quality account 2018/19. For the 2019/20 quality report the trust intends to ensure that it is reader-friendly and plans to produce an easy-to read booklet specifically for patients.
The Committee was disappointed that there was much data missing from the Commissioning for Quality and Innovation (CQUIN) Scheme Priorities section.	The trust addressed this point in the final version of the quality account 2018/19.
The Committee noted that the target of zero 'Never Events' by the end of March 2019 had not been achieved. Instead there had been an increase to nine. The Committee noticed an effort from the Trust to reduce 'Never Events' but progress had not been made at the pace required to protect patients' safety.	The trust was disappointed to report nine never events during 2018/19 and therefore agreed to retain the target of zero never events as a quality account priority for 2019/20. Details of the trust performance is reported in part 2 (page 7) of this report.
The Committee reported that it was frustrating that data was missing from the report. The data on the number of deaths reviewed contained in	

the report related to April, May and June 2018 and more up-to-date data was needed. The mid-year data had previously been made available so it was inexcusable that the final figures were not available. There was no data therefore in relation to the Priority 'Learning from Deaths'	
The Committee noted some of the 'Actions Taken During 2017/18' were self-evident and should be routine, such as reviewing safeguarding processes and reviewing the medical rota.	The trust has taken this point on board and aims to reflect this in their 2019/20 report.
The Committee was disappointed with some of the Trust's national performance targets. Its compliance for Referral to Treatment was below the national average - the latest compliance in January 2019 was 73.9% against a target of 92%. The Cancer 62-day target had also not been met although it was hoped that improvements would be achieved in the future since the Trust set up the Cancer Clinical Practice Group. Accident and Emergency targets had been at 87.4% for several months, below the 95% target, though it was acknowledged that the Trust received a huge volume of patients and was investigating how it might tackle this.	The trust has taken this point on board and aims to reflect this in their 2019/20 report.
The report does not mention the Walk-In Centres at Cricklewood and Finchley Memorial Hospital. It is believed that Finchley Memorial Hospital and Edgware Community Hospital are also run by the Trust.	The trust does not run Finchley Memorial Hospital and Edgware Community Hospital, but provide services such as out-patients clinics and neuro-rehabilitation.
Some of the Quality Priorities, such as 'further enhance and support dementia', were vague and not measurable so it was not clear how the Trust would know whether its strategies were successful.	The trust has taken this point on board and aims to reflect SMART priorities in their 2019/20 report.
The report detailed the Trust's completed actions but it would be helpful if it also included the actions outstanding and a firm timescale for dealing with them.	The trust has taken this point on board and aims to reflect this in their 2019/20 report.
The Committee noted that many of the Quality Account priorities for 2018/19 were not achieved.	The trust recognises that some of the quality account priorities for 2018/19 were not achieved, therefore the trust agreed to retain these for 2019/20. An update on the trust progress to meet the priorities is reported in part 2 of this report.

Part Two: Update on quality account priorities 2019/20

In total, all seven priorities were carried forward from 2018/19 as it was identified that during 2019/20 further improvement could be made (Figure1: Quality account priority and designated trust lead). The priorities remain within the three domains of quality (patient experience, clinical effectiveness and patient safety) and continue to have an executive sponsor, a designated lead and an associated committee where progress is monitored and assurance provided.

Figure1: Quality account priority and designated trust lead)

Quality domain	Quality account priority	Designated trust lead
Patient experience	To further enhance and support dementia care	Danielle Wilde: group dementia lead
	To improve our involvement with our patients and carers.	Richard Chester: Deputy director for patient experience
Clinical effectiveness/ quality improvement	To build capability in the workforce	James Mountford: Director of quality
	To develop a superior change-management capability putting clinicians in charge of their clinical pathway.	John Connolly: Clinical Pathway Group Director
Patient safety	To improve safer surgery	Hester Wain: Deputy director for patient safety
	To improve our learning from deaths	Hester Wain: Deputy director for patient safety
	To improve infection prevention and control	Vicky Pang: Infection Control lead

Figure 2: Executive Sponsor and Associated committees (Group level)

Quality domain	Executive Sponsor	Associated committees (Group level)
Patient experience	Deborah Sanders, interim chief executive/ Chief nurse	Population Health Committee (PHC)
Clinical effectiveness/quality improvement	Dr Chris Streather, Chief medical officer	Clinical Standards and Innovation Committee (CSIC)
Patient safety	Deborah Sanders, interim chief executive/ Chief nurse	Clinical Standards and Innovation Committee (CSIC)

The key used in this report to summarise the progress made during the reporting period is as follows:

Key:

Status	Progress as expected for the reporting period	
	Progress below expectation for the reporting period	

1. **Patient Experience:** To further enhance and support dementia care

Key measure for success • To improve the quality of care being undertaken in high need bays	
Progress	**Status**
The trust continues to build on work undertaken. Which has included the following: • Second "dementia-friendly ward" opened on 8 West. New design includes a new barbershop and day room/ theatre space • Ongoing collaboration with Chickenshed Theatre who will continue providing enhanced communication in dementia care with 3 workshops planned for Barnet and Chase over the next 9 months • Dementia and Delirium Clinical Practice Group work (CPG) has been convened and works continues around 5 strategic priorities; admission, ward-based care, distressed behaviour, delirium, risk-positive discharge • New series of "Sundown Sessions" has been recorded and broadcasted	

2. **Patient Experience:** To improve our involvement with our patients and carers.

Key measure for success • To organise a suite of tools, strategies, and cultural elements into an easy-to-follow framework	
Progress	**Status**
The trust continues the work with The Point of Care Foundation (PoCF) to improve involvement with our patients and carers. The PoCF has met with each hospital site executive team to discuss the above and commence planning for work package 1. The aim of these meetings was to: • Familiarise people with the programme and ambitions for the work. • Establish a shared framework for thinking about patient involvement and engagement across the group, based on the Carman et al Framework. • Establish where the hospitals are positioned on the framework at present. • Discuss who should attend the best practice in engagement workshop. An Involvement Programme Board was subsequently set up to plan for the best practice in engagement workshop. To date 27 people from across the Trust have been put forward for the workshop which took part in November 2019.	

3. Clinical Effectiveness: To build capability in the workforce

Key measure for success

- 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

Progress	**Status**
The Joy in Work collaborative formally launched June 2019 with 15 teams taking part from across the organisation. Most teams are now running tests of change and gathering data around their key metrics. Learning set 3 (of 5 sets) took place on 18th December. An interesting outcome of this collaborative is that many teams are choosing to work on what matters to patients in order to work on what matters to staff. This focuses their efforts on challenging operational problems such as patient experience and waiting times. Examples of project progress include: • Barnet Emergency department ran a 'perfect staffing day' and saw an increase in staff happiness from 48% to 94%. These tests of change are helping to inform their staffing model. • The 11West high fliers have introduced a new way to run their morning drug rounds. Staff prefer the new process and they have seen a decrease in drug errors. • The Allerjoy team have been working on finishing clinics on time – they have started to achieve this. • 5 East B are working to improve better nursing and HCA team work. They now write the nurse and HCA name on each patients bed board. This ensures better team working and the patient also knows who is looking after them. We continue to train and develop staff in their use of quality improvement. An important milestone has been embedding 'QI bite-size' a half-day introduction to QI which now runs regularly across all main sites – RFH, BH, CFH & ECC . Additionally, we have successfully run a first wave of The Royal Free Improvement Programme (TR-IP) which build on the IHI programme Improvement science In Action (ISIA). Successfully running this in house is a significant step to being able to build our own internal QI capability. The third wave of QI coach programme will start in March where RFL QI faculty will co-deliver 50% of the content alongside IHI faculty, with the view to then take this in house.	

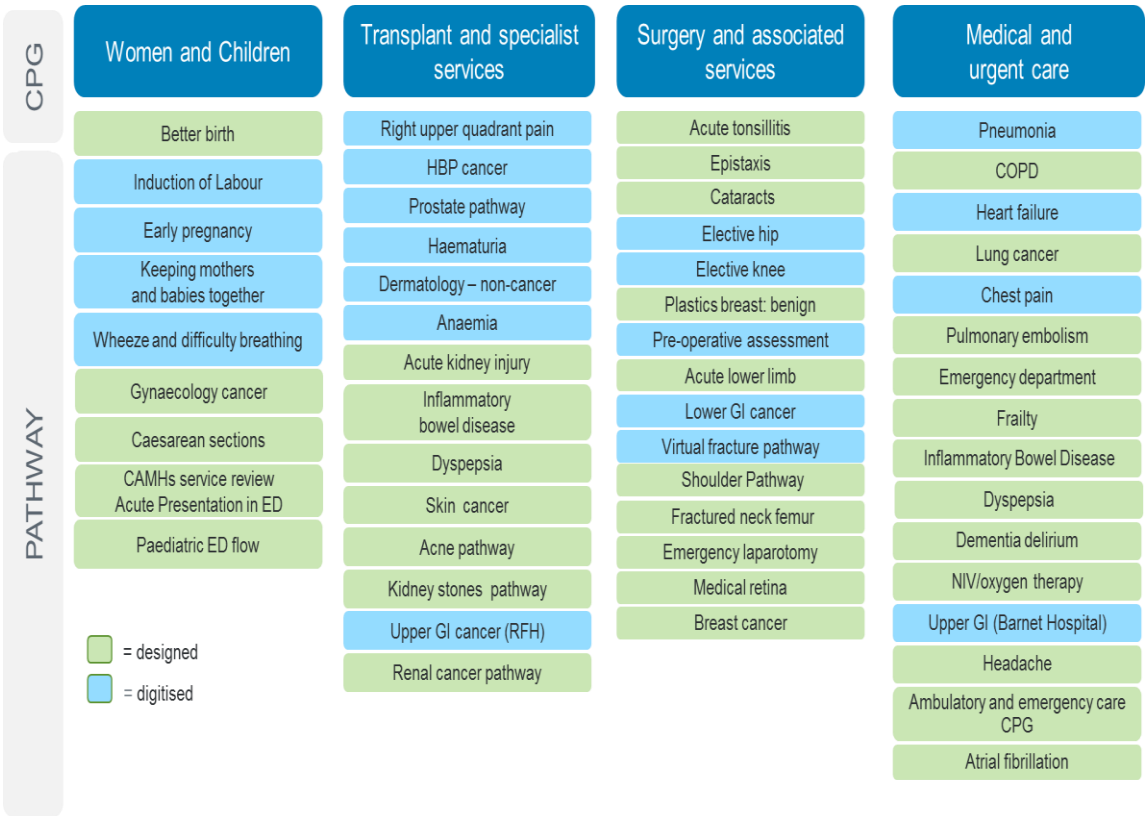
To date we have trained: 62 QI coaches, 312 QI Practitioners and 502 staff in QI bite-size QI continues to be embedded into standard processes across RFL. Projects are presented across many committtees e.g. QCRG, CSIC, CEO briefing, JiW steering group. We are also seeing the benefit of the Improvement Advisor role at Royal Free Hospital as an enabler to build local processes and embed the work further.	

4. **Clinical Effectiveness:** To develop a superior change-management capability putting clinicians in charge of their clinical pathway.

Key measure for success

- To have 20 clinical pathways digitised across our CPGs

Progress	**Status**
• Our CPGs use the latest clinical evidence to ensure that all patients have access to the best and most innovative treatments. The aim is to standardise pathways so that no matter where you get treated within the trust you will receive the same high standard of care. The trust has digitised 20 of the 54 pathway shown below we are currently monitoring adoption.	★



5. Patient Safety: To improve safer surgery

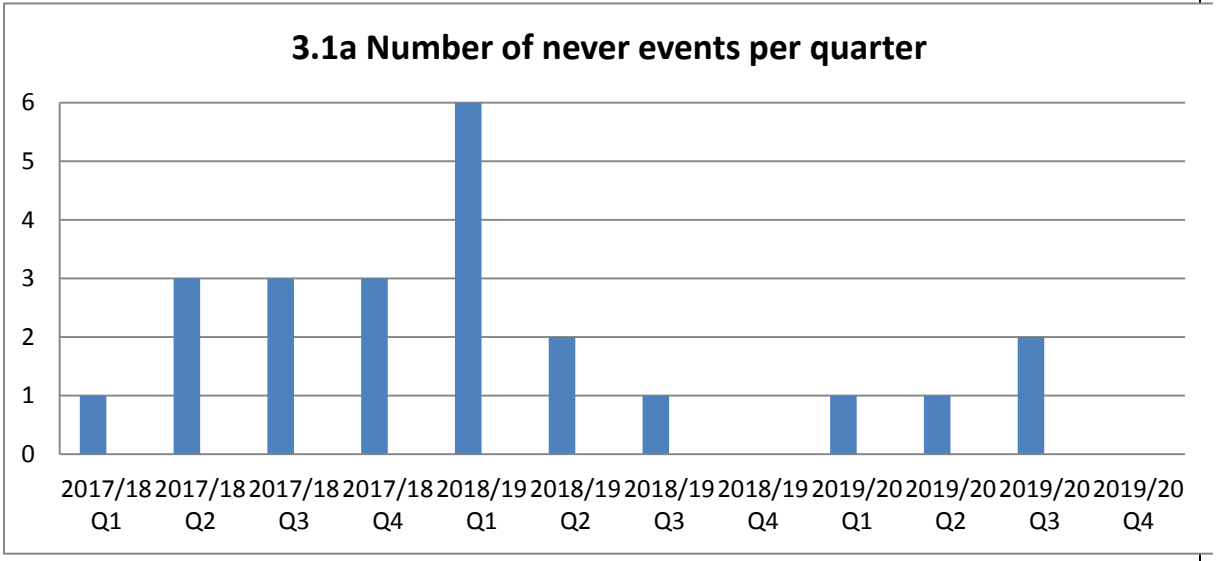
Key measure for success

- 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

Progress	Status

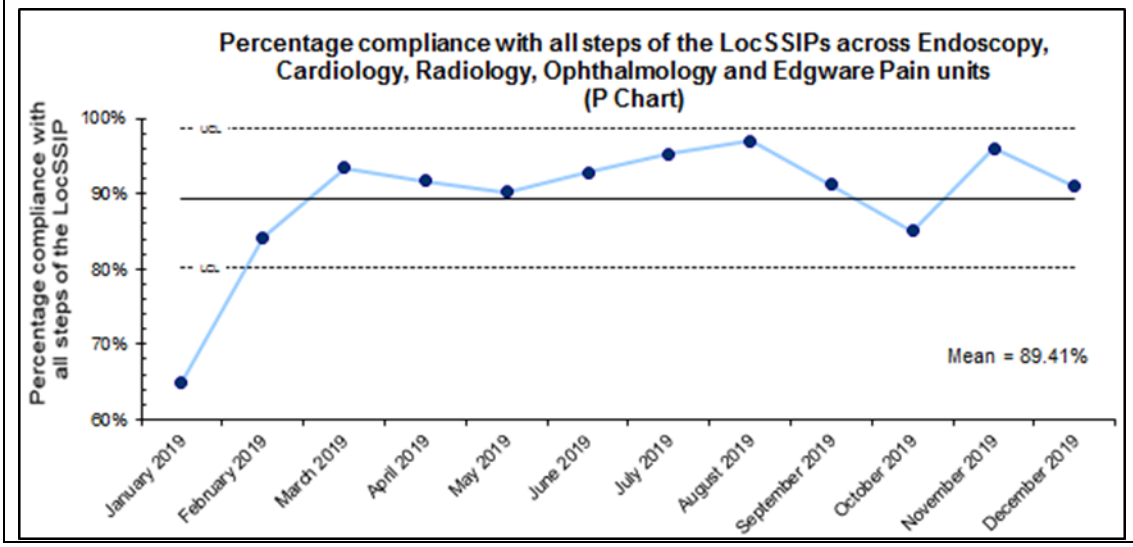
Four never events have been reported in 2019/20

Steis	Datix	Site	Type	Incident date
2019/10977	IN102302	BH	Fed via misplaced NG tube	12/05/2019
2019/15127	IN106420	RFH	ABO-incompatible blood component	07/07/2019
2019/25700	IN115817	RFH	Wrong size breast implant	18/11/2019
2019/25922	IN116494	CFH	Wrong size hip liner implant	27/11/2019



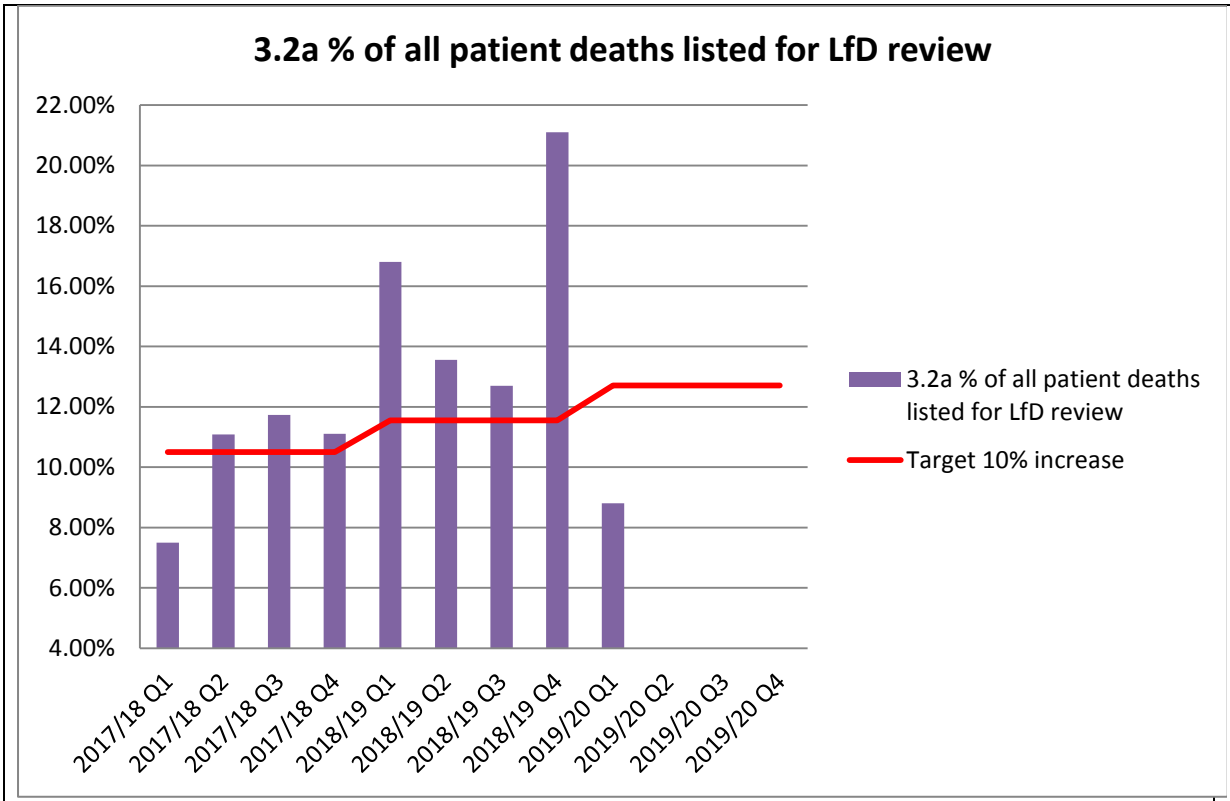
Local Safety Standards for Invasive Procedures (LocSSIPs) implementation and monitoring is now embedded into practice:

- Endoscopy, Cardiology, Radiology, Ophthalmology (Intravitreal Injections) and Dermatology are working through the implementation phase and now becoming part of business as usual. The Edgware Pain team is a new addition to this work.
- Most of the clinical areas are collecting weekly LocSSIPs compliance data on the Perfect Ward App that is in line with their implementation phase audit plan. The data collected is discussed at their user group meetings and presented to the Divisional Quality and Safety Boards.

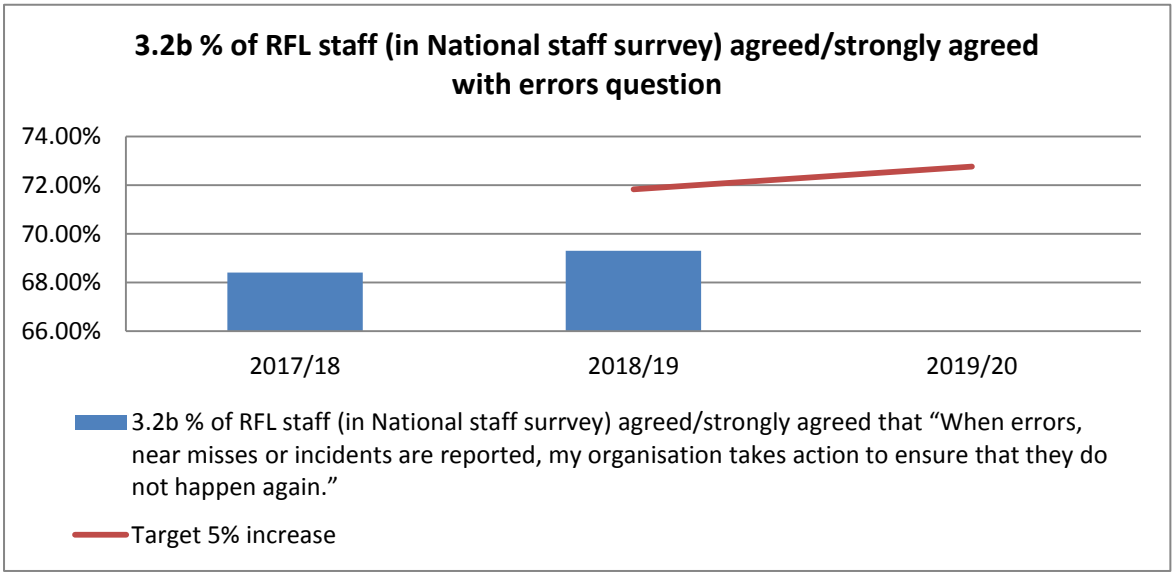
• Overall compliance with all steps of the LocSSIPs in our target areas is 89% (Graph 1). From July 2019, all clinical services are sharing their LocSSIPs data reports at the relevant Divisional Quality and Safety Board (DQSB) meetings which report into the relevant hospital Clinical performance & patient safety committees.  	

6. Patient Safety: To improve our learning from deaths

Key measure for success • 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	
Progress	**Status**
We have a backlog of overdue reviews, most of which are random reviews. To date none of the 46 random reviews undertaken have identified deaths which have been considered likely to be avoidable. Therefore, for the next six-months we will concentrate on completing the reviews for those that meet the key "must do" criteria and not list any deaths for random review. For 2019/20 Q1, we have 8.8% of patient deaths listed for review; thus we will not meet the target for increasing the number of deaths listed for review this year. Please note: the Learning from deaths (LfD) reviews are reported six-months in arrears.	★



The 2018 annual NHS staff Survey showed that 69.3% 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." This is an improvement from 68.4% in 2017. These data are only available annually

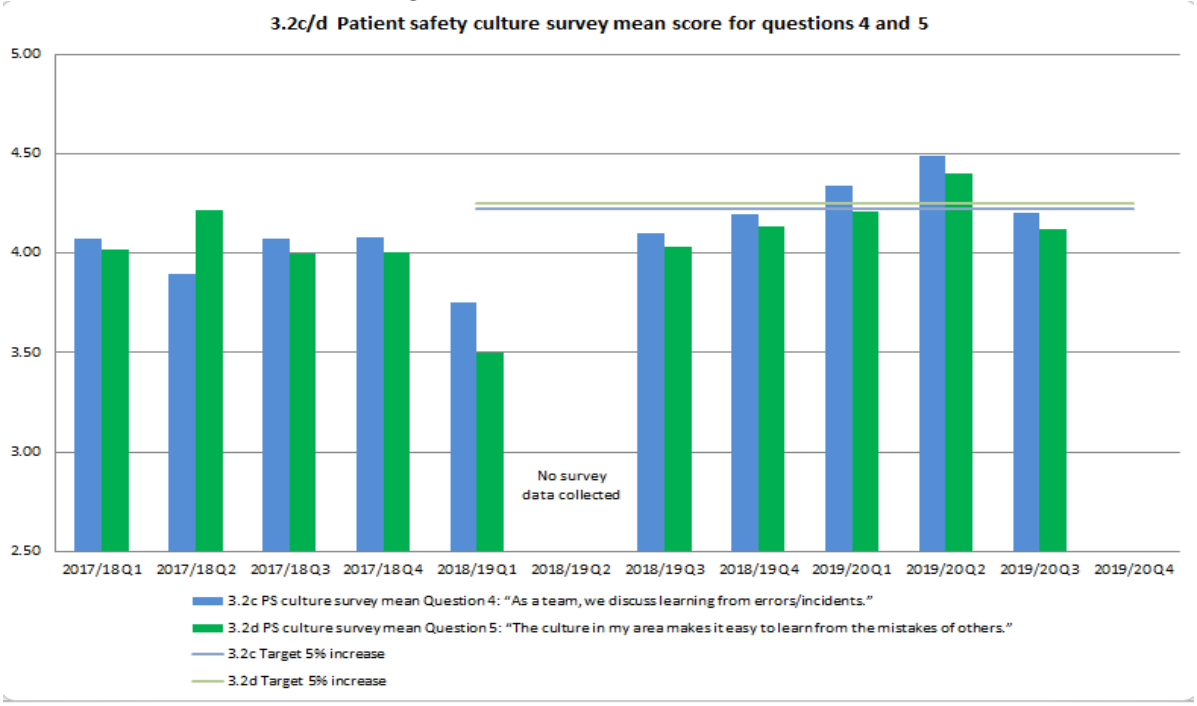


The patient safety culture survey, based on a survey tool derived from the Texas Safety Attitudes Questionnaire (Sexton et al 2006), elicits a snapshot of the safety culture from 17 questions.

We used the following two questions to generate metrics to help us to identify improvements relating to the sharing of the learning across the trust:

- Question 4: “As a team, we discuss learning from errors/incidents.” The results gave a mean of 4.02 in 2017/18 and 3.90 in 2018/19, thus we did not improve in this measure and we will review whether it is the most appropriate outcome measure.
- Question 5: “The culture in my area makes it easy to learn from the mistakes of others.” The results gave a mean of 4.05 in 2017/18 and 3.87 in 2018/19, thus we did not improve in this measure and we will review whether it is the most appropriate outcome measure.

In quarter 1 and quarter 2 of 2019/20 we improved our scores, however quarter 3 has decreased below the target.



7. Patient Safety: To improve infection prevention and control

Key measure for success

- To reduce Gram negative bacteraemia in line with mandated threshold (- 25% reduction by 2021-2022 with the full 50% by 2023-2024)
- To remain below the mandated threshold for trust-attributed *Clostridium difficile* (C.diff) (100 cases 2019/20). To have zero infections due to lapses in care

Progress	**Status**
• The trust continues to focus on reducing and preventing healthcare-associated infections and reducing inappropriate antibiotic use. We monitor our Gram-negative blood stream infections in line with details outlined in *The Five year Action Plan for antimicrobial resistance (AMR)* as published by NHS England/NHS Improvement.	★

The trust is still awaiting further details from NHS England/NHS Improvement with regards to our specific reduction targets for gram negative blood stream infections. • The trust remains below the mandated threshold for trust-attributed *Clostridium difficile* (C.diff) and had 1 lapse in care.	

Conclusion

Overall, progress was made in five out of the seven priorities and it was disappointing to report further never events. However the trust continues to ensure that we learn from our never events and continue to share immediate learning and identified risks

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