NHS
Royal Free London
NHS Foundation Trust

Royal Free London NHS Trust Quality Account – mid-year quality priorities 2022/23 review

This report provides an update on the actions completed over the last two quarters in relation to each of the quality priorities identified for 2022/23 in the quality account and submitted to NHSE in June this year. A fuller report will be given in the next quality account at the end of quarter 4.

Patient Experience	
Our quality priorities and why we chose them:	**What success looks like:**
1. Establish shared principles for involving patients and carers in our services to better monitor their experiences and make relevant improvements **NEW** This priority supports delivery of our year five ambition to ensure that the relationships we have with our patients and carers are amongst the best in the country	We will build a framework to facilitate and embed high quality, diverse involvement work across the Trust. We will work collaboratively with patients to identify and act on areas for improvement and better understand health inequalities through changes in service utilisation. We will develop clear processes to better understand the experience of patients with learning disabilities and work with patients and carers in the co-production and design of our services. We will make it easy for our patients to quit smoking, reduce their alcohol intake to safe levels and manage their weight through embedding a culture of Healthy Living across the Trust. This will help improve healthy life expectancy and in turn reduce inequalities in healthcare. **NEW WORDING**
In September 2021, the RFL Involvement Framework (IF) was signed off by GEMM and CSIC, following endorsement by each hospital business unit. The RFL IF utilises the 4Pi national standards for involvement which provide some basic principles to encourage meaningful involvement through thinking about involvement in terms of principles, purpose, presence, process, and impact (4Pi). The RFL IF describes involvement activity as belonging to three levels: 1 listen, 2 involve, 3 co-produce. Each level of involvement is important and valuable. In practice, the level of involvement will depend on the personal circumstances and interests of the patient or carer, as well as the purpose and nature of activity being undertaken. The RFL involvement framework provides a formal infrastructure for involvement across the group, to facilitate in particular, activities at levels two and three (involve and co-production). It is a simple approach designed to capitalise on the involvement work already taking place. It provides a clear structure with consistency and parity across the group that is simple for staff, patients and carers and other stakeholders to understand, whilst also allowing for flexibility of implementation in each of the hospital business units.	

An involvement register (IR) will ensure a standardised process for recruiting and supporting patients and carers in ad-hoc and regular involvement activity across the group, as well as providing evidence of involvement. The project is being co-produced with patient partners and alongside this, a recompense policy is in development, alongside a training and communications and engagement plan.

The BH patient experience team have established a relationship with Barnet MENCAP and have attended their 'have your say' meeting to understand experiences of patients with learning disabilities and what barriers they might experience in being involved in improvement work at the hospital. We have requested to be able to attend their group on a quarterly basis.

An easy-read version of the FFT/patient experience survey has been created by the lead nurse for learning disability and a process for managing these surveys will be agreed with the patient experience teams. When the contract for patient experience surveys is reviewed, a longer-term solution will be sought.

Patient Story: David, a patient with a learning disability and his wife Annette, also with a learning disability presented to the Trust Board about David's experience as a patient at RFL. David & Annette spoke about the importance of staff recognising family bonds and ensuring family are involved and kept up to date. They also spoke about reasonable adjustments and how simple changes such as changing appointment times can make a big difference to their experience coming to hospital.

Every year the Trust participates in benchmarking against the NHSI/E Learning Disability Improvement Standards. The benchmarking exercise invites 100 patients with a learning disability to complete a survey on their experience within the Trust. The benchmarking also consists of inviting 50 staff members to complete a survey on their understanding about people with learning disability and/or autism using Trust services.

We are embedding a culture of 'Healthy Living' through:

- Healthy Living Hub (HLH) pilot (smoking, alcohol and weight management) which went live in January 2022 with a diverse monthly steering group.
- Active hospital programme (physical activity) which went live in September 2022.

Together these two programmes comprise our healthy living strategy which we have aligned to the RFL health and care strategy. We are developing a healthy living/population health education and training strategy, and a healthy living/population health comms strategy to underpin this work.

To date we have:

- set up HLH steering group and programme documentation including evaluation framework and monthly reports
- Completed 'themed' meetings of smoking cessation, alcohol reduction and weight management with mapping across NCL including Trusts
- Successfully bid for funds from GLA to commission an external provider to map whole system approach to obesity across NCL and develop prioritised action plan for the NHS as well as each borough (due to be completed February 2023)
- Set up NCL networks alcohol and weight management (in addition to established NCL tobacco board) to work towards equity of access in the community
- set up task and finish groups in Barnet, Camden and Enfield to ensure we integrate our secondary prevention pathways into existing secondary and primary prevention pathways at place level. These will finish in November and December 2022.
- identified and mitigated internal system and process issues for smoking cessation referrals within RFL. Other issues identified have been escalated to regional or national leads.

Within RFL, we started with smoking cessation in order to improve systems and processes with 100% end to end audit of all smoking cessation referrals. We are just transitioning into phase 2, ceasing 100% audits and bringing on board alcohol reduction and weight management pathways.	
2. Establish a world class dementia care service operating across inpatient settings Trust wide NEW This priority supports delivery of our year one quality goal to understand and improve the experience for our patients and carers	We will ensure we remain a 'dementia friendly' hospital through ongoing delivery of the Dementia Clinical Practice Group five workstreams: Delirium, Distressed behaviour, Assessment, Discharge and Carers. We will measure the impact of the service on critical outcomes through collection of patient and carer feedback and use this to identify areas for improvement.
The aim of the CPG is to ensure every person with dementia admitted as an inpatient to RFL receives person-centred, holistic high-quality care. There are currently 5 pathways, all of which have actions integrating current National Audit of Dementia measures including: • **Discharge** - Development of a discharge information pack including signposting community resources • **Carers -** Carer support workshops and survey modelled on the NAD tool • **Distressed behaviour** - De-escalation chart and training package roll-out • **Assessment** - Digitised dementia bundle underway and currently being piloted by CNS service at BH • **Delirium** - MDT delirium simulations ongoing, e-learning module in design phase The dementia team remain committed to benchmarking against the quality metrics identified by the Royal College of Psychiatrists. In addition to the above, they will be carrying out patient experience assessments using the tool provided.	
3. Patients who are recognised as likely to be in the last year of life will be offered a conversation about their personal preferences and priorities for their future care **Continue from 21/22, wording adapted in light of new national guidance** This priority supports delivery of our year one quality goal to understand and improve the experience for our patients and carers	We will ensure that in these conversations patients' wishes, preferences and priorities for their future care will be explored. These are likely to be a number of conversations and with whomever the person wishes to involve. We will ensure that there will be agreement of treatment plans, and a comprehensive discharge/clinic summary will be written so the person can review their own care plan.
This year new national guidance has been written regarding advance care planning https://www.england.nhs.uk/publication/universal-principles-for-advance-care-planning/. We have updated our website with our patient voices group and referenced the national guidance in full and in easy read https://www.royalfree.nhs.uk/patients-visitors/advance-care-planning-and-end-of-life-care/ . We have moved, as have all of London, from the use of co-ordinate my care to the London urgent care plan to record conversations with patients about their wishes and preferences alongside appropriate urgent care plans https://ucp.onelondon.online/ . We have trained staff to use the urgent care plan and written a quick reference guide. We are waiting on One London to provide a patient portal so patients can always see their record,	

<table>
<tr><td colspan="2">otherwise it is easy to print a record off for a patient. We are waiting for One London to provide data on how we are using the clinical system.

This year we are working on using our electronic patient record (EPR) to audit all patient records. Recognising that all advance care planning does not result in either a Do Not Attempt Cardiopulmonary resuscitation (DNACPR) decision or Treatment Escalation Plan (TEP) we will use this as a proxy for some measure of advance care planning discussions.

We are working on:
1) Being able to pull a report from ePR about the patients who have a TEP / DNACPR and sampling a number for the quality of the conversations and whether they had a good discharge letter and a LUCP.
2) Designing a powerform to record the conversations.
3) Removing previous forms that may confuse clinicians from the system so that reports are accurate.

We continue to provide monthly advanced communication skills training for senior clinicians, regular “elephant in the room training” for mid-career clinicians, family meeting training three times a year and regular “SAGE and THYME” training for all staff. We have also designed specific communication skills training for family meetings https://www.youtube.com/watch?v=LaNPA23_7_k&list=PLOsHcwoB1Kf86h13CHsAc0WtvvGUQsIyg and for site specific areas such as intensive care.</td></tr>
<tr><td>4. Keep patients informed and regularly updated about waiting times in outpatient clinics
NEW
This priority supports delivery of our year one quality goal to understand and improve the experience for our patients and carers</td><td>We will identify the best methods to keep patients informed and updated of any delays.

We will monitor our progress using outpatient surveys to collect patient and carer feedback.</td></tr>
<tr><td colspan="2">The CPG methodology is being used to improve elective recovery through the OPD patient improvement programme, optimising OPD space, OPD pathways and support patient Initiated follow-up. We are also support the RFL flow programme to improve flow and by supporting better board rounds by optimising EPR and the development of standard SOP.</td></tr>
<tr><td colspan="2">Clinical Effectiveness</td></tr>
<tr><td>Our quality priorities and why we chose them:</td><td>What success looks like:</td></tr>
<tr><td>5. Implement a systematic approach to align the following activities at group and business unit levels: planning and prioritisation; progress and performance tracking; quality improvement activity
NEW

This priority supports delivery of our year one quality goal to improve health outcomes across the group</td><td>This will evidenced by:

• The Annual Planning process identifying priority themes and areas for improvement;

• Performance data, implementation updates (e.g. CQC) and other sources of insight being used regularly to understand the extent to which progress is being made in key areas of improvement;

• Quality Improvement projects and activities being aligned to the themes and areas of improvement identified from annual planning.</td></tr>
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<tr><td colspan="2">The Annual Planning process, during Spring 2022, was used by each of the Hospital Business Units to help identify priorities, projects and teams to be put forward for the QI Expedition programme – which started in May 2022. Over 25 improvement projects from our Business Units, involving nearly 250 team-members, are on the QI Expedition programme.

The Quality Improvement (QI) team is working with the Planning team to embed the process [as part of Annual Planning] for aligning the next (2023/24) cohort of QI Expedition projects / teams with Group-wide and Business-unit priorities.

The QI team is also working with colleagues to identify if and how best to support the emerging 'Performance Framework' and the 'local improvement plans' that is likely to require.

The 'Life QI' system has become further embedded as the web-based tool through which all significant QI projects and programmes are registered, categorised and tracked – which has improved visibility of progress and knowledge-sharing.

Chase Farm Hospital (CFH) Business Unit continue to roll-out and develop their 'Quality Blueprint' – which is provides an overview of the 'quality ambition' at CFH and the programmes of work that will help achieve that ambition.</td></tr>
<tr><td>6. Systematically spread learning from Quality Improvement activity across teams, services and sites and, where appropriate, scale effective interventions across the RFL group
NEW

This priority supports delivery of our year one quality goal to improve health outcomes across the group</td><td>This will be evidenced by:

• QI governance structures being updated to reflect this objective (e.g. in their Terms of Reference);

• Broaden involvement of colleagues across the organisation in relevant QI governance forums;

• A comprehensive set of processes and activities to spread learning being established.</td></tr>
<tr><td colspan="2">Quality Improvement Implementation Group (QIIG) reviewed and endorsed an approach (based on internationally-validated good practice) for 'scale and spread' at RFL, in summer 2022.

This approach is being tested with some 'early candidate' projects, including:
I. The 'patient safety dashboard', which has been spread from a small QI project at Barnet Hospital to wards across Royal Free and Chase Farm hospitals;
II. The 'Mouthcare' QI project, which has led to a change in equipment and process in nursing care across the group.

The capability development required to implement our approach to 'scale and spread' was finalised and [training] delivered, during autumn 2022 to the first cohort 'QI Practitioners' (as part of the 2022/23 QI Expedition programme). This training module evaluated well and will be a core part of the Trust's QI curriculum going forwards, including the updated offer for Senior Leaders.

A more comprehensive update on this work will be provided in the Quality Account Annual Report.</td></tr>
<tr><td>7. Over the next year the Clinical Practice Group (CPG) programme will embed a further 17 pathways and</td><td>We will have 54 CPG pathways completed, 44 of which will be built within our EPR.</td></tr>
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develop a training package to increase knowledge, skills and capabilities across operational and clinical teams. NEW This priority supports delivery of our year one quality goal to improve health outcomes across the group	We will work on developing an end-to-end patient care pathway across the integrated care system which targets existing health care inequalities whilst making sure every contact counts. We will give priority to improving emergency flow, elective recovery, cancer care and inpatient enhanced recovery pathways. We will monitor the safety and quality of diabetes care through the digital pathway for inpatient adult diabetes patients.

64 clinical pathways across all the hospital site of which 40 are digitised the plan by the end of December 22 there will be 44 digitised with 24 will have a full measurement plan the remaining 20 will have an adoption report. 71% of admitted activity related to a CPG.

		Digitised Pathway Phase 1	Status
Year 18-20	1	Hip	Live
	2	Knee	Live
	3	Non-complex RUQP	Live
	4	Haematuria	Live
	5	EPU	Live
	6	Wheezy Child	Live
	7	Chest Pain	Live
	8	Upper GI	Live
	9	Pneumonia - Ambulatory SDEC	Live
	10	Heart Failure	Live
	11	Hot Gallbladder	Live
	12	Pulmonary Embolism - Ambulatory SDEC	Live
	13	Virtual Fracture Clinic - Ambulatory	Live
	14	Pre-operative Assessment	Live
	15	Telederm	Live
	16	KMBT	Live
	17	Anaemia	Live
	18	Prostate	Live
	19	Induction of Labour	Live
	20	Lower GI	Live
	21	Lung	Live

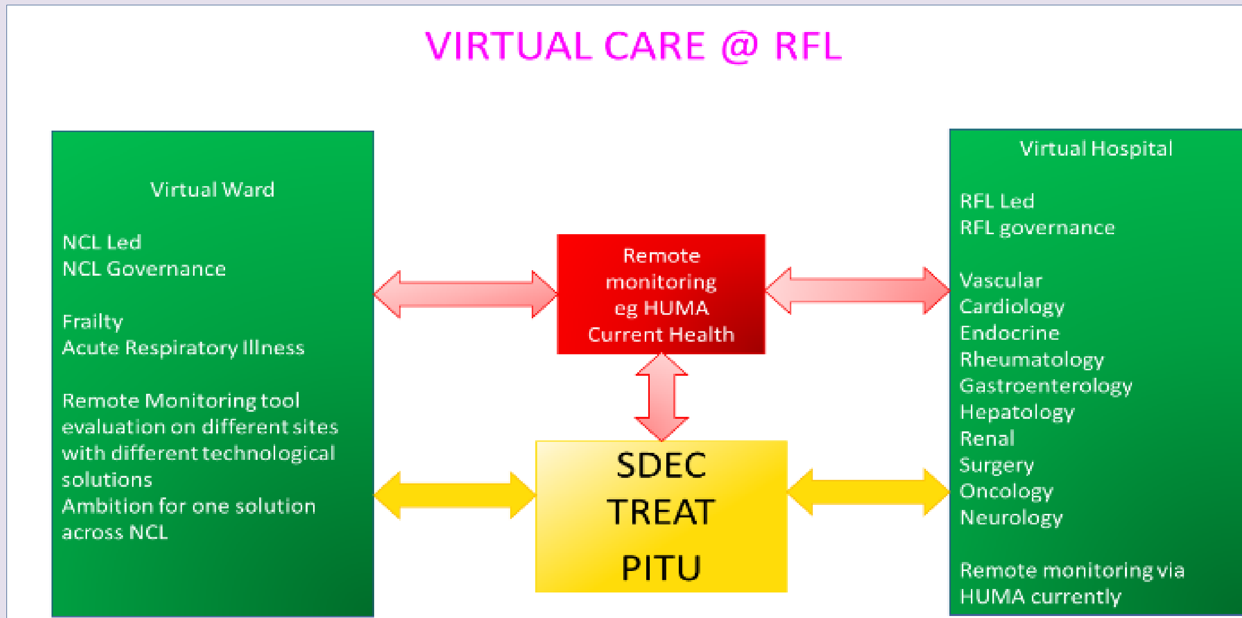
		Digitised Pathway Phase 2	Status
Year 20-21	22	HPB Cancer	Live
	23	Shoulder	Live
	24	Gynaecology Cancer	Live
	25	Haematuria (post-diagnostic)	Live
	26	Hyperemesis - Ambulatory Pathway SDEC	Live
	27	Skin Cancer	Live
	28	Surgical Management of Misscarriages	Live
	29	Kidney Stones	Live
	30	Arthroscopy - Knee	Live
	31	Arthroscopy - Shoulder	Live
	32	Ambulatory DVT - SDEC	Live
	33	Fractured Femur	Live
	34	Anaesthetic review pathway on day of surgery	Live
	35	RDC (regional diagnostic centre) STT	Live
	36	Perioperative - Complex POA	Live
Year 21-22	37	Diabetes	Live at barnet
	38	Nephrectomy Renal ERAS Protocol	Live
	39	Prostate	Live
	40	Better Birth	Live
	41	Breast	Live
	42	Renal Transplant ERAS Protocol	Live
	43	Emergency Laparotomy	Live
	44	Diabetes and Prostate optimisation	Live
	45	**Renal Cancer**	**Development In Progress**
	46	**Caesarean sections**	**Development In Progress**

Heart failure CPG pathway is an example of an integrated pathway which we are working across Royal Free and Barnet Hospitals with the local primary care providers showing:

- Major reduction in time to blood test for testing of heart strain from 1000 minutes to 100 minutes at RFL
- Very high alignment of Royal Free and Barnet sites for evidence-based prescriptions for heart failure therapies above national average for all 4 therapy groups by significant margins
- 320% and 600% increase in referrals for heart failure input since electronic pathway switched on at Barnet and Royal Free; average weekly referrals ~52 and ~60 respectively
- Consistently lower in-patient and 365-day mortality rates compared to national average in 2021
- Royal Free and Barnet data available in real time, whilst national rates likely to rise post pandemic won't be available till next year
- Downstream work on novel insights for frailty and mortality predictions in heart failure

Admission Avoidance and Virtual Care to improve emergency flow
Development of virtual care models both in the community and as extension of the hospital are being discussed in this workstream. The scope includes all hospital sites including Clinical partners to develop a potential solution

in EPR to accurately tack patients and activity. Below is a high-level overview of the work we are undertaking at RFL.

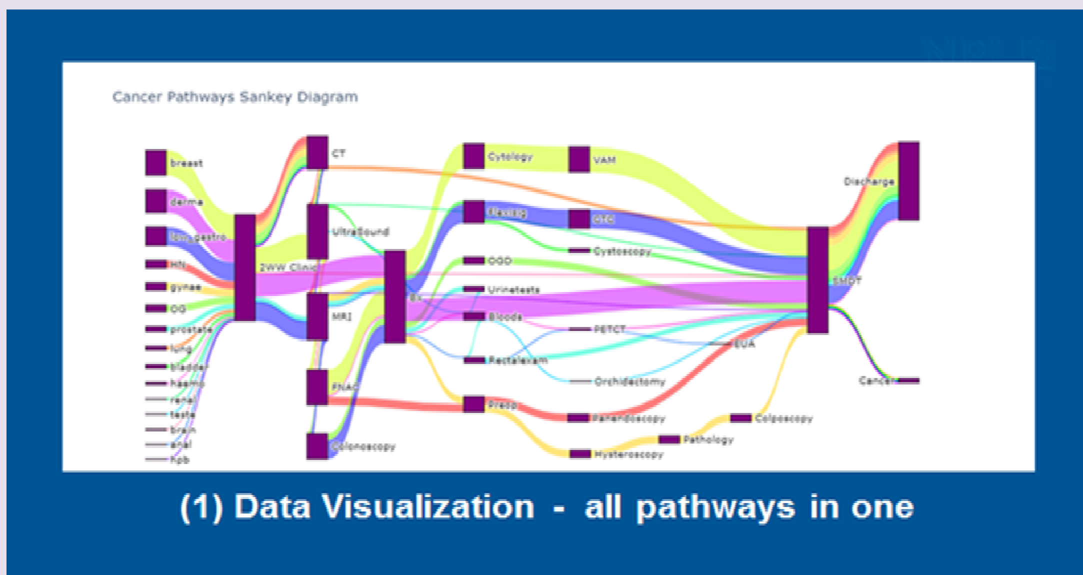


Cancer Care
The Cancer CPG is currently working with a focus on cancer recovery utilising CPG methodology.

There is a focus on cancer pathway re-design for Lower GI, Skin and Prostate as per the elective recovery guidance from NHSE/I on tier one and tier two providers. This requires meeting the milestones outlined in the Best Practice Timed Pathways for these tumour sites.

There is a key focus on productivity interventions such as outpatient clinic re-design and digital pathway adoption as well as outlining diagnostic requirements for key tumour sites.

We are maximising the opportunity to harmonise and optimise the straight to test and one stop capability across all tumour sites, to improve time to diagnosis and treatment.
In collaboration with the National Physical Laboratory utilising expert mathematical modelling capability the optimal resource allocation for cancer pathways in relation to access standards has been identified., We aspire to embed this type of analysis is all our CPG work.



Additionally, two new cancer CPG pathways have been established to focus on oncological treatment pathways. These are the Systemic Anti-Cancer Treatment (SACT) CPG and Radiotherapy CPG.

To support complex patient going for surgery we have developed a complex perioperative MDT referral and MDT into the preoperative pathways within which we have also embedded referrals to the pain team and rehabilitation team to optimise all surgical patient prior to surgery.

Safety and reduction in risk of harms caused to adults who have diabetes will be achieved at RFL by reducing unwarranted variation in and improving:
1. Timeliness of identifying patients presenting to RFL who have diabetes.
2. Triggering and delivery of agreed diabetic care packages
3. Follow up arrangements
4. What patients tell us about suitability & timing of meals, staff knowledge of diabetes, ability to self-monitor and self-administer insulin

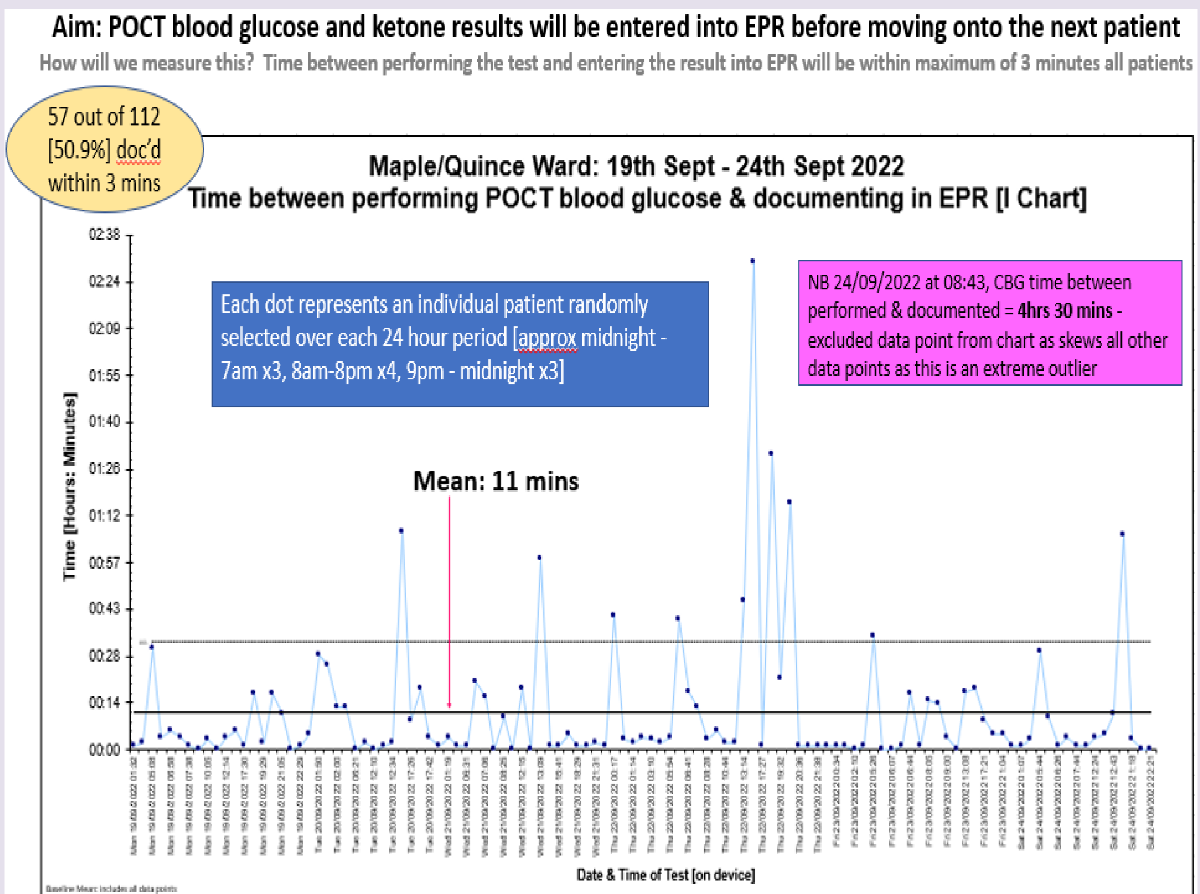
Some early learning from the new EPR diabetes pathway includes:

- Knowledge of clinical content of hypo & hyper pathways (nursing & medical staff) underpins adoption of EPR design
- Digital designs needed to make life easier and be intuitive combined with local clinical leadership, consistent and persistent reinforcement, and real time feedback
- Interventions used to launch the EPR diabetes pathway include Ward Champions – only nurses to date; due to medical rotas – more challenging but essential
- 1:1 training; Standing item on nurse morning huddle agenda
- Audit and real time feedback of adoption
- Posters in doctor’s offices; Training video (16 mins long) circulated

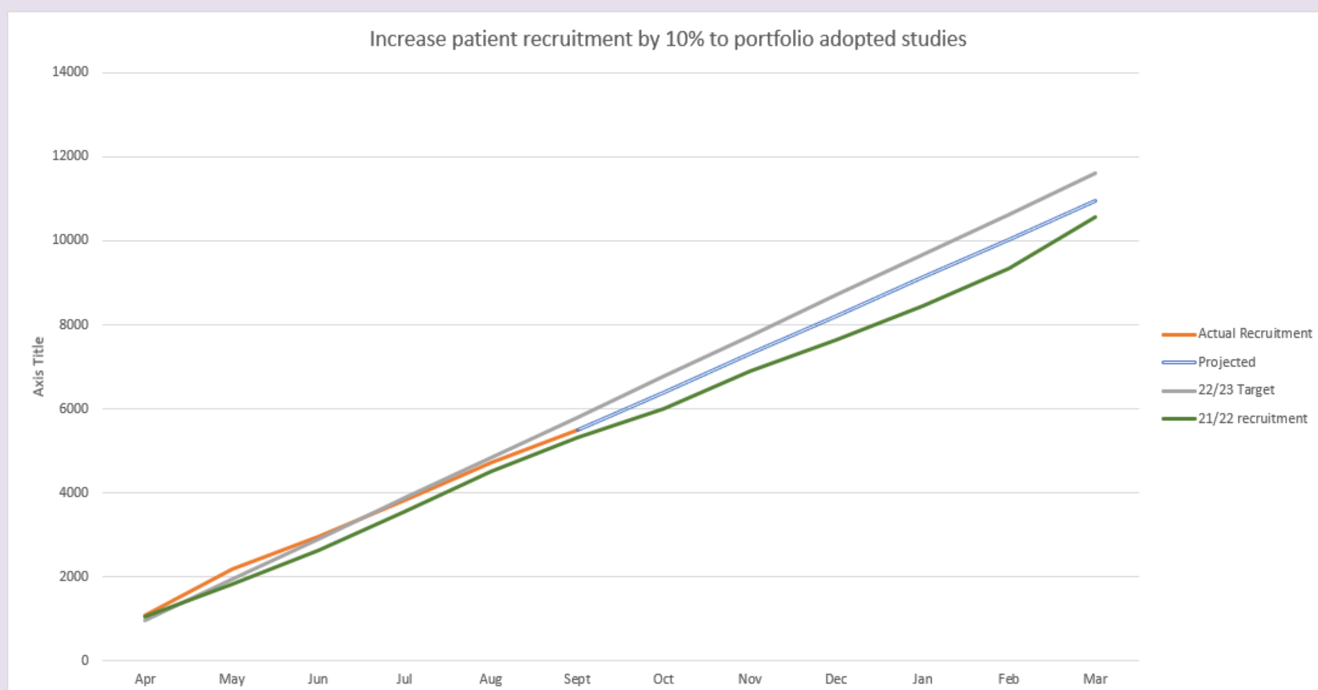
Chart below is an example of early signs of improvement

Baseline: 18.5 mins

After 3 weeks, weekly average: 11 mins



8. Increase patient recruitment by a further 10% into National Institute for Health Research portfolio to build on achievements of 2021/22 and increase RFL led research NEW This priority supports delivery of our year five ambition to provide access to research for all our patients *The measures for success detailed in the adjacent column are the strategic objectives of the 5-year Clinical Research and Development strategy and the intention is to achieve them all by 2027 and establish RFL as a top-10 NHS research hospital	We will provide rapid, responsive, cost effective and transparent clinical research support. We will improve clinical research infrastructure to enable the best possible clinical research opportunities and experience to staff/ patients. We will ensure all of our staff have the opportunity to be part of clinical research regardless of their role or site. We will ensure optimal and equitable access to excellent clinical research to all patient groups across our local populations. We will work with our partners to maximise the opportunities for clinical research for RFL patients and staff. We will ensure that digitally enhanced and data driven clinical research is enabled throughout our clinical research endeavour.

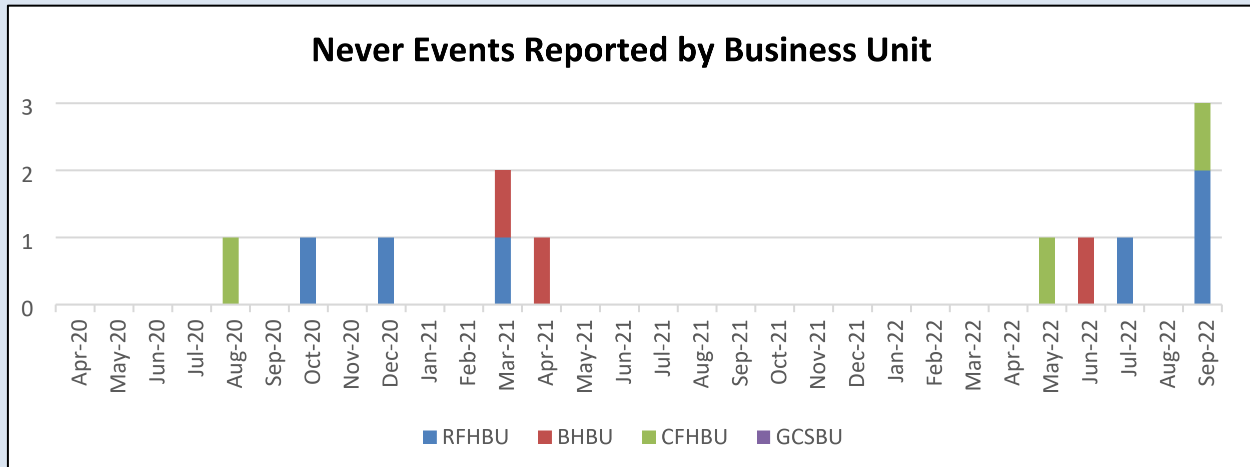


In terms of the target pertaining to increasing RFL led research, we are measuring this by the number of new RFL sponsored studies and unique Chief Investigators (CIs). Progress here is shown in the table:

Year	Number of sponsored studies opened (those currently in set-up shown in brackets)	Number of unique CIs (for studies in set-up shown in brackets)
21/22	12	11
22/23	4 (20)	4 (18)

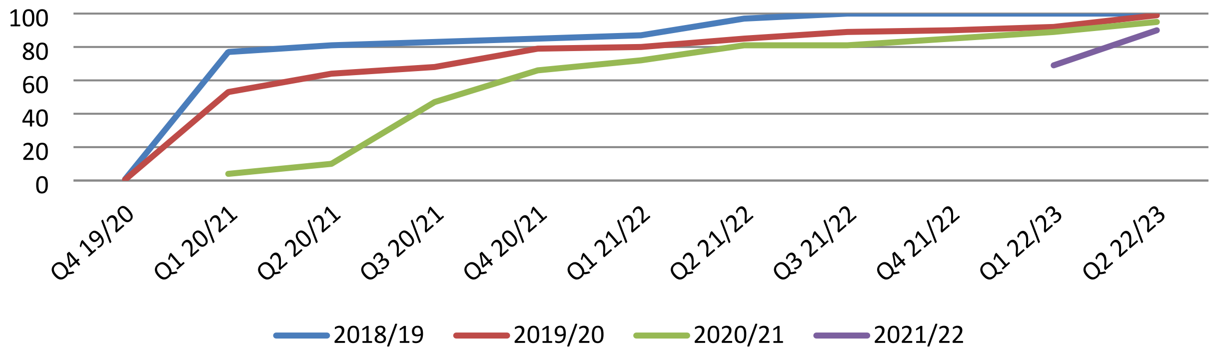
Patient Safety	
Our quality priorities and why we chose them:	**What success looks like:**
9. As part of the RFL Safety Strategy 2020-2025 to make improvements and to keep patients and staff safe, we will aim to have zero never events this year and ensure that we learn from patient safety incidents **NEW** This priority supports delivery of our year one quality goal to improve health outcomes across the group	We will do this through implementation of the new national Patient Safety Incident Response Framework and ensuring smooth transition to the new processes across the organisation by June 2023. We will embed a culture of learning from incidents through ensuring that 95% of Serious Incident actions are completed and evidenced by the deadline. We will improve our completion rate of open incident investigations. We will appoint a minimum of two 'patient safety partners' by July 2022 and ensure that they are fully trained by July 2023.

During Q1 and Q2 2022/23, 6 Never Events have been declared, whilst the incidents resulted in no or low harm to the patients the trust takes Never Events seriously and a full investigation is undertaken. Never Events are largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place.

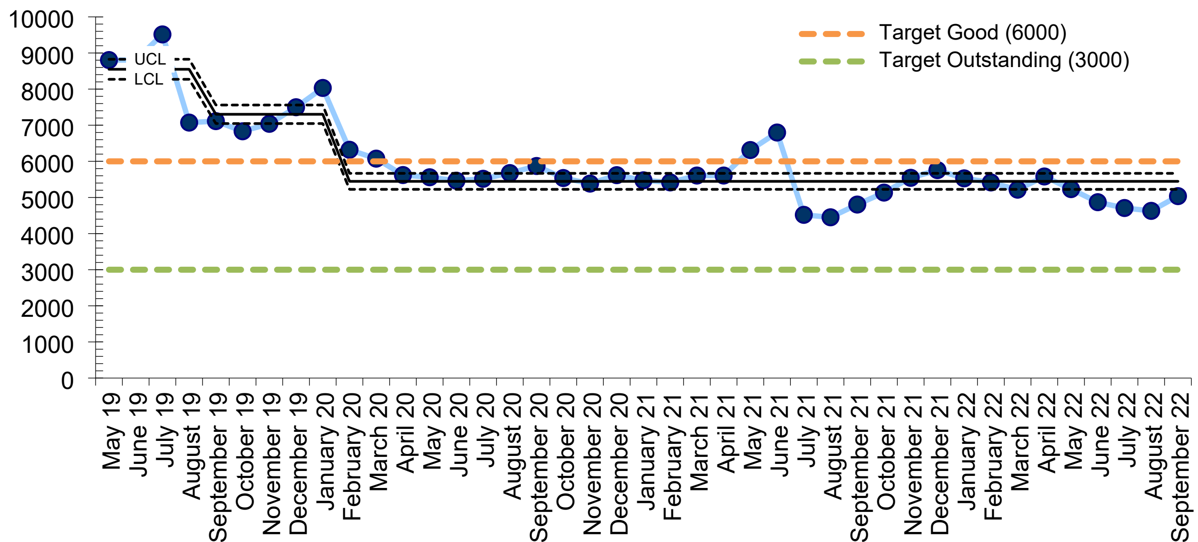


A never event summit is being held in December 2022 to share learning and look at ways to prevent further occurrences.

Actions from serious incidents are monitored by each Business Unit and through a quarterly action plan monitoring report. There are currently 241 open actions (including actions from 2022/23 serious incident reports) and the trust has completed 89% of actions, improving towards our target of 95%.



The number of open incidents are monitored in a monthly incident reporting metrics report, it is accepted that some incidents will be within this period and so a target has been set for good (6,000 open incidents) and outstanding performance (3,000 open incidents). During Q1 and Q2 of 2022/23 the average number of open incidents was 5,009 which is below the good target.



The national Patient Safety Incident Response Framework (PSIRF) was published in August 2022, following delays. There is a 12 month implementation requirement, which is now September 2023.

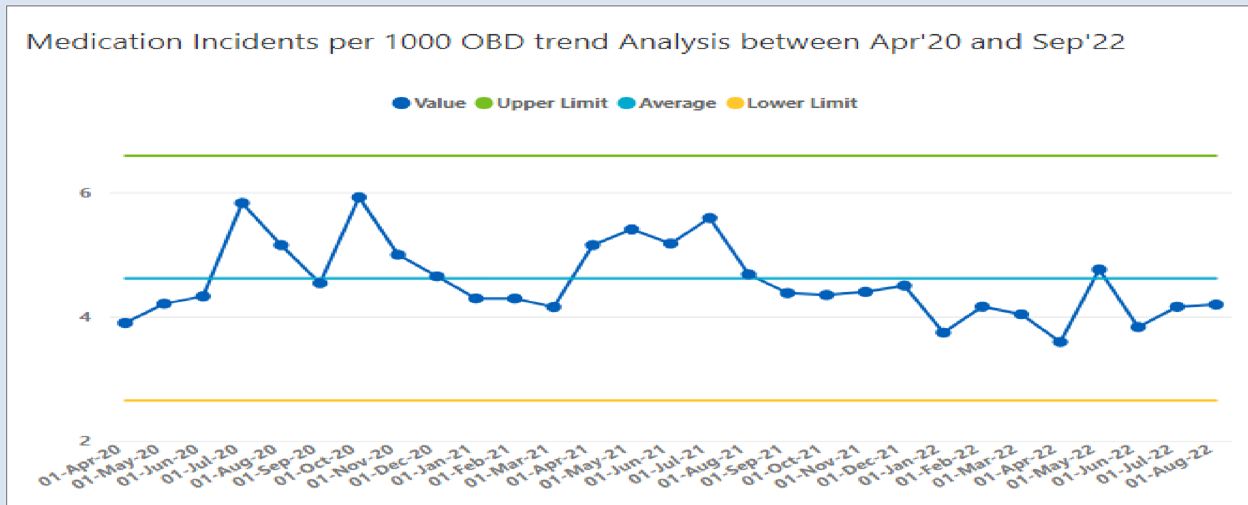
An implementation team has been set up and are working with NCL ICB to develop our policy and procedures to prepare for the transition next year. Briefings to CPPS, GEMM and CSIC have been completed as part of the start of the communication.

The deadline for appointing Patient Safety Partners has been extended, the Trust has currently advertised the role and has received a number of applications with interviews in November 2022. The new patient safety partners will receive training and also provide feedback on the PSIRF implementation.

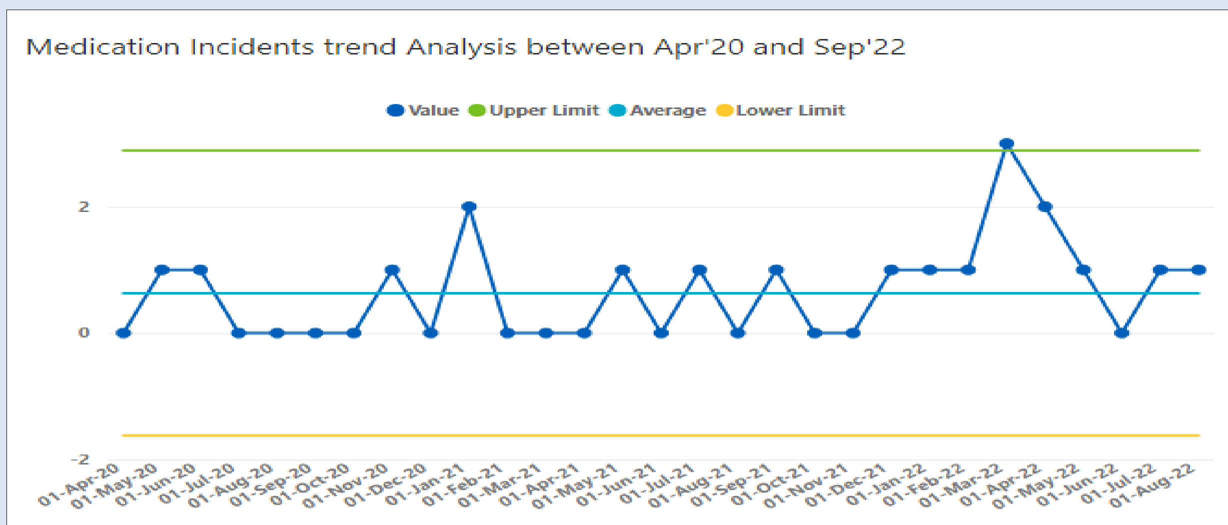
10. Improve medicines optimisation ensuring the right patient gets the right medicine at the right time **NEW**	We will reduce medicines-related problems at transfer including admission to hospital, discharge from hospital and during internal transfer through improved use of EPR.

This priority supports delivery of our year one quality goal to understand and improve the experience for our patients and carers	The Medical Safety Board will nominate a few time critical medications to reduce the missed doses as a measure of success.

The patient safety and risk department has worked with the trusts informatics department to develop a dashboard reporting tools, of which medication incidents are included. The graph below displays the rate of medication incidents per 1,000 bed days, the average for Q1 and Q2 2022/23 was 4.11.



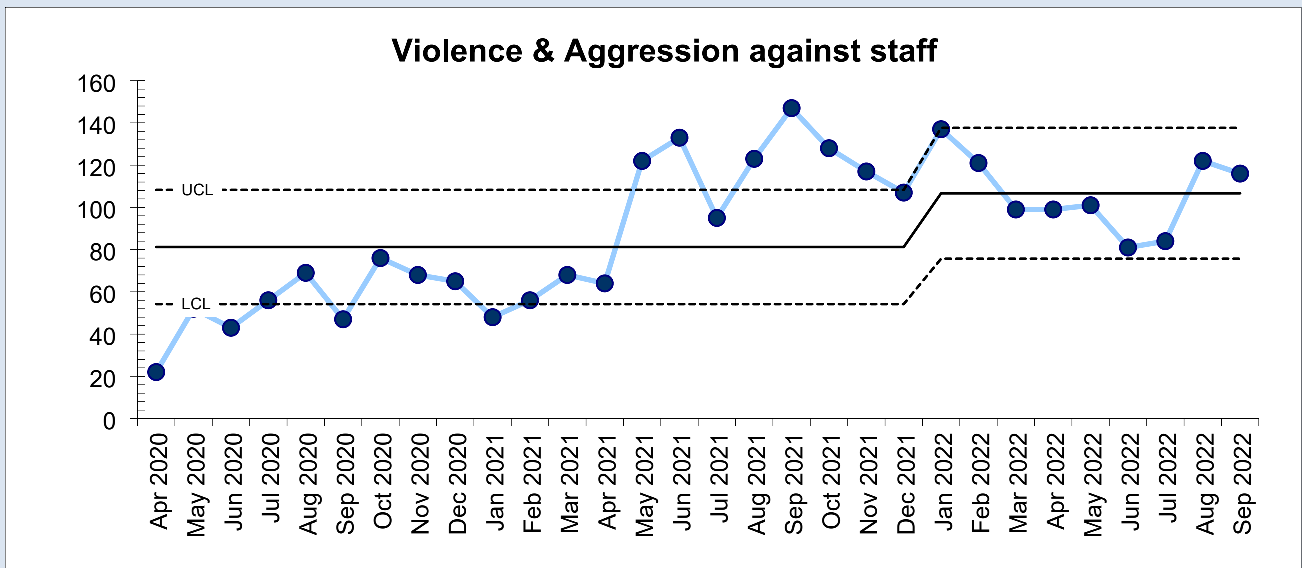
The graph below displays the number of moderate plus medication incidents, of which there was an average of 1 incident per month during Q1 and Q2 2022/23.



11. Improve the way in which we manage violence and aggression from patients NEW This priority supports delivery of our year one quality goal to support staff members' mental health and wellbeing	We will ensure staff who are in patient-facing roles receive conflict resolution training and are offered appropriate support following any incidents of violence and aggression. We will ensure all staff who are involved in patient restraint roles have a complete understanding of safe restraint techniques, the legal frameworks and legislation that applies to its use.

Of 9112 staff required to complete Conflict Resolution training as of Sept 2022 82.59% have completed the training. Additional face to face training is planned to increase the number of staff who have completed this. Staff are offered support following an incident by line managers, debriefing and via the employee assistance program.

An average of 101 incidents of violence and aggression against staff were reported during Q1 and Q2 2022/23, this is displayed in the graph below. An increase in reporting of violence and aggression incidents can be seen during August (122) and September (116), this increase represents better reporting of total incidents following Quality Improvement projects in a number of departments which identified significant under reporting of incidents.



12. Achieve zero trust attributed Methicillin-resistant Staphylococcus aureus bacteraemia (MRSA) cases
Continue from 21/22

This priority supports delivery of our year one quality goal to improve health outcomes and patient safety across the group

We will do this through continuing to action recommendations from the Trust Infection Prevention and Control Committee (IPCC) including:

- Post Infection Reviews (PIR) to be carried out to identify and act on key areas of improvement
- Implementing an education and training plan to improve line care practice

There have been three attributable MRSA bloodstream infection (BSI) since April 2022.

MRSA PIR were completed for all cases and identified the following learning:

- Non-compliant with mandatory MRSA admission swabbing
- Inadequate documentation online care
- Delay in informing the ward of the result
- Delay in starting decolonisation
- Suboptimal documentation of line insertion/care

Actions taken include:

- Improve staff compliance in swabbing admissions and documenting continuing care of cannula on EPR.
- Weekly MRSA screen for all patients on the ward in addition to the admission screen.
- Regular audits of hand hygiene, standard precautions, environment done by IPC team and ward staff.
- IPC conducted audits on MRSA admission screening compliance, documentation on 'Daily Cannula assessment/devices' and urinary catheter on EPR.

- IPC teaching sessions were provided regularly for all members of the Multidisciplinary team (MDT) including hand hygiene (Globox) training and MRSA management. Ward practice educator reviewed staff competencies for line care.
- Deep cleaning of the wards completed.
- Quality improvement project started on 9th August 2022 with aim of being "infection free" for all hospital-acquired infections. The 4 primary drivers identified were equipment, practice, cleanliness and hand hygiene. This initiative involves the MDT which are meeting weekly.

13. Achieve zero trust attributable Clostridium difficile (C. diff.) infection cases with a lapse in care Continue from 21/22 This priority supports delivery of our year one quality goal to improve health outcomes and patient safety across the group	We will do this through continuing to action recommendations from the Trust IPCC including: • Audits on commodes, mattress and pillows • Audit C. diff. knowledge and practice amongst staff • Revitalise the deep cleaning programme across all sites • Review of all cleaning audit reports at site divisional lead meetings • Root cause analysis (RCA) to be carried out in order to identify what changes would prevent reoccurrence • Develop robust and practical action plan with clinical team to reduce rates of C. diff. infection

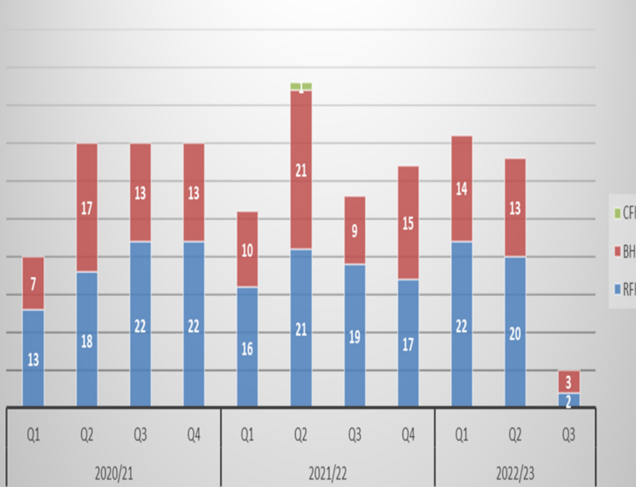
There have been 54 C. diff. (CDI) toxin cases attributable to RFL since April 2022. Cumulative total of 12 lapses in care identified since April 2022.

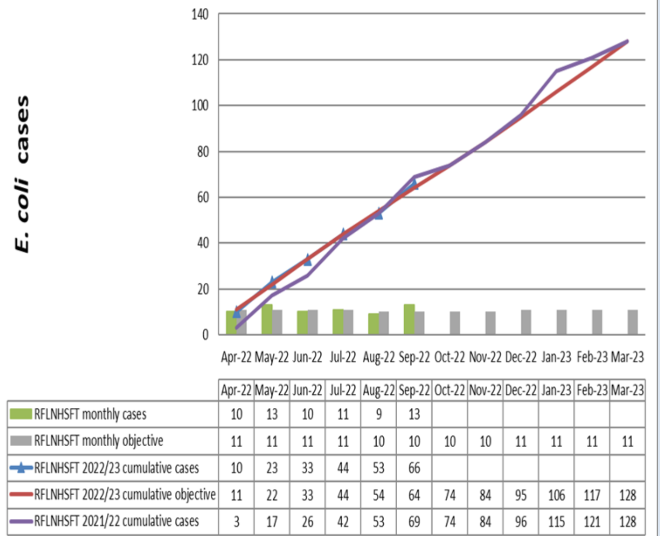
27 CDI cases were identified at RFH in Q2. Seven were reported from acute medicine, seven from medical speciality, three from cardiology and renal division, five from liver and digestive health, two from ICU, and three from private practice unit (PPU). 8 CDI cases were identified at BH in Q2. Four were reported from Medicine and urgent care (MUC) division and four in surgical associated services (SAS). One case was identified at Chase Farm hospital in Q2 from surgical associated services (SAS).

Root cause analyses (RCA) were initiated on all C diff cases and Datix completed. Learning and outcomes from the RCA were shared with the multidisciplinary teams involved (MDT). IPC supportive measures were implemented, and weekly outbreak meetings were held in areas where 2 or more cases were identified. The IPC roadshow held focusing on management of diarrhoea and hand hygiene to raise staff awareness and knowledge. Regular audits of hand hygiene, environment, standard precautions and stool chart documentation were done by IPC team and ward staff. IPC team also held ad hoc teaching sessions during audits.

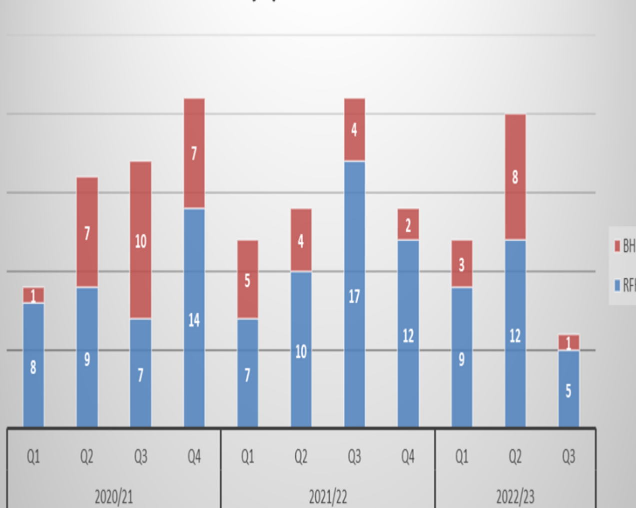
14. Reduce Gram negative bacteraemias in line with NHS Long Term Plan objective of 50% by 2024/25 Continue from 21/22 This priority supports delivery of our year one quality goal to improve health outcomes and patient safety across the group	We will do this through continuing to action recommendations from the Trust IPCC including: • Regular audits and teaching to monitor practice compliance • PIR to be carried out to identify and act on key areas of improvement • Implementing education training plan to improve line care practice

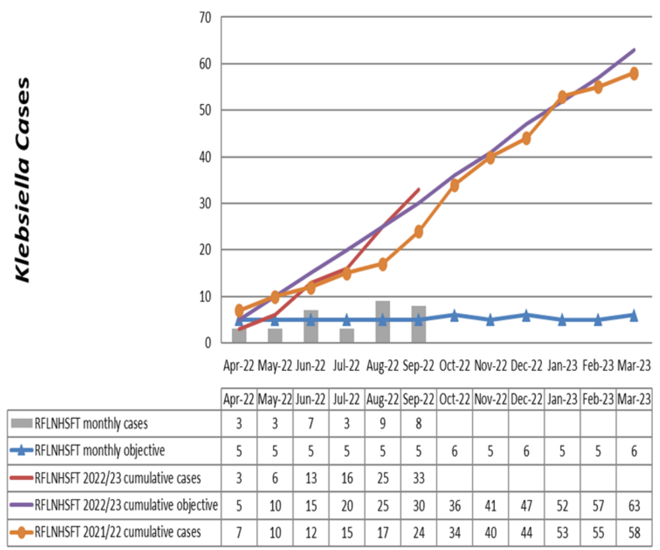
E.coli blood stream infection (BSI), 2 cases above Q2 threshold of 31. Klebsiella blood stream infection (BSI), 5 cases above Q2 threshold of 15. Pseudomonas blood stream infection (BSI), one less case against Q2 threshold of 11. (See charts below)



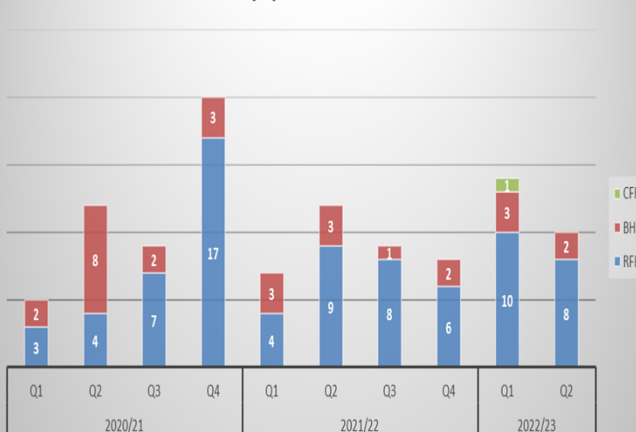


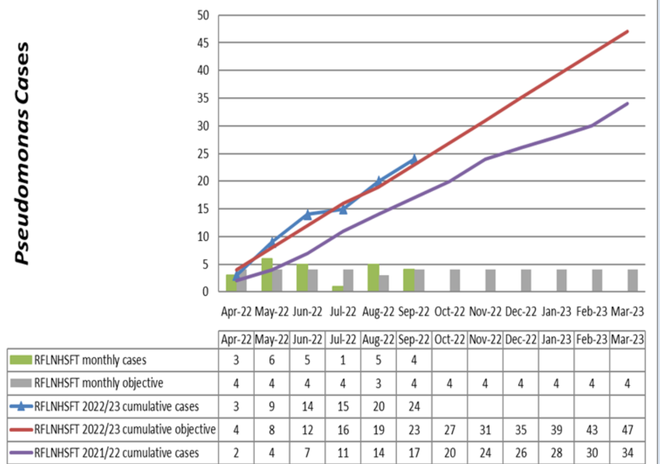
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
RFLNHSFT monthly cases	10	13	10	11	9	13						
RFLNHSFT monthly objective	11	11	11	11	10	10	10	10	11	11	11	11
RFLNHSFT 2022/23 cumulative cases	10	23	33	44	53	66						
RFLNHSFT 2022/23 cumulative objective	11	22	33	44	54	64	74	84	95	106	117	128
RFLNHSFT 2021/22 cumulative cases	3	17	26	42	53	69	74	84	96	115	121	128





	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
RFLNHSFT monthly cases	3	3	7	3	9	8						
RFLNHSFT monthly objective	5	5	5	5	5	5	6	5	6	5	5	6
RFLNHSFT 2022/23 cumulative cases	3	6	13	16	25	33						
RFLNHSFT 2022/23 cumulative objective	5	10	15	20	25	30	36	41	47	52	57	63
RFLNHSFT 2021/22 cumulative cases	7	10	12	15	17	24	34	40	44	53	55	58





	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
RFLNHSFT monthly cases	3	6	5	1	5	4						
RFLNHSFT monthly objective	4	4	4	4	3	4	4	4	4	4	4	4
RFLNHSFT 2022/23 cumulative cases	3	9	14	15	20	24						
RFLNHSFT 2022/23 cumulative objective	4	8	12	16	19	23	27	31	35	39	43	47
RFLNHSFT 2021/22 cumulative cases	2	4	7	11	14	17	20	24	26	28	30	34