# RFH Quality Accounts 2012/2013

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## PART 1
## INTRODUCTION AND STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

It once again gives me great pleasure to introduce the Royal Free's quality accounts, designed to assure commissioners, patients and our local population that we provide the highest level of clinical care and continuously seek to improve what we do.

This year has been our first year as a foundation trust (FT) and I am pleased to report that we ended the year meeting all but one of the quality objectives set for FTs. We did not achieve our goal to have 42 or fewer *clostridium difficile* (C diff) infections during the year, instead reporting 50 infections. We routinely undertake in-depth reviews of all these infections and in all but a few cases we know that the correct clinical approach was taken.

As a Foundation Trust we are now governed by our council of governors and we spent the past year working with our governors to identify the areas in which they wished to prioritise their attention. They have elected to focus on patient transport, patient discharge arrangements, the fractured neck of femur pathway and making improvements to staff facilities.

The recent report by Robert Francis QC concerning the care delivered at Mid Staffordshire NHS Foundation Trust has made us reflect once again on how we ensure that high quality patient care is at the centre of everything we do. This account contains many examples of our approach to clinical quality, but during the next few months the trust board will be considering further our response to the Francis report.

We can be proud of our many achievements over the past year. Our hospital standardised mortality rate continues to be among the lowest in the country. As promised in last year's quality accounts, we launched our world class care programme designed to improve patient and staff experience. More than 1,600 attended the launch of the programme and during the year over 3,300 participated in world class care events. We continue to promote public health and launched a programme to improve care for our patients who are homeless.

During the next year we will continue our mission to deliver world class care and expertise. We are particularly excited about the forthcoming opening of the first phase of the Institute of Immunity and Transplantation which we have developed jointly with our academic partner UCL. Providing modern co-located research and clinical facilities, the Institute will ensure we provide world class care to many of our most complex patients.

I believe the evidence provided in these quality accounts demonstrates our continuing commitment to providing the highest quality clinical care. I confirm that to the best of my knowledge the information provided in these quality accounts is accurate.

**David Sloman**

**Chief executive, Royal Free London Foundation Trust**

## PART 2
## OUR QUALITY PRIORITIES FOR 2013/14

Our mission to provide world class care and expertise reflects our desire to always provide the highest quality service to our patients. Each year we set three quality improvement priorities that are monitored by the trust board. One focuses on patient experience, one on clinical effectiveness and one on patient safety.

As in previous years, we sought the views of our patients, staff and local community to help set our three quality improvement objectives for 2013/14. We invited representatives from our commissioners, local LINKs and local councils to events where we were able to discuss quality priorities. We asked for input from our clinical teams and our governors. We asked our members to participate in an online survey and approximately 200 gave their opinion of what our quality priorities should be. The trust board then considered the responses we received and agreed the following three priorities for 2013/14.

### Priority 1: World class care

Over the past two years we have worked with patients and staff to develop our world class care values. In 2012/13 we delivered a bespoke programme of training to multidisciplinary teams across the organisation, supporting them to identify how our values can be embedded so that our patients consistently receive world class care as well as articulating the support they require from the trust to do this.

We have continued to engage with and learn from our patients and trust members through programmes of focus groups, open forums and by encouraging patients to participate in groups such as our equal access group, our safeguarding board as well as joining trust inspections reviewing the clinical environment.

We have completed a world class ward project focusing on measurable achievable improvement work, delivered through effective and proactive leadership and superb team work. The aim of this programme was to achieve

improved patient experience, reduce harm, enable quality pathways, and support effective resource management. These programmes of work have been supported by embedding our world class care values into the policies, procedures and training which we use to recruit, induct and manage our staff.

In 2013/14 we will be continuing to focus on our mission to provide world class care to our patients. We will look at the outcomes of our world class ward programme and identify themes that can be shared across a wider range of clinical settings to support better teamwork and improve patient care. We will continue to deliver development activities to our staff, ensuring that world class care remains central to the way we deliver our services and will seek to link these to emerging themes in healthcare, such as the trust response to the Francis report.

**Our specific aims are to:**

- Identify and share learning from the world class ward programme
- Continue our work around supporting teams to consistently deliver world class care through the delivery of core and bespoke development programmes, integrating these with our response to the Francis report and the minister for health's requirement to conduct listening events with staff
- Maintain and develop our programme of engagement activities with patients and the public, ensuring that the voice of our service users is central to our business

This priority is in the area of patient experience.

**Priority 2: Continue to develop our clinical outcome measures**

Over the past three years we have developed a set of clinical outcome metrics (measurements) for all our clinical specialities. Last summer we published the full list of metrics on our external website, and since then we have undertaken further work on this project. We report on progress in section three.

This year we considered choosing another project as our clinical performance quality priority, but our stakeholders told us that they valued the work we had undertaken on metric development and wished us to continue with this work. Furthermore, the NHS has increased its focus on clinical outcome

measurement. For example, national consultant level outcome metrics are due to be published in several surgical specialities this summer. In a recent report commissioned by the Secretary of State for Health, the Nuffield Trust[1] highlighted the importance of speciality level outcome metrics, observing:

*…quality of care for patients is delivered at more of a service level, for example in departments or specialities or wards. Thus service-level information on quality has much more potential to engage clinical staff...*

During next year we will therefore continue our work on clinical performance metrics.

Our specific aims are to:

- Appoint an associate medical director for clinical performance. As we note in section three, we have not been able to progress this project as rapidly as we would like. The appointment of an associate medical director whose specific role is to develop the clinical performance metrics will address this.

- Complete the publication of current data for all our speciality level metrics.

- Continue the work within our academic health science partnership, UCL Partners, to develop common clinical outcome metrics that we can use to compare performance between organisations.

- Begin the development of patient defined clinical performance metrics. We developed our initial set of metrics by asking our clinicians what they thought we should measure. We know healthcare institutions that have worked with their patients to develop additional metrics which specifically describe outcomes from a patient perspective and wish to do the same.

[1] Rating providers for Quality; a policy worth pursuing? The Nuffield Trust. 2013

This priority is in the area of clinical outcomes and is monitored by our clinical performance committee.

**Priority 3: Launch a trust wide patient safety programme**

Five years ago the trust participated in the Safer Patient Initiative (SPI), a patient safety campaign that focused on five core work streams to reduce harm using continuous quality improvement methodology. These included leadership, perioperative care, ward communication, medicine safety and infection prevention. This led to a number of changes now become embedded in the trust, such as our infection control measures.

We now wish to launch a follow-up patient safety programme building on the initial work we undertook in the SPI project. We will focus on key areas of patient safety that have arisen from our analysis of clinical incidents occurring within the trust. This was done by analysing patient complaints, national guidance and from discussion with our stakeholders, including patients and governors. Our initial analysis has suggested that the programme will include the following themes:

- Patient handover
- Medication errors
- Documentation
- Surgical safety

In addition the programme will incorporate some of our established improvement work:

- Infection control
- Enhanced early recognition and management of sepsis
- Nasogastric tube placement
- Patient falls prevention
- Pressure ulcer prevention
- Venous thromboembolism prevention

The safety campaign will complement our World Class Care programme which is aimed at improving patient and staff experience.

This priority is in the area of patient safety.

## STATEMENTS RELATING TO THE QUALITY OF NHS SERVICES PROVIDED BY THE ROYAL FREE NHS FOUNDATION TRUST

This section contains eight statutory statements concerning the quality of services provided by the Royal Free NHS Foundation Trust. These are common to all trust quality accounts and therefore provide a basis for comparison between organisations.

Where appropriate, we have provided additional information that provides a local context to the information provided in the statutory statement.

## STATEMENT ONE: REVIEW OF SERVICES

**Up to month 11 – month 12 to follow**

During 2012/13 the Royal Free London NHS Foundation Trust provided 24 NHS services.

The Royal Free London NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these services.

The income generated by the NHS services reviewed in the 2012/3 represents 96% of the total income generated from the provision of NHS services by the Royal Free London NHS Foundation Trust for 2012/13.

## ADDITIONAL INFORMATION

In this context we define each service as a distinct clinical directorate that is used to plan, monitor and report clinical activity and financial information – this is commonly known as service line reporting. Each individual service line can incorporate one or more clinical services.

Clinical directorates routinely monitor demand and output data for all services and in aggregate this includes various quality measures. Few services are

assessed as an isolated entity. Some very specialised services are routinely reviewed as part of the national commissioning group's processes.

**STATEMENT TWO: PARTICIPATION IN CLINICAL AUDIT**

During 2012/13, 39 national clinical audits and two national confidential enquiries covered NHS services that the Royal Free London NHS Foundation Trust provided.

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

The national clinical audits and national confidential enquiries in which the Royal Free London NHS Foundation Trust was eligible to participate during 2012/13 are indicated in the table below.

The national clinical audits and national confidential enquiries in which the Royal Free London NHS Foundation Trust participated, and for which data collection was completed during 2012/13, 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.

| National Clinical Audits for inclusion in Quality Accounts 2012/13 | Data collection completed in 2012/13 | RFL eligible to participate | RFL participated in 2012/13 | Rate of case ascertainment (%) |
|---|---|---|---|---|
| National diabetes audit | √ | √ | √ | 94% |
| National inpatient diabetes audit | √ | √ | √ | 106* cases |
| National elective surgery patient reported outcome measures (PROMs): four operations | √ | √ | √ | 97% |
| Adult cardiac interventions: National Institute for Cardiovascular Outcomes Research | √ | √ | √ | 100% |

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| (NICOR) coronary angioplasty | | | | |
| Myocardial ischaemia national audit project (MINAP): Acute myocardial infarction and other ACS | √ | √ | √ | 100% |
| National heart failure audit | √ | √ | √ | 100% |
| The Trauma Audit & Research Network (TARN) : severe trauma | √ | √ | √ | 94% |
| Renal registry: renal replacement therapy | √ | √ | √ | 100% |
| NHS Blood & Transplant (NHSBT): renal transplants | √ | √ | √ | 100% |
| NHS Blood & Transplant: potential donor audit | √ | √ | √ | 108% |
| College of Emergency Medicine: ureteric colic | √ | √ | √ | 50 cases (100%) |
| College of Emergency Medicine: fractured neck of femur | √ | √ | √ | 50 cases (100%) |
| College of Emergency Medicine: paediatric fever | √ | √ | √ | 50 cases (100%) |
| Royal College of Paediatrics and Child Health (RCPCH) national paediatric diabetes audit | √ | √ | √ | 100% |
| British Thoracic Society (BST): paediatric asthma | √ | √ | √ | 13* cases |
| UK carotid intervention audit | √ | √ | √ | 17* cases |
| National joint registry | √ | √ | √ | 97% |
| British thoracic society (BTS): adult asthma | √ | √ | √ | 21 cases (100%) |
| Cardiac rhythm management | √ | √ | √ | 100% |
| National hip fracture database | √ | √ | √ | 100% |
| BTS: paediatric pneumonia | √ | √ | √ | 20 cases (100%) |
| National neonatal audit | √ | √ | √ | 100% |

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| Vascular Society of Great Britain and Ireland (VSGBI): vascular surgery database | √ | √ | √ | 447 cases (c.90%) |
| Intensive Care National Audit and Research Centre (ICNARC) case mix programme database (CMPD): adult critical care | √ | √ | √ | 100% |
| Sentinel stroke national audit programme (SSNAP) | √ | √ | √ | 100% |
| National lung cancer audit | √ | √ | √ | 106% |
| National bowel cancer audit | √ | √ | √ | 84% |
| National oesophago-gastric cancer audit | √ | √ | √ | 100% |
| National comparative audit of blood transfusion: blood sampling and collection | √ | √ | √ | 541* cases |
| Inflammatory bowel disease (IBD): ulcerative colitis & Crohn's disease (adult) | √ | √ | √ | 17* adult cases |
| Inflammatory bowel disease (IBD): ulcerative colitis & Crohn's disease (paediatric) | √ | √ | √ | 6* paediatric cases |
| Parkinson's UK: national Parkinson's audit | √ | √ | √ | 30 cases (100%) |
| ICNARC: cardiac arrest | √ | √ | √ | 255* cases |
| BTS: bronchiectasis | √ | √ | √ | 25 cases (125%) |
| BTS: emergency use of oxygen | √ | √ | √ | 40 cases (1300%) |
| BTS: adult community-acquired pneumonia | √ | √ | √ | 53 cases (265%) |
| BTS: non-invasive ventilation | √ | √ | √ | 20 cases (100%) |
| National pulmonary hypertension audit | √ | √ | √ | 100% |

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| National audit of dementia | √ | √ | √ | 118% |
| National childhood epilepsy audit (Epilepsy 12) | X | n/a | n/a | n/a |
| National pain database: chronic pain services | X | n/a | n/a | n/a |
| Paediatric intensive care audit network (PICANet) | √ | x | n/a | n/a |
| Congenital heart disease | √ | x | n/a | n/a |
| Adult cardiac surgery | √ | x | n/a | n/a |
| NHSBT: cardiothoracic transplant | √ | x | n/a | n/a |
| Head and neck cancer audit | √ | x | n/a | n/a |
| Prescribing in mental health | √ | x | n/a | n/a |
| National audit of psychological therapies | √ | x | n/a | n/a |
| Total: | 46 | 39 | 39 | |
| Clinical outcome review programme (previously the national confidential enquiries and centre for maternal and child death enquiries): | | | | |
| National confidential enquiry into patient outcome and death (NCEPOD): alcoholic liver disease | √ | √ | √ | 100% |
| NCEPOD: subarachnoid haemorrhage | √ | √ | √ | 100% |
| NCEPOD: tracheostomy | X | √ | √ | Open |
| Child health review – UK | X | √ | √ | Open |
| National review of asthma deaths | X | √ | √ | Open |
| National confidential inquiry into suicides and homicides | X | x | x | - |
| Mothers and babies – reducing risk through audits and confidential enquiries across the UK (MBBRACE-UK) | X | √ | √ | Open |

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| perinatal mortality | | | | |

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| In addition, the Royal Free London NHS Foundation Trust participated in the following national audits by submitting data in 2012/13 |
| British association of urological surgeons: nephrectomy audit |
| British association of urological surgeons: surveillance and treatment of renal masses |
| Baseline survey of HIV perinatal, paediatric and young person's pathways |
| UK neonatal collaboration necrotising enterocolitis audit |
| British Association of Endocrine & Thyroid Surgeons: Thyroid and Parathyroid Audits |
| National audit of cardiac rehabilitation |
| Royal Free London NHS Foundation Trust reviewed the results of the following national audits and confidential enquiries which published reports but did not collect data in 2012/13 |
| NCEPOD: paediatric surgery: *too lean a service?* (Oct 2012) |
| NCEPOD: paediatric surgery: *time to intervene?* (Apr 2012) |
| College of Emergency Medicine: pain in children (Feb 2012) |
| College of Emergency Medicine: severe sepsis & septic shock (Feb 2012) |
| College of Emergency Medicine: consultant sign-off (Feb 2012) |
| National Comparative Blood Transfusion Audit: Medical Use of Blood (provisional report) |

Asterisks (*): Confirmation of percentage case ascertainment was not available from the national clinical audit provider in time for publication but we believe our contribution for these audits, marked by an asterisks to be 100%.

The reports (published in the calendar year of 2012) of 39 **national clinical audits** were reviewed by the provider in 2012/13 and Royal Free London NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

| **National clinical audit** | **Actions to improve quality of care** |
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| Community-acquired pneumonia | • Consider addition of severity scoring tool (CURB65) to admission documentation for patients with pneumonia to improve access to appropriate level of care. |
| Myocardial infarction | • Continue liaison work with local hospitals and London Ambulance Service to maintain and build on very high standards of access to primary angiography services for patients with heart attacks, including those with high-risk 'non-ST elevation' acute |

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| | coronary syndromes.<br>• Update integrated care pathways for chest pain, primary angiography and 'non-ST elevation' acute coronary syndromes. |
| Heart failure | • Devise a trust-wide heart failure integrated care pathway.<br>• Evaluate clinical value of greater access to specialist heart failure services, currently available to patients under care of cardiologists and acute physicians, for all patients with heart failure irrespective of reason for admission.<br>• Expand community heart failure clinic. |
| Cardiac rhythm | • Continue to improve identification of heart attack patients requiring implantable defibrillators and biventricular pacing devices.<br>• Consider business case for arrhythmia specialist nurse post.<br>• Appoint to additional specialist arrhythmia consultant post to contribute to complex arrhythmia and implanted device clinics. |
| Diabetes | • Develop intensive therapy pathway for management of patients with poorly-controlled diabetes.<br>• Improve documentation of 'essential care processes' for children with diabetes (eg eye and foot examination, and control of HbA1c, BP, cholesterol, creatinine, albumin). |
| Paediatric pneumonia | • Improve identification of the causative organism in children admitted with pneumonia. |
| Paediatric asthma | • Use the electronic doctor's handover system to generate automatic prompts to improve provision of written asthma plans for children admitted with asthma. |

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| Inflammatory bowel disease | • Introduce standardised documentation for clinical use at annual review of children with inflammatory bowel disease. |
| Neonatal care | • Implement national data collection tool for screening babies for retinopathy of prematurity.<br>• Implement UNICEF UK baby friendly initiative.<br>• Improve documentation of consultations between parent and consultants on the neonatal unit through repeat audit cycles. |
| National vascular database | • Explore use of cardiopulmonary exercise testing (CPEX) to improve risk stratification, perioperative planning, informed patient consent and access to appropriate levels of care (eg post-operative intensive care).<br>• Expand multi-disciplinary involvement in preoperative planning meetings to include anaesthetists, vascular theatre nurses and vascular clinical nurse specialists. |
| National hip fracture database | • Re-instate dedicated theatre time for hip fracture patients. |
| National joint registry | • Avoid use of metal-on-metal hip prostheses, following concerns raised by National Joint Registry data. |
| College of Emergency Medicine: severe sepsis | • Revise documentation to improve compliance with timely blood glucose measurement and recording of oxygen administration and urine output. |
| College of Emergency Medicine: consultant sign-off | • Consider possibility of automated prompts on Cerner for patients presenting with the listed conditions to be referred for consultant review. |
| College of Emergency Medicine: pain in children | • Review ‘front-end’ processes to ensure analgesia is considered and given at triage. |
| National potential donor audit | • Develop awareness of trust policy on organ and tissue donation. |

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| | • Specialist nurse for organ donation to attend the emergency department on daily basis and morning medical handover in ICU.<br>• Add prompt for referral to organ donation specialist nurse on End of Life pathway.<br>• Establish link nurse role for tissue donation in key clinical areas. |
| Renal registry | • Adopt change to management of anaemia to reduce use of erythropoietin in line with new evidence of risks.<br>• Adopt new target range for parathyroid hormone in line with KDIGO (kidney disease: improving global outcomes) guidelines. |
| Care of the dying | • Ensure regular consultant involvement in decisions regarding 'Do Not Attempt Resuscitation' and 'ceilings of care' and improve timing of regular review.<br>• Add spiritual care and bereavement care to mandatory training.<br>• Establish access to e-learning modules.<br>• Increase uptake of communication skills training.<br>• Establish Liverpool Care Pathway co-ordinator rotational post from within established Clinical Nurse Specialist team.<br>• Approve and appoint to Clinical Psychologist post in palliative care team, to meet NICE recommendations.<br>• Improve information for relatives and carers and their involvement in end-of-life decision-making, to support conversations between relatives/carers and staff and to support relatives/carers following bereavement.<br>• Continue to promote use of LCP pathway |

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| | as best practice model where it is established that the patient is in the last hours or days of life. |
| Oesophago-gastric cancer | • Review formal palliative care support for multidisciplinary meetings.<br>• Develop strategies for reducing emergency admissions through improvements to early diagnosis. |
| Falls and bone health | • Develop agreed fracture liaison service in Barnet and establish business case for same in Camden.<br>• Transfer falls service to triage, rapid elderly assessment and treatment service.<br>• Introduce additional clinics for investigation and treatment of the causes of falls.<br>• Appoint to new community geriatrician to improve education for residential and nursing homes. |
| Training needs identified from national audits | • Continence care in the elderly.<br>• Written asthma plans for children admitted with asthma.<br>• Use of specific documentation for children seen in A&E with fever.<br>• Potential organ donor identification and referral processes. |

The reports of 140 local clinical audits were reviewed by the provider in 2012/13 and the Royal Free London NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

| **Local clinical audit** | **Actions to improve quality of care** |
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| Venous thrombo-embolism (VTE) | • Change default timing of prescribed doses of pharmacological VTE prevention to facilitate compliance with recommended administration between 6 and 24 hours after surgery. |

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| Safe blood transfusion practice | • Consider need for additional automated blood pressure monitors in clinical areas with high transfusion rates. |
| **Accident & Emergency** | |
| Screening and management of alcohol disorders | • Add alcohol screening to patient assessment. Develop alcohol withdrawal pathway. |
| Diarrhoea and vomiting in children | • Improve compliance with established guidelines. |
| Children with head injuries | • Improve documentation. |
| **Child health** | |
| Pain relief prescriptions in children | • Review guidance on prescribing simple pain relief in children to improve safety and effectiveness.<br>• Consider use of a dosing calculator. |
| Routine examination of newborn babies | • Consider non-clinical support for this service to reduce time spent on administrative tasks. |
| Vitamin D supplementation | • Work with primary care to improve uptake of vitamin D supplementation. |
| **Care of the elderly** | |
| Use of nutrition screening tool and nutrition interventions | • Improve use of nutrition support pathway and prescription of nutrition supplements for appropriate admissions. |
| Prescribing of anti-psychotic medication in the elderly | • Improve documentation of decision-making in relation to the use of anti-psychotics and recording of its effectiveness. |
| Continence (essence of care) | • Work to improve compliance with our guidance on detailed assessments for patients with continence needs identified at initial assessment.<br>• Consider a continence link nurse role.<br>• Actively promote continence support to patients and carers. |
| **Acute medicine** | |
| Use of medical admission | • Review documentation of acute medicine |

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| proforma | admission, in partnership with A&E, to improve the standard of medical examinations. |
| Mortality | • Undertake further audit of mortality associated with emergency admission at weekends to guide future planning of consultant working patterns. |
| Acute medicine patients on outlying wards | • Work to reduce the number of patients admitted to outlier wards, in order to reduce length of stay associated with admission to outlier wards.<br>• Share findings at International Quality & Safety in Healthcare conference (London, April 2013). |
| **Cardiology** | |
| Falls | • Identify falls champions. |
| **Intensive care** | |
| Communication between staff and relatives | • Review documentation of information given to relatives in order to meet standards set out in NCEPOD *Caring to the End,* to better understand patients' likely wishes, better address the needs of families/carers and reduce miscommunication incidents. |
| Weaning from artificial ventilation | • Explore further interventions (eg improved management of delirium on intensive care) to reduce the need for tracheostomy after discharge from the intensive care unit to general ward. |
| Timeliness of tracheostomy formation | • Revise referral pathway to reduce non-clinical delays in tracheostomy formation, in order to reduce ICU length of stay and improve patient experience (eg by allowing ability to speak with use of special 'speaking' valves). |
| Family satisfaction and visitor experience surveys | • New intensive care on fourth floor will improve the facilities for relatives. |

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| | • Revise information for visitors, both electronic and paper. |
| Drug errors on intensive care | • Explore utility of electronic prescribing and human factors training in reducing drug errors in this complex environment. |
| **Radiology** | |
| Vacuum excision of fibroadenoma | • Offer procedure to all women requiring excision of breast lump with biopsy-proven benign lesions. |
| Use of CT scan in planning breast reconstruction surgery | • Continue use of CT planning for these cases, which has reduced length of stay and requirement for blood transfusion.<br>• Use new scanner to provide further benefits in CT planning with additional reductions in exposure to radiation. |
| CT scanning for emergency presentations to A&E | • Improve out-of-hours specialist reporting. |
| Adrenal vein sampling | • Introduce consultant radiology input to multidisciplinary team meetings for patients referred for this investigation. |
| Reporting of incidental adrenal abnormalities | • Introduce standard text into CT reports to suggest referral to endocrinology, where appropriate. |
| CT pulmonary angiography | • Revise our CT protocol to improve image quality. |
| Use of contrast agents | • Improve adherence to national guidance on management of patients with reactions to contrast agents. |
| Lumbar puncture investigation after normal CT scan in patients with suspected subarachnoid haemorrhage | • Improve referral pathway. |
| **Gynaecology** | |
| Surgical techniques for | • Prepare formal publication to share findings, |

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| management of uterine fibroids – 'triple tourniquet technique' | of reductions in blood loss, with the wider profession. |
| **Maternity and obstetrics** | |
| Care of severely ill pregnant women | • Improve documentation of clinical observations at appropriate specified frequency.<br>• Improve escalation to senior midwifery and medical staff. |
| High-dependency care in pregnant women | • Improve use of established documentation on transfer of women to intensive care. |
| Obesity in pregnancy | • Improve adherence to specific care pathway for these patients, including referral to anaesthesia, tissue viability and manual handling. |
| Severe pre-eclampsia | • Maintain and build on high standards of care by improving compliance with best practice on fluid management, through introduction of a structured management plan. |
| Vaginal birth after previous caesarean section | • Increase referrals to birth options clinic for women with previous caesarean delivery. |
| Emergency caesarean delivery | • Introduce monthly (in place of quarterly) reviews of care given to all women requiring the most urgent caesarean section to ensure the correct level of urgency for operative delivery was identified, and identify and address systemic reasons for any delays. |
| Shoulder dystocia | • Adopt the Royal College of Obstetricians and Gynaecologists (RCOG) documentation for cases of shoulder dystocia to improve documentation of shoulder position and post-delivery cord blood gases. |
| Antenatal screening | • Consider changes to our guidelines on screening for Down's syndrome to ensure |

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| | results are made available to expectant mothers in an agreed timeframe. |
| Maternal transfer by ambulance | • Improve documentation of final assessment before transfer |
| Newborn and infant physical examination programme | • Improve documentation of abnormal findings and parental consent for referral. Approach external programme administration to make similar improvements to electronic system. |
| Use of oxytocin for augmentation of labour | • Improve documentation of assessment prior to commencing augmentation. |
| **Anaesthetics** | |
| Enhanced recovery | • Introduce pocket versions of pathway for nurses. Introduce pre-operative classes for patients having major joint surgery.<br>• Distribute carbohydrate drinks at pre-assessment appointment for peri-operative use to maintain nutrition.<br>• Standardise documentation of daily ward rounds for patients on enhanced recovery programme to ensure all processes are considered. |
| Maternal sepsis | • Introduce a ‘sepsis trolley’ containing all necessary equipment to facilitate best practice. |
| Use of ultrasound-guided regional anaesthesia | • Purchase a further ultrasound machine to facilitate further expansion of this service, which avoids the need for general anaesthesia. |
| Pain relief prescriptions in children | • Revise local guidelines for prescribing pain relief in children after surgery to further improve safety and effectiveness. |
| Use of new agent for reversal of neuromuscular blockade (sugammadex) | • Reduce unnecessary cost by monitoring the use of sugammadex and compliance with local usage indications. |
| Fractured neck of femur pathway | • Revise pathway to include greater anaesthetic consultant input and early |

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| | analgesia. Improve documentation of pre-operative assessment to reduce communication failures and delays. |
| Perioperative drug management of patients with ischaemic heart disease | • Improve compliance with optimal drug therapy in the pre-operative period by providing easy reference guide for ward nurses. |
| Perioperative transfusion of blood and blood products | • Consider further opportunities for use of blood-conserving technologies (eg in orthopaedics) and to rationalise use of platelet transfusions. |
| Inadvertent migration of epidural catheter | • Adopt 'Lock-It' device as standard practice following audited reduction of inadvertent dislodgement. |
| **Urology** | |
| Infection after endoscopic surgery to lower urinary tract | • Consider deviation from standard guidelines for patients with history of recent antibiotic use. |
| Prostate cancer patient experience | • Consider business case for additional clinical nurse specialist to improve support for patients with prostate cancer |
| **Orthopaedics** | |
| Length of stay for major joint surgery patients | • Continue to implement enhanced recovery, LEAN and QIPP programmes. |
| **Breast surgery** | |
| Electro chemotherapy [New Interventional Procedures Programme] | • Monitor respiratory function in all patients having electrochemotherapy.<br>• Submit all cases to InspECT international registry (to include case selection, methods of follow-up and outcomes) in line with NICE guidance. |
| **Medical and clinical oncology** | |
| Neutropaenic sepsis | • Devise alert cards for patients to use when attending A&E in emergency to ensure swift access to antibiotics. |
| Blood tests for patients | • Devise policy to rationalise blood test |

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| with white cell malignancies | usage while preserving safety |
| Screening, prevention and management of bone loss in alloeneic bone marrow transplant | • Incorporate link to FRAX risk assessment tool from patient database.<br>• Devise guideline in conjunction with rheumatology. |
| Use of plerixafor | • Adopt agreed criteria for pre-emptive use of prelixafor for stem cell mobilisation prior to stem cell transplantation in a defined patient group |
| Radiotherapy consent forms | • Revise consent form for breast radiotherapy to include risk of secondary malignancy and cosmetic side effects. |
| Emergency admissions for patients with haematological conditions | • Provide clear written information for patients to include when to seek advice (eg fever or problematic side-effects in patients receiving chemotherapy) and how (eg direct contact details for clinical nurse specialist).<br>• Improve communication between out-of-hours teams and patient's own specialist teams through further development of written handover processes.<br>• Consider development of an integrated care pathway for these patients. |
| **Diabetes and endocrinology** | |
| Hypoglycaemia episodes | • Work toward mobile electronic access for diabetes specialist nurses to glucose monitoring results captured from all new glucose meters linked across the trust. |
| Diabetic retinopathy: joint ophthalmic and diabetes specialist nurse clinic pilot | • Further work to establish effective clinic model with optimal clinical outcomes, including optimal control of risk factors for retinopathy progression. |
| | |

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|---|---|
| Ear nose and throat (ENT) | |
| Coblation tonsillectomy [New Interventional Procedures Programme] | • Continue offering the technique in current patient groups. |
| | |
| **Nephrology** | |
| Peritoneal catheter insertion | • Increase numbers managed on day-case basis.<br>• Improve compliance with post-operative abdominal X-Ray and laxative prescription. |
| **Virology** | |
| Hepatitis B in pregnancy | • Routinely test all screening blood samples found positive for hepatitis B additionally for presence of hepatitis delta antibody.<br>• Introduce routine weekly notification of all positive screening test results to antenatal specialist midwife.<br>• Explore direct notification of hepatology service (eg through direct notification of hepatology specialist nurse) by laboratory staff to ensure clinic appointment within 6 weeks of positive test result. |
| Autopsy reporting and tissue retention | • Devise system for uploading reports from autopsies performed at UCLH or GOS.<br>• Revise current autopsy documentation to include statement relating to tissue retention. |
| **Chemical pathology** | |
| Oral glucose tolerance tests | • Improve availability and content of patient information. |
| **Genito-urinary medicine** | |
| Chlamydia testing | • Implement electronic requests for chlamydia testing.<br>• Extend pilot of recalling patients after three months of treatment for follow-up test to established practice. |

| | |
|---|---|
| Contraception | • Improve provision of family planning advice including long-acting reversible contraception in line with local guidelines |
| **Rheumatology** | |
| Monitoring of patients with rheumatoid arthritis treated with TNF-alpha inhibitors | • Consider appointment of specialist nurse. |
| **Neurosciences** | |
| Neuropsychology outpatient service | • Reconfigure job plans to reduce waiting times for first appointments. |
| **Ophthalmology** | |
| Diabetic eye screening service | • Improve patient information. |
| Clinical assessment of new referrals with glaucoma | • Improve compliance with requirements for gonioscopy and optic disc assessment after pupillary dilatation. |
| Training needs identified from local audits | Provide further training on:<br>• Prescribing pain relief in children<br>• resuscitation training for radiology staff<br>• use of lumbar puncture in suspected subarachnoid haemorrhage<br>• enhanced recovery programme<br>• falls prevention<br>• Family planning in genito-urinary medicine service<br>• Appropriate use of oral glucose tolerance tests<br>• Post-operative management of peritoneal catheter insertion.<br>• Indications for oral glucose tolerance test. |

## STATEMENT THREE: PARTICIPATION IN CLINICAL RESEARCH

The number of patients receiving NHS services provided or subcontracted by the Royal Free London NHS Foundation Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 8,185.

## ADDITIONAL INFORMATION

The above figure includes 3,220 patients recruited into studies on the National Institute for Health Research (NIHR) portfolio and 4,965 patients recruited into studies that are not on the NIHR portfolio.

The 2012/13 figure is a significant increase from the 2011/12 figure of 6,654. This increase is likely to be due to the continuing work to capture such information, as well as to the resource that has been put into facilitating and expanding the research portfolio at Royal Free London NHS Foundation Trust.

## STATEMENT FOUR: USE OF CQUIN PAYMENT FRAMEWORK

A proportion of the Royal Free London NHS Foundation Trust income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between the trust and the NHS North Central London Commissioning Support Unit and the specialised services commissioners with whom we entered into a contract, agreement or arrangement through the commissioning for quality and innovation (CQUIN) payment framework.

Further details of the agreed goals for 2012/13 and for the following 12-month period are available electronically by emailing rfquality@nhs.net

## ADDITIONAL INFORMATION

Our CQUIN payment framework for 2012/13 was agreed with NHS North Central London Commissioning Support Unit and the specialised services commissioners as follows:

| CQUIN scheme priorities 2012/2013 | Objective rationale |
|---|---|
| VTE assessment and prophylaxis | Venous thrombo embolism (VTE) is a significant cause of mortality, long-term disability and chronic ill health. |
| Improving patient experience | This indicator incorporates questions which are known to be important to patients and where past data indicates there is significant room for improvement across England. |
| Dementia screening | 25% of beds in the NHS are occupied by people with dementia, their length of stay is longer than people without dementia and they often receive suboptimal care. Half of those admitted have never been diagnosed prior to admission and referral out to appropriate specialist community services is often poor. Improvement in assessment and referral will give significant improvements in the quality of care and substantial savings. |
| NHS safety thermometer | Participation in data collection is an important preparatory step for providers reducing harm in four areas of concern highlighted nationally by establishing national baselines of performance. This will allow the establishment of quality improvement aims for future years. |
| Chronic obstructive pulmonary disease (COPD) discharge bundle | Use of the bundle has been proven to improve the care of patients admitted to hospital with an exacerbation of COPD, improve their understanding of the disease, reduce future reliance on secondary care and reduce chances of further admissions. |
| Enhanced recovery programme | To improve the quality of patient care through the implementation and development of enhanced recovery schemes. Adopting enhanced recovery models of care is proven to reduce length of stay, enhance the patient experience and improve clinical outcomes for |

| | |
|---|---|
| | some surgical procedures. |
| Stop smoking | Helping patients to stop smoking is among the most effective and cost-effective of all interventions the NHS can offer patients. Simple advice from a clinician during routine patient contact can have a small but significant effect on smoking cessation. |
| Alcohol screening | Alcohol-related problems represent a significant share of potentially preventable attendances to emergency departments and urgent care centres and emergency admissions. Screening for alcohol risk has been shown to reduce subsequent attendances and alcohol consumption. |
| Integrated care | Frail older people are a significant population in terms of numbers and hospital activity. Identification and assessment of frail older people, sharing information with primary care and participation in MDT case conferences will help in reducing expensive hospital admissions amongst this cohort of patients. |
| Cancer staging | Late diagnosis is a major contributor of poorer survival rates. To understand improvements in cancer care there is a need to have consistent accurate records of staging data. |
| National quality dashboard | The aimed is to ensure that providers implement and routinely use the required clinical dashboards for specialised services. |
| Bone marrow transplant | To improve the gathering of health outcomes data for these procedures to inform better safety and effectiveness. |
| Neonatal intensive care unit | To reduce the number of inappropriate admissions to neonatal units and reduce the length of stay of those admitted. All units should access staff competent in care following neonatal intensive care and available to provide support in the community after discharge. |

| | |
|---|---|
| HIV | Involvement of GPs in the care of patients with HIV is important for clinical safety given the increased risk of co-morbidities in patients with HIV. A drugs audit and using home delivery offers choice and convenience to patients and reduces costs associated with antiretrovirals drugs. |

**STATEMENT FIVE: STATEMENTS FROM THE CQC**

The Royal Free London NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is non-compliant with minor concerns.

The trust has the following conditions on registration: Standards for caring for people safely and protecting them from harm requires improvement in relation to outcome nine - medicines management as of 31 March 2013.

The trust has not participated in any special reviews or investigations by the CQC during the reporting period.

**ADDITIONAL INFORMATION**

Between 1 April 2012 and 31 March 2013 the trust had two inspections.

The first was on 5 September 2012 the CQC undertook an unannounced inspection of both the renal dialysis and adult acute kidney care services and our neurological rehabilitation service at Edgware Community Hospital. The inspection confirmed that we were compliant with all 16 essential standards at both these services. The inspectors found that our patients rated our care and services very highly and enjoyed attending for their care with us.

The second inspection was on 16 October 2012 at the Royal Free Hospital across a wide number of wards and departments. Ten outcomes were considered during the inspection and the trust was found to be non-compliant

with one outcome related to medicine management where there were minor concerns.

The non-compliance related to locking of drug fridges and storage of intravenous fluids. We have developed an action plan to address this area of improvement. This involves replacing all drug fridges with new self-locking fridges to ensure the safe storage of medicines and the installation of new doors to ensure all our clean utilities and drug rooms have security doors accessible only to those authorised by swipe card entry.

**STATEMENT SIX: DATA QUALITY**

The Royal Free London NHS Foundation Trust submitted records during 2012/13 to the secondary uses service 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 patient's valid NHS number was:

**98.7% for admitted patient care**
**98.8% for out-patient care**
**92.6% for accident and emergency care**

The percentage of records in the published data which included the patient's valid general medical practice code was:

**100% for admitted patient care**
**100% for out-patient care**
**100% for accident and emergency care**

**SUPPORTING INFORMATION**

The figures above are taken directly from the secondary uses service (SUS) data quality dashboard provider view, which is based on provisional April 2012 to January 2013 SUS data at the month 10 inclusion date.

## STATEMENT SEVEN: INFORMATION GOVERNANCE TOOLKIT ATTAINMENT LEVELS

The Royal Free NHS Foundation Trust 'information governance assessment report score' overall score for 2012/13 was 70% and was graded green.

### ADDITIONAL INFORMATION

Information governance is the process that ensures we have necessary safeguards in place for the use of patient and personal information, as directed by the Department of Health and set out within national standards. The trust's overall score was satisfactory, meaning that a level two or above was achieved for all 45 requirements.

## STATEMENT EIGHT: CLINICAL CODING ERROR RATE

The Royal Free London had a payment by results clinical coding audit in March 2013, therefore the results of the audit had not been published in time to include in this report.

### ADDITIONAL INFORMATION

Clinical coding is the process by which medical terminology written by clinicians to describe a patient's diagnosis, treatment and management is translated into standard, recognised codes in a computer system. It is important to note that the clinical coding error rate refers to the accuracy of this process of translation, and does not mean that the patient's diagnosis or treatment was incorrect in the medical record. Furthermore, in the definition to determine the clinical coding error rate, 'incorrect' most commonly means that a condition or treatment was not coded as specifically as it could have been, and not that there was an error.

**PART 3**

## REVIEW OF QUALITY PERFORMANCE DURING 2012/13

In this part of our quality accounts we review our performance against our key quality priorities for 2012/13 and provide examples that illustrate how individual services and specialties are focused on quality improvement. We also provide key data relating to our performance.

## PERFORMANCE AGAINST OUR KEY QUALITY OBJECTIVES

In the 2011/12 quality accounts, we set three key quality improvement objectives. These were:

**Priority one: world class care including staff satisfaction and patient experience**

**Priority two: further develop our clinical outcome measures**

**Priority three: managing the care of the deteriorating patient**

Over the next pages, we outline how we performed against these objectives.

### Priority one: world class care

We want all of our patients to be treated with dignity and respect and to rate the care they receive highly. The work we are undertaking as part of our world class care programme seeks to ensure that this is the case.

In 2012 we embedded our world class care standards developed from the listening events held in 2011 with our patients and staff members. Between May and November 2012 a bespoke training programme was delivered with 63% of our staff participating and agreeing objectives that will help them ensure the consistent delivery of world class care to our patients.

We set ourselves targets for improvements in relation to the following two questions in the national patient survey;

**Overall, did you feel you were treated with respect and dignity while you were in the hospital?**

**Overall, how would you rate the care you received?**

On the first question in 2011 we scored 8.7 and set ourselves a 2012 target of 8.9. We missed our target and scored 8.6 for this year.

For the second question we had a 2012 survey aim of 8.0 in comparison to 7.8 for the 2011 survey and achieved 7.7

The format and scoring has fundamentally changed and is therefore not comparable.

**Priority 2: Further develop our clinical outcome measures**

Over the past three years we have developed a set of clinical outcome metrics (measurements) for all our clinical business units. We believe that this work is vital to the trust because it provides a strong focus on delivering excellent clinical outcomes. As one of last year's quality account objectives, we said that we would continue work on this project by:

- Commencing regular performance monitoring of our metrics through the clinical performance committee.

- Expanding our portfolio of metrics by, for example, adding additional metrics from the many national clinical audits to which our specialties contribute.

- Working with other trusts in our academic health science partnership, UCLPartners, to develop common clinical outcome metrics that we can use to compare performance between organisations.

In July 2012 we published our list of clinical performance metrics at www.royalfree.nhs.uk/outcomes. Our aim was to publish data on each metric over the subsequent six months so that we would have a complete set of published data by the end of 2012. Unfortunately, progress has been slower

than we anticipated and we did not meet that goal. We now plan to put additional resource into this project, described in section 2, to ensure that the data is published. The clinical performance committee has overseen this work during the last year, and will shortly commence monitoring the data from individual specialities in depth.

We have expanded our metrics by incorporating the following outcomes from national clinical audits:

| **National Clinical Audit** | **Indicator** |
|---|---|
| Inpatient diabetes | Medication errors; suitable meals & mealtimes |
| Potential organ donors | Approach to potential donors following cardiac death |
| Carotid interventions | Timely GP referral |
| Neonatal intensive care | Consultation with parent |
| Bowel cancer | Mortality (adjusted) |
| Oesophago-gastric cancer | GP referral for diagnosis |
| Inflammatory Bowel Disease (paediatric) | Microbiological stool examination |
| Inflammatory Bowel Disease (adult) | Patients not seen by dietician during admission |
| BTS: Bronchiectasis | Testing for cystic fibrosis |
| BTS: Emergency Oxygen | Emergency oxygen prescribing |
| BTS: Adult pneumonia | Adherence to antibiotic prescribing guidelines |
| BTS: NIV (Non – Invasive Ventilation) | Referral to pulmonary rehabilitation |
| RCPCH Paediatric epilepsy | Specialist nurse; behavioural assessments |
| CEM: Pain in children | Timely analgesia |

We have selected these metrics because our most recent performance has been in the bottom 25% when compared to other trusts, and they are therefore areas in which we will prioritise improvement.

Finally we have worked with UCL Partners to determine how we develop common clinical outcome metrics across hospital trusts that are members of UCL Partners. As a result the UCL Partners medical directors have agreed to support this project which will be overseen by the UCL Partners director of quality.

**Priority three: managing the care of the deteriorating patient**

We introduced the sepsis six pathway pilot to enable staff to recognise the signs of severe sepsis at an early stage ensuring patients are given the care they need. The pathway includes six specific interventions (the 'sepsis six resuscitation bundle') that staff need to take in the first hour to ensure the best outcomes for patients.

Our targets by April 2013 were to ensure:

- **95% of staff have an awareness of recognition and management of severe sepsis**

- **95% of patients who meet criteria to suggest severe sepsis have severe sepsis pathway initiated**

- **95% of patients who receive the sepsis pathway receive all of the 'sepsis six resuscitation bundle' interventions.**

We have achieved both our first and second targets. Unfortunately we have not achieved our third target however we are confident that with continued work we will achieve this by the end of 2013. Achieving this in our pilot area will set the foundations for a robust, reliable and sustainable pathway that can be implemented trust wide to benefit all clinical areas.

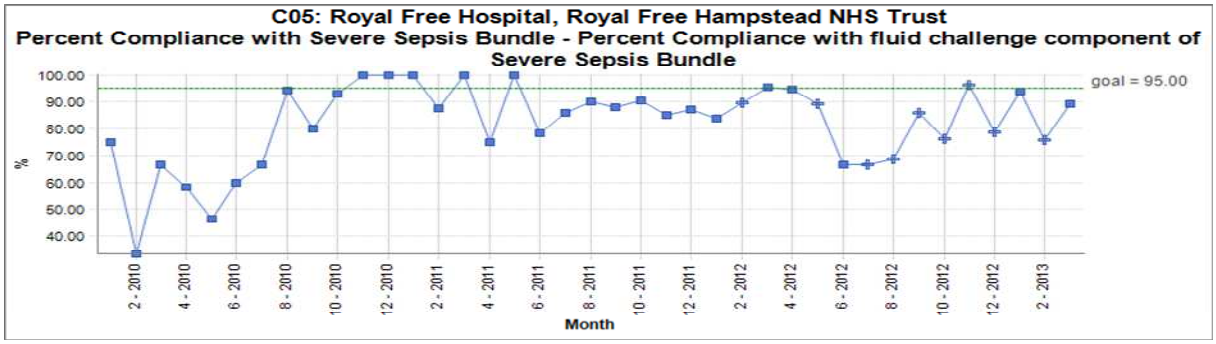
Implementing this improvement work has promoted a shared passion from clinicians and local pilot areas champions. They have demonstrated a high level of commitment and shared vision to deliver excellent clinical care.

Achievement in both the first and second target demonstrate an excellent awareness and understanding in the recognition of severe sepsis which has been achieved through targeted communication and education of staff in a variety of methods including: attending MDT handovers and inductions; implementation of severe sepsis safety cross in daily handover; daily

feedback on patient outcomes on the pathway; visiting all clinical areas in the trust for our ‘trust sepsis day’; leading sepsis simulations; and including the development of the ‘sepsis phone app’ which has been launched and is free to download at http://appstore.com/sepsis6.

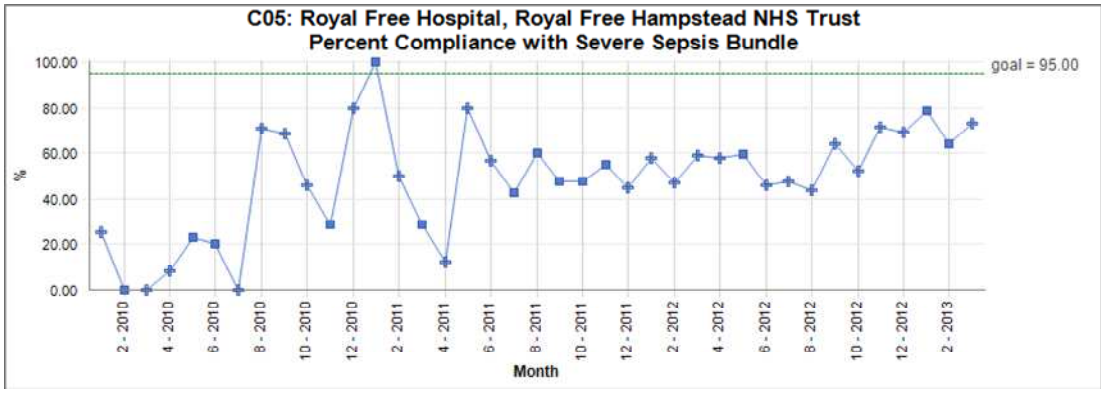
There has also been shown to be an increase in patients receiving the pathway with an average of around 30 per month. Last year a total of 265 patients had the severe sepsis pathway implemented with 81% of patients clinically recovering to be discharged home or to the designated place of care and only 6.5% requiring ITU admission.

The six individual interventions (high flow oxygen, serum lactate measure, blood culture sample, IV antibiotic administration, rapid fluid resuscitation and accurate fluid chart observations) compliance has shown varied results. Some with excellent compliance and some (such as antibiotics and fluids administration) remaining a challenge.


Following user feedback, these prompt interventions within one hour have been targeted as part of the development of the pathway. To facilitate the delivery of these interventions there has been the implementation of a sepsis trolley and sepsis grab bags within the emergency department pilot area.


## Overall 6/6 compliance- 73% in March 2013



## FOCUS ON QUALITY AND IMPROVEMENT

At the Royal Free we plan to focus even harder on our mission to provide world class care and expertise to our patients. As a campus of UCL Medical School and a founding member of UCLPartners, we conduct important research and train the healthcare professionals of tomorrow. Over the next few pages we will provide examples of how we have continually improved the quality of service we provided over the past year. You can also find a guide to quality at the Royal Free in appendix two.

### Monitoring of local audit quality improvement actions from 2011-12 quality accounts

| Local audit | Action agreed |
|---|---|
| VTE appropriate thromboprophylaxis | • Further training where risk assessment completion rates below target. |
| VTE root cause analysis | • Review compliance with guidelines in areas where VTE cases occur.<br>• Review guidelines where cases cluster despite adherence to guidelines. |
| Patient satisfaction (bladder cancer) | • Increase number of nurse-led clinics.<br>• Increase CNS provision to haematuria clinic.<br>• Provide training in psychological support.<br>• Assess need for enhanced information about complementary therapies.<br>• Establish nurse led follow-up clinics for cystoscopy and bladder cancer. |
| Hand hygiene in theatres | • Consider increasing availability of hand gel. |
| Completion of World Health Organisation (WHO) safe surgery checklist | • Redesign checklist to meet local needs and identify person responsible for completion of each section.<br>• Further redesign to incorporate into perioperative care plan. |
| Recycling in theatre | • Improve provision of recycling bags for use in theatres. |

| | |
|---|---|
| Airway risk assessment prior to anaesthesia | • Improve documentation of assessment. |
| Pregnancy testing prior to surgery | • Include pregnancy status in WHO safe surgery checklist. |
| Post- operative analgesia prescribing for children | • Review paediatric analgesia guidelines. |
| Management of hypertension on labour ward | • Update guidelines.<br>• Training for labour ward staff. |
| Knowledge of designated storage locations for anaesthetic emergency equipment | • Include in anaesthetic trainee induction pack. |
| Diabetic retinopathy | • Pilot a nurse led diabetic retinopathy clinic. |
| Implementation of a ward-level nutrition support pathway | • Training.<br>• Review of nutrition screening tool to prompt use of pathway. |
| Intrahospital transfers in critically ill patients | • Introduce end-tidal carbon dioxide monitoring.<br>• Improve documentation. |
| Compliance with guidance on consultant sign-off for certain A&E attenders | • Training for all A&E staff. |
| Use of IV contrast agent in renal impairment | • Further training for all radiology staff. |

**First online booking service for patients**

The Marlborough clinic provides a confidential, friendly and professional sexual health service, including testing and treatment for STIs, rapid HIV testing, access to contraception, advice and counselling.

As part of a quality improvement initiative, the Marlborough clinic developed an online booking service which went live in January 2013. The new service aims to make it easier for patients to book appointments.

Leena Sathia, consultant in genito-urinary medicine, said: “We want our clinic to be as accessible as possible. The new online booking system means patients can book their appointment at any time of day, rather than during

opening hours. The online system allows patients to see the time slots available and book the most convenient time for them. This can be done on a computer, smartphone or tablet, allowing people to book an appointment wherever they are, whenever they choose.

"This is the first online booking system available at the Royal Free; we hope it will prove to be a simple, efficient and convenient way of booking to attend our sexual health service."

Telephone booking is also still available.

**New imaging technology helps detect breast cancer**

Patients are benefiting from a new technology, called breast PET (positron emission tomography), or Mammi, which is a new imaging technology to diagnose breast cancer.

The breast PET produces a 3D image of the breast which clearly shows the metabolic activity of cancerous masses. The Royal Free is the first hospital in the UK and only the fourth in the world to introduce it.

Funded by the Royal Free Charity, it can be used to diagnose breast cancer and determine the response to treatment in difficult cases, particularly in younger women with dense breasts.

The use of the machine is being pioneered by a multidisciplinary team at the Royal Free including consultant oncological surgeon Mo Keshtgar, clinicians, scientists and technologists in nuclear medicine.

Mr Keshtgar said: "It will be an especially useful tool in younger patients with dense breasts, when it is often harder to detect cancer using a mammogram and we also know that breast density is associated with increased breast cancer risk. Fat appears black on mammograms and cancer and gland tissue appear white. So in dense breasts which have less fatty tissue the mammogram often has a lot of white areas, which sometimes makes finding the cancer a bit like finding a polar bear in a pile of snow. Complex cases such as these usually result in the patient having to undergo further imaging tests, such as an ultrasound or MRI and sometimes more invasive biopsies.

“Breast PET, on the other hand, allows us to study the metabolic activity going on in the breast. It involves injecting a small amount of radioactive glucose to see how the cells react to it. As cancerous cells take up more glucose than normal cells, the cancerous area lights up on the image and we can locate the cancer. The high metabolic activity of cancerous cells shows up on the image as a bright spot, so it is easy to diagnose.

“For this reason, breast PET will also be key in diagnosing cancer when previous scans have proved inconclusive in terms of identifying whether a mass is cancerous or benign.”

In certain patients the technology can also be used to monitor their response to breast cancer treatment. Results can be seen as early as after one cycle of chemotherapy, whereas with a MRI the response can usually only be determined after two or three cycles. This means that if the patient is not responding to treatment, alternative therapies can be considered sooner.

Mr Keshtgar added: “Another benefit of this technology is improved comfort for patients; there is no breast compression involved like traditional mammography, the patient simply has to lie face down.”

**Rapid HIV testing**

Patients can now access rapid HIV testing at the Royal Free five days a week. We have expanded our rapid HIV testing service so that anyone wishing to be tested can walk in to the Ian Charleson day centre on a Monday 9am and 6pm and at 9am and 4.30pm between Tuesday-Friday. The service was previously only available between 9 and 10.30am on a Tuesdays and Thursday.

The service is free and confidential and patients get their results within 30 minutes.

Amanda Evans, psychologist in the Ian Charleson day centre, said: “We wanted to increase the number of opportunities to take a test at our out-patient clinic; these new rapid access times have allowed us to do that.

“People who present early with HIV can be treated to prevent life threatening illnesses. Someone with HIV who is diagnosed and treated early can expect to remain fit and well, have a near normal life expectancy and to be able to

lead a normal and fulfilling life. That is why getting tested is so important. We want to encourage people to get tested because many people who are not diagnosed do not realise that HIV is now a treatable condition."

**Intensive Care Unit improvements**

The first patients moved into our purpose-built £11.8million intensive care unit (ICU) at the Royal Free in October 2012. The new ICU provides a modern, bright environment for patients.

The old ICU was created from a ward conversion more than 20 years ago and was housed in two separate areas on the third and fourth floors of the hospital, with staff working across both areas.

The new ICU will bring the department together on to one floor and create much more space. The unit will increase from 31 to 34 beds and provide nearly four times as many individual side rooms for patients who need to be nursed in isolation.

Dr Steve Shaw, urgent care director and former clinical director for intensive care, said: "The new unit is purpose built and provides a modern, bright environment with more natural light. We have doubled the bed space so that there will be approximately 25 square metres of bed space per patient. This means we can provide a more pleasant and comfortable environment for our patients and their families and provide staff with more space in which to work.

"The individual side rooms have specialised ventilation systems which allow us to both prevent the spread of infection and isolate patients at risk of infection. We previously had only four side rooms with this technology but the new unit will have 14. This will obviously be of great benefit to patients."

The final phase of work is underway and is due to be completed by December 2013.

**Self check-in kiosks**

We have has installed eight self check-in kiosks near the entrances to the hospital: five near the main Pond Street entrance, two by the A&E entrance and one by the Rowland Hill Street entrance.

Patients attending clinics on the first floor are now able to check in for their appointments using touch-screen kiosks easing congestion at reception desks.

Patients who have an out-patient appointment in one of the first floor clinics can use the kiosks to check in for their appointment, instead of having to go to the reception desk in their clinic.

Will Smart, director of information management and technology, said: “Around 190,000 patients have appointments in our first floor clinics every year, which means that the reception desks can get quite busy.

“The kiosks will help to relieve congestion by providing patients with an alternative way to check in for their appointment. The kiosks are very quick and easy to use – all it takes is just a few touches of the screen.”

**Improvements to patient management and diabetes care**

The introduction of networked blood glucose meters over the past year have enabled both the point of care testing (POCT) and the diabetes teams to change their approach to patient management and improve diabetes care at the Royal Free.

Gill Hall, the trust POCT manager, explains: “Our previous blood glucose meters were not networked; data had to be captured and collated manually, which was time consuming and left room for error. The ability to manage data electronically is an enormous benefit when it comes to governance. Centrally controlling the meters provides assurance that all meters in use have been quality controlled and calibrated; this is key to patient safety.”

Ruth Miller lead nurse for diabetes, describes how beneficial the initiative has been to her team: “The ability to view blood glucose data from across the hospital gives us the ability to target our resources effectively. On a daily basis the diabetes nurse team review all the capillary blood glucose results for the previous 24 hours to see if any patients have had more than one hypo or hyperglycemic reading. Interventions are then targeted immediately leading to improved patient care and outcomes that will reduce the length of their hospital stay.”

**Innovative radiotherapy treatments for more patients**

The trust was awarded £405,000 in January 2013 from the cancer radiotherapy innovation fund to expand the use of intensity modulated radiotherapy (IMRT), a treatment which allows more precise doses of radiation to be targeted at a tumour, minimising the impact on surrounding healthy tissue.

At the Royal Free, IMRT is currently primarily used in prostate cancer. Previously patients would have undergone conformal radiotherapy, which allowed for better radiation dose coverage to the tumour than previous techniques but could cause damage to surrounding healthy tissue. IMRT on the other hand, reduces the likelihood of damage to surrounding tissue whilst allowing the dose of radiation to be maintained and potentially increased.

Neil Dancer, head of radiotherapy physics, at the Royal Free, said: “IMRT is an advanced radiotherapy technique that allows us to provide a better service for our patients and we’re delighted that our bid to expand the service was successful.

“The Royal Free already provides this technique, but this funding will allow us to upgrade our equipment and improve processes to ensure that even more patients can benefit.”

**Improving care for patients with dementia**

Currently over 800,000 people in the UK suffer with dementia, with this figure set to rise to over a million by 2021. The impact of dementia on both patients and carers cannot be overstated and improving care of patients with dementia is a trust priority.

We have appointed a dementia lead supported by a dementia nurse specialist, and have implemented a wide range of initiatives to improve dementia care.

A drive to improve the diagnosis of dementia and delirium in older people across the trust has seen detection rates improve from 20% to 80% over the past three years and changes to discharge summaries have ensured better communication between the hospital, GPs, patients and carers.

There has also been a drive to improve training in dementia for both doctors and nurses with a programme of events including quarterly dementia ethics sessions. A dementia portal with a wealth of useful information about dementia has been created on the hospital intranet.

A wide range of initiatives are aimed at improving the quality of experience at the Royal Free for patients with dementia and their carers. Signs on the elderly care wards have been upgraded to be more dementia friendly, and free access to massage therapy has been widely taken up and appreciated by patients.

Looking after a relative with dementia raises many issues for carers and a carers' clinic has been launched to enable them to spend time talking to a specialist dementia nurse.

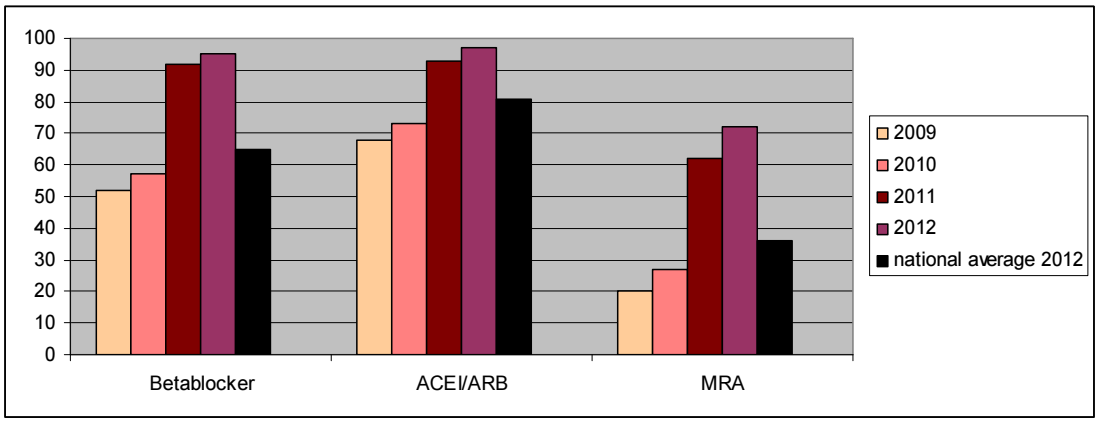
**Improving care for patients admitted with acute heart failure**

In August 2010, the Royal Free was selected by the NHS Improvement Programme to pilot an in-patient heart failure service for patients admitted to our medical assessment unit where patients with a medical problem are admitted from accident and emergency. Following the success of the pilot, this service has become standard care for acute heart failure patients.
Patients with suspected acute heart failure are fast tracked for investigations to allow rapid diagnosis and management with lifesaving heart failure medications to improve prognosis and quality of life.

This approach has led to a reduction in the length of stay in hospital, reduced re-admission rates and a vast improvement in the percentage of patients receiving appropriate heart failure treatment.

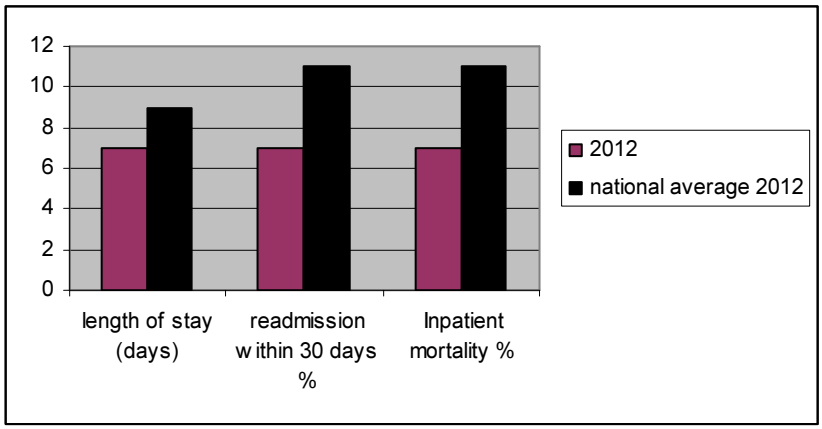
In 2012, the in-patient mortality rate for this group of patients at the Royal Free Hospital was 7% compared with 11% nationally.

**Graph 1 shows increasing percentage of patients discharged on heart failure medication 2009-2012 and compared with national average 2012.**




ACEI = angiotensin converting enzyme
ARB = Angiotensin receptor blocker
MRA = mineralocorticoid receptor antagonist

**Graph 2 shows length of stay, readmission rates and in-patient mortality rates at the Royal Free compared with national average for 2012.**




**New CT scanner to benefit more than 500 patients per year**

A new CT scanner was officially opened at the Royal Free's radiotherapy department in March 2013.

The Toshiba CT scanner replaced the previous CT scanner which was more than 10 years old. The £420,000 machine is the newest version of Toshiba's large bore scanners and we were the first trust in the UK to install one.

Kashmira Mehta, radiotherapy manager, explained: “The new CT scanner is much faster than the old machine, speeding up the process for patients and giving a clearer set of data to radiographers, thanks to higher quality images. The new technology will make a big difference in the quality and quantity of data that can now be used for radiotherapy planning.

“With this new CT scanner the data resolution has increased which allows us to better plan patient treatment. As the data is better to start with, the final treatment plan is also improved.”

The first patient to be scanned by the machine said: “I’m not very good in small spaces and get a bit claustrophobic but I found this new CT scanner to be very spacious and I didn’t feel uncomfortable at all.

“The team told me I was the first patient to be scanned by the machine and I felt very privileged. It’s an amazing piece of equipment and I felt very comfortable throughout. The radiotherapy team were very friendly and talked me through the whole process and I can’t thank them enough for making the whole process completely stress free.”

**Paediatric asthma planning**

Reliable and effective discharge planning has been proven to facilitate safe transition into primary care following admission for exacerbation of asthma. We now ensure that any child admitted with exacerbation of asthma is discharged with a personalised management plan.

Our interventions have achieved a year-on-year improvement in the issue of management plans upon discharge.  Moreover, we are now performing better than the national average in all domains of discharge planning.

Anthony Garaets, service improvement manager for child health said: “Previously verbal advice was being given out after an attack but now the personalised plan is written down and worked out with the doctor before discharge. This keeps everyone well informed. Most importantly it is keeping our patients safer and allowing families to feel more empowered as they now fully understand what actions to take should an asthma attack occur.”

## MANDATED QUALITY INIDCATORS FOR REPORTING IN QUALITY ACCOUNTS 2012/13

**Quality Account Performance Indicators**

| Indicator | Royal Free performance July 10-June 11 | Royal Free performance July 11-June 12 | National average performance July 11-June 12 | Highest performing NHS trust Performance July 11-June 12 | Lowest performing NHS trust performance July 11-June 12 | Actions to be taken to improve performance |
|---|---|---|---|---|---|---|
| The value and banding of the summary hospital-level mortality indicator for the trust | 74.34 (3) | 74.34 (3) | 102.1 (2) | 71.1 (3) | 125.6 (1) | SHMI (summary hospital mortality indicator) is a clinical performance measure which calculates the actual number of deaths following admission to hospital against those expected.<br><br>The latest data available covers the 12 months to June 2012. During this period the Royal Free had a mortality risk score of 74.3 which represents a risk of mortality 25.7% lower than expected for our case mix. This represents a mortality risk statistically significantly below (better than) expected with the Royal Free ranked third lowest amongst english NHS Trusts.<br><br>The banding (figure in brackets) is calculated 1 to 3 with 3 being the lowest (best) banding. |
| Indicator | Royal Free performance July 10-June 11 | Royal Free performance July 11-June 12 | National average performance July 11-June 12 | Highest performing NHS trust performance July 11-June 12 | Lowest performing NHS trust performance July 11-June 12 | Actions to be taken to improve performance |

| | | | | | | |
|---|---|---|---|---|---|---|
| The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. | 22.60% | 25.50% | 17.20% | 46.30% | 0.30% | 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. |
| Indicator | Royal Free performance 2011/12 | Royal Free performance April-September 12 | National average performance April-September 12 | Highest performing NHS trust performance April-September 12 | Lowest performing NHS trust performance April-September 12 | Actions to be taken to improve performance |
| Patient reported outcome measures scores for: | | | | | | 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. This helps hospitals measure and improve the quality of care provided.<br><br>A negative score indicates that health and quality of life has not improved whereas a positive score suggests there has been improvement. On this outcome measure the Royal Free is receiving negative scores for groin hernia and varicose vein surgery.<br><br>**Responsive actions to be added.** |
| (i) groin hernia surgery | -1.3 | -2.3 | -0.5 | 11.4 | -10.7 | |
| (ii) varicose vein surgery | -1.9 | -2 | 0.6 | 15.7 | -10.2 | |
| (iii) hip replacement surgery | 8.3 | 0.8 | 10.4 | 30.6 | -10.6 | |
| (iv) knee replacement surgery | 5.3 | - | 4.6 | 24.8 | -10.7 | |

| Indicator | Royal Free performance 2009/10 | Royal Free performance 2010/11 | National average performance 2010/11 | Highest performing NHS trust performance 2010/11 | Lowest performing NHS trust performance 2010/11 | Actions to be taken to improve performance |
|---|---|---|---|---|---|---|
| The percentage of patients readmitted to the trust within 28 days of discharge for patients aged:<br>(i) 0 to 15<br>(ii) 16 or over<br><br>**Note: Trusts with zero readmissions have been excluded from the data** | <br><br>6.10%<br>11.10% | <br><br>8.30%<br>12.16% | <br><br>9.41%<br>11.30% | <br><br>3.50%<br>6.30% | <br><br>14.30%<br>14.10% | 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.<br><br>The rate of readmissions at the Royal Free is below (better) the national average for children and over (worse) for adults. The trust has undertaken detailed enquiries into patients classified as readmissions with our public health doctors currently working with GPs to identify the underlying causes of readmissions. This will support the introduction of new clinical strategies designed to improve the quality of care provided and reduce the incidence of readmissions. In addition the trust has identified a number of data quality issues affecting the readmission rate, including the incorrect recording of planned admissions. The trust is working with its staff to improve data quality in this area. |

| Indicator | Royal Free performance2010/11 | Royal Free performance2011/12 | National average performance 2011/12 | Highest performing NHS trust performance 2011/12 | Lowest performing NHS trust performance 2011/12 | Actions to be taken to improve performance |
|---|---|---|---|---|---|---|

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| The trust's Commissioning for Quality and Innovation indicator score with regard to its responsiveness to the personal needs of its patients during the reporting period. | 62.10% | 66.90% | 66.80% | 85.00% | 56.50% | 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 above (better than) the national average. |
| Indicator | Royal Free performance 2011 | Royal Free performance 2012 | National average performance 2012 | Highest performing NHS trust performance 2012 | Lowest performing NHS trust performance 2012 | Actions to be taken to improve performance |
| 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. | 71.10% | 72.60% | 62.40% | 94.20% | 35.30% | 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 significantly better than the national average on this measure. |

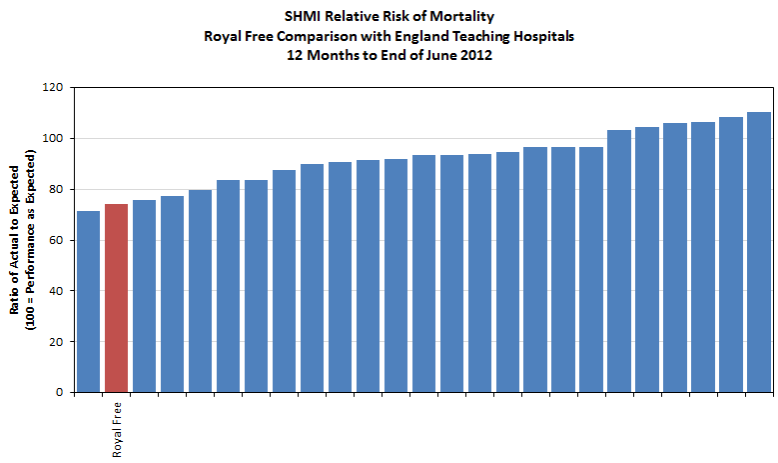
| Indicator | Royal Free performance quarter 3-4 2011/12 | Royal Free performance quarter 1-3 2012/13 | National average performance quarter 1-3 2012/13 | Highest performing NHS trust performance quarter 1-3 2012/13 | Lowest performing NHS trust performance quarter 1-3 2012/13 | Actions to be taken to improve performance |
|---|---|---|---|---|---|---|
| The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period. | 90.90% | 93.80% | 93.80% | 99.96% | 85.50% | Many deaths in hospital result each year from venous thromboembolism (VTE), these deaths are potentially preventable. The government has therefore set hospitals a target requiring 90% of patients to be assessed in relation to risk of VTE.<br><br>The Royal Free met or performed better than the 90% target for every month of the period April to December 12. For the entire period 93.80% of the trusts patients were risk assessed, exactly in line with the national average. |
| Indicator | Royal Free performance 2011 | Royal Free performance 2012 | National average performance 2012 | Highest performing NHS trust performance 2012 | Lowest performing NHS trust performance 2012 | Actions to be taken to improve performance |
| 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. | 24.1 | 26.7 | 18.4 | 0 | 36.5 | Clostridium Difficile can cause severe diarrhoea and vomiting, the infection has been known to spread within hospitals particularly during the winter months. Reducing the rate of Clostridium Difficile infections is a key government target.<br><br>Royal Free performance was significantly higher (worse) than the national average during 2012. **Further commentary to be added.** |

| Indicator | Royal Free performance October 10-September 11 | Royal Free performance October 11-September 12 | National average performance October 11-September 12 | Highest performing NHS trust performance October 11-September 12 | Lowest performing NHS trust performance October 11-September 12 | Actions to be taken to improve performance |
|---|---|---|---|---|---|---|
| The number and rate of patient safety incidents that occurred within the trust during the reporting period | 4563 (5.0) | 2613 (3.0) | 5456 (6.6) | 165 (2.0) | 19233 (23.3) | **Commentary to be added** |
| The number and percentage of such patient safety incidents that resulted in severe harm or death. | 56 (1.2%) | 41 (1.6%) | 28.5 (0.6%) | 0 (0.0%) | 230 (3.2%) | . **Commentary to be added** |

## PERFORMANCE DATA

The trust measures many aspects of its performance and this data is regularly reviewed throughout the organisation. At board level, we review a performance dashboard each month that includes some of our key measurements in the areas of patient safety, clinical effectiveness, patient experience and operational performance.

This section contains a sample of the key metrics that the trust board currently reviews on a monthly basis. Performance against each indicator is generally shown as a statistical process control chart. The purpose of these charts is to provide a simple view of performance, as well as an indication of whether any variation in performance is statistically important.




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

For the 12 month period to

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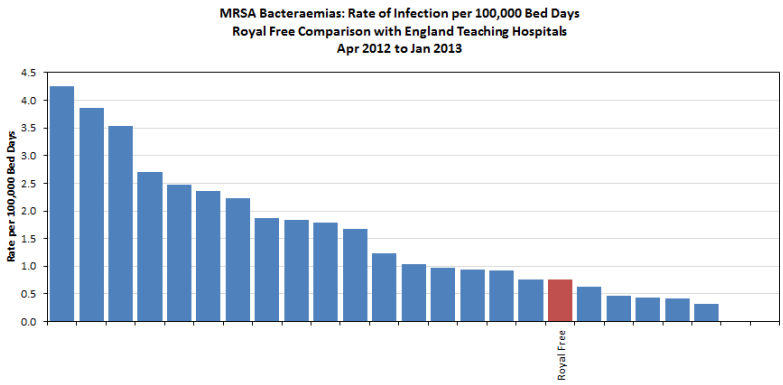
| | June 2012, the most recent period for which data is available, the Royal Free's SHMI ratio was 74.3 or 25.7% better than expected. For this period the Royal Free had the second lowest rate of any English teaching trust. |
|  | MRSA is an antibiotic resistant infection associated with admissions to hospital. The infection can cause an acute illness particularly when a patient's immune system may be compromised due to an underlying illness.<br><br>Reducing the rate of MRSA infections is a key government target and is indicative of the degree to which hospitals prevent the risk of infection by ensuring cleanliness of their facilities and good infection control compliance by their staff.<br><br>During 2012/13 the Royal Free had one attributable case of MRSA, compared to the previous year's total of four. The trust rate per 100,000 bed |

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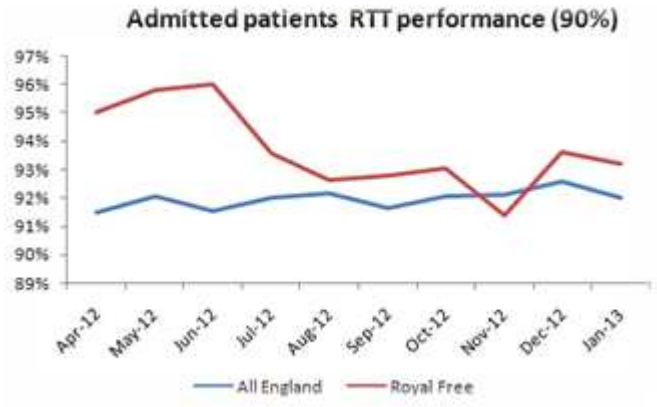
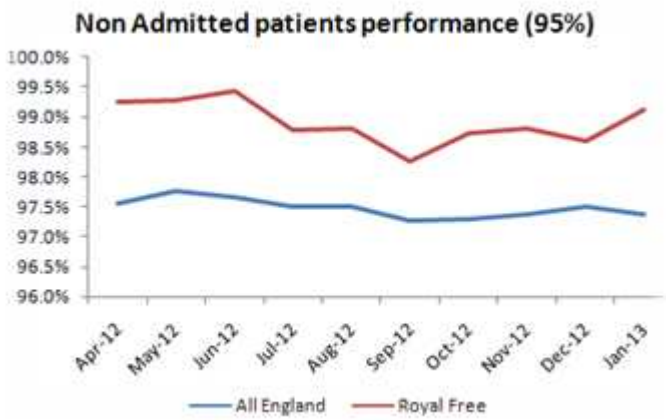
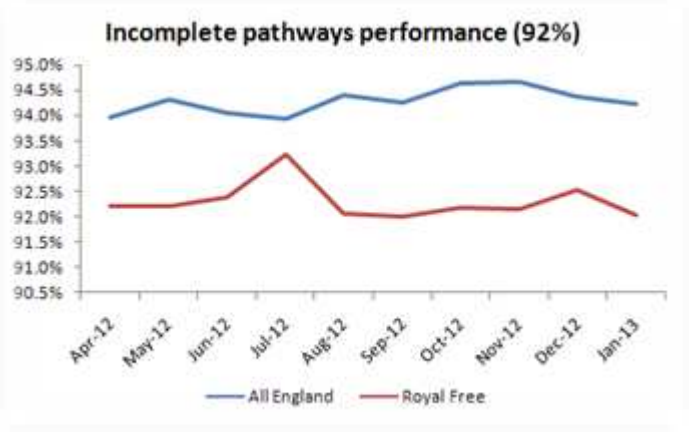
| | days between April 12 and January 13 was 0.8 resulting in the Royal Free being the joint eighth best performing out 25 English teaching hospitals during this period.<br><br>While this is a low rate of bacteraemias the trust wants to do better and is aiming for zero MRSA bacteraemias during 2013/14. |
|  | A maximum waiting of 18 weeks from referral to treatment is a key government access target with the NHS Constitution guaranteeing every citizen the right to treatment within 18 weeks.<br><br>Performance for patients requiring admission to hospital has remained consistently above the 90% standard with the Royal Free performing better than the average performance of English acute trusts in all but one month.<br><br>However, as the chart demonstrates, the proportion of patients treated within 18 weeks has reduced from 95% in the first quarter of 2012/13 to 92% between October and |




December. This is mainly due to seasonal pressures with extra capacity being made available for emergency rather than elective patients.

95% of patients on an outpatient pathway must have their treatment completed within 18 weeks. The Royal Free performed better than the average performance of English acute trusts in every month for the period April 12 to January 13.

Longer waits for treatment for patients with incomplete pathways suggest that some patients may be actively waiting for treatment for longer than the 18 week target. The Government has therefore set an additional target requiring 92% of patients actively waiting for treatment to have waited less than 18 weeks.

The trust has achieved this standard each month throughout the period April 12 to February 13 but has not performed as well as other English acute trusts. This is mainly due to longer waits for surgical treatment in a small

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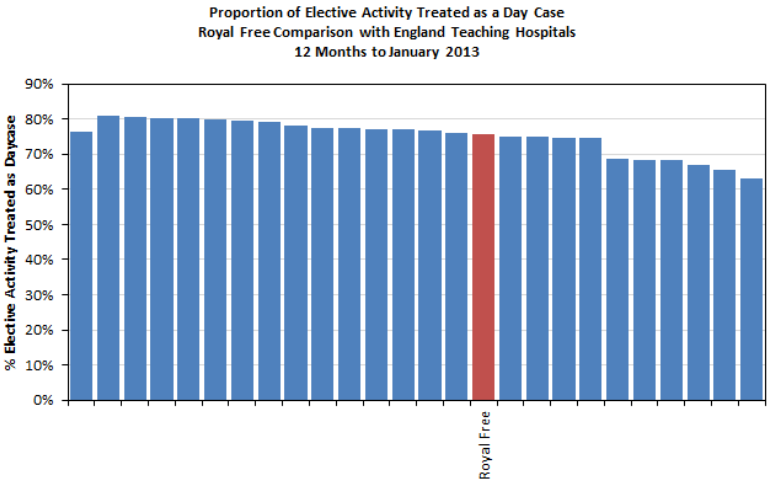
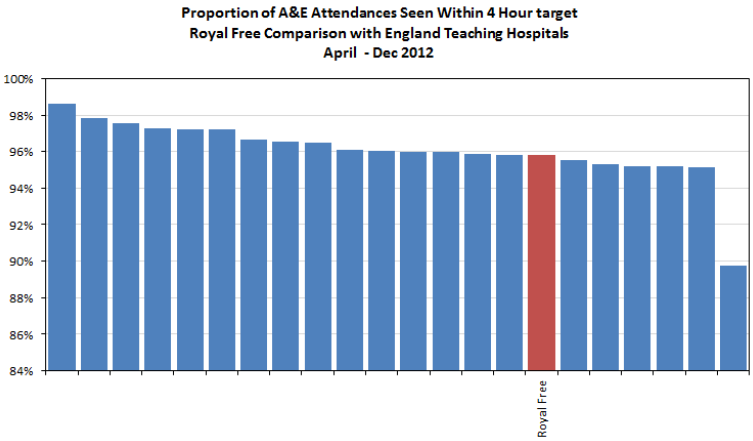
| | number of specialties<br><br>The Royal Free will prioritise waiting list reductions in these specialties in the first half of 2013/14. This will ensure that performance improves and patients have shorter waits for admission and treatment. |
|  | Day cases are procedures that allow patients to come to hospital, have treatment and go home, all on the same day. A high day case rate is seen as good practice both from a patient's perspective and in terms of efficient use of resources.<br><br>The graph compares the Royal Free's performance to the performance of English teaching trusts. |
|  | The accident and emergency department is often the patient's point of arrival, especially in an emergency when patients are in need of urgent treatment.<br><br>Historically, patients often had to wait a long time from arrival in A&E to be assessed and treated.<br><br>The graph summarises the Royal Free's performance in |

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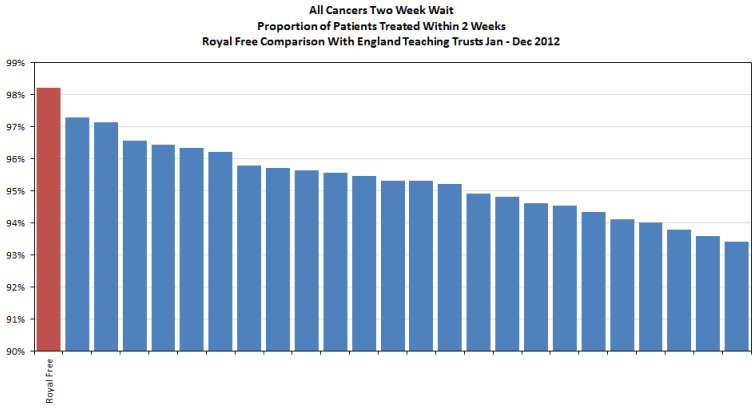
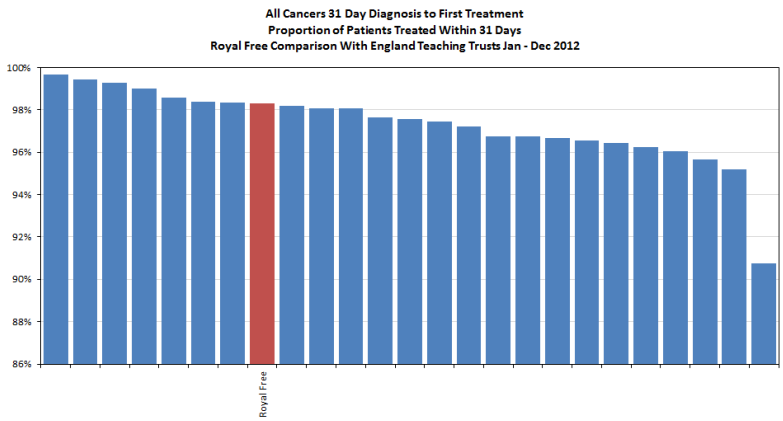
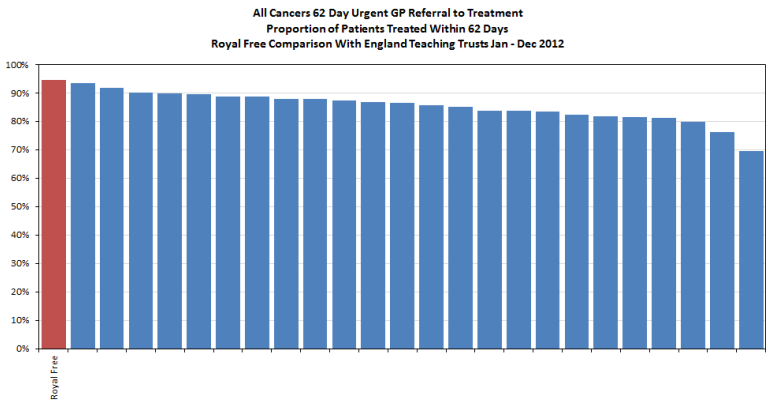
| | relation to meeting the four hour maximum wait time standard compared to the performance of English teaching hospitals.<br><br>A higher percentage is good as it reflects short waiting times. |
|  <br>  <br>  | Clinical evidence demonstrates that the sooner patients urgently referred with cancer symptoms are assessed, diagnosed and treated the better the clinical outcomes and survival rates.<br><br>National targets require 93% of patients urgently referred by their GP to be seen within two weeks, 96% of patients to be receiving first treatment within 31 days of the decision to treat and 85% of patients to be receiving first definitive treatment within 62 days of referral.<br><br>For the most recent period for which national data is available, January to December 2012, the Royal Free performed better than the national targets on all these measures and was the best performing English teaching hospital in relation to two week waits and the 62 day target. |

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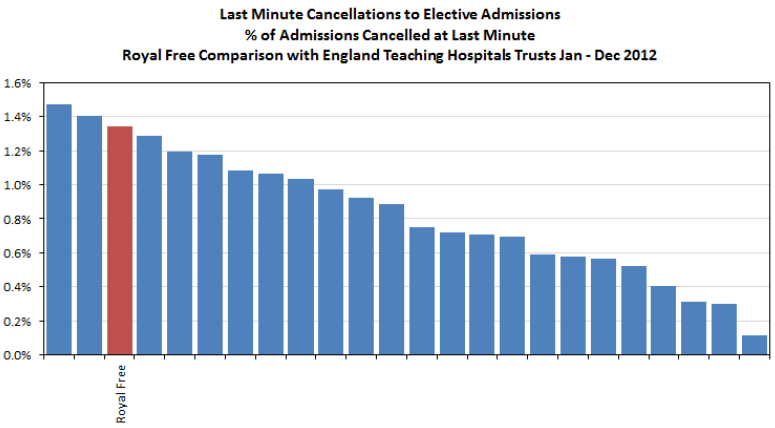
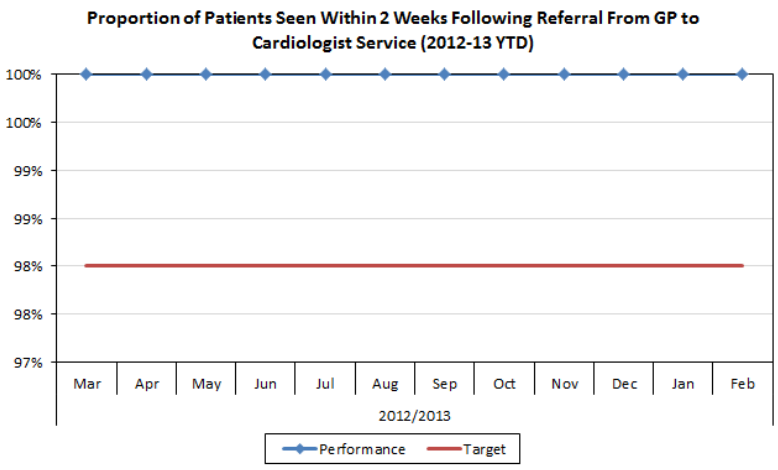
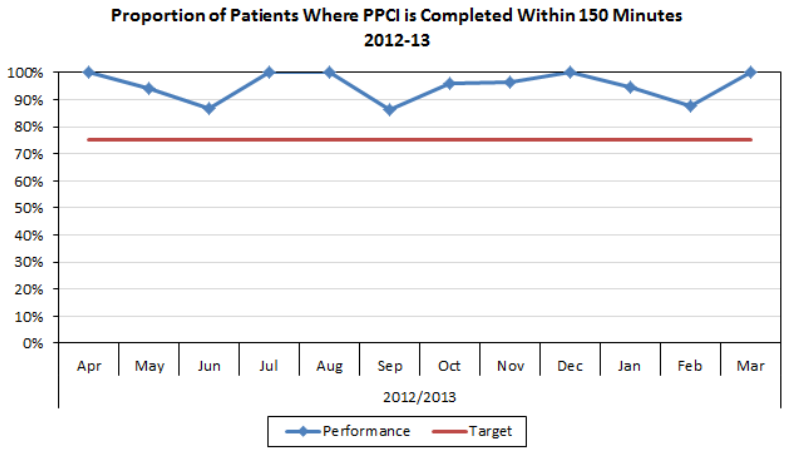
| | The graphs present the Royal Free's performance relative to English teaching trust performance. |
|  | Cancelling operations at the last minute, sometimes after admission, is extremely upsetting for patients and results in longer waiting times for treatment.<br><br>Despite the trust reducing the number of operations cancelled over the course of the last three years, this year there has been an increase. In part this has been due to an increase in emergency activity with the trust having to prioritise admissions especially for those patients attending A&E.<br><br>For 2013/14 the trust will look closely at profiling planned and emergency activity particularly over the winter months to ensure there is sufficient emergency capacity without the need to inconvenience patients by cancelling planned operations. |




The trust has retained a former national target as a clinical quality standard. This requires 98% of GP referrals for patients with chest pain to be seen in a specialist cardiology clinic within two weeks.

The standard is designed to reduce preventable deaths from heart attack. For every month of the period April 12 to February 13 all patients referred to the Royal Free were seen within 2 weeks.




Cardiovascular disease is a preventable disease that kills nearly 198,000 people in the UK every year.

The key to improving outcomes after heart attack is to re-establish coronary artery flow as quickly as possible and limit damage to the heart muscle.

Primary angioplasty (also known as PPCI) is a technique for unblocking arteries carrying blood to the heart muscle. It is most effective when undertaken within 150 minutes.

The Royal Free has therefore set a clinical quality indicator requiring 75% of PPCIs to be

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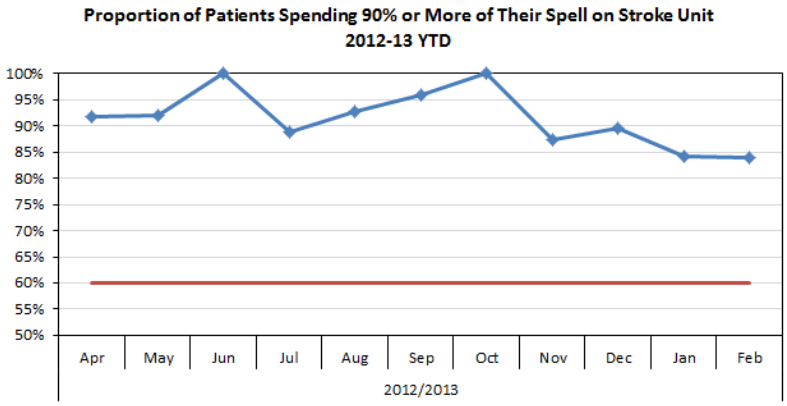
| | undertaken within 150 minutes. The Royal Free performed far better than this with 95.3% of PPCIs completed within this time. |
|  | Clinical evidence demonstrates that patients admitted to a specialist unit following a stroke and who are then treated in this environment for the majority of their care experience far better outcomes.<br><br>The trust has therefore retained a former national target as a clinical quality indicator. This requires that 60% of patients must spend 90% of their time on a stroke unit.<br><br>The Royal Free exceeded this target for every month between April 12 and February 13. However performance has reduced since November 12. For the entire period April 12 to February 13 91.6% of the trusts patients spent 90% of their hospital stay on a stroke unit.<br><br>The trust will investigate the issues affecting the period November 12 to February 13 in order to ensure a return to |

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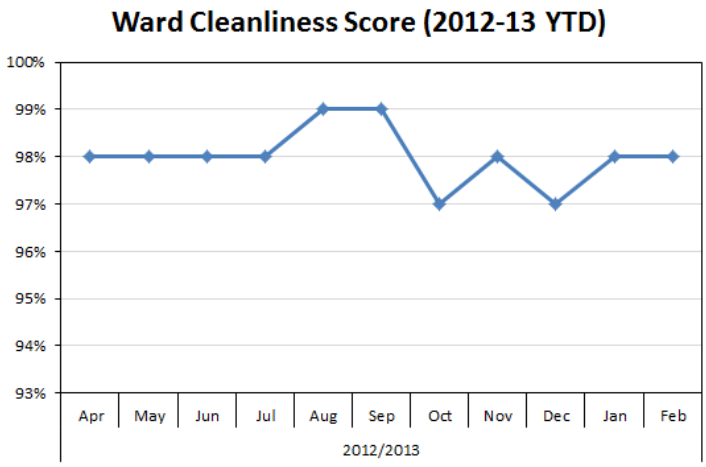
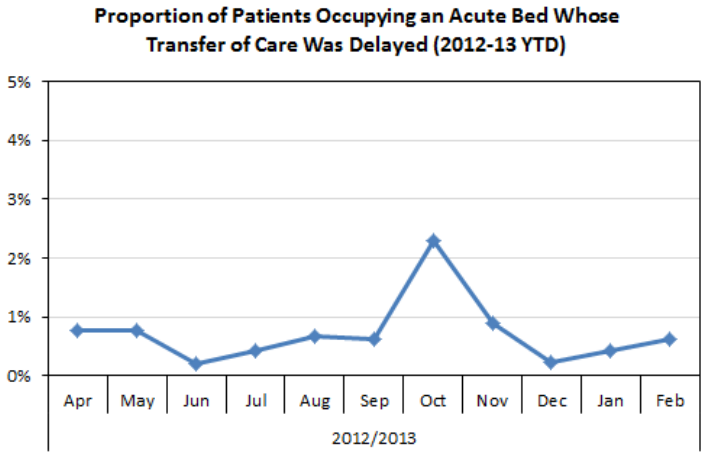
| | previous high levels of performance. |
|  | Ward cleanliness scores are derived from assessments undertaken by the patient environment action team, which includes patients, patient representatives and members of the public.<br><br>The scores were well above the required standard throughout the year. |
|  | Delayed transfers occur when patients no longer need the specialist care provided in hospital but instead require rehabilitation or longer term care in the community. A delayed transfer is when a patient is occupying a hospital bed due to the lack of appropriate facilities in the community or because the hospital has not properly organised the patients transfer.<br><br>This results in the waste of hospital resources and inappropriate care for the patient and the aim therefore is to reduce the rate of delayed transfers.<br><br>Through more effective working with our community |

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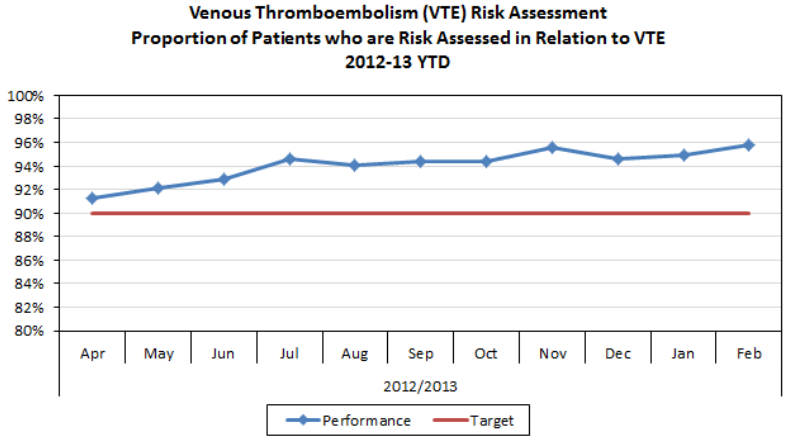
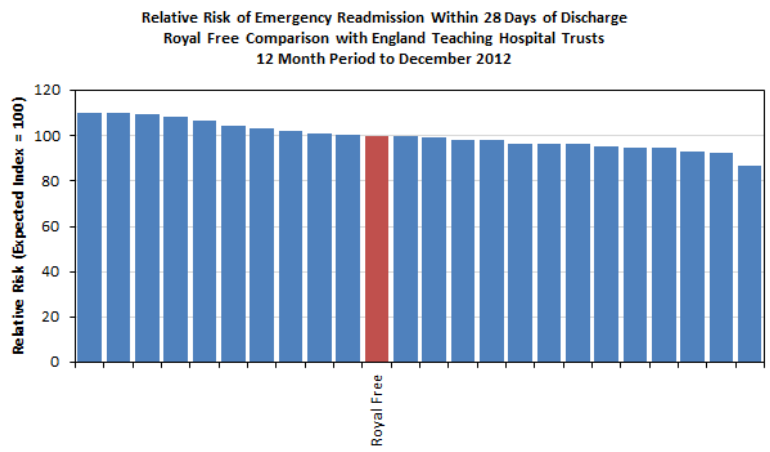
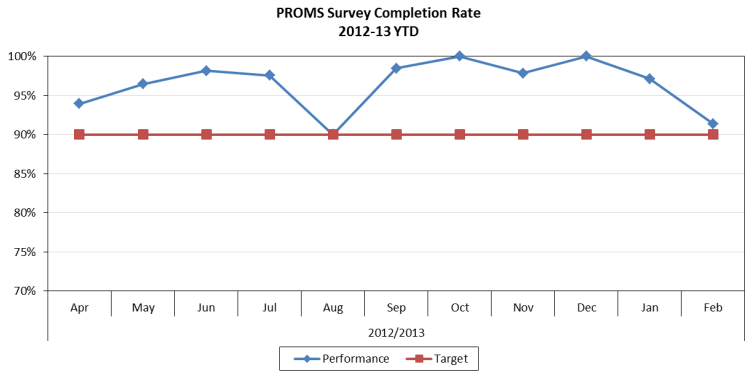
| | partners and better internal organisation, the rate of delayed transfers of care has reduced significantly since 2009. However this year we have seen an increase. Most of these delays were associated with patients waiting for further NHS care provision. These included patients waiting for general, stroke and neurological rehabilitation and continuing healthcare funded placements.<br><br>The trust is working with its partners and commissioning agencies to improve the position for 2013/14. |
|  | Many deaths in hospital result each year from venous thromboembolism (VTE), these deaths are potentially preventable. The government has therefore set hospitals a target requiring 90% of patients to be assessed in relation to risk of VTE.<br><br>The Royal Free met or performed better than the 90% target for every month of the period April 12 to January 13. For the entire period 94% of the trusts patients were risk assessed. |




The Royal Free carefully monitors the rate of emergency re admissions as a measure for quality of care and the appropriateness of discharge. The hospital is working with commissioners, GPs and local authorities to provide reablement and post discharge support in order to reduce the rate of readmissions.

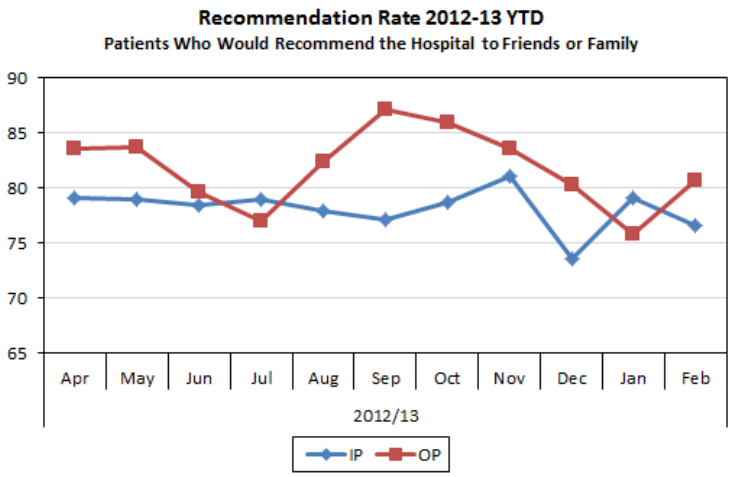
A low, or reducing, rate of readmission is seen as evidence of good quality care. The chart presents the Royal Free's performance relative to English teaching hospital performance.




The trust is required to record national patient reported outcomes measures in four clinical procedures:

- Inguinal hernia
- Varicose veins
- Knee and hip replacement

The trust has achieved or exceeded the 90% target for every month of the period April 12 to February 13.




The inpatient and outpatient recommendation rate is derived from patients entering data onto touch screen devices available on the wards and in clinics.

Patients are asked if they would recommend the hospital to friends or family; a score of 100 would be the highest rating. For the period April 12 to February 13 the trust's recommendation rate for in-patients was 78.3% and for out-patients 82.4%.

**Appendix A**

**A GUIDE TO QUALITY WITHIN THE TRUST**
**APRIL 2013**

## INTRODUCTION

This guide describes how the Royal Free London NHS Foundation Trust ensures the provision of high quality services for its patients. It sets out to describe what quality means for the trust, how the trust sets a culture of quality and high standards throughout the organization.

The guide was originally adapted from the quality governance memorandum prepared for our 2011 foundation trust application and has most recently been revised and updated for inclusion in the trust's 2012-13 Quality Accounts. It is based on the quality governance framework used by Monitor, the independent regulator of foundation trusts. This subdivides quality governance into four main domains: *strategy*, *cultures & capabilities*, *processes* & *structures* and *metrics.*

### What is quality?

The term 'quality' can be used in a number of different ways. In some circumstances it describes how a product measures up to a predetermined specification – *did it do what it said on the tin?* In other contexts quality is measured against expectation – *was it what I thought it would be?* Frequently it is simply used to mean excellence– *a quality product.*

At the Royal Free our focus is on excellence and we therefore aim to provide services of the highest possible quality. This is reflected in the trust's logo – *world class care and expertise*. It is also embedded in our corporate objectives, which reflect our governing aims:

- To deliver excellent patient outcomes, teaching and research. Our aim is to be in the top 10% of our relevant peers. This means maintaining our excellent infection control and patient safety record, continuing to develop and invest in our research and research capacity and developing outcomes measures at clinical service line level.
- To offer excellent patient and staff experience. Our aim is again to be in the top 10% of our relevant peers. The main challenge here is addressing the variability of the patient experience and ensuring we engage all staff in the running and development of the trust and give our staff the skills, resources and support they need to perform to the optimum of their ability.

- To deliver excellent financial performance and value for taxpayers money. Once again. We want to be in the top 10% of our relevant peers. We must have a major focus on productivity and service transformation as we meet the financial challenges ahead.
- To be strongly compliant with the law and the standards and targets set by our regulators and other relevant bodies. This includes health and safety legislation, the CQC regulatory standards and the standards and targets within the NHS operating framework
- To build a strong organization fit for the future. We must ensure that we have the infrastructure, processes and people in place to enable us to deliver the four objectives described above.

In autumn 2011 we commenced our world class care programme, designed to improve patient and staff experience within the trust. As part of this we listened to hundreds of our patients and staff members and have worked with them to develop a set of commitments and standards which we expect all staff to adopt. The standards are:

- to be positively **welcoming**
- to be actively **respectful**
- to **communicate** clearly
- to be visibly **reassuring**

The Royal Free already demonstrates high quality performance in many areas. For example:

- The trust consistently has one of the lowest hospital standardized mortality rates (HSMR) in England
- During 2012-13 only one acquired MRSA (methicillin resistant *staphylococcus aureus*} bacteraemia occurred within the trust
- The trust has the second highest number of highly cited research publications of English NHS trusts

There are also areas in which we know quality must improve. These include:

- The administrative processes which support patients and staff, such as our out patient appointment system
- Levels of reported bullying by staff
- Overall patient experience

**What is quality governance?**

Monitor defines quality governance as the combination of structures and processes at and below board level to lead on trust wide quality performance including

- Ensuring required standards are achieved
- Investigating and taking action on substandard performance
- Planning and driving continuous improvement
- Identifying, sharing and ensuring delivery of best practice
- Identifying and managing risks to quality of care

Monitor requires that the board of directors of an applicant trust confirms, through a board statement and memorandum that it is satisfied that:

- the trust has, and will keep in place, effective leadership arrangements for the purpose of monitoring and continually improving the quality of healthcare delivered to its patients; and

- due consideration has been given to the quality implications of future plans (including service redesigns, service developments and cost improvement plans).

In preparation for its foundation trust application, the trust undertook a review of quality governance led by the medical director and director of nursing. Recommendations from this review were subsequently implemented. In September 2011 the Board commissioned KPMG to undertake an independent review of quality governance. Their report assessed the trust as amber/green against the Monitor quality governance framework and concluded that 'there is sufficient evidence that the appropriate quality governance arrangements are in place to enable the Board of Directors to confirm, by way of a Board Statement and detailed Board Memorandum, they are satisfied that the trust has effective leadership arrangements for the purpose of monitoring and continually improving the quality of healthcare delivered to its patients'. Monitor assessed the trust's quality governance as part of our foundation trust application and determined that it met the criteria for authorisation. The trust plans to undertake a major review of its quality governance every three years, including an external review against Monitor's framework. The next review is due in 2014.

The following sections describe our approach to quality in each domain of Monitor's quality governance framework.

**STRATEGY**

**How quality drives the trust's strategy.**

Each year the board approves three high-level quality improvement objectives that are published in our annual Quality Account. These are agreed following extensive consultation with external stakeholders including the trust's governors, Barnet and Camden Local Involvement Networks (LINKs), Barnet and Camden health scrutiny committees, North London Acute Commissioning Agency and London SHA. In addition our trust members complete an on-line survey. Internally, discussions are held at executive and board level and with staff groups. Our 2012-13 quality improvement objectives were:

- in the area of patient experience, to continue our world class care programme with all staff taking part in a team workshop to set standards and expectations of each other and to agree priorities for improvement. This will support our aim to deliver world class care to every patient, every day. The executive lead for this improvement priority is the director of nursing

- in the area of clinical effectiveness, to continue the development of our clinical specialty based clinical outcome metrics This includes expanding the list of metrics and working with our Academic Health Science centre, UCLPartners, to extend the work to other trusts. The executive lead for this improvement priority is the medical director

- in the area of patient safety, to develop methods for early recognition of severe sepsis. We know this can be a serious cause of patient deterioration and high mortality rates and we are working with staff to raise awareness and education around sepsis. We are developing a pathway to support staff to recognise signs of severe sepsis at an early stage and use an evidence-based "sepsis six resuscitation bundle" to escalate treatment within the first hour. This includes a set of actions which staff must undertake to ensure the best outcomes for patients. This project has been introduced in acute medical wards, renal wards and A&E as pilot areas, with the aim of eventually continuing the improvement work to include all trust areas. The executive lead for this improvement priority is the medical director.

The clinical performance committee and trust board receive regular updates on progress against these objectives.

The trust also drives quality improvement through its Quality, Innovation, Productivity and Prevention (QIPP) programme, led by Director of Integrated Care; and the Commissioning for Quality and Innovation (CQUIN) scheme led by Director of Planning. The QIPP programme incorporates transformational and transactional aspects of clinical management to support the delivery of quality

services whilst at the same time reducing costs over the next five years. The programme responds both to financial pressures, resulting from flat income and expected increase in demand, and our commitment to delivering high quality services. There are currently over 70 active QIPP projects. The CQUIN programme is agreed each year with our local acute commissioners following extensive discussion at a joint monthly clinical quality review group that now also includes input from local general practitioners.

In addition to our annual high-level quality objectives, QIPP and CQUIN programmes, the trust has demonstrated innovation in its approach to quality improvement. This includes development of adult and paediatric early warning systems, the first introduction in the UK of Schwartz rounding, introduction of the productive ward, participation in the Institute of Health Improvement's Safer Patient Initiative and improvement work aimed at early recognition of sepsis. A selection of other quality improvement initiatives is described within our annual "Quality Account". In the latest "Quality Account", published in June 2012, we reported on projects to:

- Improve diagnosis and treatment of heart failure
- Improve waiting times for cancer patients
- Help patients with diabetes receive safer care
- Cure haemophilia through gene therapy
- Prevent elderly patients having unnecessary admissions to hospital
- Improve in-patient care of the elderly

The board is particularly concerned that improvements occur with respect to patient and staff experience, particularly through our world class care programme. The trust communicates and discusses quality initiatives with staff, patients and other external stakeholders in a variety of ways. These include the annual "Quality Account", which we publish with our financial accounts in a single document, regular electronic briefings by the chief executive, meetings of governors, and staff QIPP engagement sessions.

**How the board is aware of potential risks to quality**

Our risk management strategy outlines the trust's approach to risk and details the processes in place to manage risk. The trust maintains a risk register and a board assurance framework, both of which are reviewed and revised on a regular basis. The risk, governance and regulation committee leads this process, but additional review is also undertaken at the trust executive committee, the clinical performance committee, the audit committee and the board. The risk register is populated from a variety of sources including risk registers maintained within

each clinical division, incident forms, audits, benchmarking and external reviews. The risk register and board assurance framework both contain actions to mitigate risk: these are also regularly reviewed.

The board also uses a variety of other mechanisms to assess potential risks to quality. These include, for example, our programme of 'Go See' visits, in which directors are paired with clinical areas that they visit on a regular basis; regular reports to the board from the director of infection prevention and control (DIPC); a range of inspections by external regulators that are monitored by the risk, governance and regulation committee; our quality road map self-assessment process for CQC outcomes; and a wide range of metrics used to monitor performance. The trust participates in national in-patient and out-patient surveys, and uses patient experience trackers throughout the organisation to collect real time feedback from patients and other users of our services. The trust encourages external stakeholders to identify risks to quality through a variety of formal and informal means. These include the patient advice and liaison service (PALS), patient representative groups, LINks forums, public board meetings, local commissioners, governors and the local health scrutiny committees. The board's user experience committee has the key responsibility for monitoring and improving the quality of user and staff experience.

The QIPP programme is a key component of the trust's quality improvement process. However, we recognise that there is also a potential for some QIPP projects that primarily focus on cost reduction to have an adverse effect on quality. To avoid this all QIPP projects are assessed for their potential impact on quality before and after implementation, including a detailed quality impact assessment. Senior clinicians are included within the membership of both the QIPP steering group and the QIPP board, and QIPP projects are separately reviewed by the medical director and the director of nursing for any potential negative impact on quality. A separate clinical advisory group, chaired by a non-executive director and consisting of clinicians not directly involved in developing QIPP programmes, also provides additional scrutiny. In addition the board monitors a set of specific trust wide metrics that may be adversely affected by cost improvement projects.

## CAPABILITIES AND CULTURE

### How the board ensures it has the necessary leadership, skills and knowledge to deliver the quality agenda

The trust board consists of five executive directors (including the chief executive) and six non-executive directors (including the chairman). Three of the executive directors and one of the non-executive directors have clinical backgrounds. In addition, board meetings are attended by a number of other executives, including the three divisional directors who are practicing clinicians. Board members have a wide range of experience and backgrounds, including other NHS organisations, other public sector bodies and the private sector.

The board committee structure is shown in Figure 1 and has been designed to ensure that integrated quality governance is aligned with our governing principles and corporate objectives. A non-executive director chairs all board committees, with the exception of the trust executive committee. Three clinical divisions, established around strong clinical leadership, support the board.

Quality is central to the agendas of the board and all its committees, with a regular focus on quality metrics. Recent examples where the board has clearly taken a central role in quality improvement include the focus on infection control with a sustained reduction in acquired MRSA bacteraemias and the development of a set of around 90 clinical outcome metrics, mostly at specialty level.

The board participates in a comprehensive continuing development programme, which has included an external assessment of its skills and capabilities. Regular board seminars provide the opportunity for directors to expand their knowledge and skills of specific issues including quality governance.

### How the board promotes a quality-focused culture throughout the trust

The board has promoted a number of quality strategies and initiatives that have been developed and implemented with extensive staff engagement. As already described, these include the development of the “Quality Account”, the drive to improve infection control, the QIPP programme, the Safer Patient Initiative, the development of clinical outcome metrics for each clinical business unit and most recently our world class care programme. These and other quality-focused programmes have helped promote a quality-focused culture throughout the organisation. Senior executives are directly involved in quality improvement initiatives: for example the director of nursing is responsible for the falls reduction programme, our infection control programme and the world class care programme; the medical director is responsible for the development of clinical outcome metrics; the Director of Integrated Care is responsible for the QIPP programme.

The board actively encourages staff to participate in quality initiatives. Our EUREKA scheme encouraged staff to suggest quality schemes as part of the QIPP programme. Annual staff achievement awards recognise those individuals and teams that have made a significant contribution to high quality within the trust. Using our clinical incident reporting system, we encourage staff to report errors and adverse events that have, or could have, an adverse impact on quality. Staff receive training and experience in service improvement methodology through direct participation in quality improvement projects, such as our theatre improvement project and our work on sepsis management. Quality improvement projects are reported and communicated by a number of means, including the annual “Quality Account”, Freemail (our regular staff news update) and the chief executive bulletin.

The trust carries out robust recruitment and HR practices that ensure we have a high quality workforce that is safe and responsible in delivering care. We review our policies and procedures regularly with service user involvement and our staff are equipped with the right skills and professional training to keep us compliant with our external and regulatory obligations. We have recently focussed on embedding our world class care values in our recruitment processes.

## PROCESSES AND STRUCTURES

### Roles and accountabilities in relation to quality governance

The trust board is ultimately responsible for the quality of service provided by the Royal Free. It agrees the overall strategic direction for continuous quality improvement, encapsulated by the top 10% aspiration within the governing objectives; sets a culture which promotes the delivery and development of high quality services; and monitors how the trust performs against objectives. Trust board meetings do not treat quality as a separate agenda item as we believe quality should form an integrated part of discussions and decisions in all areas, clinical and non-clinical. Each year the board agrees three high level quality improvement goals that are published in the annual “Quality Account”.

The chief executive’s scheme of delegation describes the responsibilities of individual executive directors. The medical director has overall accountability for the quality of clinical services and is responsible for clinical performance and patient safety; the director of nursing is responsible for CQC compliance and patient experience.

Board committees are aligned with the governing objectives and have a key role in quality governance (Annex 4).

- The *Clinical Performance Committee* meets quarterly and is responsible for seeking and securing assurance that the trust's clinical services, research efforts and education activities achieve the high levels of performance expected of them by the board, namely "outcomes consistently in the top 10% in the UK versus relevant peers". It monitors performance against the trust's three high-level quality indicators, reviews data concerning mortality by specialty and diagnostic group, and undertakes reviews of specialties where concerns may have arisen regarding clinical quality. It is currently working with clinical business units (specialties) to develop a series of outcome measures which, whenever possible, will be benchmarked against other organisations.

- The *User Experience Committee* meets quarterly and is responsible for seeking and securing assurance that the trust's services are delivered to its customers (GPs and patients) so as to achieve the high levels of performance expected of them by the board, namely "recommendation rates consistently in the top 10% in the UK versus relevant peers".

- The *Risk, Governance and Regulation Committee* meets quarterly and is responsible for ensuring that the trust is fully compliant with all its regulatory duties and for ensuring that all material risks to trust objectives are understood and appropriately addressed.

- The *Trust Executive Committee* meets weekly. The role of the committee is to support and advise the chief executive in running the trust, in meeting the requirements of the operating framework, and on strategic priorities and objectives.
- The *Finance and Performance Committee* meets monthly and is responsible for seeking and securing assurance that the trust achieves the high levels of financial and operational performance expected by the board, namely "consistently in the top 10% in the UK versus relevant peers".

- The *Strategy and Investment Committee* meets monthly and is responsible for ensuring that the trust's strategy and investment decisions support the achievement of its governing objectives.

- The *Audit Committee* meets five times annually. It provides the board with an independent and objective review of the effectiveness of the organisation's governance, risk management and internal control systems. It receives evidence and gathers assurance from a variety of sources about the overall quality of care provided by the trust.

- The *Remuneration Committee* meets as required and consists of the trust chairman and non-executive directors. It is responsible for all decisions concerning the remuneration and terms of service for directors.

Beneath the level of board committees, other committees and working groups also play an important role in quality governance. These include groups that have a focus on a specific issue, such as the committee that ensures the trust is compliant with the Human Tissue Act, to those with a broader remit such as the education committee. Our review of quality governance recommended that the majority of these groups should report into the trust executive committee, as this is the board committee that meets most regularly and is able to address operational issues most rapidly. It also provides a key link to the trusts clinical divisions. Reports from these groups are also made available to other board committees, on a regular or *ad hoc* basis as appropriate.

The Trust's clinical services operate within three divisions, *Transplantation and Specialised Services*, *Urgent Care*, *Surgery and Associated Services*. Each division contains a number of clinical business units. Divisions focus on quality within a variety of forums, including divisional safety and quality assurance boards to provide a specific divisional focus to quality governance.

**Processes for escalating and resolving issues and managing performance**

The trust committee and reporting structure has already been described. In addition, the trust uses other mechanisms to gather and escalate quality issues. These include the risk register and the board assurance framework, risk management reports, clinical audit programmes and our internal audit plan. The trust has a whistleblowing policy that is available to all staff on our intranet.

**How the board actively engages patients, staff and stakeholders**

To emphasise our patient focused approach, each board meeting begins with 'patient voices' in which an executive director reads one recent letter of complaint and one of thanks.

The board actively encourages patients, staff and other stakeholders to engage in our drive for high quality through a variety of means. Examples include:

- The extensive engagement that was undertaken for our "Quality Account".
- Patient focus groups that have been established in a number of specific areas.
- The trust's council of governors and membership which have been in place since 2008 (in shadow form to April 2012). The board regularly consults the council and members concerning quality and responds to quality issues raised by the governors. Governors sit on the clinical performance committee and the user experience committee.
- The clinical performance committee has involved governors in the development of specialty clinical outcome metrics.

- Board members regularly undertake 'Go See' visits to clinical areas, which involves speaking with patients.
- The user experience committee regularly reviews the results of patient and staff feedback.
- The board regularly engages with local LINKs and health scrutiny committees.
- The trust meets commissioners, including GP representatives, in a monthly clinical quality group, attended by the trust medical director.
- The trust has appointed a director of integrated care who is responsible for working with commissioners and GPs to develop high quality community based services.
- We are one of the few acute trusts to have appointed a public health lead who works within the trust and with our local community to promote health improvement.

The trust is committed to making its quality performance outcomes as accessible as possible. For example, our comprehensive board performance dashboard is included within the published papers of our quarterly public board meetings. Our "Quality Account" includes a comprehensive set of quality data together with easily understandable descriptions of each metric. Performance metrics are also discussed with commissioners at regular monthly quality review meetings. We have recently begun placing performance metrics on our external internet site.

**MEASUREMENT**

**How appropriate quality information is analysed and challenged**

The trust already generates a large volume of metrics relating to the quality of operational performance, patient safety, patient experience and clinical outcomes. The trust metrics library currently consists of over 200 measurements. This is supplemented by metrics provided by external agencies such as Dr Foster. Additional metrics are also under development; for example the clinical performance committee has developed clinical outcome metrics at clinical business unit level and 6 education and research metrics at organizational level.

Since the appointment of a director of information management and technology in 2010, the board performance dashboard has undergone extensive development. This now provides a comprehensive set of clinical and non-clinical metrics and includes:

- Metrics related to national priorities and regulatory requirements eg A&E metrics

- Metrics specifically related to safety, clinical effectiveness and patient experience e.g. standardized hospital mortality; rapid access chest pain; net promoter score
- Metrics specifically related to early warning of quality deterioration eg patient falls, average length of stay
- Metrics related to adverse events and harm eg never events, MRSA rates
- Monitors risk ratings
- RAG rating and an overall commentary on performance.

The board dashboard is focused on those metrics that are most relevant to the governing principals and corporate objectives. Further metrics are reviewed in other trust committees: for example the operations board reviews a comprehensive set of operational performance metrics and the user experience committee reviews patient and staff survey metrics. Divisional dashboards include division-specific metrics. The trust executive committee reviews a ward-based 'heat map' of patient experience, workforce and safety metrics on a monthly basis. The Risk, Governance & Regulation committee reviews the trusts quarterly self-assessment of compliance with CQC standards.

The trust is currently implementing service line reporting within its clinical business units. This will facilitate better analysis of metrics at specialty and consultant level. Consultant level review is being incorporated into our revalidation processes for medical practitioners.

Each metric is 'owned; by a board committee and/or executive director.

**How the board assures the robustness of quality information**

The data quality committee is responsible for monitoring and reviewing the quality of data captured by the trust's systems. This is supplemented by internal audit reviews and external reviews such as the payment by results audit. External auditors also review the quality of data in our most recent "Quality Account". Action plans are agreed following data audits and monitored by the relevant committee.

The accuracy of coding is reviewed as part of the payment by results audit and is reported in the Quality Account. The trust has established a clinical data quality group to drive improvement in clinical documentation and coding quality.

The trust is increasingly using electronic systems to capture and report key metrics and the information team is currently developing the automation of such reporting.

The trust actively encourages participation in national clinical audits and confidential enquiries. In 2011/12 we participated in 98% of the 42 national clinical audits for which we were eligible and both of the national confidential enquiries for which we were eligible. The trust reviews the outcome from these audits and when concerns arise will undertake specific reviews.

**How quality information is used effectively**

The trust dashboard includes RAG rating of individual metrics against targets and shows trends of performance overtime. Wherever possible, the trust also benchmarks performance against comparable organisations. All reports include the most recently available data. The trust is increasingly working towards on-demand electronic availability of metrics from its extensive metrics library.

The regular review of metrics has helped drive a number of improvements in quality. Examples include:

- Improvement in MRSA rates
- Improvement in the number of cancelled operations
- Improvement in early intervention in sepsis

All metrics are now presented in a consistent format within the board dashboard. Furthermore, descriptors are being developed that provide an easily understandable guide to the purpose and source for each metric: the Quality Account provides an example of this approach.

**CONCLUSION**

This guide describes how the Royal Free London NHS Foundation Trust approaches quality. It complements the trust's annual Quality Account, which reports on the quality of our services over a specific 12-month period. The latest Quality Account is available at rfquality@nhs.net. This guide is revised on an annual basis and is included it as part of our Quality Account. The guide was last revised in April 2013.