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Part one: Embedding quality

Statement on quality from the chief executive

I would like to welcome you to the 2016-17 quality report which is designed to summarise our performance at the Royal Free London NHS Foundation Trust. It provides assurance to our commissioners and patients that we provide high quality clinical care, and also identifies areas where we could perform better and what we are doing to improve.

We have a huge amount to be proud of. Our staff are hugely committed and skilled and deliver a high quality service to our local population, and also nationally and internationally to those who require our specialist expertise. Our trust also has a strong focus on teaching and education and with that comes a willingness to learn and push ourselves to be the very best.

We were delighted that in August 2016 the Care Quality Commission rated the trust as ‘good’, recognising the hard work of all of our staff. All three of our hospitals, Barnet Hospital, Chase Farm Hospital and the Royal Free Hospital, were rated ‘good’ – an unprecedented achievement for a London trust.

We were rated ‘good’ in the four categories of effectiveness, care, responsiveness and well-led, as well as in the twenty-one core services inspected. However we were rated as ‘required improvement’ in the safety category, although the inspectors found examples of safe care in many of the services they inspected.

This is a significant expression of confidence in our progress as a trust and we look forward to going from strength to strength as we build on this success. Our ambition is to achieve an ‘outstanding’ rating next time the CQC visit. Our quality account provides details of our high level quality priorities for the next year which will help us achieve this objective. This includes further enhancing and supporting dementia care initiatives and plans to recruit 30 patient and family experience partners to support improvements in patient care.

Quality improvement is a major focus for our organisation and we strongly believe it is an ongoing process. For that reason we have chosen to continue with our improvement projects from last year, including our patient safety programme which covers such important areas such as reducing the proportion of patients that experience moderate harm (or above) from falls and reducing the number of cardiac arrests.

We continue to develop our Royal Free London group model as part of the NHS England new care models programme. This gives us the freedom to form stronger partnerships with other NHS trusts. Alongside other healthcare experts we can share ways of working which we know deliver the best outcomes. Through close collaboration we can reduce variations in patient care and the cost of treatment. This is a very exciting opportunity, and we continue to work closely with the North Middlesex University Hospital NHS Trust in particular to share learning and best practice across both organisations.

Detailed action plans are in place to ensure we meet the standards all of our patients expect in these important areas. We recognise there are specific areas where we still need to improve – the 62 day cancer target and our A&E performance will both be areas of intense focus over the coming 12 months.

I believe the evidence provided in this quality report demonstrates our commitment to providing the highest quality clinical care. I confirm to the best of my knowledge the information provided in this document is accurate.

David Sloman
Chief executive
30 May 2017
Part two: priorities for improvement and statements of assurance from the board

This section of the quality report describes the progress made against our priorities during 2016/17. It includes a look back on how the priorities were chosen and the process for monitoring and reporting improvements throughout the year. Our priorities for the year ahead are also presented, along with a series of mandatory statements on key quality activities, which are outlined within the section, statements of assurance from the board.

Priorities for improvement

In 2015/16, following consultation with our key stakeholders, we agreed that during 2016/17 we would focus on three areas of quality; patient experience, clinical effectiveness and patient safety.

During the year, progress to achieve our quality priorities has been led by a designated senior executive lead and monitored at our board level committees as illustrated in table 1. Further discussions were held with our trust executive committee (TEC) and council of governors with overall ratification given by our trust board.

Table 1: Quality domains with designated trust lead and associated committee

<table>
<thead>
<tr>
<th>Quality domain</th>
<th>Designated trust lead</th>
<th>Associated committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient experience</td>
<td>Associate medical director for patient experience</td>
<td>Patient and staff experience committee (PSEC)</td>
</tr>
<tr>
<td>Clinical effectiveness</td>
<td>Associate medical director for clinical effectiveness</td>
<td>Clinical performance committee (CPC)</td>
</tr>
<tr>
<td>Patient safety</td>
<td>Associate medical director for patient safety</td>
<td>Patient safety committee (PSC)</td>
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Progress against 2016/17 quality priorities

This section provides details on how the trust has performed against its 2015/16 quality account priorities. Overall the results presented relate to the period April 2016 to March 2017 or the most recent available period.

Overarching quality priorities: Continual development of a strong organisation

In addition to agreeing to have quality priorities, the trust also agreed to have an over-arching quality priority – the continual development of a strong and highly capable organisation – that originated from the five principles identified within our quality strategy.
Principles for our quality strategy

1

Everyone’s primary goal and duty is improvement on things that matter to patients. Patients, families and carers will genuinely and consistently be at the centre of the work.

2

We will constantly deploy iterative, reflective cycles of planned changes, linked to measurement over time, led by the multi-professional teams which serve patients (or other ‘customers’).

3

We will build capabilities in continuous improvement, build capacity in coaching for improvement and build a learning organisation.

4

Our approach will focus on equipping front-line staff to gain greater control of the systems that they work in.

5

All trust initiatives and strategies will dovetail and pursue the same goal of quality and continuous improvement.

Led by our director of quality, the quality strategy centred on equipping staff with the capabilities to make continuous improvement central to their daily work. The strategy outlined five principles which supported our governing objective for continual development of a strong and highly capable organisation.

An evaluation process was built into the implementation and delivery of the quality strategy, which identified five success measures which were to be achieved by 2020. Progress was also monitored at TEC and the trust board.

Five tests of successful implementation of our quality strategy

1 That critical numbers of staff have been trained in and meaningfully use RFL’s approach to quality improvement in daily work.

2 That patients and carers are pleasantly surprised by how well their needs and preferences are anticipated and acted on – reflected in increased positive feedback and fewer complaints.

3 That all staff can articulate the quality metrics most relevant to the context in which they work, and are aware of current performance level and trend.

4 That staff morale, recruitment and retention rise. Over time, that people choose RFL as a place to work because of its reputation for embedding continuous improvement into routine practice.

5 That RFL’s performance on “hard” system quality metrics and efficiency is exemplary and improving over time: for example, patients report greater satisfaction through better access and find services more responsive to their needs and preferences; staff report greater satisfaction from greater support and enhanced capabilities, reflected in national surveys.
Improving quality priorities for 2016-17

<table>
<thead>
<tr>
<th>What were our aims?</th>
<th>What did we achieve?</th>
</tr>
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<tbody>
<tr>
<td>For the trust board and senior leadership to work on their collective development, enabling them to provide effective leadership for improvement across our hospitals.</td>
<td>Workshops on ‘leading for improvement’ were led by Institute for Healthcare Improvement (IHI). Attendees included:</td>
</tr>
<tr>
<td></td>
<td>• trust executive committee</td>
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<td></td>
<td>• trust board</td>
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<tr>
<td></td>
<td>• 112 senior leaders across disciplines and professions trust-wide</td>
</tr>
<tr>
<td>To use a diagnostic tool assessing our readiness for quality improvement (QI), helping us prioritise and focus our work to implement the quality strategy.</td>
<td>Trust wide QI diagnostic assessment sessions were held with IHI in June 2016 over three days. In total, over 70 sessions were conducted with patients and over 500 staff participated.</td>
</tr>
<tr>
<td>To begin to build our trust wide improvement team and faculty whose job is to support quality improvement work at the front line across the trust.</td>
<td>The trust has developed a QI team and plans are in place to recruit members in the first half of 2017/18.</td>
</tr>
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Priority one: Improving patient experience – delivering excellent experiences

We aim to put the patient, carer and our staff at the heart of all we do in delivering excellent experiences. The trust’s definition of patient experience is derived from the Beryl Institute: ‘The sum of all interactions, shaped by the culture of the Royal Free London that influence patient and carer perceptions across their pathway’.

We are fully aware that in delivering this definition we need to do more than provide excellent clinical outcomes. At the start of each board meeting patient stories are presented which articulate the experience of the care we deliver through a complaint and a compliment. It allows the board to see the impact of decisions they are making and how embedded the world class care values are in the organisation.

Building on our four-year patient experience strategy (which was published in autumn 2015) we continued to focus on making improvements for those who use our services, their carers and families; with an added emphasis on dementia and end of life care. Through the patient and staff experience committee (PSEC) we have monitored, measured and reported progress to achieving our priorities. The committee reports quarterly to the trust board.
<table>
<thead>
<tr>
<th>What were our aims?</th>
<th>What did we achieve?</th>
</tr>
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<tr>
<td>To publish an annual report; to include a statement of dementia care on progress against the trust dementia strategy and fixed dementia care (Alzheimer’s Society report) metrics.</td>
<td>We successfully published our annual report in November 2016 and included a statement on progress against the trust dementia strategy. Our dementia lead has written the trust dementia strategy for 2017-2019 which has been approved and agreed by the dementia implementation group (DIG) and is currently being implemented.</td>
</tr>
<tr>
<td>To allow flexible visiting times for carers of people living with dementia on 100% of in-patient wards</td>
<td>For this priority, the trust chose to embed the principle of ‘John’s Campaign’, which focuses on the right of people with dementia to be supported by their carers in hospital. John’s Campaign was founded after the death of Dr John Gerrard in November 2014. John Gerrard had been diagnosed with Alzheimer’s disease. The DIG has taken a non-prescriptive approach to implementing John’s Campaign as we strongly feel that participation must be at the discretion of the ward manager and their matron. As a result, implementation of John’s Campaign remains voluntary. We now have 71% of all wards signed up and actively practising John’s Campaign. We have three champion wards across our sites, which collect feedback and data related to the campaign. DIG members from these wards will share this information and encourage the remaining wards to participate.</td>
</tr>
</tbody>
</table>
| To achieve trust certification for ‘The Information Standard’ by 2018.            | Supported by NHS England, The Information Standard is a certification programme designed to ensure that public health information services adhere to:  
  • a set of best practice principles  
  • use only recognised evidence sources  
  • present all information in a clear and balanced way.  
In January 2016, we produced a patient information policy and are in the process of implementing this across the trust. This forms the foundation for the trust’s future application for the Information Standard and to achieve certification by 2018. |
| To ensure that 95% of patients (identified as end of life) have an end of life care bundle in place. | Subsequent to the Royal College of Physicians (RCP) – National Care of the Dying Audit of Hospitals (2015), the palliative care team is working with renal, intensive care unit (ICU), health services for elderly people (HSEP) and cardiology teams to identify patients who are likely to be approaching the end of their lives to assess of their capacity to be involved in decisions about their care. The assessment allows the patient to make know their wishes and preferences and to support them and their families in ethical decision-making about end of life care. The results of this work are in their infancy but will be available for publication in due course. The palliative care team have also contributed to the patient safety work around the deteriorating patient and we have also applied for funding for an end of life care programme manager to further drive improvements in this area. |
Priority two: Improving clinical effectiveness – delivering excellent outcomes

Clinical effectiveness can be measured using various methods including clinical audit, to ensure high quality patient care and outcomes. During 2016/17, we chose to further drive improvements in dementia care, building on the key messages that were identified from the National Audit of Dementia (NAD) 2013 and the pilot for national dementia 2015/16. Through the clinical performance committee (CPC) we monitor, measure and report progress. The CPC reports quarterly to the trust board.

Clinical effectiveness priorities for 2016/17

<table>
<thead>
<tr>
<th>What were our aims?</th>
<th>What did we achieve?</th>
</tr>
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</table>
| To further enhance and support dementia care initiatives across the trust, as previously identified in the National Audit of Dementia (NAD) 2013 and more recently in the pilot for national dementia 2015/16. | According to the NAD (2013), at any one time, a quarter of acute hospital beds are occupied by dementia patients.  
We recognise that caring for someone with dementia or a terminal illness can be stressful and difficult, so it is important our services provide people with dementia and their carers with the support they need.  
As a result, we have developed a ‘passport’ that entitles carers of people with dementia to reductions in the canteen, reduced parking costs, free massages and companionship from our dementia volunteers. |
| Linked with our patient experience priorities on dementia, we will work to improve our discharge co-ordination for patients with dementia. | The trust is currently participating in the national audit of dementia, which is due to publish its findings in May 2017. The national audit supplier has recently commended both the Royal Free and Barnet hospitals on their carers questionnaire submission, asking for feedback on our process so it can be shared with other trusts. |
| To develop those metrics which will enable us to measure improvements in dementia care | The metrics have been developed by our dementia lead and work is in progress to embed these across the trust. |
Additional measures to support dementia

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

The trust has continued prioritising dementia care, and our dementia lead and dementia implementation group have developed metrics which includes monitoring length of stay, place admitted from, discharge destination and readmission within 30 days.

Additionally we have developed a framework called CAPER which is designed to support and upskill staff working with patients experiencing dementia and/or enhanced care needs.
CAPER stands for:

C Collateral and communication getting the right information from the right people and using specialist communication techniques

A Assessment understanding behaviour as a form of communication and understanding reversible causes of distressed behaviour, pain and delirium

P Partnership working alongside patients, families and carers

E Enablement helping patients maintain the skills and function they came in with

R Role-modelling using your own skilled practice to inspire cultural change
High priority: Delivering safe care – improving patient safety

Through the patient safety committee (PSC) we have monitored, measured and reported progress made during 2016/17 to achieve the set priorities. The committee reports quarterly to the trust board.

Our aim is to become a zero avoidable harm organisation by 2020, initially by reducing the level of avoidable harm at the trust (measured by incidents relating to NHS Litigation Authority claims) by 50% by 31 March 2018. Our targets are set out in our three year patient safety programme (PSP) improvement plan and we will be delivering key milestones along the way.

While the quality report's focus is on patient safety (as determined by the legal framework), we also take our staff safety just as seriously. Throughout the progress updates reviewed here, there are references to communication, debriefs and huddles, and all of these help support our staff to provide quality care to our patients. Our chosen priorities for 2016/17 were as follows:

**Falls prevention**

- To decrease by 25% the rate of falls incidents per 1000 occupied bed days (OBDs) from a mean of 4.9 in 2014/15 to a mean of 3.7 in 2017/18.

- To reduce by 20% the proportion of patients that experience moderate harm or above from falls from a mean of 0.134 in 2014/15 to a mean of 0.107 in 2017/18.

**What were our aims for 2016/17?**

- We aimed to harmonise documentation relating to falls risk assessment so that we could introduce a falls package that includes the falls assessment, specialising assessment, care plan, bedrail assessment and post-fall checklist.

- We aimed to develop an amended ‘immediate post falls care guideline’ that can work across all sites.

- We aimed to continue with the trust-wide IHI learning sessions and increase our informal meetings to enable monthly peer review, sharing and challenge.

**Progress to date**

As part of the IHI breakthrough series collaborative process we have implemented small changes in pilot wards and assessed progress and shared learning in formalised learning sessions, webinars and action periods.

We are actively counting the number of days since the last fall on each pilot ward to encourage engagement and develop healthy competition.

We submitted our falls improvement work to the Patient Safety Awards, held at the Patient Safety Congress and were short listed as a finalist. We also presented our falls improvement work at the ‘falls prevention and management’ conference on 6 July 2016.

We have shared our work at both national and international conferences – 17th International Conference on Falls and Postural Stability (September 2016), The Science of Improvement Conference (November 2016) and National Patient Falls Improvement Collaborative run by NHS Improvement and NHS England where 21 trusts participated from across the UK.

We are capturing plan, do, study, act (PDSA) improvement cycles for each pilot ward and in total, we have tested 33 PDSAs, of which: 16 PDSAs were completed and adopted; two PDSAs were completed and abandoned; and 15 PDSAs are currently in progress.

At the third learning session in September 2016, all 10 participating wards shared their successes, barriers and lessons learnt via storyboard presentations and informal dialogue and exchange. In addition to this, the focus of the third learning sessions was to understand the legal implications associated with an in-patient fall and also to understand their systems or processes. 37 staff attended this session with many completing the patient safety culture survey.

The most improvement in our patient safety culture was demonstrated between learning sessions 2 and 3 relating to question 10 – ‘I have made a mistake that had the potential to harm patients’. We believe that this is due to increased awareness of patient safety, rather than a decrease in quality. In addition, improvements were also sustained in questions 3, 4 and 7, where staff are reporting that they regularly discuss learning from falls incidents, were involved in safety briefings where falls are discussed; and are receiving detailed handover of falls.
For IHI ‘action period 3’ of the breakthrough series collaborative, falls champions shared their work and there was a decrease in falls incidents and harmful falls in the pilot areas in comparison to last year:

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls incidents</td>
<td>471</td>
<td>434</td>
</tr>
<tr>
<td>Harmful falls</td>
<td>11</td>
<td>4</td>
</tr>
</tbody>
</table>

**Figure 1:**
Rate of falls: April 2014-February 2017

**Figure 2:**
Rate of harm: April 2014-February 2017
Acute kidney injury (AKI)

Aims

• To increase by 25% the survival for in-patients with AKI, by increasing from 73% to 80% by 2018.
• To increase by 25% the proportion of patients who recover renal function from 68% to 85% by 2018.
• To reduce by 25% length of stay of AKI patients from 5 days to 3.5 days by 2018.
• To measure and improve patient experience and wellness scores by 31 March 2018.

What were our aims for 2016/17?

- We aimed to co-design and deliver an educational package to build capability and knowledge around recognition and treatment of AKI.
- We aimed to co-design a care bundle package to support local clinical teams to deliver interventions specific to AKI pathology, such as hypoperfusion, toxicity, obstruction and primary renal disease.
- We aimed to develop a reliable creatinine review and response system.

Progress to date

Initial AKI improvement work has started at the Royal Free Hospital before rolling out to the other sites. This improvement work is a collaboration between the renal team, patient at risk resuscitation team (PARRT), the patient safety programme team, pharmacy services and dietetic services alongside DeepMind Health.

Our AKI champions have been collecting and analysing baseline data for Royal Free Hospital patients. The champions presented the Royal Free London storyboard at the regional University College London Partners (UCLP) measurement day with eight other trusts.

Changes that are currently being tested include the designing and testing of enhanced care AKI care pathway:

a) A technology platform (Streams App), developed in partnership with DeepMind Health. It utilises the national mandated AKI detection algorithm and sends AKI alerts with other relevant data to the clinical responders.

b) Response team, which consists of the on-call renal consultant and the renal registrar as primary responders. Secondary responders will include the PARRT team and renal pharmacy.

c) AKI care plan – completed by the response team as a written handover to the clinical ward team.

We are now also testing our AKI patient experience survey on the renal ward at the Royal Free Hospital, 10East. This survey has been co-designed with AKI patients and our patient experience team.

We have analysed last year’s data relating to the number of new AKI patients identified per ward. This data identified the six wards on which the highest numbers of the AKI triggers were received.

These are all non-renal wards: emergency department, 8 North, 9 North, 8 West, 9 West and 10 West. We are in the process of developing a training pack for AKI education to all multi-disciplinary team on these wards.

Our progress is shown below:
Figure 3: Survival for inpatients with AKI

Figure 4: Proportion of patients who recover from renal function

Figure 5: Length of stay for AKI patients
Safer Surgery

Aims

- To improve compliance to 95% with each of the five steps to safer surgery by 2018
- To reduce by at least 50% the number of surgical never events from nine in 2015/16 to four by 2018.

What were our aims for 2016/17?

- By scaling up our plan-do-study-act (PDSA) cycles, we aimed to develop locally driven methods to robustly embed the quality of the content within steps 1 and 5 (the brief and debrief) in the theatre lists across all sites.
  (See glossary of terms for details on the five steps for safer surgery)
- We aimed to co-design and test interventions to improve team culture and buy-in across general theatres, particularly during sign in, time out and sign out (steps 2, 3, 4). This will include the co-designing and implementation of a local theatre/surgery faculty to build human factors skills and knowledge capabilities.
- We planned to co-ordinate the development of an organisational framework for implementation and co-design of local national standards for invasive surgical – related procedures.

Progress to date

We have continued to test the debrief tool (step 1 and 5) in nine theatres. Testing of this tool started in October 2015 and we have now captured over 995 team debriefs.

Current multidisciplinary team (MDT) contribution of the three most senior disciplines and observed ‘buy-in’ to the running debrief continues to be captured and measured monthly.

Recent learning includes improving the effectiveness of the debrief by testing the idea of weekly summaries of Monday to Friday debrief data. This is expected to be the most efficient method for collection, analysis and sharing of information from the debrief tool.

Through this testing it has been highlighted that staff did not feel confident with how to escalate some issues raised. This has resulted in an escalation ladder to accompany the debrief tool, with clearer instructions and contact details for different categories of issues.

We have co-ordinated the development of an organisational framework for implementation and co-design of local national standards for invasive surgical related procedures (NatSSIPs) and will include this within our approach as we develop our safer surgery improvement plan over the next two years. The safer surgery policy incorporates LocSSIPs.

We have identified a more robust observational tool for counting swabs and instruments within maternity services (step 4). Our updated swabs, instruments and needles counting policy has been developed and dissemination of this includes a new peer review of competency of scrub practitioners. The collection of step 4 data started in February 2016 with weekly updates. The observational collection of counting swabs and instruments within maternity services (step 4 data) now happens on three sites.

By incorporating the findings of root cause analysis (RCA) of previous never events and conducting a literature search of the relevant evidence base, the team have commenced observational data collection of distractions and interruptions. We are having active collaborative discussions with Loughborough University human factors team about the participation in their study of the processes that influence distractions and interruptions.
Continual measurements:
The charts in figure 6 and 7 shows where the key members of the MDT observed ‘buy in’ at various steps for safer surgery.

**Figure 6: Improving compliance for safer surgery**

The charts in figure 6 and 7 shows where the key members of the MDT observed ‘buy in’ at various steps for safer surgery.

**Figure 7: Improving compliance for safer surgery**

In 2016/17, we reported four never events (in comparison to 10 in 2015/16); two were surgical never events: the wrong tooth was extracted and the wrong endoscopy performed (see part 3.3 for more information on our never events).

**Figure 8: Number of never events**

In 2016/17, we reported four never events (in comparison to 10 in 2015/16); two were surgical never events: the wrong tooth was extracted and the wrong endoscopy performed (see part 3.3 for more information on our never events).
Deteriorating patient

A deteriorating patient is someone who becomes acutely unwell in hospital. This deterioration is recognised by staff who monitor the patient's vital signs such as heart rate and blood pressure, and who will then deal with this deterioration by acting directly, or escalating issues to more senior staff when needed. Occasionally, a patient's deterioration is not identified, recognised, or not acted upon sufficiently rapidly and this can lead to sub-optimal care and a patient safety incident such as an unexpected cardiac arrest. By focussing on this area, we will improve the quality of care for all our patients.

Aims

- To reduce the number of cardiac arrests to less than 1 per 1,000 admissions at both Barnet and Royal Free hospitals by 2018.

What were our aims for 2016/17?

- Five pilot wards were identified across the trust (including obstetrics) where we sought to trial specific change interventions such as SBAR (situation, background, assessment, recommendation) handover quality, ward rounds, board rounds and safety huddles.
- These interventions were to be measured so that staff receive timely feedback and PDSA cycles of improvement can be enacted.
- We aimed to introduce ward-based metrics, such as ward cardiac arrest rates, so that staff can understand their baseline data and have real-time feedback on progress.
- We planned to undertake targeted case note review and audit of patient deaths (both unexpected and expected) in the pilot ward areas involving ward staff alongside members of deteriorating patient workstream. Areas for improvement and lessons learnt were to be shared back with ward staff.

Progress to date

We are drafting a communication bundle and are starting to define what to measure for handovers, ward rounds and board rounds and the risk and resuscitation team- (Patient At Risk and Resuscitation Team (PARRT) are testing a handover tool. We have observed a variety of handover and board rounds in pilot areas to develop understanding of the quality of staff-to-staff communication.

We have undertaken 12 staff interviews at the Royal Free and Barnet hospitals where strong themes have emerged and potential gaps have been identified. We have also hosted our first patient community focus group, with charity funding, where we tested narrative relating to clinical end of life discussions with patients and families. Coding of these interviews and discussions is being undertaken against the COM-B behavioural model to help narrow the focus on what to measure.

The clinical MDT on our cardiology ward has collaborated with PARRT to review processes around the recognition and management of the deteriorating patients. Initially a medical records review was undertaken relating to 31 patient deaths over a nine month period (November 2015-August 2016). This review identified 20 patient deaths that were expected, and 11 where resuscitation was undertaken, ie the death was not planned for. Of these 11 patients, four patients died less than 24 hours after PCI (percutaneous coronary intervention) and the other 7 had multiple co-morbidities. No problems in care or service delivery were identified as contributing to these patient deaths. These reviews identified the following themes that have been shared with consultants, the cardiac catheter laboratory and ward staff:

- delayed recognition of poor trajectories of chronic conditions
- delayed end of life decision making
- all those patients who died following cardiac arrest were in a ‘non-shockable’ rhythm, which is indicative of expected very poor clinical outcomes, most often resulting in death.
The initial planning phase on 10 West has identified team communication processes and lack of opportunity for the MDT to make shared decisions as areas for improvement. Rapid PDSA cycles have commenced to re-design the content and structure of information on the ward white boards. These boards display significant pieces of clinical and social information to support anticipatory care planning discussions and help facilitate a planned weekly MDT meeting, supported by PARRT and palliative care teams. Recent testing has provided shared knowledge and learning around:

- early identification of complex patients with chronic poor trajectory of health conditions
- timely identification of patients that require MDT discussion e.g. complex social and medical needs have been highlighted
- how to better recognise patients ready for discharge, prompting discussion of potential discharge date and synchronising care packages accordingly.

**Figure 9:**
Trust wide cardiac arrest rates

**Figure 10:**
Cardiac arrest rates at Royal Free Hospital

**Figure 11:**
Cardiac arrest rates at Barnet Hospital
Deteriorating unborn baby

Our initial work in this area has been funded by the NHS Litigation Authority, based on the extremely high costs of claims. Therefore, our aim is to reduce these claims, which will ultimately be reflected in a reduction in harm to the unborn baby. We realise that this is not a person-centred aim and are in the process of developing more relevant measures for this workstream.

Aims

- To reduce by 50%, the number of incidents resulting in a claim relating to deterioration of the unborn baby from a mean of two per year to a mean of one per year, during three years: 2015-2018.

What were our aims for 2016/17?

- We planned to set up the unborn baby working group and sought out to map out ideas for change/improvement. This was to include the identification of a clear aim, driver diagram and process measures.
- We planned to identify pilot area champions within Barnet and Royal Free hospitals’ labour ward

Progress to date

Baseline data have been collected from incidents to provide a themed analysis to understand current barriers. The baseline data have been shared with staff at audit and perinatal meetings and will be absorbed into the online maternity ‘lesson of the week’ feedback processes.

We have identified champions and have hosted two maternity ‘planning meetings’ with neonatologists, midwives and obstetricians where they have created a driver diagram.

External collaboration with Scottish National Maternity Patient Safety team has enabled sharing of ideas and approaches including testing MDT huddles.

We have spent some time information gathering to triangulate data sources for the tracking of new-born episodes, including accessing the national database ‘Badgernet’ and local maternity unit systems to capture babies transferred externally.

A staff confidence survey for all maternity staff was undertaken to help influence the design phase of the planned cardiotocograph (CTG) education package for 2017.

NHS England ‘Sign up to Safety’ campaign launched a ‘national safety kitchen table’ week, and this was undertaken on Barnet and Royal Free labour wards. Themes and discussions were collated and shared through maternity staff.

As part of our sepsis programme, we have included the 2016/17 national sepsis CQUIN which focusses on timely screening, identification and treatment for sepsis in the following areas: ED, acute inpatient settings and paediatrics.

Data collection included: sepsis screening and documentation with observations recorded, and severe sepsis/shock and timely intravenous antibiotics (IVAB) within one hour and review of IVAB at 72 hours.

Figure 12: Number of claims per year

![Deteriorating unborn baby number of claims per year](image-url)
Sepsis

Aims

• To reduce by 50% severe sepsis-related serious incidents across all sites.
• To increase survival by 50% for those patients on the sepsis bundle across all sites.

What were our aims for 2016/17?

• We aimed to use continual PDSA cycles to improve our compliance in the newer pilot ward areas such as Barnet Hospital’s emergency department and maternity.
• We aimed to test the behavioural theory-identified recommended modifications for improvement: standardisation of education sessions, partnership agreement, and frequently asked questions guidance in our pilot ward and measure this in practice.
• We aimed to further develop the sepsis champion role in pilot areas to enable long term sustainability in all 10 pilot wards.

Progress to date

Over 2015/16 there was four serious incidents relating to sepsis, with an additional incident in 2016/17 to date. The majority of these incidents occurred in Barnet Hospital and so this has influenced our drive for sepsis improvements in this location for 2016/17.

The sepsis bundle is now implemented in 10 of our clinical areas, which includes our labour wards and emergency departments (ED). In August 2016 at Barnet emergency department (ED) compliance with the sepsis six bundle was 65% - the highest compliance since pilot launch. Tests of change have included using a sepsis stamp for documentation and a sepsis trolley to ensure prompt treatment.

Three nurse champions have now been recruited, though a new consultant is needed as sepsis lead. The severe sepsis pathway has now been added to the ED admission booklet.

The maternity sepsis team published their sepsis improvement poster at the Royal College of Obstetricians and Gynaecologists (RCOG) conference in June 2016. This collaborative piece of work outlined the success of obstetric Sepsis 6 improvement work on RFH and BH labour wards, highlighting the success of sharing and learning from each other. Sepsis pathway triggers and pathways have been standardised across trust with the implementation of sepsis stickers and sepsis trollies. Feedback from maternity staff has shown that the implementation of a Sepsis 6 pathway has improved and simplified the management of severely septic women in the maternity service.

Barnet labour ward has celebrated an achievement of 100% compliance for all Sepsis 6 within an hour in August 2016. Monthly sepsis improvement meetings continue and champions are encouraged to attend and present their data.

UCL Partners (UCLP) sepsis collaborative hosted an informative measurement day 21 September 2016. The Royal Free London champions presented our approach at the final UCLP collaborative summit event on 2 December 2016.

To support the sepsis improvement work across both the Royal Free and Barnet hospitals, an awareness day was set up to support the clinical teams involved. Sepsis champions showcased their experiences of Barnet labour ward and ED successes. The event was held at Barnet Hospital and about 40 doctors, nurses and nursing students attended. This event was well supported by the trust executive team.

In the session staff gained knowledge on:
• the use of behavioural science research in the sepsis improvement work (COM-B model);
• current National Institute of Clinical Excellence for Health and Care Excellence (NICE) guidance;
• role of a sepsis champion; and
• how to manage sepsis with a multi-professional team – demonstrated by simulation.

One of our patients has been treated at the trust for sepsis many times, and he kindly agreed to create a short video that documents his journey over the past 10 years as a patient. This video uses the power of transformational storytelling to positively influence and educate clinical teams with the delivery of the sepsis care bundle.

This video will be incorporated into future internal e-learning packages and sepsis awareness raising events.
As part of our sepsis programme, we have included the 2016/17 national sepsis CQUIN which focuses on timely screening, identification and treatment for sepsis in the following areas: ED, acute inpatient settings and paediatrics.

Data collection included: sepsis screening and documentation with observations recorded, and severe sepsis/shock and timely Intravenous antibiotics (IVAB) within one hour and review of IVAB at 72 hours.

Figure 13: Sepsis survival to discharge

Sepsis survival to discharge for those patients on the sepsis bundle
Summary of our key achievements on a month-by-month basis

<table>
<thead>
<tr>
<th>Date</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2016</td>
<td>In April 2016 the outpatient improvement programme set out to improve communication and patient access to information for over 1.1 million appointments across our sites. This is part of the trust’s transformational programme for ‘vision 2020’.</td>
</tr>
<tr>
<td>May 2016</td>
<td>In May 2016 the lung biopsy team won a British Medical Journal award. Thanks to the new method Barnet Hospital performed around 300 biopsies between April 2015 and April 2016, other hospitals of an equivalent size expect to do around 40 biopsies each year.</td>
</tr>
<tr>
<td>June 2016</td>
<td>In June 2016 the new virtual fracture clinic at the Royal Free Hospital saw improvements in fast tracking patients to the appropriate specialist. The virtual fracture clinic dramatically improved the waiting room environment for patients, clinical and clerical staff.</td>
</tr>
<tr>
<td>July 2016</td>
<td>In July 2016 staff at the Royal Free London recruited 100 patients to the groundbreaking 100,000 Genomes Project. The project aims to improve the diagnosis and increase our understanding of cancer and rare diseases.</td>
</tr>
<tr>
<td>August 2016</td>
<td>In August 2016 the trust received and celebrated a CQC rating of ‘Good’ overall following an inspection in February 2016.</td>
</tr>
<tr>
<td>September 23, 2016</td>
<td>On September 23, 2016 the trust celebrated 100 days since our last surgical never event. This achievement is real recognition of the excellence and effort theatre staff have made in driving improvements.</td>
</tr>
<tr>
<td>October 2016</td>
<td>In October 2016 the outpatient parental antibiotic therapy (OPAT) service became available at Barnet Hospital. The service facilitates early and safe discharge for our patients.</td>
</tr>
<tr>
<td>November 2016</td>
<td>In November 2016 the lung cancer team at Royal Free London won a Health Service Journal award after developing a new lung biopsy method.</td>
</tr>
<tr>
<td>November 2016</td>
<td>In November 2016 the Royal Free Hospital signed a new partnership agreement with DeepMind to develop a new app to help improve care for patients with acute kidney injury.</td>
</tr>
<tr>
<td>January 2017</td>
<td>In January 2017 the trust committed to embed quality improvement (QI) into everyday work, by introducing a monthly executive ‘back to the floor’ week.</td>
</tr>
<tr>
<td>February 2017</td>
<td>In February 2017 staff celebrated their achievements at our Oscars awards ceremony. Around 280 members of staff attended the event and more than 30 awards were handed to staff that had made a significant contribution to patient care in 2016.</td>
</tr>
<tr>
<td>March 2017</td>
<td>In March 2017 the RFL was one of 10 trusts in the country to be selected as a specialist centre for the rapid diagnosis of cancer. A one-stop shop for cancer testing that will allow many patients to be diagnosed and start their treatment much sooner.</td>
</tr>
</tbody>
</table>
Priorities for improvement 2017/18

This section of the quality report details what the quality improvement priorities will be for the year ahead. All three priorities fall within the quality domain and were drawn from our local intelligence, engagement with the Commissioning for Quality and Innovation (CQUIN), performance and feedback following consultation with key stakeholders. Progress in achieving the priorities will be monitored at our board level committees and our trust board.

Our consultation process

As part of our consultation process, external stakeholders, the council of governors, patients and staff were invited to share their views on our proposed priorities and were also asked if there were any other priorities that the trust should consider for 2017/18.

In addition, we consulted with both in-patients and out-patients at Barnet and Chase Farm hospitals to ascertain their views on the trust priorities. On the whole, the patients were in agreement with our proposed priorities but suggested that a focus on nutrition could be considered.

STEP 1

- The initial proposed quality improvement priorities were generated following discussion at the associated committee and drawn from our intelligence and performance.
- Our stakeholders were invited to attend our consultation event.

STEP 2

- The stakeholders event was held on the 13 January 2017 and was attended by over 80 people.
- Attendees included members for our council of governors, joint overview and scrutiny health committee, healthwatch and commissioners.

STEP 3

- Feedback from the consultation event was analysed and changes were made accordingly to our quality improvement priorities.
- The priorities were agreed and signed-off by our trust executive committee (TEC) on behalf of our trust board.
- The priorities were finally presented to our trust board, along with an update on progress to achieve the previous 2016/17 priorities.

Priority 1: Improving patient experience: delivering world class experience

Our quality priorities for 2017/18 are:

- To achieve trust certification for the 'Information Standard' by 2018.
- Improve how patients, carers and families can provide feedback to the trust. Each service must have at least three ways of allowing feedback about a person’s experience.
- To systematically analyse the experience of bereaved families and friends.
- To further enhance and support dementia care initiatives across the trust through the delivery of the dementia strategy by 2018.
- To recruit 30 patient and family experience partners.*

We have chosen these priorities as they are linked to specific strands of work which are ongoing within the trust as part of our 2015-19 patient experience strategy. This strategy outlined our vision of being strong leaders of positive patient experience so we can effectively serve our communities.

During 2017/18, progress on achieving these priorities will be monitored and defined metrics will be measured at our patient and staff experience committee. In addition, progress on areas relating to dementia will also be monitored by our dementia implementation group.

* A partner is a person who:
- wants to help enhance the quality of our hospitals care for all patients and family members.
- gives advice to the hospital based on his or her own experience as a patient or family member
- partners with hospital staff on how to improve the patient and family experience through short and/or long-term projects and volunteers his or her time.
Priority 2: Improving clinical effectiveness

Our quality priorities for 2017/18 are:

• To improve key effectiveness metric(s) relevant to 20 priority pathways by deploying multi-professional pathway teams to reduce unwarranted variation.

• Each pathway team to deploy a standardised approach to design and execution, within the umbrella of the clinical practice groups (CPGs)

These priorities have been chosen because they directly align with our trust wide plans to focus on the reduction of unwarranted clinical variation. This will strengthen the delivery of the local and national effectiveness agenda and support the delivery of significant improvements in the quality of patient care.

During 2017/18 the trust will commence the deployment of a trust-wide methodology to manage unwarranted variation in clinical care, through the creation of CPGs. CPGs will be led by senior clinicians and will be fully embedded within our day to day operations. Their aim is to develop standardised guidelines for key clinical pathways in each of our four clinical divisions, and then implement and monitor these across all our hospitals.

In addition, to support this approach, the trust is implementing a unified approach to quality improvement (QI) which will equip and empower local teams to address opportunities to improve the quality of care they deliver both within and outside the scope of CPGs.

By the end of 2017/18 we aim to have

• At least 20 key clinical pathways identified with standardised guidelines developed

• At least 50 QI projects in place. The projects are required to have core features which includes a clear aim, change logic, ongoing PDSA and measurement linked to learning

Progress for these priorities will be measured and monitored at least quarterly through our executive committee and the new board clinical standards and innovation committee.

Priority 3: Our focus for Safety

Our quality priorities for 2017/18 are:

ACUTE KIDNEY INJURY (AKI)

• We will test the new AKI Streams App at RFH, will enable the development of a trust wide implementation plan.

• We will co-design an AKI proforma via PDSA cycles to support local clinical teams to deliver interventions specific to AKI pathology.

• We will identify high prevalence AKI areas and co-design an educational package to increase the recognition and treatment of AKI.

• We will develop and test methods for patient involvement that include a patient experience survey and an AKI patient information leaflet.

DETERIORATING PATIENT (DP)

• We will use one pilot ward to test continual PDSA cycles to improve processes and mechanisms to enhance timely communication within and between teams through the use of SBAR handover tools, enhanced ward rounds, board rounds and safety huddles.

• We will use ward-based metrics such as cardiac arrest rates, PARRT referral and numbers of multidisciplinary team meetings triggered to track progress.

• We will develop the ‘champion’ role further in this pilot area to enable long term sustainability.

• We will identify the best implementation of communication mechanisms and processes and spread these to other areas within the organisation.
We chose these priorities as they form part of our established patient safety programme. As part of this programme, the trust has set an ambitious target to become a zero avoidable harm organisation by 2020; initially reducing the level of avoidable harm by 50% by March 2018. The targets for safety principally follow a three year plan, with discrete deliverables for 2017/18.

Progress to achieve the milestones for 2017/18 will be measured and monitored at our patient safety committee on a quarterly basis throughout the year.

- **DETERIORATING UNBORN BABY**
  - Using the results from the thematic analysis of: (1) Unexpected admission of term babies to neonatal unit and (2) Unexpected intrauterine death and reducing smoking in pregnancy; we plan to:
    - Scope current processes around elective caesarean sections performed before 39 weeks gestation and identify areas that could be improved to reduce preventable caesarean sections.
    - Improve team communications of potential expected admission to NICU, through PDSA cycles to implement team huddles, SBAR handovers.
    - Undertake staff confidence survey associated with CTG interpretation; using this information to co-design teaching and skills package to improve cardiotachograph (CTG) staff confidence with interpretation.
    - Use PDSA cycles to identify methods of standardising the administration of the oxytocin infusion.

- **FALLS PREVENTION**
  - We will evaluate phase 1 of 24/7 falls free care.
  - We will initiate phase 2 of the programme by recruiting six to seven wards.
  - We will implement and spread the new falls prevention plan and bedrail assessment tool (enabling policy harmonisation) across the trust.

- **SEPSIS**
  - We will be further consolidating sustained improvement in existing pilot areas.
  - We will be generating a sepsis workstream plan of spread across the organisation with all key stakeholders, including establishing mechanisms to continue monitoring progress beyond the formal life of the workstream.
  - We will be sharing the learning from the 10 pilot sites in the workstream with everyone involved and impacted by this spread, including further expansion of the ‘champion’ role to support long term sustainability.

- **SAFER SURGERY**
  - We will spread and implement our tested methods to deliver robust processes of care at safer surgery steps 1 and 5 (brief and debrief).
  - We will develop locally driven methods by scaling up our PDSA cycles, to robustly embed the quality of step 4 (counting swabs, needles and instruments).
  - We will help co-ordinate the development of theatre team human factors skills and knowledge. This will include establishing a staff-developed framework for theatre etiquette and WCC behaviours.
Statements of assurance from the board

This section contains eight statutory statements of assurance from the board, regarding the quality of services provided by the Royal Free London NHS Foundation Trust. Where relevant we have provided additional information for local context to the information in the statutory statements.

Review of services

Quality is monitored in each of our four clinical divisions, with regular reviews of safety, clinical effectiveness and patient experience. Assurance is provided from each division to our strategic quality committee.

During 2016/17, the Royal Free London NHS Foundation Trust (RFL) provided and/or sub-contracted 40 relevant health services. The RFL has reviewed all the data available on the quality of care in 40 of these relevant health services. The income generated by the relevant health services reviewed in 2016/17 represents 100% of the total income generated from the provision of relevant health services by the Royal Free London NHS Foundation Trust for 2016/17.

Participating in clinical audits and national confidential enquiries

The trust continues to participate in clinical audit programmes and has integrated this within our quality improvement programme. We continue to review our clinical audit processes, ensuring that we have evidence of improvements made to practice.

During 2016/17 42 national clinical audits and 8 national confidential enquiries covered relevant health services that the Royal Free London NHS Foundation Trust provides.

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

The national clinical audits and national confidential enquiries that the Royal Free London NHS Foundation Trust was eligible to participate in, during 2016/17 are listed in table 2:

The national clinical audits and national confidential enquiries that the Royal Free London NHS Foundation Trust participated in, during 2016/17 are also listed in table 2:

The national clinical audits and national confidential enquiries that RFL Trust participated in, and for which data collection was completed during 2016/17, are listed in table 2 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.
Table 2: Participation in national clinical audits and national confidential enquiries

Case ascertainment relates to the proportion of all eligible patients captured by the audit during the sampling period compared to the number expected according to other data source, usually hospital episode statistics (HES) data. HES is a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England.

Key:

* data submitted during 2016/17 relates to an earlier timeframe.

* timeframe for data collection

<table>
<thead>
<tr>
<th>National clinical audits for inclusion in quality report 2016/17</th>
<th>Data collection completed in 2016/17</th>
<th>Eligibility to participate</th>
<th>Participation 2016/17</th>
<th>Rate of case ascertainment (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Association of Endocrine and Thyroid Surgeons (BAETS)</td>
<td>√*</td>
<td>x</td>
<td>n= 432 (CFH and RFH)</td>
<td>2011/15</td>
</tr>
<tr>
<td>British Association of Urological Surgeons (BAUS): Nephrectomy audit</td>
<td>√*</td>
<td>x</td>
<td>See RF</td>
<td></td>
</tr>
<tr>
<td>BAUS: Percutaneous nephrolithotomy (PCNL)</td>
<td>√*</td>
<td>x</td>
<td>n= 84</td>
<td>2014/15</td>
</tr>
<tr>
<td>BAUS: Stress urinary incontinence</td>
<td>√*</td>
<td>x</td>
<td>n= 12 (121.4%)</td>
<td>2014-2016</td>
</tr>
<tr>
<td>British Thoracic Society (BTS): Adult asthma</td>
<td>√</td>
<td>x</td>
<td>n= 13 (100%)</td>
<td></td>
</tr>
<tr>
<td>BTS: Paediatric pneumonia</td>
<td>√</td>
<td>x</td>
<td>n= 20 (100%)</td>
<td></td>
</tr>
<tr>
<td>Cancer: National bowel cancer audit</td>
<td>√*</td>
<td>x</td>
<td>n= 146 (108%)</td>
<td>2014/15</td>
</tr>
<tr>
<td>Cancer: National lung cancer audit</td>
<td>√*</td>
<td>x</td>
<td>See RFH</td>
<td></td>
</tr>
<tr>
<td>Cancer: National oesophago-gastric cancer audit</td>
<td>√*</td>
<td>x</td>
<td>n= 314 (81-90%)</td>
<td>2015</td>
</tr>
<tr>
<td>Cancer: National prostate cancer audit</td>
<td>√*</td>
<td>x</td>
<td>See RFH</td>
<td></td>
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</tbody>
</table>

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<table>
<thead>
<tr>
<th>National clinical audits for inclusion in quality report 2016/17</th>
<th>Data collection completed in 2016/17</th>
<th>Eligibility to participate</th>
<th>Participation 2016/17</th>
<th>Rate of case ascertainment (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic obstructive pulmonary disease (COPD) audit programme: Secondary care</td>
<td>x</td>
<td>✓</td>
<td>✓ BH</td>
<td>Audit due for completion 2017/18</td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>x</td>
<td>CFH</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>✓ RFH</td>
<td>Audit due for completion 2017/18</td>
<td></td>
</tr>
<tr>
<td>COPD audit programme: Pulmonary rehabilitation</td>
<td>x</td>
<td>x</td>
<td>x BH</td>
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</tr>
<tr>
<td></td>
<td>x</td>
<td>x</td>
<td>CFH</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>✓ RFH</td>
<td>Audit due for completion 2017/18</td>
<td></td>
</tr>
<tr>
<td>Dementia: National audit of dementia</td>
<td>✓</td>
<td>✓</td>
<td>✓ BH</td>
<td>Organisational audit: n=1 (100%) Clinical audit: n=55 Carer questionnaire: n=61 Paper staff questionnaire: n=55 Online staff questionnaire: n= 63</td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>x</td>
<td>CFH</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>✓ RFH</td>
<td>Organisational audit: n=1 (100%) Clinical audit: n=55 Carer questionnaire: n=76 Paper staff questionnaire: n=56 Online staff questionnaire: n= 65</td>
<td></td>
</tr>
<tr>
<td>Diabetes: National diabetes audit (NDA)</td>
<td>✓*</td>
<td>✓</td>
<td>✓ BH</td>
<td>n= 718 *2015/16</td>
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<td></td>
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<td>✓ CFH</td>
<td>n= 548 *2015/16</td>
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<td>✓</td>
<td>✓ RFH</td>
<td>n= 1726 *2015/16</td>
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<tr>
<td>Diabetes: National footcare in diabetes audit</td>
<td>✓*</td>
<td>x</td>
<td>x BH</td>
<td></td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>x</td>
<td>CFH</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>✓ RFH</td>
<td>n= 56 *2014/16</td>
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<tr>
<td>Diabetes: National diabetes in-patient audit (NaDIA)</td>
<td>✓</td>
<td>✓</td>
<td>✓ BH</td>
<td>n= 57</td>
</tr>
<tr>
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<td>x</td>
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<td>Diabetes: National diabetes transition audit</td>
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<td>✓ BH</td>
<td>NEW – first round of audit</td>
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<td>✓ CFH</td>
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<td>Diabetes: National paediatric diabetes audit (NPDA)</td>
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<td>n= 119 *2015/16</td>
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<td>n= 60 *2015/16</td>
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<td>Diabetes: National pregnancy in diabetes (NPID)</td>
<td>✓*</td>
<td>✓</td>
<td>✓ BH</td>
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<tr>
<td></td>
<td>x</td>
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<td>CFH</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>✓ RFH</td>
<td>n= 37 *2015</td>
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</tr>
<tr>
<td>Falls and fragility fractures audit programme (FFFAP): Fracture liaison service database</td>
<td>✓</td>
<td>✓</td>
<td>✓ BH</td>
<td>NEW – first round of audit</td>
</tr>
<tr>
<td></td>
<td>x</td>
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<td>CFH</td>
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</tr>
<tr>
<td></td>
<td>x</td>
<td>x</td>
<td>RFH</td>
<td></td>
</tr>
<tr>
<td>FFFAP: National hip fracture database</td>
<td>✓*</td>
<td>✓</td>
<td>✓ BH</td>
<td>n= 370 (92.9%) *2015</td>
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<tr>
<td></td>
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<td>CFH</td>
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<td>✓ RFH</td>
<td>n= 190 (85.4%) *2015</td>
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<td>National clinical audits for inclusion in quality report 2016/17</td>
<td>Data collection completed in 2016/17</td>
<td>Eligibility to participate</td>
<td>Participation 2016/17</td>
<td>Rate of case ascertainment (%)</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
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<td>-------------------------------</td>
</tr>
<tr>
<td>Heart: National audit of percutaneous coronary interventions</td>
<td>✓*</td>
<td>x</td>
<td>x BH</td>
<td></td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>x CFH</td>
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<td>✓ RFH</td>
<td>n = 829 *2014</td>
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</tr>
<tr>
<td>Heart: Cardiac rhythm management</td>
<td>✓*</td>
<td>✓</td>
<td>✓ BH</td>
<td>n = 304 *2015/16</td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>x CFH</td>
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<td>✓</td>
<td>✓ RFH</td>
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<td>Heart: Myocardial infarction national audit project (MINAP)</td>
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<td>✓</td>
<td>✓ BH</td>
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<td></td>
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<td>x CFH</td>
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<td>✓ RFH</td>
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<td>Heart: National heart failure audit</td>
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<td>✓ BH</td>
<td>n = 402 (81%) *2014/15</td>
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<tr>
<td></td>
<td>x</td>
<td>x CFH</td>
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<td></td>
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<td></td>
<td>✓</td>
<td>✓ RFH</td>
<td>n = 260 (76%) *2014/15</td>
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<td>Intensive care national audit and research centre (ICNARC): National cardiac arrest audit (NCAA)</td>
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<td>✓</td>
<td>✓ BH</td>
<td>n = 121 *2015/16</td>
</tr>
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<td></td>
<td>x</td>
<td>x CFH</td>
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<tr>
<td></td>
<td>✓</td>
<td>✓ RFH</td>
<td>n =320 *2015/16</td>
<td></td>
</tr>
<tr>
<td>ICNARC: case mix programme: Adult critical care</td>
<td>✓*</td>
<td>✓</td>
<td>✓ BH</td>
<td>n =1017 *2015/16</td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>x CFH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>✓ RFH</td>
<td>n=1628 *2015/16</td>
<td></td>
</tr>
<tr>
<td>Inflammatory bowel disease (IBD): Biological therapy audit</td>
<td>x</td>
<td>✓</td>
<td>✓ BH</td>
<td>Transition to IBD Registry. Next audit round due for completion 2017/18</td>
</tr>
<tr>
<td>Adult services</td>
<td>x</td>
<td>x CFH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>✓ RFH</td>
<td>Transition to IBD Registry. Next audit round due for completion 2017/18</td>
<td></td>
</tr>
<tr>
<td>IBD: Biological therapy audit</td>
<td>x</td>
<td>x</td>
<td>x BH</td>
<td></td>
</tr>
<tr>
<td>Paediatric services</td>
<td>x</td>
<td>x CFH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>✓ RFH</td>
<td>Transition to IBD Registry. Next audit round due for completion 2017/18</td>
<td></td>
</tr>
<tr>
<td>NHS Blood and Transplant (NHSBT): Patient blood management in scheduled surgery</td>
<td>✓*</td>
<td>✓</td>
<td>✓ BH</td>
<td>n = 23</td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>✓ CFH</td>
<td>n = 8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>✓ RFH</td>
<td>n= 23 *2015</td>
<td></td>
</tr>
<tr>
<td>NHSBT: Red cell and platelet transfusion in adult haematology patients</td>
<td>✓*</td>
<td>✓</td>
<td>✓ BH</td>
<td>n = 32 *Jan-16</td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>x CFH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>x RFH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National elective surgery PROMs: Four operations</td>
<td>✓*</td>
<td>✓</td>
<td>✓ BH</td>
<td>n=748 (74.3%) *Apr-14/Mar-15</td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>✓ CFH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>✓ RFH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National emergency laparotomy audit (NELA)</td>
<td>✓*</td>
<td>✓</td>
<td>✓ BH</td>
<td>n = 10 *2014/15</td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>x CFH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>✓ RFH</td>
<td>n= 92 *2014/15</td>
<td></td>
</tr>
<tr>
<td>National clinical audits for inclusion in quality report 2016/17</td>
<td>Data collection completed in 2016/17</td>
<td>Eligibility to participate</td>
<td>Participation 2016/17</td>
<td>Rate of case ascertainment (%)</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>-----------------------------------</td>
<td>-----------------------------</td>
<td>-----------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>National joint registry (NJR)</td>
<td>√*</td>
<td>√ BH</td>
<td>n= 42 * data to Dec-15</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>√ CFH</td>
<td>n= 573 * data to Dec-15</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>√ RFH</td>
<td>n= 427 * data to Dec-15</td>
<td></td>
</tr>
<tr>
<td>National neonatal audit programme (NNAP)</td>
<td>√*</td>
<td>√ BH</td>
<td>n=1255 *2015</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>x CFH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>√ RFH</td>
<td>n=368 *2015</td>
<td></td>
</tr>
<tr>
<td>National pulmonary hypertension audit</td>
<td>√*</td>
<td>x BH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>x CFH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>√ RFH</td>
<td>n= 1080 *2014/15</td>
<td></td>
</tr>
<tr>
<td>National vascular registry</td>
<td>√*</td>
<td>x BH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>x CFH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>√ RFH</td>
<td>n= 257 *2015</td>
<td></td>
</tr>
<tr>
<td>National ophthalmology audit: Adult cataract surgery</td>
<td>√</td>
<td>√ BH</td>
<td></td>
<td>NEW – first round of audit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>√ CFH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>√ RFH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal replacement therapy (renal registry)</td>
<td>√*</td>
<td>x BH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>x CFH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>√ RFH</td>
<td>n= 229 *2014</td>
<td></td>
</tr>
<tr>
<td>Royal College of Emergency Medicine (RCEM): Asthma (adults and children)</td>
<td>√</td>
<td>√ BH</td>
<td>n=101 (100%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>x CFH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>√ RFH</td>
<td>n=117 (100%)</td>
<td></td>
</tr>
<tr>
<td>RCEM: Severe sepsis and septic shock-care in emergency departments</td>
<td>√</td>
<td>√ BH</td>
<td>n=101 (100%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>x CFH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>√ RFH</td>
<td>n=81 (100%)</td>
<td></td>
</tr>
<tr>
<td>Sentinel stroke national audit programme (SSNAP)</td>
<td>√*</td>
<td>√ BH</td>
<td></td>
<td>Case ascertainment = 90+% *2015/16</td>
</tr>
<tr>
<td></td>
<td></td>
<td>x CFH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>√ RFH</td>
<td></td>
<td>Case ascertainment = 90+% *2015/16</td>
</tr>
<tr>
<td>Trauma audit research network (TARN)</td>
<td>√*</td>
<td>√ BH</td>
<td></td>
<td>Case ascertainment = 27-100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>x CFH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>√ RFH</td>
<td></td>
<td>Case ascertainment = 95%</td>
</tr>
<tr>
<td>Rheumatoid and early inflammatory arthritis</td>
<td>x</td>
<td>√ BH</td>
<td></td>
<td>Audit did not collect data in 2016/17</td>
</tr>
</tbody>
</table>
### National clinical audits for inclusion in quality report 2016/17

<table>
<thead>
<tr>
<th>National audit title</th>
<th>Data collection completed in 2016/17</th>
<th>Eligibility to participate</th>
<th>Participation 2016/17</th>
<th>Rate of case ascertainment (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult cardiac surgery</td>
<td>√*</td>
<td>x</td>
<td>x</td>
<td>Trust not eligible to participate in the national audit, as the service is not provided by the trust</td>
</tr>
<tr>
<td>Congenital heart disease</td>
<td>√*</td>
<td>x</td>
<td>x</td>
<td>Trust not eligible to participate in the national audit, as the service is not provided by the trust</td>
</tr>
<tr>
<td>Chronic kidney disease in primary care</td>
<td>√*</td>
<td>x</td>
<td>x</td>
<td>Trust not eligible to participate in the national audit, as this relates to primary care</td>
</tr>
<tr>
<td>Mental health clinical outcome review programme</td>
<td>√*</td>
<td>x</td>
<td>x</td>
<td>Trust not eligible to participate in the national audit, as the service is not provided by the trust</td>
</tr>
<tr>
<td>PICANet</td>
<td>√*</td>
<td>x</td>
<td>x</td>
<td>Trust not eligible to participate in the national audit, as the service is not provided by the trust</td>
</tr>
<tr>
<td>Prescribing observatory for mental health</td>
<td>√*</td>
<td>x</td>
<td>x</td>
<td>Trust not eligible to participate in the national audit, as the service is not provided by the trust</td>
</tr>
<tr>
<td>Specialist rehabilitation for patients with complex needs</td>
<td>√*</td>
<td>x</td>
<td>x</td>
<td>Trust not eligible to participate in the national audit, as the service is not provided by the trust</td>
</tr>
<tr>
<td>UK Cystic fibrosis registry</td>
<td>√*</td>
<td>x</td>
<td>x</td>
<td>Trust not eligible to participate in the national audit, as the service is not provided by the trust</td>
</tr>
<tr>
<td>National lung cancer audit consultant-level data</td>
<td>√*</td>
<td>x</td>
<td>x</td>
<td>Trust not eligible to participate in the national audit, as the service is not provided by the trust</td>
</tr>
<tr>
<td>National oesophago-gastric cancer audit - consultant-level data</td>
<td>√*</td>
<td>x</td>
<td>x</td>
<td>Trust not eligible to participate in the national audit, as the service is not provided by the trust</td>
</tr>
<tr>
<td>National neurosurgical audit programme - consultant-level data</td>
<td>√*</td>
<td>x</td>
<td>x</td>
<td>Trust not eligible to participate in the national audit, as the service is not provided by the trust</td>
</tr>
</tbody>
</table>

The Royal Free London NHS Foundation Trust also participated in the following national audits by submitting data 2016/17:

- During 2016/17, the trust participated in several other national audits which were not in the HQIP ‘Quality accounts’ list, published in December 2016. Shown in the table on the right.

### National audit title

- 7-day service audit
- BTS: smoking cessation
- Maternity and perinatal audit
- National audit of cardiac rehabilitation
- National complicated diverticulitis audit (CAD)
- NHSBT: kidney transplantation
- NHSBT: liver transplantation
- Potential donor
- RCEM: consultant sign-off
- Royal College of Anaesthetists: national of perioperative anaphylaxis
- The iBRA-2 study: a national prospective multi-centre audit of the impact of immediate breast reconstruction on the delivery of adjuvant therapy
National confidential enquiries for inclusion in quality report 2016/17

The trust continues to review national confidential enquiries into patient outcomes and death (NCEPODs) on an annual basis until they are fully implemented. Progress is reported at both divisional and corporate levels.


<table>
<thead>
<tr>
<th>National confidential enquiries for inclusion in quality report 2016/17</th>
<th>Data collection completed in 2016/17</th>
<th>Eligibility to participate</th>
<th>Participation 2016/17</th>
<th>Rate of case ascertainment (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and surgical clinical outcomes review programme: Physical and mental health care of mental health patients in acute hospitals</td>
<td>✓</td>
<td>✓</td>
<td>BH</td>
<td>Clinical questionnaire and casenotes: n= 15/15 (100%) Psychiatric liaison questionnaire: 5/5 (100%) Organisational audit: n= 3/3 (100%)</td>
</tr>
<tr>
<td>Medical and surgical clinical outcomes review programme: Non-invasive ventilation</td>
<td>✓</td>
<td>x</td>
<td>BH</td>
<td>Clinical questionnaire and casenotes: n= 5/5 (100%) Organisational audit: n= 2/2 (100%)</td>
</tr>
<tr>
<td>Medical and surgical clinical outcomes review programme: Acute pancreatitis</td>
<td>✓</td>
<td>x</td>
<td>BH</td>
<td>Clinical questionnaire: n= 10/10 (100%) Casenotes: n=10/10 (100%) Organisational audit: n= 3/3 (100%)</td>
</tr>
<tr>
<td>Maternal, newborn and infant: Maternal programme</td>
<td>√*</td>
<td>✓</td>
<td>BH</td>
<td>Case ascertainment = 100% *2015</td>
</tr>
<tr>
<td>Maternal, newborn and infant: Perinatal programme</td>
<td>√*</td>
<td>✓</td>
<td>BH</td>
<td>Case ascertainment = 100% *2015</td>
</tr>
<tr>
<td>Learning disability review programme (LeDer)</td>
<td>x</td>
<td>✓</td>
<td>BH</td>
<td>Enquiry due for completion 2017/18</td>
</tr>
<tr>
<td>Child health clinical outcomes review programme: Young people’s mental health</td>
<td>x</td>
<td>✓</td>
<td>BH</td>
<td>Enquiry due for completion 2017/18</td>
</tr>
<tr>
<td>Child health clinical outcomes review programme: Chronic neurodisability</td>
<td>x</td>
<td>✓</td>
<td>BH</td>
<td>Enquiry due for completion 2017/18</td>
</tr>
</tbody>
</table>

The reports of 49 national clinical audits were reviewed by the provider in 2016/17 and the Royal Free London NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Actions to improve the quality of healthcare provided:

- We will continue to scrutinise and share learning from national audit reports at our corporate committee (clinical governance and clinical risk committee).
- We will use outcomes from national clinical audits to help us prioritise pathway work in our clinical practice groups across our new group of hospitals.
- We will continue to make improvements to our clinical processes where national clinical audits suggest care could be improved.

(A full list of specific actions or a summary of key findings/outcomes undertaken to improve quality are presented in table 3).
### Summary of our key achievements relating to national audits

<table>
<thead>
<tr>
<th>The Royal Free Hospital achieved the <strong>highest</strong> risk-adjusted survival rates at 5 years for <strong>first adult kidney transplant</strong> in London, and better than national average.</th>
<th>Out of 96 participating sites nationally, <strong>Chase Farm Hospital is the 2nd best performing hospital</strong> for adult patients with type 1 diabetes achieving all 3 treatment targets, the Royal Free is <strong>4th</strong> and Barnet <strong>15th</strong>.</th>
<th>Our <strong>stroke</strong> patients receive a world class stroke service with Barnet and Royal Free hospitals among the <strong>top 18%</strong> of teams nationally.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Royal Free Hospital is the <strong>3rd</strong> best performing hospital nationally for <strong>paediatric diabetes</strong> patients receiving all 7 best practice recommended processes.</td>
<td>The Trust participated in <strong>50</strong> national audits and confidential enquiries.</td>
<td>Better than national and London risk-adjusted mortality at 90-days and 2-years for <strong>bowel cancer</strong> surgery at Barnet Hospital.</td>
</tr>
<tr>
<td>The Royal Free Hospital is in the <strong>best 25%</strong> of hospitals nationally for <strong>diabetes care in pregnant women</strong> for blood glucose control for pregnancies in the first trimester and at 24 weeks+</td>
<td>More <strong>major trauma patients</strong> presenting at the emergency department at Barnet and Royal Free hospitals <strong>survive compared to expected</strong> based on the severity of their injury.</td>
<td><strong>0%</strong> rate of stroke/ death reported for patients undergoing a <strong>carotid endarterectomy</strong> at the Royal Free Hospital.</td>
</tr>
</tbody>
</table>
| **Barnet Hospital intensive care unit:**  
- Achieved **best ratings** for all RAG-rated quality indicators.  
- **Improved compared to previous year** for 5/7 indicators (reduction of high risk sepsis admissions, out of hours discharges to the wards and risk-adjusted mortality).  
- Has significantly fewer unplanned readmissions within 48 hours than nationally. | **Barnet and Royal Free hospitals** are both in the **best 25%** of hospitals nationally for 5 best practice care process or outcomes for **hip fracture** patients, including **best practice tariff achieved** at Barnet Hospital and **overall hospital length of stay** at Royal Free Hospital. | The Royal Free hospitals paediatric emergency department:  
- Is in the **best 25% of hospitals** nationally for 4/5 best practice criteria relating to **vital signs**.  
- For all cases where abnormal vital signs were present the clinician recognised the abnormal vital signs and they were acted upon appropriately. |
Table 3: Details of specific actions undertaken or a summary of key findings/outcomes from a national clinical audit

**Key** CFH (Chase Farm Hospital); BH (Barnet Hospital); RFH (Royal Free Hospital)

<table>
<thead>
<tr>
<th>National clinical audit</th>
<th>Actions or summary of key findings/outcomes to improve quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Association of Endocrine and Thyroid Surgeons (BAETS)</td>
<td>Data was submitted to the registry by three consultants who work across sites – none of whom have been identified as outliers. During the audit period the trust data shows that there were no post-operative deaths, that length of stay was the same or better than the national average and that better than national average rates were achieved for related re-admission, re-exploration for bleeding and late hypocalcaemia.</td>
</tr>
<tr>
<td>Published: January 2016</td>
<td>Reporting period: 01/07/10 – 30/06/14</td>
</tr>
<tr>
<td>Site: RFH and CFH</td>
<td></td>
</tr>
<tr>
<td>British Association of Urological Surgeons (BAUS) - nephrectomy audit</td>
<td>Neither the trust nor any of the eight consultants who submitted data to the audit are identified as outliers for complication rate, transfusion rate or mortality. Royal Free Hospital – No deaths were reported during the audit period, and the complication and transfusion rates are better than the national average. Barnet Hospital – The transfusion rate and mortality rate are 0. The complication rate is within control limits and not identified as an outlier.</td>
</tr>
<tr>
<td>Published: September 2016</td>
<td>Reporting period: BH: 2013 and RF: 2013-15</td>
</tr>
<tr>
<td>Site: RFH and BH</td>
<td></td>
</tr>
<tr>
<td>BAUS – percutaneous nephrolithotomy (PCNL) audit</td>
<td>The data shows that the trust achieved a transfusion rate of 0% during the audit period, and that the post-operative length of stay is in line with the national average.</td>
</tr>
<tr>
<td>Published: May 2016</td>
<td>Reporting period: 2014-15</td>
</tr>
<tr>
<td>Site: RFH only</td>
<td></td>
</tr>
<tr>
<td>British Thoracic Society (BTS): adult asthma audit</td>
<td>Asthma is a common lung condition that causes occasional breathing difficulties. It affects people of all ages and often starts in childhood, although it can also appear for the first time in adults (source: NHS Choices). The performance of the respiratory team in the audit demonstrates areas of excellence in the care provided to our patients with the most recently published data showing that above average performance was provided at Barnet and Royal Free hospitals for the following best practice criteria: • Awareness that patients with severe asthma and one or more adverse psychosocial factors are at risk of death. • Supplementary oxygen is provided to hypoxaemic patients with acute severe asthma to maintain an SpO2 level of 94-98%. • People presenting with a severe or life-threatening acute exacerbation of asthma receive oral or intravenous steroids within one hour of presentation. • People with asthma who present with an exacerbation of their symptoms receive an objective assessment of severity at the time of presentation. • Hospital follow up arranged. In addition the Royal Free Hospital achieved above average performance for asthma care bundle used and patients receiving each care bundle element (inhaler technique, medication review, written action plan and triggers considered), while Barnet Hospital achieved above average performance for smoking status recorded. Royal Free Hospital is in line with the national average for this criteria. No patient deaths were recorded and length of stay is similar to the national average.</td>
</tr>
<tr>
<td>Published: February 2017</td>
<td>Reporting period: 01/09/16 - 31/10/16</td>
</tr>
<tr>
<td>Site: RFH and BH</td>
<td></td>
</tr>
</tbody>
</table>
### BTS: National smoking cessation audit

**Published:** November 2016  
**Reporting period:** 01/04/16 – 31/05/16  
**Site:** RFH and BH

Millions of people attend hospital as inpatients and outpatients each year, many of whom will be current smokers and at significant risk of development, or exacerbation of, tobacco-related disease. Treating tobacco dependence in hospitals therefore represents a significant opportunity to improve the lung and general health of our patients (source: national audit report).

Our performance in the national audit demonstrates excellence in the care provided to our patients, with the most recently published data showing above average performance for smoking status recorded at the Royal Free Hospital; and for current smokers asked if they would like help to stop smoking at both the Royal Free and Barnet hospitals. In addition the trust provides all organisational standards of best practice measured by the audit.

Improvements made at the Royal Free Hospital to increase accurate recording and increase referrals include implementing annual education for junior doctors about the importance of accurate recording; sending reminders to staff on recording accurately; undertaking audits on ward performance with regards to the percentage of patients with smoking status recorded as “unable to assess” and providing feedback on this to the junior doctors; and having a pharmacy lead. The implementation of electronic prescribing will further improve documentation.

At Barnet Hospital audits on recording smoking status are undertaken. In addition pharmacy lead on improving pharmacy recording of patients smoking status, providing very brief advice, referral to smoking cessation services and education.

### BTS paediatric asthma

**Published:** Nov-16  
**Reporting period:** 01/11/15 – 30/11/15  
**Site:** RF and BH

Acute attacks of asthma are amongst the most common medical reasons for hospital admissions in children in the UK (source: national audit report).

The performance in the audit demonstrates excellence in the quality of care provided to our patients across sites with the most recently published data showing that for:

Initial treatment of asthma: both sites provided above average care for provision of oxygen, treatment with a beta agonist, and treatment with ipratropium bromide.

Discharge planning: at Royal Free Hospital 100% of patients had a written asthma plan in place at discharge.
### National clinical audit

**Cancer: national bowel cancer audit**

- **Published:** December 2016
- **Reporting period:** 01/04/14 – 31/03/15
- **Site:** RFH and BH

**Data quality:**

Barnet Hospital achieved the top ‘green’ rating for case ascertainment and all four data completeness items reported by the audit.

Royal Free Hospital achieved the top ‘green’ rating for all 4 criteria relating to data quality except pre-treatment staging which received an ‘amber’ rating. During the multidisciplinary meeting the pre-treatment staging is sometimes not available and therefore goes unrecorded. The new merged IT system will address this issue. All patients who underwent major surgery at both sites had their ASA* recorded to allow risk-adjustment.

*The ASA physical status classification system is a system for assessing the fitness of patients before surgery adopted by the American Society of Anesthesiologists (ASA) in 1963.

### Actions or summary of key findings/outcomes to improve quality

Bowel cancer is a major cause of illness, disability and death in the United Kingdom (UK) (source: national audit report).

The performance of the trust in the audit clearly demonstrates areas of excellence in our care, with the most recent published data showing better than average performance at both hospital sites for proportion of patients seen by a clinical nurse specialist, major surgery carried out as a planned procedure and laparoscopic (‘keyhole’) surgery attempted.

The audit data also demonstrates excellent outcomes for our patients. In particular, at Barnet Hospital the adjusted 90-day mortality, adjusted 30-day unplanned re-admission and two year mortality rates are better than the national and network averages. The abdominoperineal resection (APER) rate is also better than the national average and the adjusted 18-month stoma rate whilst just above the national average is within control limits.

At the Royal Free Hospital the audit again demonstrates better than average outcomes for 90-day mortality and 30-day unplanned readmissions, with the APER and 18 month stoma rates in line with the national average. The two year mortality rate for patients seen at the Royal Free Hospital was identified as an outlier by the national audit. An internal mortality review was completed for 23 patients who underwent surgery during the audit period 01/04/12 to 31/03/13.

From those patients, 13 underwent palliative surgery from the outset (disease was too advanced for surgery treatment) and death was not unexpected; three patients died due to peri-operative complications and death was unexpected although unrelated to the treatment; a further seven died from causes unrelated to colorectal cancer or colorectal cancer surgery. No quality of care issues were identified through the mortality review.
<table>
<thead>
<tr>
<th>National clinical audit</th>
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<tbody>
<tr>
<td><strong>Cancer: National lung cancer audit</strong></td>
<td>Lung cancer is the second most common cancer in the UK after breast cancer, and is the commonest cause of cancer-related death. Current survival rates for lung cancer are the second lowest out of 20 common cancers in England and Wales (source: national audit report). Trust-level performance in the audit demonstrates good practice and areas of excellence, with the most recently published data showing that performance is equal to or exceeds the recommended level for the:</td>
</tr>
<tr>
<td><strong>Published:</strong> January 2017</td>
<td>• Stage completeness ie the extent of the cancer, such as how large the tumour is and whether it has spread.</td>
</tr>
<tr>
<td><strong>Reporting period:</strong> 01/01/2015 – 31/12/15</td>
<td>• Pathological diagnosis. This is the preferred means of diagnosis, as it is more accurate and helps to determine the most appropriate form of treatment. Trust performance for pathological diagnosis has both improved compared to the previous patient cohort (2014 data) and is statistically better than the national average.</td>
</tr>
<tr>
<td><strong>Site:</strong> RFH and BH</td>
<td>• The use of chemotherapy for both non-small-cell lung cancer (NSCLC) patients and small-cell lung cancer (SCLSC) patients.</td>
</tr>
<tr>
<td><strong>Data quality:</strong></td>
<td>Patient outcome is in line with the national average for survival to one year.</td>
</tr>
<tr>
<td>Using a multitude of data feeds (COSD feed, pathology reports, radiology reports, treatment events and death certificates) the national audit has identified an additional 6,000 lung cancer cases in England compared with historical LUCADA records, an increase of 20%.</td>
<td></td>
</tr>
<tr>
<td>Of the 314 cases assigned to RFL in the 2015 audit report, 220 were recorded as trust first seen RFL and entered by the local teams, an additional 94 cases have also been allocated via to the RCP algorithm and will be reviewed for appropriateness by the local teams once the patient-level data is received.</td>
<td></td>
</tr>
<tr>
<td><strong>Cancer: National oesophago-gastric cancer audit (NOGCA)</strong></td>
<td>Oesophago-gastric cancer is the 5th most common cancer in the UK, affecting around 16,000 people each year. Overall, survival in England and Wales is poor, with only 15% of oesophageal cancer patients and 19% of gastric cancer patients surviving five years after diagnosis (source: national audit report). Patients diagnosed with high-grade glandular dysplasia (HGD) at Royal Free and Barnet hospitals are referred to University College London Hospital (UCLH) for surgery.</td>
</tr>
<tr>
<td><strong>Published:</strong> September 2016</td>
<td>Excellence in terms of quality of care and data quality are demonstrated by our performance in the most recently published report, with the data showing that the trust achieved the top ‘green’ rating for adjusted rate of diagnosis after emergency admission, referral source and case ascertainment.</td>
</tr>
<tr>
<td><strong>Reporting period:</strong> 01/04/12 – 31/03/15</td>
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<tr>
<td><strong>Site:</strong> RFH and BH</td>
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### National clinical audit

#### Cancer: National prostate cancer audit (NPCA)

**Published:** February 2017 (revised data)

**Reporting period:** 01/04/14 – 31/03/15

**Site:** RFH and BH

**Data quality:**
Areas highlighted for improvement by the national audit report include data completeness across key data items, specialist multidisciplinary team (MDT) data items and EBRT (myelodysplastic syndromes (MDS)-3) data items.

- **Prostate cancer** is the most frequently diagnosed solid cancer in men and the second most common cause of cancer-related death in the UK (source: national audit report).

- The quality of care received by patients at the trust is demonstrated by an above average performance achieved for all patient reported experience measures (PREMS) for radical prostatectomy patients – with 100% rating their overall care as excellent, and 100% reporting they were involved in decisions about their care and provided information about their condition and treatment.

- The experience reported by radical radiotherapy – EBRT – patients was mixed. The data is currently under review within the specialty and an action plan is in development to improve further.

### Actions or summary of key findings/outcomes to improve quality

Prostate cancer is the most frequently diagnosed solid cancer in men and the second most common cause of cancer-related death in the UK (source: national audit report).

- The quality of care received by patients at the trust is demonstrated by an above average performance achieved for all patient reported experience measures (PREMS) for radical prostatectomy patients – with 100% rating their overall care as excellent, and 100% reporting they were involved in decisions about their care and provided information about their condition and treatment. The experience reported by radical radiotherapy – EBRT – patients was mixed.

- The data is currently under review within the specialty and an action plan is in development to improve further.

#### Diabetes: National diabetes audit (NDA): care processes and treatment targets

**Published:** January 2016

**Reporting period:** 2013/14 and 14/15

**Site:** RFH and BH

**Data quality:**
We believe that some of our care processes were not captured reliably in our data submission for 2013/14. We made improvements to our data processes for 2014/15, including the introduction of Diamond, a diabetes IT management system, at the Royal Free Hospital site. This improved data is reflected in the most recent NDA report published in January 2017.

- The IT system will be rolled out across our other sites in 2017; accompanied by a data validation and cleaning exercise across all sites prior to data submission.

#### Actions or summary of key findings/outcomes to improve quality

Diabetes is a lifelong condition that causes a person’s blood sugar level to become too high. There are two main types of diabetes with type 2 being far more common than type 1. In the UK, around 90% of all adults with diabetes have type 2 (source: NHS Choices – diabetes).

- At Barnet and Chase Farm hospitals performance was lower than expected for the provision of each of the eight best practice care processes for patients with type 1 and type 2 diabetes; fewer patients were achieving the three treatment targets compared to the national average. Performance at Royal Free Hospitals was mixed for the provision of the eight best practice care processes and the achievement of the three treatment targets.
National clinical audit | Actions or summary of key findings/outcomes to improve quality
--- | ---
Diabetes: National diabetes audit (NDA): care processes and treatment targets | The results of the latest national diabetes audit report demonstrate improvements since the 2014/15 audit.
The audit measures performance against eight best practice care processes, against which:
- Performance has improved at all three sites for patients with type 1 and type 2 diabetes for all individual measures and as a composite measure.
- For patients with type 1 diabetes performance is average or higher than average for seven measures at Barnet and Chase Farm hospitals. Performance for smoking status is lower than expected at both sites but has improved from 8.2% (2014/15) to 60.7% at Barnet and from 18.4% (2014/15) to 63.9% at Chase Farm. Royal Free Hospital performance is average or higher than average for each of the eight measures. Performance on a composite measure (ie provision of all 8 measures) has improved from 30.9% to 56.5%, placing the Royal Free Hospital in the best quartile nationally.
- For patients with type 2 diabetes performance in 2015/16 is average or higher than average for seven measures across all three sites. Whilst lower than average performance is reported for foot surveillance, performance has improved from 18.3% (2014/15) to 63.8% at Chase Farm and from 44.3% (2014/15) to 68.8% at Royal Free. Whilst lower than average performance is reported for smoking status at Barnet, performance has again improved from 5.6% (2014/15) to 52.6%. Actions are already planned to improve foot surveillance (see National Diabetes Footcare Audit and NaDIA) and the documentation of smoking status (see BTS Smoking Cessation Audit).
The percentage of patients with type 1 diabetes achieving all three treatment targets is above national average performance and has improved compared to previously at all three sites. Out of 96 participating sites nationally, Chase Farm Hospital is the 2nd performing trust for this measure, with the Royal Free Hospital 4th and Barnet Hospital 15th. The data is currently under review within the specialty and actions will be reported in next year’s quality report.

Published: January 2017
Reporting period: 2015/16
Site: RFH, BH and CFH
### National clinical audit

**Diabetes: National insulin pump audit**

**Published:** April 2016  
**Reporting period:** 2013/14 and 14/15  
**Site:** RFH and BH  
**Data quality:**

The trust has had challenges in the collection of data this audit year, due to limitations of the national diamond diabetes data management system. Considerable work has been carried out internally and with the diamond system developers to improve the quality and accuracy of data to reflect the quality of care provided.

### Actions or summary of key findings/outcomes to improve quality

Insulin pump therapy has a pivotal role to play in the management of type 1 diabetes; use in type 1 diabetes is associated with improved quality of life and glycaemic control in addition to reductions in hypoglycaemia, diabetic ketoacidosis (DKA) admissions and, according to more recent evidence, cardiovascular mortality *(source: national audit report)*.

The trust has now employed a specialist nurse lead for insulin pump therapy, which will further improve patient care quality, and data collection. Since joining in November 2016, the specialist nurse has reviewed the audit data and found that 60 patients with type 1 diabetes on insulin pump therapy had been incorrectly reported as type 2. Therefore 258 out of the 1,183 (22%) patients with type 1 diabetes were on insulin pumps in line with NICE best practice guidance, rather than 198 (7%) reported by the audit. The local review shows that more patients are receiving best practice care at the trust compared to 13.5% nationally.
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<tr>
<td><strong>Diabetes: National diabetes foot care audit</strong></td>
<td>The impact of diabetic foot disease on people with diabetes is profound. It can be associated with disability, amputation and premature mortality. Its cost to the health service is considerable (<em>source: national audit report</em>).</td>
</tr>
<tr>
<td><strong>Published:</strong> March 2016</td>
<td>Royal Free Hospital’s performance in the national audit was mixed. Our diabetes team has submitted a bid to NHS England for a multidisciplinary diabetes foot team. This will enable the trust to implement a hot clinic and improve podiatry care to our in-patients.</td>
</tr>
<tr>
<td><strong>Reporting period:</strong> 14/07/14 – 10/04/15</td>
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<tr>
<td><strong>Site:</strong> RFH</td>
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<tr>
<td><strong>Data quality:</strong></td>
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<tr>
<td>The service has reported the challenges experienced with the audit back to the audit provider. For example patients must sign an initial consent form to be included in the audit. The leaflet that explains the audit is currently only available in English. The audit provider is investigating the feasibility of making the leaflets available in different languages. This would assist our participation in the audit as many of our patients do not have English as their first language.</td>
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The impact of diabetic foot disease on people with diabetes is profound. It can be associated with disability, amputation and premature mortality. Its cost to the health service is considerable (*source: national audit report*). Royal Free Hospital’s performance in the national audit was mixed. Our diabetes team has submitted a bid to NHS England for a multidisciplinary diabetes foot team. This will enable the trust to implement a hot clinic and improve podiatry care to our in-patients.
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<td><strong>Diabetes: National Diabetes inpatient audit (NaDIA)</strong></td>
<td>The National Diabetes in-patient Audit is a snapshot audit of diabetes inpatient care. Performance across sites is in line with or above national average:</td>
</tr>
<tr>
<td><strong>Published:</strong> June 2016</td>
<td>• At Royal Free Hospital for foot assessment (within 24 hours and during stay) and patients admitted with active foot disease seen by multidisciplinary foot care team (MDFT) within 24 hours.</td>
</tr>
<tr>
<td><strong>Reporting period:</strong> 21/09/15 – 25/09/15</td>
<td>• At Barnet Hospital for appropriate blood glucose testing, good glucose days and patients admitted with active foot disease seen by MDFT within 24 hours. In addition performance against the patient safety indicators (medication, prescription, management and insulin errors) is better than the national average.</td>
</tr>
<tr>
<td><strong>Site:</strong> RFH and BH</td>
<td>Areas marked for improvement include reducing patient safety errors (medication, prescription, management and insulin) at the Royal Free Hospital, improving foot assessments at Barnet Hospital and reducing hypoglycaemic episodes across all sites.</td>
</tr>
<tr>
<td></td>
<td>Action taken to reduce hypoglycaemic episodes includes the introduction of hypo boxes. In addition the diabetes team is working with the patient safety team to identify the underlying causes so that targeted action can be taken.</td>
</tr>
<tr>
<td></td>
<td>The diabetes team is working with the podiatry service, and providing education to ward nurses to enable them, to increase their provision of foot assessments. An NHS bid has also been submitted that, if successful, will include additional recruitment. The role will include assessing diabetic feet in the emergency department before the patient's admission to a ward.</td>
</tr>
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</table>

<p>| <strong>Diabetes: National Diabetes Paediatric Audit (NPDA)</strong> | Diabetes is a condition where the amount of glucose in the blood is too high because the body cannot use it properly. High blood glucose levels over time may cause complications associated with diabetes including damage to small and large blood vessels and nerves. Over time this can result in blindness, kidney failure, heart disease, stroke and amputations. However, with good diabetes care and blood glucose control, the risks of complications are markedly reduced, enabling children and young people with diabetes to live a healthy, happy and longer life (source: national audit report). |
| <strong>Published:</strong> July 2016 | The performance of the Royal Free Hospital in the audit demonstrates excellence in the quality of care provided to our patients with the most recently published data showing that the hospital is: |
| <strong>Reporting period:</strong> 2014/15 | • A positive outlier for all seven care processes performed for young people aged 12 years and older. |
| <strong>Site:</strong> RFH, BH and CFH | • Above the national average for screening for thyroid disease and coeliac disease (Type 1 diabetes). |
| | Since the completion of the audit a new consultant has been appointed; additional paediatric diabetes specialist nurse and dietetic resources are now available; and an insulin pump service is offered at all three sites. This has always been in place at the Royal Free Hospital, and is being put in place in Barnet and Chase Farm hospitals, led by the newly-appointed consultant. In addition further discussions are underway to streamline the out-patient process across all three sites, and the use of volunteers and iPads to elicit feedback before a patient leaves the diabetes clinic will commence shortly. |</p>
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<tr>
<td><strong>Diabetes: National Pregnancy in Diabetes Audit (NPID)</strong></td>
<td>Most women with diabetes have healthy pregnancies and healthy babies. However, there are risks, and these sometimes cause serious health problems, either for the mother or the newborn child. So it is important expectant mothers with diabetes get the right care, support and information to help them and their baby stay well. For a healthy, safe pregnancy with diabetes, planning and care starts before conception (source: NPID patient summary report).</td>
</tr>
<tr>
<td><strong>Published:</strong> October 2016</td>
<td>The performance of the Royal Free Hospital in the audit demonstrates excellence in the quality of care provided to our patients with the most recently published data showing that the hospital is in the best quartile for blood glucose control (&lt;48 mmol/mol) for pregnancies in the first trimester and at 24 weeks or more. To improve practice further, the following actions will be undertaken:</td>
</tr>
<tr>
<td><strong>Reporting period:</strong> Pregnancies between 01/01/13 and 31/12/15</td>
<td><strong>Barnet Hospital:</strong></td>
</tr>
<tr>
<td><strong>Site:</strong> RFH and BH</td>
<td>• The process for the referral of patients with type 1 and type 2 diabetes to the joint endocrine clinics has been amended so that the GP referral letter is sent to the diabetes team, and will no longer be dependent on the antenatal booking midwife seeing the patient first.</td>
</tr>
<tr>
<td><strong>Data quality:</strong></td>
<td>• Education will be provided to patients and GPs about the importance of early referral to the diabetes antenatal team.</td>
</tr>
<tr>
<td>The process of consenting for the audit has been changed for 2016 data, this should ensure that all data collected is submitted.</td>
<td>• A pathway is being drawn up to aid GPs in the early management and the referral of type 1 and type 2 diabetic patients.</td>
</tr>
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</table>

**Royal Free Hospital:**

• Educating GPs about the importance of early referral.

• Making GPs aware about the service of preconception counselling.

• Developing a leaflet to give to type 1 and type 2 diabetes patients at postnatal discharge with advice for future pregnancies.

• Making the patient and GPs aware of structured diabetes educational programmes.
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| End of Life Care Audit (EOLCA): dying in hospital | Nearly half of all deaths in England occur in hospitals – 22,307 out of a total of 46,997 in 2014 ([source: national audit report](#)). In 2016 the Care Quality Commission (CQC) rated the provision of end of life care (EoLC) at the trust as ‘good’, reporting that the EoLC team are a dedicated team providing holistic care for patients with palliative and EoLC care needs in line with national guidance.  

The quality of care provided to patients at the end of their life is also demonstrated by the trust level performance in the national audit, which shows above average performance for three out of five clinical indicators of best practice: recognition that the patient would die; that the needs of the person important to the patient were asked about; and that a holistic assessment of the patients’ needs was made in last 24 hours. Three out of eight organisational indicators were also met: bereaved relatives views sought; and formal training provided to both medical and nursing staff. In addition the audit data demonstrated improvements since the previous audit round in relation to communication with the family.  

The recommendations made by both the national audit and the NICE Quality Standard on EoLC for adults provide the evidence base upon which the trusts’ EoLC strategy has been developed. The strategy will drive the implementation of best practice care across the trust. In addition work is ongoing with the patient at risk and resuscitation team (PARRT), as part of the patient safety EoLC work stream on the deteriorating patient, to further improve the early identification of the dying patient.  

A seven day palliative care service, which is already available at the Royal Free Hospital, will be available at Barnet Hospital from April 2017 following the recruitment of an additional clinical nurse specialist. Training is being developed on leading difficult conversations and accreditation for the course will be sought. Student nurse training provided in 2016 will be repeated in 2017. The curriculum is being rewritten to ensure that students have the opportunity to care for dying patients, the development of a masters-level EoLC module is being looked into and clinical psychologist support for Barnet Hospital has been recruited. |
For older people, hip fracture is the commonest serious injury; the commonest reason for emergency surgery; and the commonest cause of accidental death. Patients may remain in hospital for a number of weeks, leading to one and a half million bed days being used each year, which equates with the continuous occupation of over 4,000 NHS beds. Only a minority of patients will completely regain their previous abilities, most will encounter difficulty walking which increases dependency and means that a quarter will need long-term care. As a result, hip fracture is associated with a total cost to health and social services of over £1 billion per year (source: national audit report).

Our performance in the national audit demonstrates excellence in the care provided to our patients with best quartile performance achieved by:

- Barnet Hospital for mental test score recorded on admission, perioperative medical assessment provided, best practice tariff achievement, surgery on day of, or day after, admission and proportion of general anaesthetic with nerve blocks.
- Royal Free Hospital for overall hospital length of stay and proportion of arthroplasties using techniques recommended by NICE (i.e. a cemented technique, sliding hip screw (SHS), intramedullary nail (IM)) and overall hospital length of stay.

In addition the risk adjusted 30 day mortality rate at both Barnet Hospital and Royal Free Hospital is better than the London average and similar to the national average. Whilst Barnet Hospital achieved the second lowest rate in London for hip fractures sustained as an in-patient, the rate at the Royal Free Hospital is similar to the London average and above the national average.

A series of actions have been implemented as a result of the audit to improve patient care and outcomes further. At the Royal Free Hospital these include:

- Ongoing work to improve education provided to junior medical staff involved in seeing patients on admission, which should improve the assessment of cognitive function on admission.
- All hip fractures admitted during the week will be discussed at a multidisciplinary team and suitable patients will be offered total hip replacement surgery. Day of admission will not impact the choice of therapy offered.
- The lack of documentation on pressure ulcers has been highlighted to nursing staff and we believe this will address our documentation issues and we plan to audit this and other items on a periodic timescale.

Barnet Hospital is the third busiest hip fracture unit in London. We have established a dedicated hip fracture physiotherapy team. To co-ordinate care and reduce the length of stay we are assessing patients earlier and discussing discharge planning every morning on the multidisciplinary team meeting.

We are also working on a number of quality improvement projects that will address haemoglobin check on day of surgery, mobilisation out of bed on day one and post-operative analgesia.
Coronary heart disease (CHD) is the largest cause of death and disability in the United Kingdom (UK). It causes around 73,000 deaths in the UK each year and around one in five men and one in seven women will die from the disease.

The PCI procedure works by mechanically improving blood flow to the heart. During the procedure, a small balloon is inserted which, when inflated widens the artery. In most cases a ‘stent’ - metal mesh scaffold - is implanted to keep the artery wall open (source: national audit report).

The performance of the Royal Free Hospital in the audit demonstrates excellence in the quality of care and outcomes for our patients.

The most recently published data shows that the hospital is:

- Within expected range for the risk-adjusted measures survival at 30 days post PCI procedure and major adverse cardiac and cerebrovascular event (e.g. death, stroke, myocardial infarction caused by PCI and the need for emergency cardiac surgery because of a complication of PCI).
- A positive outlier for the time between the first call for professional help and the time that the PCI procedure is performed (call to balloon time less than 150 minutes).
- Above the national average for all other call to balloon times, as well door to balloon times for both direct admissions and inter-hospital transfers.
- Performing more PCIs within 72 hours of arrival for non-ST-elevation myocardial infarction (nSTEMI) or unstable angina, i.e. patients with heart attacks where the electrocardiogram (ECG) does not show a typical pattern of ST elevation, than the national average.

To improve patient outcomes further ongoing training is in place to help increase the number of procedures where arterial access was via the radial artery; and a new London Procurement Partnership (LPP) arrangement is in place that will increase access to and the use of drug eluting stents at the Royal Free Hospital. In addition an enhanced pathway and tools are in development to improve further the inpatient management of nSTEMIs.
Heart: National Audit of Cardiac Rhythm Management (CRM) Devices

**Published:** August 2016

**Reporting period:** 01/04/14 – 31/03/15

**Site:** RFH and BH

The national audit is a development of the national device registry which was the first in the world and now documents approximately a million device procedures. It collects information about all implanted cardiac devices and all patients receiving interventional procedures for management of cardiac rhythm disorders in the UK to improve the quality of care provided (source: national audit report).

The data published by the national audit shows that activity at the Royal Free Hospital and Barnet hospital exceeds the minimum number of recommended new pacemaker implants per year, and the number recommended for a training centre. In addition the Royal Free Hospital exceeds the minimum number of recommended new implantable cardioverter defibrillator (ICD) or cardiac resynchronization therapy (CRT) implants per year.

Atrial based pacing in sinus node disease is recommended by the National Institute of Health and Care Excellence (NICE). For the reporting period 2014/15, the proportion of patients receiving atrial based pacing implants for sick sinus syndrome has increased at both sites compared to previous (2013/14) and is within expected range nationally.

Since 2014 two dedicated CRM consultants have been in post and an increase in the use of dual chamber pacemakers is expected to be reflected in the 2016/17 dataset, which is due for publication in 2018. In addition work is ongoing to increase capacity in the catheter laboratory to enable more procedures to be undertaken at the trust.

Heart: National Audit of Cardiac Rhythm Management (CRM) Devices

**Published:** February 2017

**Reporting period:** 01/04/15 – 31/03/16

**Site:** RFH and BH

**Data quality:**

The reported number of implantable cardioverter defibrillator (ICD) implants undertaken has been affected by data completeness issues and does not reflect clinical practice. This issue has been greater at Barnet Hospital than at Royal Free. The move of complex device implantation in November 2015 from Royal Free Hospital to Barnet Hospital has further exacerbated the issue. Cardiology is investigating how to resolve this.

The 2015/16 data published by the national audit shows that activity at the Royal Free Hospital and Barnet Hospital continue to exceed the minimum number of recommended new pacemaker implants per year, and the number recommended for a training centre.

The proportion of patients receiving atrial based pacing implants for sick sinus syndrome as recommended by NICE has improved from 73% (2014/15) to 100% (2015/16) at the Royal Free Hospital. Barnet Hospital remains at 86% and is within typical range achieved by NHS trusts nationally.

A recent local audit conducted at Barnet Hospital covering the period October 2015 to October 2016 shows that the complication rate remains low at 3.7% and in line with previous years despite the increase in number of procedures.
### National clinical audit

**Heart: Myocardial Ischaemia**  
National Audit Project (MINAP)  
**Published:** January 2017  
**Reporting period:** 01/04/14 – 31/03/15  
**Site:** RFH and BH

A heart attack occurs when the flow of blood to the heart is blocked, most often by a build-up of fat, cholesterol and other substances, which form a plaque in the arteries that feed the heart (coronary arteries). The interrupted blood flow can damage or destroy part of the heart muscle. This is known as a heart attack or myocardial infarction (MI). Typical symptoms include chest pain or discomfort, sweating, breathlessness, and sudden changes in blood pressure, heart rate, and heart rhythm, which may lead to collapse or sudden death (*source: national audit report*).

The performance of the trust in the audit demonstrates areas of excellence in the quality of care provided to our patients with the most recently published data showing that the performance at both Barnet and Royal Free hospitals is above the national average for the proportion of patients seen by a cardiologist, patients admitted to a cardiac ward and patients who received all secondary prevention medication for which they were eligible. In addition performance at Barnet Hospital has improved compared to previous (2013/14) for all 3 criteria, whilst the Royal Free Hospital has either improved (percentage of patients admitted to cardiac ward) or remained consistently high (i.e. equal to or exceeding 99%).

The average length of stay at both sites is in line with the national average for both non-ST-elevation myocardial infarction (nSTEMI) and ST-elevation myocardial infarction (STEMI) patients; and whilst the Royal Free Hospital performance for all five ‘door to balloon time’ and ‘call to balloon time’ criteria are above the national average, performance is lower for 4/5 criteria compared to previous (2013/14). This slight drop in performance reflects the increase in activity we are seeing and is something we will be watching carefully.

### Heart: National Heart Failure Audit

**Published:** July 2016  
**Reporting period:** 01/04/14 – 31/03/15  
**Site:** RFH and BH

Heart failure means that the heart is unable to pump blood around the body properly. It usually occurs because the heart has become too weak or stiff (*source: NHS Choices*). Approximately 900,000 people in the UK have heart failure. It causes or complicates about 5% of all emergency hospital admissions in adults and consumes up to 2% of total NHS expenditure (*source: national audit report*).

The performance of the heart failure team at both the Royal Free and Barnet hospitals in the audit demonstrates excellence in care, with the most recently published data showing that for:

- In-hospital care, both sites provided above average use of appropriate specialist diagnostics, care on cardiology ward and input from specialist.

- On discharge, both sites provided above average care for heart failure medication in line with best practice, and specialist cardiology follow up.

The data also demonstrates improvement, with the audit data showing that at the Royal Free Hospital performance has improved by at least 20% for three out of the four in hospital care criteria – cardiology in-patient, input from consultant cardiologist and input from specialist. Performance at Barnet Hospital has remained consistently high for all four criteria.

To improve further an improved pathway of care, and discharge process are being implemented, and additional clinical nurse specialist support is being sought.
### National clinical audit

**Intensive Care National Audit and Research Centre (ICNARC) - National Cardiac Arrest Audit (NCAA)**

**Published:** June 2016  
**Reporting period:** 01/04/15 – 31/03/16  
**Site:** RFH and BH

The national cardiac arrest audit collects data on in-hospital cardiac arrests in the UK and Ireland (source: ICNARC website). The total rate of in-hospital cardiac arrests and survival at Royal Free and Barnet hospitals are displayed below. The risk adjusted survival data produced by the audit shows that survival at both the Royal Free and Barnet hospitals is in line with expected (1.0).

#### Royal Free Hospital

![Graph showing survival ratio for Royal Free Hospital](image1.png)

#### Barnet Hospital

![Graph showing survival ratio for Barnet Hospital](image2.png)

This data has been used to drive local quality improvement activity to reduce the number of in-hospital cardiac arrests as part of the patient safety programme. A pilot is currently underway within cardiology at the Royal Free Hospital aimed at improving processes to identify and manage deteriorating patients. Current tests of change include the redesign and evaluation of team handover and record keeping and trial of a weekly multi disciplinary team meeting to assist complex decision making.
ICNARC: Case mix programme (CMP)

Published: July 2016
Reporting period: 01/04/15 – 31/03/16
Site: RFH and BH

The case mix programme is an audit of patient outcomes from adult, general critical care units covering England, Wales and Northern Ireland (source: ICNARC website). Trust wide performance in the audit demonstrates excellence in quality, with the most recently published data showing that:

- Barnet Hospital achieved a green rating (good to excellent) for 7/7 quality criteria reported by the audit. In addition performance improved for 5/7 criteria compared to previous results (2014/15) this includes the reduction of high risk sepsis admissions, out-of-hours discharges to the ward and risk-adjusted mortality. Performance for unplanned readmissions within 48 hours has improved compared to the previous year and the hospital is now a positive outlier for this criteria.

- Royal Free Hospital achieved a green rating for 5/7 quality criteria. The remaining two criterion have been investigated. The first of these criteria relates to the rate of unit-acquired infections in blood at Royal Free Hospital. This has been investigated as it appeared to be above the national average. It was thought that the length of stay of immunocompromised patients was associated with acquisition of infection. However, local review of patients admitted to intensive care unit (ICU) shows that the majority of patients suffered sepsis on the ward prior to admission to ICU. The second criteria relates to sepsis and is being progressed via the improvement work that is led by the patient safety programme to improve the identification and treatment of patients with sepsis on the wards.

Delayed discharges from the ICU at Barnet Hospital has been identified as an area for improvement and is now the subject of a local Commissioning for Quality and Innovation (CQUIN) target.

Risk-adjusted mortality data shows that the mortality rate for the Royal Free and Barnet hospitals is in line with expected (1.0).
### National clinical audit

**UK inflammatory bowel disease (IBD) audit**

**Published:** September 2016  
**Reporting period:** 01/03/15 – 29/02/16  
**Site:** RFH and BH

Over the last 10 years, biological therapies have transformed treatment for people with inflammatory bowel disease (IBD). Most of these drugs work by targeting a protein in the body called tumour necrosis factor alpha (TNFα). Overproduction of this protein is thought to be partly responsible for the chronic inflammation in people with IBD (source: national audit report).

Insufficient cases were submitted in 2015/16 for detailed analysis by the national audit provider. Following the 2014/15 data collection period a number of actions were implemented to improve data input. Weekly multidisciplinary team meetings are held to capture the biologics data and, wherever possible, submit this information to the audit.

We are in the process of appointing IBD nursing staff who, in addition to their clinical roles, will provide data management support in order to collect and input the relevant data.

### Actions or summary of key findings/outcomes to improve quality

**UK IBD audit: National clinical audit of biological therapies (paediatric service)**

**Published:** September 2016  
**Reporting period:** 12/09/11 – 29/02/16  
**Site:** RFH

Ulcerative colitis (UC) is the most common type of inflammatory bowel disease (IBD); it is a lifelong, chronic, relapsing-remitting condition. Reported prevalence is as high as 505 per 100,000. This corresponds to 320,000 people in the UK with a diagnosis of UC. The cause of UC is unknown and, although it can develop at any age, the peak incidence is between the ages of 15 and 25 years, resulting in profound effects on education, work, social and family life. The three month, per-patient cost for UC was calculated at £1,211 in 2010, with the majority of this cost attributed to inpatient stays (source: IBD national audit report).

The paediatric service did not participate in the national audit in 2015/16. Upon publication of the national report the service compared their practice to the recommendations made and in line with best practice, the trust screens all patients prior to treatment with biological therapies (hepatitis B and tuberculosis), has clear arrangements in place for follow-up within three months, records the patients’ disease activity score using a defined disease activity index, has a reduction regime in place for all patients on steroids at first infusion, and records data on all patients on biologics, submitting it to the IBD Registry for national analysis.

### National comparative audit of blood transfusion programme: audit of the use of blood in lower gastrointestinal bleeding

**Published:** May 2016  
**Reporting period:** 01/09/15 – 01/12/15  
**Site:** RFH and BH

Lower gastrointestinal bleeding accounts for up to 20% of hospital admissions for gastrointestinal bleeding a year in the UK (source: national audit report). Barnet Hospital demonstrated above average performance against the following audit standards:

- All patients with lower gastrointestinal bleeding had a digital rectal examination (100%).
- Platelet transfusion was offered to all eligible patients (100%).
- Best practice procedures were performed for patients with rectal bleeding.
- The cause and site of clinically significant lower gastrointestinal bleeding was determined following the early use (within 24 hours) of best practice procedures.

Organisational audit demonstrates the provision of best practice services across both hospital sites.

The quality of the clinical data produced in the national audit report was affected by the low number of cases submitted nationally. In line with the majority of participating hospitals a site-level report was not produced for the Royal Free Hospital due to the low number of cases. Actions are being put in place to address this issue.
### National clinical audit

#### National comparative audit of blood transfusion programme: Audit of patient blood management in scheduled surgery

**Published:** Summer 2016  
**Reporting period:** 01/02/15 – 30/04/15  
**Site:** RFH, BH and CFH  

**Data quality:**  
The quality of the clinical data produced by the audit was affected by the low number of cases submitted nationally.

Patient blood management (PBM) is a multidisciplinary, evidence-based approach to optimising the care of patients who might need a blood transfusion. National, regional and local audits in England consistently show inappropriate use of all blood components; 15-20% of red cells and 20-30% of platelets/plasma. Evidence shows that the implementation of PBM improves patient outcomes by focussing on measures for the avoidance of transfusion and reducing the inappropriate use of blood and therefore can help reduce healthcare costs (source: national audit report).

The hospital-level data produced by the audit has been reviewed locally and indicates that practice is in line with or better than average across sites against a number of criteria including:

- pre-operative anaemia optimisation (Barnet and Royal Free hospitals).
- pre-operative anticoagulant and antiplatelet management (Royal Free Hospital).
- patient blood management in theatre and recovery (Chase Farm and Royal Free hospitals).
- post-operative transfusion indicated (Barnet Hospital).
- patient blood management in the post-operative period (Chase Farm and Royal Free hospitals).

### National comparative audit of blood transfusion programme: Audit of red cell and platelet transfusion in adult haematology patients

**Published:** Autumn 2016  
**Reporting period:** Jan-16  
**Site:** BH

The audit aimed to examine the use of red cells and platelets in a sample of patients who had a known haematological condition and identify variation in practice and compare practice against guidelines (source: hospital-level audit report).

A national audit report was not produced due to the small number of cases submitted nationally, which affected data quality and the audit supplier's ability to draw meaningful conclusions from the clinical data. Site-level data was however made available to participating trusts, which has been reviewed locally and taking the small patient numbers into account early indications show that good practice is being achieved against a number of criteria including:

- Local written guidelines are available for the management of blood component transfusions in haematology patients.
- Haemoglobin is measured within 24 hours prior to the transfusion of red cells if the patient is an inpatient or within 72 hours if the patient is a day patient
- When platelets are prescribed for prophylactic use, this should not be more than one adult therapeutic dose.
## National clinical audit

### National elective surgery

**PROMs: Four operations**

**Published:** August 2016  
**Reporting period:** 01/04/14 – 31/03/15  
**Site:** Trust-level data

Patient reported outcomes measures (PROMs) is a national programme organised by NHS England looking at a number of elective procedures. The latest available data shows that the Trust is within control limits for adjusted health gain for hip and knee replacement primary procedures.

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

For more up to date PROMS information for hip and knee procedures, see the summary below on NJR consultant-level data.

For hernias and varicose veins the numbers submitted were too few to be benchmarked. However work is ongoing with the pre-assessment teams, who give out the PROMs questionnaires, to improve patient participation.

### National emergency laparotomy audit (NELA)

**Published:** July 2016  
**Reporting period:** 01/12/14 – 30/11/15  
**Site:** RFH and BH  
**Data quality:**

At Barnet Hospital very few patients were entered into the audit. Since the completion of the audit we have implemented a number of actions to address this issue and our participation for the year has increased from 10 patients to over 100. To improve further a new pathway has been created to ensure that the best practice criteria are followed and also documented in a timely manner. The audit database has been set up on all operating theatres’ computers to facilitate the management of patient’s data.

More than 30,000 patients undergo an emergency laparotomy each year in NHS hospitals within England and Wales. The majority of patients undergoing emergency bowel surgery have potentially life-threatening conditions requiring prompt investigation and management. These procedures are associated with high rates of postoperative complications and death; recent studies have reported that overall 15% of patients die within one month of having an emergency laparotomy ([source: national audit report](#)). The clinical pathway for patients undergoing emergency bowel surgery is complex, and requires input from clinicians from several specialties including emergency departments, acute admissions units, radiology, surgery, anaesthesia, operating theatres, critical care and elderly care. Unlike elective (planned) care, there is often limited time to investigate and prepare these patients before surgery. This creates challenges in the delivery of care on a day-to-day basis and in bringing about long-term service improvement.

The trust’s performance in the audit demonstrated areas of excellence. To improve further at Barnet Hospital, the recording the risk score (P-Possum score) prior to operation has been mandated and this is already showing significant improvement. In addition a consultant anaesthetist and surgeon will always be present in theatre for high risk patients.

At the Royal Free Hospital we have employed a consultant in specialised surgical medicine who has extensive geriatric experience and assesses all our elderly patients. We have implemented a new operating theatre booking form where risk scoring is mandatory therefore risk of death is documented prior to theatre booking. We have also taken action to improve the pre-operative review by a consultant surgeon and anaesthetist when the risk of death is higher than 5%.
<table>
<thead>
<tr>
<th>National joint registry (NJR) annual report</th>
<th>Actions or summary of key findings/outcomes to improve quality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Published:</strong> September 2016</td>
<td>Hip, knee, ankle, elbow and shoulder joint replacements are common and highly successful operations that bring many patients relief from pain and improved mobility. Thousands of these joint replacement operations take place in the UK every year (source: national audit website).</td>
</tr>
<tr>
<td><strong>Reporting period:</strong> Various</td>
<td>The trust’s performance in the national audit clearly demonstrates excellent outcomes and with all three hospitals achieving the top ‘green’ rating for 90-day mortality and revision rates for hips and knees.</td>
</tr>
<tr>
<td><strong>Site:</strong> RFH, BH and CFH</td>
<td>To ensure our elderly patients have the best specialist input, our elderly care physicians are closely involved in the care of elective patients with more complicated health needs. The orthopaedic team at the Royal Free Hospital review their rate of cemented versus non cemented total hip replacement. We also continuously submit surgical site infection data to the Get it Right First Time (GIRFT) national surveillance team.</td>
</tr>
<tr>
<td><strong>Data quality:</strong></td>
<td>The latest consultant-level data from the national registry clearly demonstrates excellent outcomes with the patient reported outcomes measures (PROMs), 90-day mortality rate and revision rates within expected range for hip and knee surgery at Royal Free, Barnet and Chase Farm hospitals.</td>
</tr>
</tbody>
</table>

The trust’s performance in the national audit clearly demonstrates excellent data quality with all three hospitals achieving the top ‘green’ rating for linkability (records submitted to the registry with valid NHS number). The Royal Free Hospital also achieved the top ‘green’ rating for consent rate. Consent rate has been identified as an area for improvement at Barnet and Chase Farm hospitals. While consent to participate in the NJR is being taken appropriately for patients attending pre-assessment at Barnet Hospital a copy of the consent form is not always received at Chase Farm Hospital for data entry into the NJR. Action is in place to improve this process and is being monitored.

In terms of data quality a better than expected rating was achieved for the Royal Free Hospital for consent rate and valid NHS number. This data set also highlights consent as an ongoing area for improvement at Barnet Hospital. See section above for progress with actions to improve. The impact of these actions on data quality is expected to be evidenced in the 2017/18 data.
National clinical audit

National neonatal audit programme (NNAP)

Published: September 2016
Reporting period: 01/01/15 – 31/12/15
Site: RFH and BH

The national neonatal audit programme (NNAP) annual report summarises data which is collected directly from the NDAU (National Data Analysis Unit) database which takes data directly from the Badgernet system, used by all UK neonatal units, with data being added every day for each resident baby. The 2016 report reflects the 2015 data that was logged into the Badgernet system by either clinical, nursing or administrative staff on the trust’s two neonatal sites – level 1 special care baby unit (SCBU) at Royal Free Hospital and the level 2 neonatal unit (NNU) at Barnet Hospital.

The performance of the neonatal teams at Royal Free and Barnet hospitals in NNAP demonstrates excellence in the quality of care provided to babies who are born too early, with a low birth weight or who have a medical condition requiring specialist treatment.

Teams on both sites have improved the proportion of babies who are receiving some mother’s milk at discharge.

At the Royal Free Hospital site, the team have improved eye (retinopathy of prematurity) screening for eligible babies to ensure more babies are screened at the correct time for optimal prevention of visual problems following neonatal care. The Barnet NNU has eradicated variation from best practice altogether on this important care process, with 100% of babies being screened.

The audit data also shows that fewer babies developed lung disease as a consequence of neonatal care (bronchopulmonary dysplasia) compared to other UK neonatal units.

The neonatal team at the Royal Free Hospital has also made some progress in the documentation of when parents are consulted within the first 24 hours. Both neonatal sites allow parents on the ward rounds, and all babies are seen by a consultant or senior registrar on the daily ward rounds. Therefore there is a robust process in place for ensuring parents are consulted promptly. However, historically, our documentation of this element of care has been poor. In the most recent report, there is an improvement in the documentation of the proportion of parents who had a consultation with a consultant neonatologist within 24 hours of their baby’s admission and further quality improvement is already in place to ensure the accuracy of the data submitted going forward.

Actions or summary of key findings/outcomes to improve quality

The national neonatal audit programme (NNAP) annual report summarises data which is collected directly from the NDAU (National Data Analysis Unit) database which takes data directly from the Badgernet system, used by all UK neonatal units, with data being added every day for each resident baby. The 2016 report reflects the 2015 data that was logged into the Badgernet system by either clinical, nursing or administrative staff on the trust’s two neonatal sites – level 1 special care baby unit (SCBU) at Royal Free Hospital and the level 2 neonatal unit (NNU) at Barnet Hospital.
### National clinical audit

<table>
<thead>
<tr>
<th>National audit of pulmonary hypertension</th>
<th>Actions or summary of key findings/outcomes to improve quality</th>
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<tbody>
<tr>
<td>Published: February 2016</td>
<td>Pulmonary hypertension is raised blood pressure within the pulmonary arteries, which are the blood vessels that supply the lungs. In the UK, around 6,000-7,000 people have pulmonary hypertension. It is also thought that more remain undiagnosed. Pulmonary hypertension can affect people of any age, although some types are more common in young women (source: NHS Choices).</td>
</tr>
<tr>
<td>Reporting period: 2014/15</td>
<td>The performance of the Royal Free Hospital in the audit demonstrates excellence in care, with the most recently published data showing that in line with best practice more patients treated at the Royal Free Hospital are started on a phosphodiesterase 5 inhibitor before other pulmonary hypertension drugs compared to the national average since 2010/11, and all other centres nationally since 2012/13. Mortality outcomes for all trusts are within the predicted range.</td>
</tr>
<tr>
<td>Site: RFH only</td>
<td>The audit has highlighted some areas that require further attention. The time from referral to diagnosis may reflect the special nature of the population referred to at the Royal Free Hospital, namely those with connective tissue disease. This is the only population where screening for the future development of pulmonary hypertension is possible. To improve patient care and outcomes a detailed audit of our referral pathways is being conducted with external funding and aided by external audit providers to identify whether delays in the referral process are occurring.</td>
</tr>
</tbody>
</table>

### National vascular registry (NVR) consultant-level outcomes

| Published: September 2016               | An abdominal aortic aneurysm (AAA) is a swelling (aneurysm) of the aorta the main blood vessel that leads away from the heart, down through the abdomen to the rest of the body. AAAs are most common in men aged over 65. A rupture accounts for more than one in 50 of all deaths in this group and a total of 6,000 deaths in England and Wales each year (source: NHS Choices). |
| Reporting period:                        | The latest consultant-level data published by the national registry shows that for elective infra-renal AAA repair the risk-adjusted mortality rate is within expected range for the trust and for each individual surgeon that performs the procedure at the trust. The surgical team strives for the achievement of excellent outcomes and to help achieve this has changed the composition of each firm to ensure clinicians have maximal opportunities for shared experience and learning when managing infra-renal aortic disease. |
| Site: RFH                                | **Carotid endarterectomy** is a surgical procedure to unblock a carotid artery. The carotid arteries are the main blood vessels that supply the head and neck. People who have previously had a stroke or a transient ischaemic attack (TIA) are at risk of having another stroke or TIA. Surgery can reduce the risk of a further stroke in people with severely narrowed carotid arteries by a third (source: NHS Choices). |
|                                         | The latest consultant-level data from the national registry clearly demonstrates excellent outcomes, with a risk-adjusted 0% rate of stroke/ death for patients operated on at the Royal Free Hospital during the audit period at both trust-level and for each individual surgeon performing the procedure. |
### National clinical audit

#### National vascular registry (NVR) annual report

- **Published:** November 2016
- **Reporting period:** 01/01/15 – 31/12/15
- **Site:** RFH and BH

The latest annual report produced by the national registry shows excellent outcomes for the trust with a risk-adjusted stroke and/or death rate of 0% for carotid endarterectomy (see below). In addition, the risk-adjusted in hospital mortality is within expected range for elective infra-renal abdominal aortic aneurysm (AAA) repair (see below), repair of ruptured AAA and lower limb revascularisation.

#### Carotid endarterectomy

![Carotid endarterectomy graph](image1)

The audit identified that surgery for carotid endarterectomy is sometimes delayed beyond 14 days for some of our patients. We are working toward improving our surgical capacity to reduce these delays.

#### Elective infra-renal AAA repair

![Elective infra-renal AAA repair graph](image2)

The report also demonstrates excellence in patient care with above average performance for patients undergoing elective infra-renal AAA repair for the criteria patients receiving anaesthetic review and patients undergoing pre-operative CT/MR angiogram assessment. The vascular radiology and anaesthesia teams have worked hard to improve this part of the pathway. All aortic cases are discussed at the aortic multi-disciplinary meeting, the timing of which was recently changed to accommodate as many clinicians as possible, making sure all our patients are discussed and reviewed by our specialists.
National clinical audit

NHS blood and transplant: potential donor audit

Published: October 2016 (provisional data)

Reporting period: 01/04/16 – 30/09/16

Site: Trust-level data

<table>
<thead>
<tr>
<th>Actions or summary of key findings/outcomes to improve quality</th>
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<tbody>
<tr>
<td>Trust-level performance in the audit demonstrates good practice and areas of excellence, with the most recently published data showing that:</td>
</tr>
<tr>
<td>- The average number of organs donated per donor is above the national average. In particular donation after brainstem death (DBD) donors average 6.0 organs per donor compared to 3.8 nationally.</td>
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<tr>
<td>- A statistically acceptable level was achieved for 8/9 measures of best practice (DBD and donation after circulatory death (DCD)), with the top gold rating achieved for:</td>
</tr>
<tr>
<td>- Referral to senior nurse-organ donation (DBD).</td>
</tr>
<tr>
<td>- Family approached with senior nurse-organ donation involved (DCD).</td>
</tr>
<tr>
<td>- Consent granted (DCD).</td>
</tr>
<tr>
<td>- Neurological death tested (DBD) performance has improved from 50% (Apr-Sep 2015) to 89% (Apr-Sep 2016).</td>
</tr>
</tbody>
</table>

To improve patient care, a neurological death testing masterclass was given to all intensive care unit (ICU) staff by the regional clinical lead for organ donation; and the events Organ Donation Awareness Week and Medicine for Members were held in September 2016 to raise awareness of organ donation to staff, patients, families and carers.

To improve further the following are being undertaken – to recruit nursing and emergency department (ED) representation on the Organ Donation Committee; to investigate the inclusion of organ donation on trust induction for medical and nursing staff; to implement a trust-wide teaching programme on nurse-led referral in ED and ICU; and to implement training on breaking bad news – currently being developed at Barts Health NHS Trust.

UK renal registry

Published: April 2016

Reporting period: Various

Site: RFH and BH

The UK Renal Registry (UKRR) is part of the Renal Association, a not-for-profit organisation registered with the Charity Commission. The Registry is recognised as having one of the very few high quality clinical databases open to requests from researchers. The UKRR collects, analyses and reports on data from 71 adult and 13 paediatric renal centres nationally (source: Renal Registry website).

First adult kidney transplant: The risk-adjusted five year patient and graft survival rates for both deceased and living donors at the Royal Free Hospital remained high in comparison to the previous report, and are above the national average and all other London centres, whilst the one year survival rates are in line with both the national and peer figures.

Adult patients on renal replacement therapy: The one year after 90 day age adjusted survival for incident renal replacement therapy patients in the 2013 cohort at Royal Free (91.6%) is similar to the national average (91.4%).

Rate of infectious episodes in patients with established renal failure: The rates of methicillin-resistant staphylococcus aureus (MRSA), methicillin sensitive staphylococcus aureus (MSSA) and clostridium difficile infection (CDI) per 100 dialysis patient years is better than the national average. The rate for escherichia coli (E.Coli) has reduced from 2.21 to 1.90, but remains just above the national average (1.90 vs. 1.49).
### National clinical audit

**National clinical audit for rheumatoid and early inflammatory arthritis**  
**Published:** October 2016  
**Reporting period:** 01/02/14 – 30/04/15  
**Site:** RFH and BH

Rheumatic diseases, including inflammatory arthritis, account for significant ill health and disability, and cost, to the NHS, social care and wider economy. Dramatic advances have been made in the treatment of inflammatory arthritis by effective use of traditional disease modifying agents (DMARDs) as well as the introduction of newer biological therapies (source: national audit report).

The performance of the rheumatology team in the audit demonstrates above average care for:

- assessment within three weeks of referral for people with suspected early inflammatory arthritis (EIA)
- effective treatment offered to people with newly diagnosed rheumatoid arthritis within six weeks of referral
- monthly treatment escalation offered to people with active rheumatoid arthritis until the disease is controlled to an agreed target
- advice received within 1 working day of contacting the rheumatology service for people with rheumatoid arthritis and disease flares or possible drug related side effects.

To improve patient care and management further, an early inflammatory arthritis (EIA) service has been set up on all three main hospital sites and four community hospitals. A standardised referral form and EIA treatment plan have been developed, care processes have been re-organised to allow for timely patient review so that disease-modifying medication can be started by the clinical nurse specialist or consultant as soon as possible, telephone consultation slots have been introduced, patient information leaflets are available, and patients are encouraged to access the National Rheumatoid Arthritis Society resources.

The improvement work at the Royal Free Hospital has been recognised as exemplary by the British Rheumatology Society in its national audit report. A strong team of clinical nurse specialists, strong IT and good team working are keys to our success. Good IT support includes an electronic referral form for EIA which is available to all the local clinical commissioning groups. Consultant electronic triage allows blood results to be checked once referrals are received and ordered if not already available prior to the patient’s first appointment. The electronic patient record allows immediate access to all relevant patient information on all peripheral sites, and for (most) GP-ordered tests to be available to hospital clinicians.

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### Royal College of Emergency Medicine (RCEM): venous thromboembolism (VTE) risk in lower limb immobilisation  
**Published:** June 2016  
**Reporting period:** 2015/16  
**Site:** RFH and BH

VTE is the formation of blood clots in the vein. When a clot forms in a deep vein, usually in the leg, it is called a deep vein thrombosis (DVT). If that clot breaks loose and travels to the lungs, it is called a pulmonary embolism (PE). Collectively these are known as VTE and can be life-threatening if not treated quickly. Patients who are treated for lower limb injuries and put into plaster casts are at significant risk of developing VTE (source: national audit report press release).

The performance of the Royal Free Hospital in the audit demonstrates excellence in care provided, with the most recently published data showing that if a need for thromboprophylaxis is indicated, there was written evidence of the patient receiving or being referred for treatment. To improve further VTE training a VTE sticker have been introduced at the Royal Free Hospital. A re-audit will be undertaken 2017/18 to assess their impact on practice.

To improve practice across sites the Royal Free Hospital VTE assessment pathway for patients immobilised with lower limb casts has been rolled out at Barnet and Chase Farm Hospitals.
### National clinical audit

**RCEM: vital signs in children**  
**Published:** June 2016  
**Reporting period:** 2015/16  
**Site:** RFH and BH

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Vital signs are important to record in children presenting at the emergency department (ED) because, if abnormal, they indicate that a patient may be at risk of a disease process with an increased risk of morbidity and mortality. The detection of abnormal vital signs, appropriate escalation and response can avoid patient deterioration and improve patient outcomes (<a href="#">source: national audit report</a>).</td>
</tr>
</tbody>
</table>

The performance of the Royal Free Hospital in the audit demonstrates excellence in care provided, with the most recently published data showing that:

- a formal vital signs scoring system was used for 100% of patients
- performance was in the best quartile nationally for 4/6 audit criteria, including complete set of vital signs measured and recorded, a further complete set of vital signs recorded within 60 minutes of the first set if abnormal vital signs were present, evidence the clinician recognised the abnormal vital signs (100% achieved), and that abnormal vital signs (if present) were acted upon in all cases (100% achieved).

Since the completion of the audit the new paediatric ed has opened at the Royal Free Hospital, which includes an extra triage nurse.

To improve further a common approach to the paediatric early warning system (PEWS) will be implemented across all trust ed and urgent care sites. As such the patient documentation chart has been updated to include the PEWS and is currently being piloted at the Royal Free Hospital, prior to adoption across all our sites.
<table>
<thead>
<tr>
<th>National clinical audit</th>
<th>Actions or summary of key findings/outcomes to improve quality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RCEM: procedural sedation in adults</strong></td>
<td>The delivery of safe sedation is a key component of the skill-set of any emergency medicine physician. Newer agents, better monitoring and a larger caseload have substantially changed sedation practice in the emergency department (ED) over the last few years. Patients have benefited from this change in practice – better sedation/analgesia has increased the success rate of many procedures, shorter-acting agents have allowed same day discharge of most patients and formal training and audit has promoted best practice and reduced the likelihood of complications. Sedating patients safely in eds reduces admissions, pressure on theatre and costs. Importantly, no deaths were recorded as a consequence of a sedation performed in an ed in the national audit (source: national audit report). In line with the national picture, mixed results were achieved for the audit across sites. To improve documentation the Royal College of Emergency Medicine (RCEM) procedural sedation proforma has been adapted and will be rolled out at the Royal Free Hospital and a patient information leaflet has also been developed to be given out at discharge in line with the best practice standards which will be re-audited locally in 2017/18. At Barnet Hospital:</td>
</tr>
<tr>
<td>Published: June 2016</td>
<td>- teaching given to middle grade and senior doctors via the ed teaching programme now includes the use of end tidal CO2 capnography in the non-ventilated patient, re-enforces the use of applicable guidelines in practice and teaching, and reiterates that procedural sedation must take place in resuscitation room only.</td>
</tr>
<tr>
<td>Reporting period: 2015/16</td>
<td>- compatible nasal prongs for end tidal CO2 monitoring kit ordered into stock and used in all procedural sedation and other suitable cases (non-ventilated patients requiring end tidal CO2 monitoring) .</td>
</tr>
</tbody>
</table>
### National clinical audit

**Sentinel stroke national audit programme (SSNAP)**

**Clinical audit**

Published: October 2016  
Reporting period: 01/04/16 – 31/06/16  
Site: RFH and BH

### Organisational audit

Published: September 2016  
Reporting period: Services as of 01/07/16  
Site: RFH and BH

### Mortality data

Published: January 2017  
Reporting period: 01/04/15 – 31/03/16  
Site: RFH and BH

### Actions or summary of key findings/outcomes to improve quality

A stroke is a serious, life-threatening medical condition that occurs when the blood supply to part of the brain is cut off (source: NHS Choices). Stroke remains the third commonest cause of death and the most common cause of complex disability in the UK, and can occur at any age. More than 80,000 people each year are admitted to hospital with a stroke in England, Wales, and Northern Ireland and while most people are elderly, a significant proportion are of working age, and of course stroke can affect children and young people too (source: national audit report).

Performance in the clinical audit demonstrates excellence in quality of care provided at the Royal Free and Barnet Hospitals, with the most recently published data showing that:

- both hospitals are providing a world class stroke service – achieving an ‘A’ rating for overall performance (SSNAP level), placing them amongst the top 18% performing teams nationally
- both sites achieved an ‘A’ rating for case ascertainment.

Performance in the organisational audit clearly demonstrates the provision of best practice services, with the Royal Free Hospital meeting 9/10 key indicators of best practice, placing the stroke team within the top 10 performing teams nationally.

Barnet Hospital met 7/10 key indicators of best practice, placing them within the top third of teams nationally. No deaths were recorded at Royal Free Hospital during the audit period, which is lower than expected. The number of deaths at Barnet Hospital equalled the number expected, and is not identified as an outlier.

### Royal Free Hospital

![Standardised Mortality Ratio with 99.8% Control Limit](image)

Your team has lower than expected mortality
### National clinical audit

#### Actions or summary of key findings/outcomes to improve quality

**Barnet Hospital**

![Standardised Mortality Ratio with 99.8% Control Limit](image)

**Your team is not an outlier for mortality**

The multi-disciplinary team regularly reviews the quarterly audit data to identify further improvement actions. This has included encouraging the participation of health partners across north central London (NCL) in the audit – this has helped improve the audit compliance around the referral process to early supported discharge; multi-disciplinary team meetings have led to an improved assessment process and the implementation of group therapy sessions; multi-disciplinary mortality and morbidity meetings have been set up across sites to discuss all stroke deaths to ensure learning is captured and fed back into improving clinical practice; and work is ongoing with the ambulance service to ensure patients are admitted to the appropriate hospital. To improve further the stroke team is actively seeking a full-time stroke co-ordinator at Barnet Hospital – this will further improve the identification and management of stroke patients.
### National clinical audit

#### Trauma audit and research network (TARN) – online survival data

**Data quality:**

TARN data entry shows good performance on data accreditation and completeness at the Royal Free Hospital.

### Actions or summary of key findings/outcomes to improve quality

Every year across England and Wales, 12,500 people die after injury. It is the leading cause of death among children and young adults of 44 years and under. In addition, there are many thousands who are left severely disabled for life (*source: TARN website*).

The latest data shows that more patients presenting at both the Royal Free and Barnet Hospitals are surviving compared to expected (1.0) based on the severity of their injury.

#### Rate of survival: January 01 2013 – December 31 2016

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Additional Survivors Out of Every 100 Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Free</td>
<td>4.3</td>
</tr>
<tr>
<td>Barnet</td>
<td>1.5</td>
</tr>
</tbody>
</table>

Royal Free: To improve the care provided to trauma patients the following actions are in progress – ward nurses are receiving training to provide basic swallowing assessments out of hours; proposals have been made to senior management and the trauma network on how to develop the trauma and rehabilitation coordinator roles which are much needed. Multi-specialty trauma governance mortality and morbidity (M&M) meetings have been set up at the Royal Free Hospital; the trauma calls have been rejuvenated and training is beginning to be implemented with a trauma team members (TTM) course planned this year; and time to CT will improve with the completion of the new build.

Barnet: Additional specialist trainee (Grade 3) cover has been put in place to support junior staff 24 hours a day, seven days a week. All middle-grade doctors have received advanced trauma life support training and nursing staff have the opportunity to undertake a university accredited trauma module as well as focused assessment with sonography (FAST) ultrasound training.
National clinical audit

UK Parkinson’s audit
- Elderly care: clinical report
- Neurology: clinical report and PREMs report
- Therapies: clinical report

Published: August 2016
Reporting period: 2015/16
Site: Elderly care RFH only, Neurology and Therapies RFH and BH

Actions or summary of key findings/outcomes to improve quality

Parkinson’s disease is a condition in which parts of the brain become progressively damaged over many years. One person in every 500 has Parkinson’s. That’s about 127,000 people in the UK. Symptoms and how quickly they progress are different for everyone. There’s currently no cure, but drugs and treatments are available to manage many of the symptoms (source: Parkinson’s UK website).

Performance in the clinical audit demonstrates excellence in quality of care provided at the Royal Free and Barnet Hospitals, with the most recently published data showing that above national average performance was identified for:

- discussion of end of life care issues and care planning, and information offered about, or has set up a, lasting power of attorney – elderly care team
- patient reviewed by a specialist within the last year – 100% achieved for neurology services across sites
- conversation with the patient and/or carer and/or provision of written information regarding potential side effects for any new medications – elderly care team and neurology services across sites.

For patients referred to physiotherapy above national average performance was demonstrated for:

- time from referral to initial assessment for urgent or routine cases
- reports made back to the referrer/other key people at the conclusion of the intervention period (or interim reports where treatment lasts a longer time)
- where a goal plan was included in the notes, outcome measures were used.

The patient experience questionnaire showed that overall patients were happy with the quality of services at both sites, and that in comparison to the national average more neurology patients at both hospital sites felt involved in decisions about their care and listened to; that patients were happy with the amount of time available to them; and that at Barnet Hospital patients were happy with the level of information provided on Parkinson’s disease, new medications and side effects, how to access support and information, and the role of social work for people with Parkinson’s and their carers.

Actions planned to improve performance further include:

- Parkinson’s UK information leaflets will be routinely available at the elderly care parkinson’s disease clinic, to supplement existing signposting to the Parkinson’s UK website.

- in the neurology parkinson’s disease clinic blood pressure and weight are now measured at all appointments. To improve the quality of information given to, and discussions with, the patient an information leaflet is being developed that will include information on the Parkinson’s support worker, side effects of medications, bone health, driving and end of life care which will supplement the Parkinson’s UK leaflets. A checklist of important issues to be discussed with the patient is also being developed as an aide memoire.

- in addition, work is ongoing to improve the integrated care pathway for parkinson’s disease via London’s parkinson’s disease excellence network, University College London (UCL) Partners Parkinson’s Disease Pathway redesign and frailty hub. Once the pathway of care is confirmed it will be included in the patient information making the care provided inside the hospital and across the network easier to navigate.
# National confidential enquiry

<table>
<thead>
<tr>
<th>National confidential enquiry</th>
<th>Actions or summary of key findings/outcomes to improve quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mothers and babies: reducing risk through audit and confidential enquiries across the UK (MBRRACE-UK): perinatal mortality report: 2014 births</td>
<td>The work of the trust in providing excellent care to mothers and their babies by continuously driving up standards of obstetric and neonatal care in order to reduce perinatal mortality is exemplified by our performance in the May 2016 MBRRACE-UK report which clearly demonstrates excellent outcomes, with the data showing that:</td>
</tr>
<tr>
<td>Published: May 2016</td>
<td>• the mortality rate for neonatal and extended perinatal deaths at the trust is more than 10% lower than the average for similar trusts and health boards, and that;</td>
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<tr>
<td>Reporting period: 01/01/14 – 31/12/14</td>
<td>• the stillbirth rate is nearly 10% lower than the average for similar trusts and health boards. This is despite the local population having a high proportion of mothers with demographics associated with poorer outcomes.</td>
</tr>
<tr>
<td>Site: RFH and BH</td>
<td>To improve patient care and outcomes further, the team is reviewing and implementing a continuity of care pathway and introducing further measures to reduce the stillbirth rate. Midwives are working in hubs alongside other specialists in the community to reduce variation and improve co-ordination of care. The trust forms part of the national maternal and neonatal health safety collaborative focusing on improving outcomes in perinatal mortality and morbidity nationally.</td>
</tr>
<tr>
<td>MBRRACE-UK: saving lives, improving mothers’ care – surveillance of maternal deaths in the UK 2012-14 and lessons learned to inform maternity care from the UK and Ireland confidential enquiries into maternal deaths and morbidity 2009-14</td>
<td>The trust makes continuous efforts to ensure that standards for the care of women and ongoing work to reduce maternal deaths continues to be part of the quality agenda of the maternity services.</td>
</tr>
<tr>
<td>Published: December 2016</td>
<td>The maternity services have benchmarked the current services against the report MBRRACE-UK: Saving lives, improving mothers’ care – Surveillance of maternal deaths in the UK 2012-14 and lessons learned to inform maternity care from the UK and Ireland confidential enquiries into maternal deaths and morbidity 2009-14. These include the following areas:</td>
</tr>
<tr>
<td>Reporting period: Various</td>
<td>• the services across both Royal Free Hospital and Barnet Hospital sites possess co-located obstetric and cardiac services. There are multi-disciplinary care plans and pathways for women with cardiac disease to support effective inter-disciplinary working and communication.</td>
</tr>
<tr>
<td>Site: RFH and BH</td>
<td>• both Royal Free Hospital and Barnet Hospital sites have early pregnancy and gynaecology assessment units (Monday to Saturday) and a full range of Maternity services (24/7) to assess this category of women.</td>
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<td></td>
<td>• it is established practice across the trusts maternity services that unwell antenatal women are only transferred to other units with on-site obstetric cover.</td>
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<td></td>
<td>• the consultant-led maternity units across both sites have readily available and seven days a week access to an electrocardiogram (ECG) machine and echocardiography, as well as staff who can interpret ECGs.</td>
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<tr>
<td></td>
<td>The recommendations of the report focus on messages for critical care, lessons for early pregnancy care and caring for women with hypertensive disorders in pregnancy, lessons on cardiovascular disease and there is work going on within the maternity services to incorporate these key messages into local cross site guidance as well as to share these messages during local clinical audit and governance meetings.</td>
</tr>
</tbody>
</table>
A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help you breathe. If necessary, the tube can be connected to an oxygen supply and a breathing machine called a ventilator. The tube can also be used to remove any fluid that’s built up in the throat and windpipe (source: NHS Choices).

Barnet Hospital is fully compliant with 20 out of 25 recommendations. This is an improvement from 13 in 2016. Actions implemented over the course of the last year include the provision of training (including blocked/displaced tubes and airways) to all multi-disciplinary staff, the patient at risk and resuscitation team (PARRT) attend the tracheostomy ward round with physiotherapy and the ear, nose and throat (ENT) clinical nurse specialist weekly and speech language therapy referrals are made for all swallow impairments and patients with high risk factors. To further improve, staff training and competency levels will be taken into account at patient allocation meetings and all patients undergoing a tracheostomy without a trial of extubation will have the reason clearly documented in the notes.

Royal Free Hospital is fully compliant with 23 out of 25 recommendations. This is an improvement from 21 in 2016. Actions implemented over the course of the last year include the availability of capnography on all wards to confirm tube placement, supply of end-of-bed tracheostomy packs including a summary of care, safety and information posters, and weaning plan from PARRT. To further improve, the hospital IT system cerner will be modified to enable the collection of electronic information on percutaneous tracheostomy insertion in the intensive care unit (ICU) and ICU consultants will use the World Health Organisation (WHO) checklist and document consent for all percutaneous tracheostomies.

Sepsis is a systemic inflammatory response to microbial infection, causing damage to organs then shock and ultimately death: the international prevalence is estimated at 300 per 100,000, suggesting that there are around 200,000 cases a year in the UK alone (source: NCEPOD report)

The implementation of the study recommendations is being led by the sepsis work stream group, which is also leading on the sepsis work being undertaken as part of the patient safety programme (PSP) – for more information on the PSP work see Part 2: priorities for improvement.

In relation to the NCEPOD study, the trust is currently fully compliant with 15 out of 19 applicable recommendations. To further improve the care provided to our patients with sepsis, local guidelines are in development to ensure surgical site bundles are in place for any invasive procedure; the development of a video is being considered for patients and their relatives regarding the recognition of sepsis, its long-term complications, recovery and risk of occurrence; the head of coding has joined the sepsis work stream group; and the need to include sepsis on the death certificate, when diagnosed, in addition to the underlying source of infection will be added to staff education and training.
<table>
<thead>
<tr>
<th>National confidential enquiry</th>
<th>Actions or summary of key findings/outcomes to improve quality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The national review of asthma deaths (NRAD) Adults</strong></td>
<td>It is not clear why the number of deaths per year from asthma in the UK has not reduced significantly from around 1,200 for many years, even though it is widely accepted that there are preventable factors in 90% of deaths. The aim of the project was to understand why people of all ages die from asthma so that recommendations could be made to prevent deaths from asthma in the future (source: national review report).</td>
</tr>
<tr>
<td><strong>Published:</strong> May 2014</td>
<td>The respiratory team has moved to full compliance with the implementation of 14 out of 14 applicable recommendations. In line with best practice the trust has a designated consultant with a special interest in severe asthma; at both Barnet and the Royal Free Hospitals a clinical nurse specialist liaises with the emergency department reviewing asthma patients and arranging follow up; every asthmatic has a personal asthma action plan; asthmatics in the out-patient clinic are usually seen more frequently than yearly, exceeding the best practice target; factors that trigger or exacerbate asthma and an assessment of recent asthma control form part of a standard asthma clinic review; staff are aware of the features that increase the risk of asthma attacks and death, including the significance of concurrent psychological and mental health issues and refer patients where necessary to the health psychologist; every patient that staff are concerned about are referred to either our nurse specialist or to their GP practice nurse to go through inhaler technique; at every out-patient clinic appointment patients are asked about their adherence to therapy (GP prescription records or exhaled nitric oxide levels are sometimes checked to help this process) and patients are told how important their inhaled steroids are; patients are not prescribed with a single agent long-acting beta-agonist; patient self-management forms part of a standard asthma clinic review, this is also encouraged by our asthma clinical nurse specialists; and every patient attending clinic or admitted to hospital will be asked about their smoking history or exposure.</td>
</tr>
<tr>
<td><strong>Annual Update on Progress:</strong> February 2017</td>
<td><strong>Site:</strong> RFH and BH</td>
</tr>
</tbody>
</table>

Clinical audit remains a key component of improving the quality and effectiveness of clinical care, ensuring that safe and effective clinical practice is based on nationally agreed standards of good practice and evidence-based care.

The trust remains committed to delivering safe and effective high quality patient centred services, based on the latest evidence and clinical research. Through our four clinical divisions, work is in progress to dove-tail our clinical audits and quality improvement initiatives which will provide better outcomes for our patients.

The reports of 18 local clinical audits* were reviewed by the provider in 2016/17 and RFL intends to take the following actions to improve the quality of healthcare provided.

(* the local audits undertaken relate to the divisional priority quality improvement projects)

**Actions to improve the quality of healthcare provided:**

- To ensure that all local audits are monitored effectively throughout our clinical divisions, with an increased focus on identifying the outcomes and embedding recommendations
- To ensure that any key themes which cross divisions are addressed appropriately

(A full list of specific actions are presented in table 4)
## Table 4: Details of specific actions undertaken as the result of a local clinical audit

<table>
<thead>
<tr>
<th>Local clinical audit</th>
<th>Actions to improve quality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surgery and associated services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>The anderson criteria: a model for improving patient handover and safety</strong> Divisional priority audit 2016/17</td>
<td>This audit was not undertaken in 2016/17. During the financial period the service’s priorities changed to focus on improving its submission to the national emergency laparotomy audit (NELA) and has successfully improved their submissions over the course of the year across sites. This audit is planned to be undertaken once the service is confident of sustained submissions to NELA.</td>
</tr>
<tr>
<td><strong>Closing the loop: strategies to minimise preoperative delay in emergency general surgery at the Royal Free Hospital (re-audit)</strong> Divisional priority audit 2016/17</td>
<td>This audit focuses on issues highlighted by the National Audit of Emergency Laparotomy (NELA), assessing the extent to which emergency general surgery patients were facing unacceptable delays for surgery and whether or not this had improved following reconfiguration of emergency services. It is well recognised that delaying emergency general surgery operations, especially for patients with sepsis, results in poorer patient outcomes, including higher complication and mortality rates. Even for those without sepsis, delayed surgery leads to unnecessary prolongation of patient discomfort, recovery and hospital stay resulting in a significant cost for the NHS. The results of the latest audit demonstrate significant improvements compared to the first round with 96% of patients meeting the Royal College of Surgeons (RCS) “time to treat” recommendations. Only four cases (4%) exceeded the recommendations a significant reduction from 25% identified in the first round of audit. None of the patients identified as exceeding the RCS “time to treat” recommendations were operated on at the weekend or out of hours. One of the areas identified as good practice was the reconfiguration of the emergency service with theatre access, which occurred after the first audit, which included separating the trauma and Orthopaedic list from the main emergency theatre. This has resulted in improved compliance with the best practice standards set by RCS and the national confidential enquiry into patient outcome and death (NCEPOD). There is no evidence from this audit that emergency general surgical patients are disadvantaged by current weekend working practices. For patients admitted between 8am and 6pm on a week day the mean time between the decision to operate and the start of operation was 8.48 hours, compared to 7.95 hours for patients admitted out of hours which shows virtually no difference.</td>
</tr>
<tr>
<td><strong>Ultrasound diagnosis of “U” classification thyroid nodules</strong> Divisional priority audit 2016/17</td>
<td>The U classification is essential in establishing correct pathways for the management of thyroid nodules by stratifying risk. Its increased use results in fewer fine-needle aspiration’s (FNAs), fewer ultrasonograms (US), fewer clinic appointments and better patient experience, which results in lower costs to the trust as well. The quality improvement project used pdsa (plan, do, study and act) methodology to assess the percentage of ultrasound reports using the U classification for thyroid nodules between March 2015 and June 2016 following the implementation of a series of interventions to improve practice. The data shows a clear and steady improvement in the use of U classification from 23% to 88% over the audit period. This has been driven by the implementation of regular interventions to educate staff and promote the use of the U classification including discussions with radiologists, an update to the thyroid protocol (oral and maxillofacial surgery (OMFS) clinical rooms), a request to specify U classification on all orders by OMFS and ear, nose and throat (ENT) clinicians, training provided to OMFS Dental Core Trainees and the U classification laminated and put up on the wall in the radiology treatment rooms as a visual aid.</td>
</tr>
</tbody>
</table>
### Virtual fracture clinic cross site comparison
**May-16**
Divisional priority audit 2016/17

The virtual fracture clinic at Barnet Hospital was set up to mirror the clinic at the Royal Free hospital. This audit compared the service plan assumptions to the actual challenges faced by the virtual fracture clinic following implementation at Barnet and aimed to address any issues found.

The data analysis showed that the implementation of the virtual fracture clinic at Barnet has brought a number of improvements, including to the fracture clinic waiting area, patient flow and the discharge rate, which has improved from 23% to 34%.

The audit also showed that the increase in demand for the service was not being met. To improve access to the service, funds have been agreed to resource three extra part-time sessions on a Monday, Tuesday and Friday afternoon. Additional administrative support for clinical staff has also been agreed for four hours a day. In addition early talks are in progress regarding the implementation of an IT system to underpin the virtual fracture clinic process.

### Swabs, needles and instrument count
Divisional priority audit 2016/17

Following serious incidents in 2015/16 regarding retained swabs and needles a new policy has been implemented in all theatres across the organisation. Following this implementation all staff have been assessed to ensure they are following the policy and fully competent.

In addition all theatre areas are doing monthly observational audits of swabs, needles and instrument count, using pdsa (plan, do, study, act) methodology. Results are reviewed locally by matrons and actions put in place to try to address any issues. Measurement then takes place again to check if the actions have been successful in solving these issues. The data is regularly reviewed at the monthly safer surgery board meeting; and later this year we will analyse all data to assess our improvement progress. Further action to improve will then be taken as required.

### Transplant and specialist services (TASS)

#### A local audit of tuberous sclerosis specialist service at the Royal Free Hospital for patients presenting with renal angiomyolipomas (AMLs)
Divisional priority audit 2016/17

Tuberous sclerosis is a multi-system genetic disorder, causing benign tumours to grow. This condition can affect any organ, but most commonly presents in the heart, lungs, kidneys, skin and eyes.

The audit demonstrated excellent patient care – all patients referred to the clinic with renal AMLs had an individual care plan in place, all patients had the appropriate follow up arranged and all patients that required specialist input had been referred and an appointment arranged.

To ensure patients have their renal scan ordered appropriately once a patient has been reviewed in clinic a decision will be made as to when their imaging is next due for review, this will be clearly documented in the patient notes and booked as soon as possible. Work is ongoing with the scanning department to ensure scans are booked in a timely manner.

Some patients are needle phobic and are not keen to have blood tests. To improve the documentation of eGFR the importance of documenting clinical decisions to omit blood tests has been discussed with the renal genetics team (i.e. patient choice).

Following the recent relaxation of the eligibility criteria for the genome project it is now possible to enrol suitable patients with tuberous sclerosis complex (TSC) into this programme. The study team has been informed and patients are now being approached at their clinic appointments.
Audit of fatigue syndrome presenting with joint hypermobility syndrome (JHS) on referral to service
Divisional priority audit 2016/17

The initial screening five part JHS questionnaire has been posted to 160 prospective patients, of which 102 (64%) have been completed and returned. 69 of these report benign JHS, and these will be assessed further to confirm chronic fatigue syndrome and JHS using the Beighton and Brighton criteria for JHS diagnosis.

17 further patients who have either already been assessed and/or re-assessed by the physician in clinic post therapy for fatigue, or re-assessed by a graded exercise therapist for further fatigue treatment, have been diagnosed according to Beighton and Brighton criteria. These numbers are already higher than expected.

The completion of this audit has been a challenge, with limited time and resource. However, we are committed to complete the audit and all data should be collected by the end of April 2017, which will allow analysis to be completed by the end of June 2017. Joint physician and physiotherapy clinics are being arranged to confirm the diagnoses in March and April 2017.

The American Association of Rheumatologists will shortly release a new definition and new criteria for some classes of JHS. This will be taken into account in the analysis, and we hope that the new criteria will be available before our planned audit completion date.

Renal dialysis patient reported experience measures (PREM) 2016-17: Patient experience and satisfaction with dialysis
Divisional priority audit 2016/17

Whilst PREM data has been collected by the renal dialysis specialty for a number of years the short renal-specific PREM questionnaire has been used to examine patients’ experience of and satisfaction with their dialysis treatment every year since 2013.

The findings of the latest review are very similar to those in previous years and show that:

- Nearly half of all respondents perceived their health to be good, very good or excellent yet bodily pain remains an ongoing difficulty for patients.
- More than half of respondents reported to have experienced at least moderate levels of bodily pain in the month prior to completing the questionnaire. However, although over one third of patients who had experienced pain had had no analgesia prescribed for them, patients experiencing severe or very severe pain reported taking medication for pain ‘very often’ suggesting that a number of respondents are likely to be taking medicines purchased over-the-counter.
- Symptoms of depression were explored for the first time using Patient Health Questionnaire-9 (PHQ-9). Results indicated moderate levels of depressed mood with 39% of respondents experiencing moderately severe or severe symptom of low mood which could warrant antidepressant and/or psychological therapy.
- Over the years, patient satisfaction has been consistently good with 59% of respondents scoring their care highly as an eight, nine or ten. This year, far less variability in satisfaction was noted between dialysis units.
- A number of positive comments commending the organisational qualities of their dialysis unit were received. The caring attitude of staff and the pleasant physical environment were also noted. Contrastingly, comments relating to the need for better patient-staff communication and more reliable transport, were frequently cited as suggestions for improvement.

As a result of the audit a number of recommendations have been made and are in the process of being implemented:

- consultants should routinely enquire about patients’ pain at each consultation.
- patients reporting psychological difficulties should be referred to the renal clinical health Psychology service for assessment and treatment, or for signposting to more relevant mental health services.
- staff should attend the trust’s Sage and Thyme communication skills training course which teaches staff to work effectively with patients in distress. To supplement this, dialysis staff should receive brief, accessible training to facilitate better understanding of common psychological problems experienced by patients receiving dialysis treatment. Training should be undertaken in dialysis units.

To further improve practice brief monthly training of dialysis staff in stress management and in the recognition of psychological distress in dialysis patients began at Tottenham Hale dialysis unit in September 2016.
### Assessment of all patients who died within 30 days of chemotherapy

Local audit of recommendations from the national confidential enquiry into patient outcome and death (NCEPOD)

**Divisional priority audit 2016/17**

Undertaken periodically since 2009, the audit assesses our performance against the NCEPOD recommendations. The audit has already led to a number of improvements including improved documentation of performance status, increased patient assessment by consultant staff and the development and implementation of a formal pathway for HIV positive patients.

The most recent audit results show areas of excellent practice – all patients had systemic anti-cancer therapy (SACT) prescribed by a consultant or senior registrar, all prescriptions were checked by a senior pharmacist, all drugs that should have been dose-modified had the correct dose prescribed and performance status was generally well documented. Patient performance status is an important part of cancer care and treatment. It plays a role both in shaping prognosis and in determining the best treatment for a patient with cancer.

As a result of the audit actions are in progress to improve the documentation of cause of death and to ensure that SACT related deaths in all patients treated with curative intent, all unexpected deaths and all deaths from neutropenia are discussed in depth at the mortality and morbidity meetings.

### Adherence to treatment in the lupus and vasculitis nephritis clinic

**Divisional priority audit 2016/17**

Medicine compliance is an ongoing challenge with 35-50% of all medicines prescribed for long-term conditions not taken as recommended. This represents a personal and economic loss to patients, the healthcare system and the society (source: National Institute for Health and Clinical Excellence (NICE) clinical guideline 76: Medicines Adherence).

The specialist renal clinic at the Royal Free Hospital sees patients predominantly with vasculitis and systemic lupus erythematosus (SLE). These conditions are both characterised by their autoimmune nature, chronicity, multi-system involvement and polypharmacy including long-term.

The survey findings demonstrated that the clinic was fully compliant with 16 out of the 19 NICE standards audited (84%), and partially compliant with three (16%). The audit data has been reviewed and a list of recommendations developed for action. These are:

- the most common reason for non-adherence to the prescribed medications was “forgetfulness”. To improve adherence the following have been recommended – the provision of practical tips and advice as part of an education session with the clinician or assisted by the pharmacy (such as dosset boxes/electronic reminders); and to identify patients with increased risk of forgetfulness and ensure they have access to additional support.
- keeping track of hospital appointments was one of the identified obstacles to adherence. This can be managed by further improving the hospital’s notification and reminder services, aspiring to minimise outpatient appointments, and emphasising the importance of attendance and diarising for patients.
- the major concern reported by the patients was the immunosuppressants and their side-effects. This can be addressed by enhancing education regarding the medication at the time of starting treatment and supporting the patients with provision of information leaflets and discussion about potential side effects and action plans if they experience side effects. Clear communication and correct direction to appropriate helpline/advice line or to the clinic team will enhance confidence in treatment and prevent early discontinuation of treatment.
- flexible follow-up intervals and adjusting doses or changing medications as soon as patients start experiencing side effects will improve symptoms before they affect their adherence with medication.
- many of the medications prescribed for vasculitis and SLE patients are essential and cannot be minimised or stopped. Identifying personal barriers to treatment early during follow up consultations allows for intervention before adherence is affected. This should include specific questions about side effects and current adherence, adjusting dosing schedule/frequency to suit the patient, and considering an early change of medication where side effects are problematic.
### Urgent Care

#### In-patient falls

**Divisional priority audit 2016/17**

The aim of the project is to reduce falls by 25%, as measured by incidents reported on DATIX by 31 March 2018. To date across the Trust 33 pdsa (plan, do, study, act) cycles have been instigated – 17 completed, 15 in progress and one intervention abandoned.

To reduce falls on:

- **8 West:** A review of the toilet areas on the ward has been completed. A thematic review (via staff focus groups) for falls prevention in patients with behavioural issues is being undertaken and all multidisciplinary team members are trailing writing their notes in the patient bays.

- **neurological rehabilitation centre:** A multidisciplinary falls assessment, falls care plan discussions at multidisciplinary team meetings and a multidisciplinary post-fall incident review have all been tested and implemented. The implementation of new falls documentation and toilet grab bags are in progress.

- **Juniper Ward:** A shortened board meeting and inclusion of discussion on falls and risk management has been completed. The use of 4 A’s Test (4AT), a short tool developed to increase rates of detection of delirium and cognitive impairment in acute general hospitals, and the use of bedside white boards are in progress.

- **Medical Short Stay Unit:** Toilet grab bags have been implemented and testing is in progress on laminated pictorial mobility signs and staff education on falls prevention.

- **Days since last harmful fall:** 8 West = more than 854 days, neurological rehabilitation centre = 487, Juniper Ward = 88 days and Medical Short Stay Unit = 24.

The falls work stream is part of the patient safety programme – for more information see Part 2: Priorities for improvement: patient safety priorities.

#### Deteriorating patient

**Divisional priority audit 2016/17**

To achieve the project aim to reduce the number of cardiac arrests to less than one per 1,000 admissions by 31 March 2018, the following interventions have been tested using the PDSA (plan, do, study, act) methodology on 10 West:

- re-design and evaluation of the new team ‘board round’ content and function – trigger questions include current issue, recurrent hospital admissions, acute concerns, resuscitation status, clinical criteria for discharge, social criteria for discharge, estimated date of discharge and multidisciplinary team involvement.

- the patient at risk and resuscitation team (PARRT), palliative care and parent team hold weekly multidisciplinary meetings – approximately six have been triggered to date.

- streaming nurse to nurse verbal handover.

- merging nursing, multi-disciplinary team and medical written handover.

The deteriorating patient work stream is part of the patient safety programme – for more information see Part 2: Priorities for improvement: patient safety priorities.
**Acute kidney injury (AKI)**

Divisional priority audit 2016/17

The aim of the project is to increase the number of patients who recover from AKI within 72 hours of admission by 25% by 31 March 2018. To meet this target:

- a technology platform (AKI Streams App) has been developed in partnership with DeepMind Health. It utilises the national mandated AKI detection algorithm and sends AKI alerts with other relevant data to the clinical responders.

- 15 to 20 alerts are received a-day with an average of five to six patients to be seen. Over 26 clinicians are currently using the device.

- the emergency department (ED) and medical admissions Unit (MAU) teams actively participated in the process mapping of the AKI pathway; ‘Streams’ alerts have been designed and deployed; and further updates and upgrades have been made to the app based on the testing phases in the ED and in patient areas.

- an ED capability package is currently being developed; ED observations data for processes of taking blood samples, gaining blood results and escalation to interventions is underway; and various iterations and changes have been made based on the feedback received.

- a real time study is in progress to identify the time saved by clinical teams using the app over the computer.

The AKI work stream is part of the patient safety programme – for more information see Part 2: Priorities for improvement: Patient safety priorities.

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**Sepsis**

Divisional priority audit 2016/17

The project aims for a 50% reduction in serious incidents related to sepsis.

- It has been 280 days since the last sepsis related serious incident.

- Since 2011 the total number of sepsis pathways started in the emergency departments (ED) at both hospital sites is 2,500.

- Current compliance with the provision of all 6 sepsis interventions within an hour is 80% at Barnet Hospital ED, and 66% at the Royal Free Hospital ED.

- An E-learning video is being filmed with the ED champions that will include acute kidney injury (AKI) and neutropenic sepsis.

- The use of a sepsis grab bag is being tested at Chase Farm Urgent Care Centre.

- The ED and 8 North are both participating in the Sepsis Commissioning for Quality and Innovation (CQUIN) scheme.

The sepsis work stream is part of the Patient Safety Programme – for more information see Part 2: Priorities for improvement: Patient safety priorities.

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**Diabetes**

Divisional priority audit 2016/17

The aim of the project is for zero avoidable harm from hyperglycaemia and hypoglycaemia events in a pilot ward by 2018. The project is being undertaken on the wards 10 West and 10 South.

- currently time to control hypoglycaemia in less than 30 minutes is achieved by 30% of patients; and in less than 6 hours by 76% of patients.

- collaborative support is being provided by staff from 10 West to 10 South.

- patient Safety Team to design confidence survey with 10W champions.

- the Trust aims to reduce incorrect medical record number mistypes to less than 19%.

- pdsa (plan, do, study, act) methodology is currently being used to test the hypoglycaemia pathway with additional glucometer and timer on 10 West.

The diabetes work stream is part of the patient safety programme – for more information see Part 2: Priorities for improvement: Patient safety priorities.
| **Improving quality of endobronchial ultrasound (EBUS) coding** | A monthly submission of EBUS procedures is made to the head of clinical coding who then ensures that correct codes have been applied and provides training to coders to improve coding quality further. The monthly return also allows the trust to correct billing in time. Coding accuracy has improved from 50% (February 2016) to 100% (November and December 2016). |
| **Improving the patient pathway for patients with breathlessness** | The specialist complex unexplained breathlessness (CUB) clinic organises pre-visit investigations and uses a multi-disciplinary team approach (physician, psychology and physiotherapy) in managing these patients. Compared to “usual care” patients in the CUB clinic had a significantly shorter time from referral to discharge (CUB: 137 days vs. usual care 251 days), fewer clinic attendances (1.5 visits vs. 2.7 visits) and better patient related outcome measures for the criteria: better understanding of condition, greater confidence in ability to self-manage breathlessness, feel less distressed about my breathlessness and overall satisfaction. This is likely to result in whole system cost reduction. |
| **Outlying patients under acute medicine** | An audit completed in 2012/2013 found that the average length of stay for outlying patients’ (acute medicine patients not admitted onto the medical admissions unit (MAU)) was 3.38 days longer than patients on the MAU. As a result of the audit following actions were implemented to improve the care provided to patients on outlying wards:  
• dedicated outlier consultant ward round implemented Monday, Tuesday, Thursday and alternate Fridays  
• flexible staffing – increased use of ward team to cover outliers.  
The repeat audit undertaken in February 2016 demonstrated that there had been a reduction in the difference in mean length of stay to 0.47 days; however the length of stay of patients on outlying wards has increased and their discharge continues to occur later in the day.  
To improve consideration is being given to electronic and other improved handover and bed management processes. |
| **Improving HIV testing in acute medical admissions** | HIV screening in acute medical admissions has been recommended in national guidance since 2008. Baseline data showed that 13% of patients less than 80-years old are being screened.  
The quality improvement methodology pdsa (plan, do, study, act) has been used to improve practice which has included the introduction of stickers for notes, posters to educate staff and feedback of data collected by the team. Initial improvements were seen at launch, although these have been difficult to sustain.  
This is an ongoing quality improvement project, extended to August 2017. |
The aim of the audit is to improve compliance with National Institute for Health and Clinical Excellence (NICE) guidance on IV fluid prescribing.

To improve practice changes have been made to the drug charts in line with recommendations for fluid and electrolyte prescriptions and teaching has been provided as both formal sessions, and ad-hoc for nurses and junior doctors. This has resulted in improvements across all criteria – see data below.

To improve practice further, the Step Up to Lead group is working on improved fluid prescribing in acute kidney injury (AKI) and complex patients, and new fluid balance charts will be developed to improve documentation of fluid management plans.

### IV maintenance re-audit results

<table>
<thead>
<tr>
<th>Category</th>
<th>Pre-audit</th>
<th>Post-audit</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-100g/day glucose</td>
<td>15%</td>
<td>69%</td>
<td>54%</td>
</tr>
<tr>
<td>Prescription 25-30mL/kg water</td>
<td>8%</td>
<td>78%</td>
<td>70%</td>
</tr>
<tr>
<td>Details of fluid management plan</td>
<td>20%</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Fluid management plan</td>
<td>20%</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Type and volume of fluids recorded</td>
<td>40%</td>
<td>100%</td>
<td>60%</td>
</tr>
<tr>
<td>Fluid and electrolyte review on every ward</td>
<td>20%</td>
<td>100%</td>
<td>80%</td>
</tr>
</tbody>
</table>

### IV resuscitation re-audit results

<table>
<thead>
<tr>
<th>Category</th>
<th>Pre-audit</th>
<th>Post-audit</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expert help sought if in shock but not fluid...</td>
<td>50%</td>
<td>70%</td>
<td>20%</td>
</tr>
<tr>
<td>Another bolus given if &gt;2000mL given and...</td>
<td>33%</td>
<td>50%</td>
<td>17%</td>
</tr>
<tr>
<td>Expert opinion given if &gt;2000mL given</td>
<td>47%</td>
<td>75%</td>
<td>28%</td>
</tr>
<tr>
<td>Reassessed using ABCDE</td>
<td>26%</td>
<td>62%</td>
<td>36%</td>
</tr>
<tr>
<td>Fluid deficit cause identified</td>
<td>48%</td>
<td>67%</td>
<td>19%</td>
</tr>
<tr>
<td>IV fluid management plan</td>
<td>48%</td>
<td>90%</td>
<td>42%</td>
</tr>
<tr>
<td>Fluid type, rate and volume recorded</td>
<td>40%</td>
<td>100%</td>
<td>60%</td>
</tr>
</tbody>
</table>
Women's Children’s and Imaging

Two person swab count audit  
Divisional priority audit 2016/17

This is an on-going quality improvement project led by the Royal Free and Barnet Labour Ward Matrons in conjunction with the Patient Safety Team. On-going observational audits continue and there have been a number of improvements made such as the introduction of white boards and a theatre checklist in the obstetric theatres on the Royal Free Hospital site. The process for counting swabs, needles and instruments has undergone a detailed process mapping exercise. Work is currently being undertaken in relation to cross site harmonisation of the Operational Theatre Policy and revision of the cross site Perineal Trauma and repair including 3rd and 4th degree tears (OASIS) guideline to align with the process mapping.

Post-menopausal bleeding management audit  
Divisional priority audit 2016/17

The aim of the audit, which commenced in January 2017, is to assess whether the pathway of care for women presenting with post-menopausal bleeding is being followed, and is appropriate given the presenting nature of their condition. A data collection proforma has been agreed for cross-site use. At the Royal Free, data collection has commenced and the audit is due for completion in June 2017 and at Barnet Hospital site the audit is due to commence at the time of publication of this report.

Paediatrics early warning score (PEWS) cross-site  
Divisional priority audit 2016/17

This project aims to implement PEWS charts and monitor compliance and performance through PDSA (plan, do, study, act) cycles. This quality improvement project is linked to the Institute for Health Improvement work, and has been introduced at the Royal Free London involving a revision of the PEWS charts. The timescale for completion of the first PDSA cycle is expected to be quarter 1 2017/18, with cross-site implementation by quarter 2, 2017/18. The first revision of the PEWS chart is undergoing piloting.

Neonatal safety huddles  
Divisional priority audit 2016/17

This project aims to introduce safety huddles to neonatal clinical areas on both sites. This quality improvement project is currently being set up cross-site, focussing on the development of the structure of the huddles and the recruitment of a representative from the core team, and champions in each area at both sites. The first improvement cycle has been launched and it is undergoing piloting in the neonatal settings.

Emergency CT head report authorisation (re-audit)  
Divisional priority audit 2016/17

The aim of the audit was to assess the process for CT head investigations to be reported in a timely fashion and subsequently authorised by a Neuroradiologist, as per National Institute for Health and Clinical Excellence (NICE) guidance. It was undertaken at the Royal Free Hospital in quarter 4, 2016/17, comparing practice to the previous audit completed in quarter 4, 2015/16. The audit was completed at Barnet Hospital in January 2017. The key findings were:

- For ward patients the average time to report was 2.16 hours with 46% within the 1 hour standard.
- For ward patients the average time to endorse a report was 92.3 hours with 72% of all reports being endorsed at all and 9% of reports being endorsed within the 1 hour standard.
- For Emergency Department patients the average time to report was 5.8 hours with 54% within the 1 hour standard.
- For Emergency Department patients the average time to endorse a report was 21.1 hours with 74.4% of all reports being endorsed at all and 14% of reports being endorsed within the 1 hour standard.

The limitations of the audit are that the option for endorsement drops off after 30 days; if the report is reviewed on PACS then there is no need to endorse the report; there is no trust guidance/protocol regarding endorsement; patients transitioning wards/teams are not necessarily transitioning to the corresponding pool; and in the Emergency Department patients being endorsed in groups by nurse in charge and being escalated to clinician responsible.

The following actions were recommended as a result of the re-audit and discussed at the Imaging Audit Presentation Day in January 2017 for implementation:

- Formal trust guidance regarding Endorsement target.
- If there is no viewable report on PACS then this must be checked on the Powerchart.
- Limiting access to the report unless willing to endorse.
- Consider named person responsible for endorsing (“Nurse in Charge”).
| **Novasure endometrial ablation** | This project is linked to the introduction of a new interventional procedure. This audit is currently being undertaken on the Royal Free Hospital site since the finalisation of the methodology and standards by the Gynaecology team.

Discussions continue to determine the applicability of this intervention to Barnet Hospital site. |
| **Truclear hysteroscopic tissue removal system** | This new interventional procedure has been audited on the Barnet site, with a re-audit being undertaken and presented in December 2016 showing progress on the first audit on time taken, polyps removed, pain experienced by the women, and willingness to recommend the service to a friend. Following advice from senior colleagues, future plans include making the Truclear system available in day surgery and main theatres and training the nursing staff to set the machine.

A similar prospective audit has begun at the Royal Free, with a report anticipated in May/June 2017. |
| **Percutaneous radiofrequency ablation (RFA) for lung cancer** | This new interventional procedure has established datasets on both sites. The Royal Free site data has undergone analysis which found that:

- There were 58 lung RFAs between December 2007 and June 2016.
- 50% of these patients had no complications, 21 patients (36.2%) had complications but these had no clinical significance and 8 patients (13.8%) had complications with some clinical significance.
- In 47 patients (81%) track ablation was achieved.
- 57 patients (98.3%) had a successful procedure.

The Barnet Hospital site dataset is undergoing analysis. |
| **Manual vacuum aspiration for termination** | This new interventional procedure has been recently audited on the Royal Free site.

- All 24 patients audited had a successful procedure and did not require further surgical or medical treatment.
- Patient satisfaction was very high with 98% satisfied with their procedure. Only 1 was moderately satisfied with the procedure.
- 95.9% would recommend this procedure to a friend and 4.1% would not recommend it.

Of the 24 respondents only 19 answered the question on pain after procedure. 3 out of 19 (15.8%) had pain for 2-3 days post procedure. As for pain during the procedure only 8.3% recorded the pain as moderate or more, while 91.7% recorded mild to minimal pain. 12.5% recorded no pain at all. These findings are in keeping with the evidence available in literature of 79% of patients experiencing minimal pain.

No allergic reaction was noted in any of our patients and none required an overnight stay or Entonox for pain relief.

Pain post procedure appeared to be the only complication. The complication rate was much less than that reported in the published literature where retained products, cervical rigidity, allergic reaction and false passage were highlighted although the numbers are small. This may well be due to routine use of cervical priming, screening for allergy at pre-assessment and ensuring completeness using an ultrasound post-procedure at the Royal Free Hospital site. |
| **Fetal pillow** | This new interventional procedure has been audited at Barnet Hospital site maternity unit and is the subject of a continuous audit managed by the clinical lead. The findings of the initial audit were:

- There were 8 cases where the fetal pillow was used and 7 case notes were reviewed.
- There were no major complications in relation to maternal or fetal outcomes.

Although the numbers are small the results are promising and the fetal pillow is noted to be easy to use. A similar prospective audit began at the Royal Free site in November 2016, with the report anticipated in May/June 2017. |
### Engaging parents in 6 north safety culture (Royal Free only)

Multidisciplinary ward safety huddles to improve situation awareness have been embedded on the paediatric ward on Royal Free Hospital site (6 North) for the last 2 years. During these twice-daily huddles, children at risk of deterioration are identified and discussed by means of their paediatric early warning score (PEWS), clinician impression or parental concern. Parental concerns were identified as not being reliably brought to the huddle by staff members or registered on the PEWS chart. The aim of the quality improvement project was to engage parents in the ward safety culture and to ensure any concerns regarding their child are highlighted to the multidisciplinary team as soon as possible.

As part of the project parents were engaged in the design of bedside safety information packs and “daily plan” whiteboards to improve communication with the multidisciplinary team and parents/carers. A “Traffic light” system has recently been developed by frontline clinicians using the Model for Improvement to assess parental concerns: green- happy their child is getting better, amber- unsure they are getting better, and red- worried they are not getting better. An interview of 30 parents on the ward revealed that 12 felt their concerns were ‘green’, 12 were ‘amber’, and 6 were ‘red’, but none of the parents with ‘red’ concerns were highlighted at the huddle.

The following actions for improvement have been implemented:

- **A traffic light concern chart has been put next to every bed space on ward 6 North. This will open a discussion between the parent and the nurse to identify the concerns early.**
- **The aim is for the ‘traffic light’ data to be collected by the housekeeping staff (who visit every parent on their breakfast round) and brought to the morning safety huddle. Using the Model for Improvement, the service shall continue to measure the percentage of parental concerns that are discussed at the huddle and test our approach using PDSA cycles.**
Paediatric intensive care retrievals to provide learning and feedback to the multidisciplinary team

A multi-disciplinary team of anaesthetics, emergency physicians, paediatricians, Patient at Risk and Resuscitation Team (PARRT) nurses and the children’s acute transfer service (CATS) is involved in the acute management and stabilisation of children being transferred from our Emergency Department (ED)/Ward 6N to a tertiary paediatric intensive care unit (PICU). This project focuses on the management of this patient group and the aims were to identify areas for improvement, share the learning and enhance patient safety and care.

A modified version of the Rapid Evaluation Cardio-respiratory Arrest with Lessons for Learning (RECALL tool) has been used for analysis of children transferred from ED/Ward 6 North to PICU. This tool provides a structured template to review notes of children who deteriorate and identify areas for improvement. It focuses on assessment (recording of early warning scores), escalation in response to deterioration, clinical reviews at appropriate points, interventions implemented and additional information (staffing, parental concerns). The cases are analysed monthly by a multidisciplinary group and one case is identified to be presented at the clinical risk meeting (to highlight learning or excellent care). Learning is disseminated to the teams by email and displayed in clinical areas.

The paediatric services have set up new teaching session (last Friday of every month) providing feedback and learning themes. The services have also implemented the following:

- Debriefs within a week of every CATS transfer (being documented on the high dependency unit (HDU) patient forms).
- Monitoring of the incidence of CATS transfers within our trust.
- A new monthly clinical risk meeting focused on CATS liaison and transfers within the hospital.

The initial feedback from trainee doctors prior to interventions was that they felt ‘supported but anxious, stressed, worried, concerned, nervous, apprehensive, uncomfortable, frightened and uneasy’. Following two focused meetings to date, paediatric trainees are feeling less anxious and stressed about the retrievals and are keen for the teaching to continue.

The following actions have been taken for improvement:

- New monthly trust-wide newsletter to paediatric consultants, anaesthetic team and PARRT team.
- New monthly learning topics newsletter to paediatricians and allied staff - placed on news boards and sent out as email.
- A monthly CATS learning meeting.

There are ongoing plans to continue this intervention and the dissemination of learning, and to widen the teaching sessions to a trust-wide basis.
### Asthma tool kit for clinic pilot for Royal Free Hospital site

There has been increased focus on asthma and as part of this quality improvement work there has been a pilot project on reducing the variability in assessment of wheeze/asthma patients in the allergy clinic on the Royal Free Hospital site.

The aim is for 100% patients with wheeze/asthma to have structured documented assessment and discharge plan as per British Thoracic Society (BTS)/National Institute for Health and Clinical Excellence (NICE) asthma guidelines i.e. correct assessment and discharge in the domains of smoking cessation, written asthma plan, flu vaccination recommendation and inhaler technique assessment.

High levels of variation in practice were found in the first 8 weeks of the audit and this was noted to be dependent on clinicians. Smoking cessation and flu vaccine recommendation were the areas which with greatest opportunity for improvement.

As part of this quality improvement project ideas were collected from staff as to how to improve practice and it was agreed that a crib sheet would be helpful as aide memoire to staff. This has been instituted and a further pilot is in progress to incorporate the crib sheet in EDRM (electronic patient record system).

### Too much huff, not enough puffs

This quality improvement project was initiated to improve the low confidence parents may have in managing wheeze at home which can lead to unnecessary presentations to the Emergency Department (ED).

The aim of the project is to ensure that all parents of children who have previously presented with wheeze have confidence to administer 10 puffs of Salbutamol to child before bringing them to ED. 15 measures collected, 4/15 gave 10 puffs, 1/15 gave more than 10 puffs (15), 10/15 gave less than 10 puffs.

As part of this quality improvement project ideas were collected as to how to improve and the most popular idea amongst staff and parents was a sticker to put on inhaler boxes outlining a condensed wheeze plan. This sticker is in the process of being designed and printed.

### Learning from excellence

This quality initiative was introduced with the aims to celebrate and learn from our everyday success, to share good practice and improve staff morale by embedding the “little fixes” we undertake to deliver high quality paediatric patient care.

Electronic nominations via the IT incident reporting system DATIX were launched in November 2016 following successful implementation of paper nominations at the Barnet Hospital site paediatric department. There are now an increasing number of nominations from Royal Free Hospital site and there is work underway to encourage nominations from other specialties.
Participating in clinical research

Involvement in clinical research demonstrates the trust’s commitment to improving the quality of care we offer to the local community as well as contributing to the evidence base of healthcare both nationally and internationally.

Our participation in research helps to ensure that our clinical staff stay abreast of the latest treatment possibilities and active participation in research leads to better patient outcomes.

Our reputation attracts outstanding staff and researchers from many different countries. The close collaboration between staff and the research department of the medical school is one of our unique strengths - patients are involved in research allowing our staff to provide the best care available whilst working to discover new cures for the future.

The number of patients receiving relevant health services provided or sub-contracted by the Royal Free London NHS Foundation Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 13,559

The figure includes 5,206 patients recruited into studies on the National Institute for Health Research (NIHR) portfolio and 8,353 patients recruited into studies that are not on the NIHR portfolio. This figure is higher than that reported last year.

The Trust is supporting a large research portfolio of over 700 studies, including both commercial and academic research. 190 new studies were approved in 2016/2017.

The breadth of research taking place within the Trust is far reaching and includes clinical and medical device trials, research involving human tissue and quantitative and qualitative research, as well as observational research.

CQUIN Payment framework

A proportion of the Royal Free London NHS Foundation Trust income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between the Royal Free London NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment Framework.

Further details of the agreed goals for 2016/17 and for the following 12-month period are available electronically at https://www.royalfree.nhs.uk/about-us/corporate-information-and-accountability/cquin-scheme-priorities/
<table>
<thead>
<tr>
<th>CQUIN scheme priorities 2016/2017</th>
<th>Objective rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff health &amp; well being</strong></td>
<td>This national initiative made up of three areas of improvement:</td>
</tr>
<tr>
<td>1)</td>
<td>Introduction of health and wellbeing initiatives covering physical activity, mental health and improving access to physiotherapy for people with MSK issues</td>
</tr>
<tr>
<td>2)</td>
<td>Healthy food for NHS staff, visitors and patients</td>
</tr>
<tr>
<td>3)</td>
<td>Improving the uptake in the flu vaccination for frontline staff</td>
</tr>
<tr>
<td><strong>Sepsis</strong></td>
<td>Timely identification and treatment of sepsis in emergency departments and acute inpatient settings</td>
</tr>
<tr>
<td></td>
<td>Sepsis is a common and potentially life-threatening condition with around 32,000 deaths in England attributed to sepsis annually.</td>
</tr>
<tr>
<td><strong>Antimicrobial</strong></td>
<td>Reduction in antibiotic consumption across the Trust and a empiric review of antibiotic prescriptions.</td>
</tr>
<tr>
<td></td>
<td>Antimicrobial resistance has risen alarmingly over the last forty years and inappropriate plus overuse of antimicrobials is a key driver.</td>
</tr>
<tr>
<td><strong>Discharge summaries</strong></td>
<td>Improvement of discharge summaries in A&amp;E and the Medical Admissions Unit.</td>
</tr>
<tr>
<td></td>
<td>The Trust has worked closely with Barnet CCG and local GP's to improve the accuracy and detail in its discharge summaries which is an important driver in providing better patient care and management of long terms conditions as well as reducing readmissions and A&amp;E attendances.</td>
</tr>
<tr>
<td><strong>Cancer referrals</strong></td>
<td>Streamlining urgent GP (GMP, GDP or Optometrist) referrals for suspected cancer for the first appointment with a target of two weeks for all cancers</td>
</tr>
<tr>
<td></td>
<td>Review of cancer patients waiting longer than 104 days from urgent GP referral to first definitive treatment. Ensuring efficient investigation, diagnosis and treatment of cancer is essential to ensuring a positive patient experience.</td>
</tr>
<tr>
<td><strong>Maternal &amp; child health</strong></td>
<td>To embed a public health approach and implement a maternal and child health programme across the Trust. Beginning at the first antenatal booking ,through maternal health and paediatric care up to the age of sixteen. This affords huge potential to support, educate and refer patients early on for a range of health and social risk factors and to help prevent future ill health.</td>
</tr>
<tr>
<td><strong>Hepatitis C virus</strong></td>
<td>Supporting the infrastructure, governance and partnership working across healthcare providers working in HCV networks in their second and third years of operation to increase engagement with patients, rollout new clinical and cost effective treatment guidance, improve participation in clinical trials and enhance data collection.</td>
</tr>
<tr>
<td><strong>Severe Haemophilia</strong></td>
<td>The HAEMTRACK patient reporting system is an electronic (or paper) patient-reported record of self-managed bleeding and blood product home-therapy usage. This scheme aims to establish the use of the Haemtrack patient home therapy diary as an integral part of clinical care. The scheme offers financial support to all centres to improve recruitment and data quality, and to use Haemtrack as one of the tools in an increasingly interventionist approach to individual treatment optimisation.</td>
</tr>
<tr>
<td><strong>Dose Banding Adult Intravenous SACT</strong></td>
<td>A national incentive to standardise the doses of SACT (Systemic Anticancer Therapy) in all units across England in order to increase safety, to increase efficiency and to support the parity of care across all NHS providers of SACT in England.</td>
</tr>
<tr>
<td><strong>Adult critical care timely discharge</strong></td>
<td>To reduce delayed discharges from ACC to ward level care by improving bed management in ward based care, thus removing delays and improving flow.</td>
</tr>
<tr>
<td><strong>Telemedicine</strong></td>
<td>To improve patient experience by reducing the number of times a patient is required to attend a face to face outpatient appointment; but instead has their follow-up care and advice conducted through a non-face to face method.</td>
</tr>
<tr>
<td><strong>ARV Cost Effective Prescribing</strong></td>
<td>The scheme has identified a number of switches of drug regimen making the best use of available antiretroviral drug regimens that have all been agreed by the clinical and patient leadership of the National HIV CRG Drugs Sub-Group. This approach provides a range of appropriate switches that provide the best approach to ensuring there is opportunity for clinicians to make choices of commissioned treatments which meet the needs of individual patients, whilst being able to maintain an effective overall approach to cost management.</td>
</tr>
<tr>
<td><strong>Multisystem Autoimmune Rheumatic Disease</strong></td>
<td>This CQUIN is to support the development of coordinated MDT clinics for patients with multisystem autoimmune rheumatic diseases. This MDT arrangement will also enable longitudinal data collection, particularly of outcome measures using validated tools and the use of patient activation measurement (PAM)</td>
</tr>
<tr>
<td><strong>Dental</strong></td>
<td>Collection and submission of data on priority pathways procedures by Tier and to participate in referral management and triage and with active participation in Managed Clinical Networks (MCN)</td>
</tr>
</tbody>
</table>
In 2016/17 the Clinical Commissioning Group (CCG) monetary total was £10.9 million and the NHS England (NHSE) monetary total was £3.4 million conditional upon achieving quality improvement and innovation goals. In 2015/16 the trust chose to opt for the default tariff rollover (DTR) rather than the enhanced tariff option (ETO).

**Registration with the Care Quality Commission (CQC)**

The Royal Free London NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered. The Royal Free London NHS Foundation Trust has no conditions on registration.

The CQC has not taken enforcement action against RFL during 2016/17. The Royal Free London NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The CQC undertook a full comprehensive hospital inspection during the week 1-5 February 2016. The trust was rated good overall as a provider and rated good at each hospital site and for each core service at all sites an unprecedented rating for a London trust (See Part Three for further information on CQC).
Comments from the CQC Inspection - February 2016

What we say...

Royal Free London chief executive Sir David Sloman said:

“We are delighted to receive a rating of “Good” across all our hospitals and I am proud that the report highlights many areas of practice where we are delivering outstanding treatment to our patients.

“This is a fantastic achievement given that Barnet and Chase Farm hospitals only joined us in 2014. Staff should be incredibly proud of how well this reflects on their professionalism and the care and compassion they demonstrate every day.”

What they said...

Professor Sir Mike Richards, the Chief Inspector of Hospitals, said in the report:

“Across the organisation, staff demonstrated compassion, kindness and respect for the patients and families they worked with.

“Staff told us they were proud to work at the Royal Free and were enthusiastic about the service they provided.”

What they said...

Professor Ted Baker, the Deputy Chief Inspector of Hospitals said:

“As one of the largest acute trusts in England, the Royal Free London NHS Foundation Trust sees 1.6 million people a year. The trust and its staff should be proud of the fact that all three hospitals in London were rated “Good” by CQC inspectors. This is a considerable achievement. Overall, the service patients receive is effective, responsive and compassionate.”
Information on the quality of data

Good quality information ensures that the effective delivery of patient care and is essential for quality improvements to be made. Improving information on the quality of our data includes specific measures such as ethnicity and other equality data will improve patient care and increase value for money.

This section refers to data that we submit nationally.

The Patient’s NHS number

A patient’s NHS number is the key identifier for patient records. It is a unique 10-digit number which is given to everyone who is registered with the NHS and allows staff to find patient records and provide our patients with safer care.

The Royal Free London NHS Foundation Trust submitted records during 2016/17 to the Secondary Uses service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

The percentage of records in the published data that included the patients’ valid NHS numbers was:

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>For admitted patient care</td>
<td>98.8%</td>
<td>98.6%</td>
<td>98.15%</td>
</tr>
<tr>
<td>For out-patient care</td>
<td>99.2%</td>
<td>98.6%</td>
<td>98.65%</td>
</tr>
<tr>
<td>For accident &amp; emergency care</td>
<td>92.6%</td>
<td>94.4%</td>
<td>94.89%</td>
</tr>
</tbody>
</table>

General Medical Practice Code

In order to transfer clinical information from the trust to our patient’s GP, it is essential that the information sent is accurate. Data which included the patients’ valid General Medical Practice Code was:

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>For admitted patient care</td>
<td>99.8%</td>
<td>99.95%</td>
<td>99.92%</td>
</tr>
<tr>
<td>For out-patient care</td>
<td>99.9%</td>
<td>99.96%</td>
<td>100%</td>
</tr>
<tr>
<td>For accident &amp; emergency care</td>
<td>99.9%</td>
<td>99.94%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Information Governance (IG)

The Royal Free London NHS Foundation Trust Information Governance Assessment Report overall score for 2016/17 was 66% and was graded satisfactory (green).

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<tr>
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<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
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<tbody>
<tr>
<td>Information governance assessment report score</td>
<td>70%</td>
<td>68%</td>
<td>66%</td>
</tr>
<tr>
<td>Overall grading</td>
<td>satisfactory</td>
<td>satisfactory</td>
<td>satisfactory</td>
</tr>
</tbody>
</table>
Payment by Results

The Royal Free London NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Data quality

The trust continues for focus on this area to ensure that high quality information is available to support the delivery of safe, effective and efficient clinical services.

The Royal Free London NHS Foundation Trust will be taking the following actions to improve data quality:

We have recently implemented a revised Data Improvement Strategy which sets out how data will be assured in the Trust. The Strategy sets out:

- A set of principles to support production, and assurance, of high quality data and its management and defines what “high-quality data” means in practice and the national and local information and information governance standards to which the Trust works;

- Roles and responsibilities for delivering high-quality data from front-line staff and their managers through to senior managers and executives;

- A Data Improvement Programme to systematically assure high-quality data and address data quality issues and their underlying causes. The Strategy defines a framework to assess and routinely report on the underlying quality of data, with additional support and resources available for those priority areas where data quality needs to improve.

The revised Data Improvement Strategy will be implemented in 2017/18.

Reporting against core indicators

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

Areas covered will include:

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

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

Indicator:

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

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<tbody>
<tr>
<td>0.8027 (Lower than expected)</td>
<td>0.8956 (Lower than expected)</td>
<td>0.8623 (Lower than expected)</td>
<td>0.9086 (lower than expected)</td>
<td>1.0 (as expected)</td>
<td>0.6897 (lower than expected)</td>
<td>1.1638 (higher than expected)</td>
</tr>
</tbody>
</table>

The SHMI score published in this report has been calculated by NHS Digital and uses finalised HES data for the financial years 2012-13, 2013-14, 2014-15, 2015-16 and provisional data for the financial year 2016-17 (month 8 extract). NHS Digital have indicated that they believe there is a shortfall in the number of records in the HES data for discharges in the reporting period October 2015 – September 2016 for Royal Free London NHS Foundation Trust (provider code RAL). This has the potential to either under or over represent performance against this indicator and as such the report should be viewed with caution, however it should be noted that the Royal Free London NHS Foundation Trust participates in the HSCIC NHS Choices / Clinical Indicator sign off programme whereby data quality is reviewed and assessed on a monthly and quarterly basis. No significant variance between the data held within Trust systems and data submitted externally has been observed.

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

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

The latest data available covers the 12 months to September 2016. During this period the Royal Free had a mortality risk score of 0.9086, which represents a risk of mortality 9.14% lower than expected for our case mix. This represents a mortality risk statistically significantly below (better than) expected with the Royal Free ranked 19th out of 137 non-specialist acute trusts.

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

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

https://indicators.hscic.gov.uk/webview/
The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from NHS Digital. As noted above, NHS Digital has indicated that there appears to be a deficit in the number of records submitted by the trust. The trust fully understands the importance of data accuracy and, accordingly, it reviews data held by NHS Digital on a monthly and quarterly basis. No significant discrepancies have been indicated as part of this sign off process.

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.

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

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

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

### Patient deaths with palliative care code

**Indicator:**

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

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<tbody>
<tr>
<td>24.6%</td>
<td>28.2%</td>
<td>24.4%</td>
<td><strong>27.3%</strong></td>
<td><strong>30.0%</strong></td>
<td>56.3%</td>
<td>0.4%</td>
</tr>
</tbody>
</table>
### Patient reported outcome measures scores (PROMS)

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<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>0.07</td>
<td>Low number rule applies</td>
<td>Low number rule applies</td>
<td>Low number rule applies</td>
<td>0.09</td>
<td>0.16</td>
<td>0.02</td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td></td>
<td>0.08</td>
<td>Low number rule applies</td>
<td>Low number rule applies</td>
<td>0.12</td>
<td>0.09</td>
<td>0.15</td>
<td>0.02</td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td></td>
<td>0.38</td>
<td>0.38</td>
<td>0.74</td>
<td>0.43</td>
<td>0.44</td>
<td>0.51</td>
<td>0.32</td>
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</tbody>
</table>

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</thead>
<tbody>
<tr>
<td></td>
<td>0.26</td>
<td>0.30</td>
<td>0.68</td>
<td>0.31</td>
<td>0.32</td>
<td>0.40</td>
<td>0.20</td>
</tr>
</tbody>
</table>

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.

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

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

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

- obtaining data of actual number of procedures undertaken to compare with figures
- amending processes at Barnet Hospital and Chase Farm Hospital for all submissions to come through governance team
- reviewing where pre-operative questionnaires are completed

http://content.digital.nhs.uk/proms
Emergency readmissions within 28 days

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

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</thead>
<tbody>
<tr>
<td>Patients aged 0 to 15 years old</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.93%</td>
<td>10.1%</td>
<td>5.2%</td>
<td>6.4%</td>
<td>3.3%</td>
<td>10.5%</td>
</tr>
<tr>
<td>Patients aged 16 years old or over</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.5%</td>
<td>8.5%</td>
<td>8.3%</td>
<td>10.6%</td>
<td>5.5%</td>
<td>10.6%</td>
</tr>
</tbody>
</table>

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

The Royal Free carefully monitors the rate of emergency readmissions as a measure for quality of care and the appropriateness of discharge. A low, or reducing, rate of readmission is seen as evidence of good quality care. The Royal Free London Foundation NHS Trust performance against non-specialist providers throughout England.

The table above demonstrates that the 28 day readmission rate at the Royal Free London NHS Foundation Trust compares favourably with the rate amongst the 136 non-specialist providers in England; with a lower than average readmission rate observed at Royal Free London Foundation NHS Trust in both paediatric and adult cohorts.

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

The RFL has taken the following actions to improve this percentage, and so the quality of its services, by:

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

Responsiveness to the personal needs of our patients

Indicator:

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

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</tr>
</thead>
<tbody>
<tr>
<td>65.6</td>
<td>67.4</td>
<td>68.6</td>
<td>69.9</td>
<td>69.6</td>
<td>86.2</td>
<td>58.9</td>
</tr>
</tbody>
</table>

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

The NHS has prioritised, through its commissioning strategy, an improvement in hospital’s responsiveness to the personal needs of its patients. Information is gathered through patient surveys. A higher score suggests better performance. Trust performance is below (worse than) the national average.

The Royal Free London NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by developing a comprehensive patient experience improvement plan overseen by the patient and staff experience committee, a sub-committee of the trust board

https://indicators.hscic.gov.uk/webview/
Friends and Family test (Staff)

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

| Indicator: The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends. |
|---|---|---|---|---|---|---|
| 76% | 71% | 72% | 75% | 70% | 85% | 49% |

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

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

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

- undertaking activities to enhance engagement of staff have resulted in an increase of the percentage of staff who would recommend their hospital as a care provider to family or friends
- implementing a world class care programme embodying the core values of welcoming, respectful, communicating and reassuring. These are the four words which describe how we interact with each other and our patients. For the year ahead the continuation of our world class care programme anticipates even greater clinical and staff engagement.

http://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2016/
Venous thromboembolism (VTE)

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

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

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>98.0%</td>
<td>96.1%</td>
<td>97.1%</td>
<td>96.6%</td>
<td>94.5%</td>
<td>100.0%</td>
<td>76.5%</td>
</tr>
</tbody>
</table>

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

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.

In the latest quarter for which data is available, the Royal Free Hospital performed better than the 95% national target and performed better than the national average, achieving 96.6%.

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

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

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

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

C. 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 C. difficile infections is a key government target.

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

Delivery of educational programmes, comprehensive antibiotic policies, good bed management with early isolation of symptomatic patients and enhanced environmental cleaning.

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

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

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


### Indicator:

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

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<tbody>
<tr>
<td>17.0</td>
<td>18.8</td>
<td>17.8</td>
<td><strong>21.0</strong></td>
<td><strong>14.9</strong></td>
<td>0</td>
<td>66</td>
</tr>
</tbody>
</table>

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

C. 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 C. difficile infections is a key government target.

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

Delivery of educational programmes, comprehensive antibiotic policies, good bed management with early isolation of symptomatic patients and enhanced environmental cleaning.

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

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

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

Every six months, NHS Improvement publishes official statistics on the incidents reported to the NRLS. These reports give NHS providers an easy-to-use summary of their current position on patient safety incidents reported to the NRLS, in terms of patient safety incident reporting and the characteristics of their incidents.

The information in these reports should be used alongside other local patient safety intelligence and expertise, and supports the NHS to deliver improvements in patient safety. The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the National Reporting and Learning System (NRLS). The National Patient Safety Agency regard the identification and reporting of incidents as a sign of good governance with organisations reporting more incidents potentially having a better and more effective safety culture.

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

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

- There is also clinical judgement in the classification of an incident as ‘severe harm’ as it requires moderation and judgement against subjective criteria and processes. This can be evidenced as classifications can change once they are reviewed. Therefore, it could be expected that the number of severe incidents could change from that shown here due to this review process.

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

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

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<tr>
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</thead>
<tbody>
<tr>
<td>2,528 (6.3)</td>
<td>2,422 (6.9)</td>
<td>5,734 (34.7)</td>
<td>5,915 (36.5)</td>
<td>3,643 (47.9)</td>
<td>11,998 (40.9)</td>
<td>334 (16.1)</td>
</tr>
<tr>
<td>25 (0.99%)</td>
<td>22 (0.91%)</td>
<td>43 (0.75%)</td>
<td>26 (0.44%)</td>
<td>20.09 (0.55%)</td>
<td>0 (0.00%)</td>
<td>119 (3.00%)</td>
</tr>
</tbody>
</table>
### Part three: review of quality performance

This section of the quality report presents an overview of the quality of care offered by the trust based on performance in 2016/17 against indicators and national priorities selected by the board in consultation with our stakeholders.

#### Summary of our performance against key national indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Our SHMI ratio</strong> was 90.53 or 9.47% better than expected.**</td>
<td>For this period the Royal Free London had the 9th lowest relative risk amongst the 26 large England Teaching Hospitals.</td>
</tr>
<tr>
<td><strong>We recorded the 7th lowest relative risk of mortality (HSMR)</strong> of any English Teaching Trust with a relative risk of mortality of 92.36 which is 7.64% below (statistically significantly better than expected).**</td>
<td></td>
</tr>
<tr>
<td><strong>Against the 25 teaching trusts, the trust is ranked 8th lowest with a rate of 1.21 MRSA bacteraemias per 100,000 bed days.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>For C.diff, the trust is ranked 23rd out of 25 English Teaching Hospitals for the 12 month period to end January 2017 with a reported rate of 41.8 per 100,000 bed days.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>The trust returned to compliance against the (RTT) incomplete pathway standard in June 2016 and continues to maintain compliance.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>During the period April 2016 to January 2017, we achieved 87.92% compliance against the 95% 4 hour standard for our A&amp;E performance.</strong></td>
<td></td>
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<tr>
<td><strong>We performed better than the national targets in relation to the two week wait and 31 day cancer waits standards.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>We treated 84.7% of elective admissions as day cases; this was the highest proportion across the group of large teaching providers.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>We reported the 10th lowest average length of stay across the large teaching provider peer group.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>The trust underperformed against the 62 day cancer waits standard.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>As a ratio, the Trust rate of 0.2% is the eighth lowest rate of cancellations across the English teaching hospitals peer group.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>30% of the delayed transfers of care observed across Royal Free London NHS Foundation Trust were attributable to social care delays.</strong></td>
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</table>
Overview of the quality of care in 2016/17

In 2016/17, the trust has continued to address some of the challenges it has faced since the acquisition of Barnet and Chase Farm hospitals in July 2014. In the case of the 18 week Referral to Treatment (RTT) and six week diagnostics waiting time standards, significant progress has been made as a result of work to validate historically poor data and to clear backlogs. The trust returned to standard against diagnostics in March 2016 and also returned to standard against RTT in June 2016 and has been compliant since.

The trust has continued work to improve our cancer pathways, with a full recovery programme for the 62 day GP referral to first treatment waiting times standard in operation since July 2016. Progress to date has seen performance sustained above 80% since November and the trust is working towards compliance with the 85% standard by the beginning of 2017/18. Particular progress has been made in ensuring prostate patients receive diagnostic imaging and biopsies on the same day, significantly reducing waiting times.

Performance against the four hour A&E waiting time standard over 2016/17 has continued to be challenged and the trust is currently ranked tenth in comparison to other London A&E providers. The trust is working closely with its system partners to deliver a programme of work that will address these issues in 2017/18.

We are ranked between seventh and ninth best performing against the two main measures of mortality risk (HSMR and SHMI) compared to our peer group of 26 English teaching trusts.

We continue to develop our world class care programme, which is designed to improve patient and staff experience and we have retained our focus on safety by continuing to promote our patient safety programme.

Our estate modernisation programme has continued with the first two phases of the new ed redevelopment completing and opening to the public. The new dedicated paediatric department, ambulatory emergency care and temporary short stay wards opened in August 2016, and the new waiting room and reception area were commissioned in February 2017. The Chase Farm Hospital new build is currently on schedule to open in autumn 2018.

Our focus for 2017/18 is to ensure that all parts of our trust can reach and maintain the standards of our best services. The group model developments, including the new clinical practice groups, will be core to delivering this. Our key challenge will be to return to compliance with the A&E four-hour standard while maintaining performance against the other waiting time standard.

The charts and commentary contained in this report represents the performance for all three of our hospitals (i.e. including the performance in aggregated form across all sites where services are provided by the trust).

This approach has been taken to ensure consistency with the prescribed indicators the trust is mandated to include in the quality accounts. The prescribed indicators data is sourced from the Health and Social Care Information Centre where in the majority of cases are also aggregated.

Quality performance indicators

The trust presents a number of non-prescribed indicators that describe our performance on a number of indicators that cover; patient safety, clinical effectiveness and patient experience. The indicators were chosen by our trust board and reported accordingly in previous quality reports. No changes have been made in our 2016/17 report from the indicators used in the 2015/16 report which allows our historical data to be presented with benchmarking data as available.

The charts and commentary contained in this report represents the performance for all three of our hospitals (i.e. including the performance in aggregated form across all sites where services are provided by the trust). Where possible, performance is described within the context of comparative data which illustrates how the performance at the trust differs from that of our peer group of English teaching hospitals. The metrics reproduced in this section are a list of well-understood metrics that help measure clinical outcomes, operational efficiency, waiting times and patient safety.

<table>
<thead>
<tr>
<th>Relevant quality domain</th>
<th>Quality performance indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient safety</strong></td>
<td>summary hospital mortality indicator (SHMI)</td>
</tr>
<tr>
<td></td>
<td>hospital standardised mortality ratio (HSMR)</td>
</tr>
<tr>
<td></td>
<td>methicillin-resistant staphylococcus aureus (MRSA) C. difficile</td>
</tr>
<tr>
<td><strong>Clinical effectiveness</strong></td>
<td>referral to treatment (RTT)</td>
</tr>
<tr>
<td></td>
<td>A&amp;E performance</td>
</tr>
<tr>
<td></td>
<td>day case rate</td>
</tr>
<tr>
<td></td>
<td>in-patient length of stay</td>
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<tr>
<td></td>
<td>cancer waits</td>
</tr>
<tr>
<td></td>
<td>readmissions</td>
</tr>
<tr>
<td><strong>Patient experience</strong></td>
<td>last minute cancellations</td>
</tr>
<tr>
<td></td>
<td>delayed transfer of care</td>
</tr>
<tr>
<td></td>
<td>friends and family test</td>
</tr>
</tbody>
</table>
The following table sets out the definition for each performance measure. These are, to the best of our knowledge, consistent with standard national NHS data definitions. There has been no change in the basis for calculation for any of these measures since 2015/16.

<table>
<thead>
<tr>
<th>Indicator / Metric</th>
<th>Description / Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident and emergency – 4hr standard</td>
<td>Percentage of A &amp; E attendances where the patient was admitted, transferred or discharged within 4 hours of their arrival at an A &amp; E department.</td>
</tr>
<tr>
<td>Summary hospital mortality indicator (SHMI)</td>
<td>Each methodology uses routinely collected data to calculate an overall “expected” number of deaths if the trust matched the national average performance. The result is a ratio (calculated by dividing the observed number of deaths by the expected deaths). Fundamentally, the main difference is found in the data coverage; a) while HSMR only considers around 80% of deaths the SHMI metric ostensibly covers all hospital spells, b) definition of death in HSMR includes in-hospital mortality only whilst SHMI captures any death occurring 30 days post discharge, c) adjustments are made for palliative care in HSMR only.</td>
</tr>
<tr>
<td>Average length of stay</td>
<td>Measured in days, the average length of stay is the result of calculating the difference between the admission date and the discharge date for each patient treated as an inpatient over the period.</td>
</tr>
<tr>
<td>Daycase rate</td>
<td>The proportion of elective admissions that are treated on a day case basis.</td>
</tr>
<tr>
<td>Readmission rate</td>
<td>The relative risk of a patient being readmitted as an emergency within 28 days of a previous discharge. The result is a ratio (calculated by dividing the observed number of emergency readmissions by the expected volume emergency readmissions).</td>
</tr>
<tr>
<td>RTT incomplete performance – % waiting less than 18 weeks</td>
<td>Percentage of patients on the incomplete RTT who are waiting no more than 18 weeks from referral.</td>
</tr>
<tr>
<td>Two week wait – All Cancer</td>
<td>Percentage of patients referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment.</td>
</tr>
<tr>
<td>Two week wait – symptomatic breast</td>
<td>Percentage of patients referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatients appointment.</td>
</tr>
<tr>
<td>31 day wait diagnosis to treatment</td>
<td>Percentage of patients waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers.</td>
</tr>
<tr>
<td>31 day wait – subsequent surgery</td>
<td>Percentage of patients waiting no more than 31 days for subsequent treatment where that treatment is surgery.</td>
</tr>
<tr>
<td>31 day wait – subsequent drug treatment</td>
<td>Percentage of patients waiting no more than 31 days for subsequent treatment where that treatment is an anti-cancer drug regimen.</td>
</tr>
<tr>
<td>31 day wait – subsequent radiotherapy</td>
<td>Percentage of patients waiting no more than 31 days for subsequent treatment where the treatment is a course of radiotherapy.</td>
</tr>
<tr>
<td>62 day wait – from urgent GP referral</td>
<td>Percentage of patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer.</td>
</tr>
<tr>
<td>62 day wait – from screening service referral</td>
<td>Percentage of patients waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers.</td>
</tr>
<tr>
<td>C. difficile Lapses in care</td>
<td>Number of C. difficile infections due to lapses in patient care.</td>
</tr>
<tr>
<td>Friends and family IP &amp; AE score</td>
<td>The number of responses that scored likely and extremely likely as a percentage of the total number of responses to the IP &amp; AE friends and family tests. (neither likely or not likely excluded from responses)</td>
</tr>
</tbody>
</table>
Summary hospital mortality indicator (SHMI)

SHMI (Summary Hospital Mortality Indicator) is a clinical performance measure which calculates the actual number of deaths following admission to hospital against those expected. This expression of mortality risk includes all diagnoses groups and mortality occurring up to 30 days post discharge.

The observed volume of deaths is shown alongside the expected number (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. The data below shows our performance for 12 months ending in June 2016 in comparison to the previous months ending in September 2015.

SHMI data is presented below is for the 12 month period ending June 2016 and therefore covers the 12 month period post-acquisition of Barnet and Chase Farm Hospitals NHS Trust. For this period the Royal Free London NHS Foundation Trust SHMI ratio was 90.53 or 9.47% better than expected. For this period the RFH had the 9th lowest relative risk amongst the 26 large England teaching hospitals (data source: Dr Foster Intelligence/Health and Social Care Information Centre). Our SHMI data reported in section 2.3 is reported until September 2016 and shows that the trust’s score was 0.9086 which was lower than expected.
The HSMR includes 56 diagnoses groups responsible for 80% of deaths and only includes in-hospital mortality. Data shows that for the 12 months to the end of November 2016, the Royal Free London NHS Foundation Trust recorded the 7th lowest relative risk of mortality of any English Teaching Trust with a relative risk of mortality of 92.36 which is 7.64% below (statistically significantly better than expected) (Data source: Dr Foster Intelligence/Health and Social Care Information Centre).

The data presented below is not presented for the full period as this data is not available.

Data shows that for the 12 months to the end of December 2015, RFL recorded the seventh lowest relative risk of mortality of any English teaching trust with a relative risk of mortality of 88.8 which is 12.2% below (statistically significantly better than expected).

(Data source: Dr Foster Intelligence/Health and Social Care Information Centre)

Overall the trust remains better than expected during 2016/17.
Methicillin-resistant staphylococcus aureus (MRSA)

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.

Reducing the rate of MRSA infections is key in ensuring patient safety 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. In the twelve months to the end of March 2017 the Royal Free reported 4 MRSA bacteraemias. Against the 25 teaching trusts, the Trust is ranked 8th highest with a rate of 2.42 bacteraemias per 100,000 bed days (Data source: Public Health England).

In the 12 months to the end of March 2016 the trust reported four MRSA bacteraemias. Against the 25 teaching trusts, we ranked 11th highest with a rate of 0.92 bacteraemias per 100,000 bed days.

(Data source: Trust assigned MRSA bacteraemias from Public Health England and bed days from NHS England (KH03).)
**C. difficile**

In relation to C. difficile the trust’s regulator, Monitor (NHS Improvement), assesses performance in relation to those infections deemed to result from “lapses in care”.

Against this measure of performance the trust has been compliant with its national trajectory for the entirety of 2015/16. The Royal Free London NHS Foundation Trust is ranked 23rd out of 25 English teaching hospitals for the 12 month period to end January 2017 with a reported rate of 42.4 per 100,000 bed days.

It is important to note that the objective for C. difficile cases in 2016-17 was rolled over from 2015-16 and remained at 66 cases for RFL NHS FT. The rate represented by our numerical objective is 41.9 infections per 100,000 bed days. The trust is therefore non-compliant with this objective for the most recent 12 month period for which data is available (Data source: Public Health England). However comparative data is not available for ‘lapses in care’ infections.

This is a reduction in performance compared to last year. Looking at all infections, including those not resulting from “lapses in care”, RFL was ranked 23rd out of 25 English teaching hospitals for the period April to March 2016 with a reported position of 20.9 per 100,000 bed days. (Data source: Public Health England)
Clinical effectiveness

Referral to treatment (RTT)

In England, under the NHS Constitution, patients have the right to access consultant-led services within a maximum waiting time of 18 weeks. This is known as referral to treatment (RTT) and we report our performance to the Government on a monthly basis.

From September 2015, NHS England has used as the single measure of compliance with the NHS Constitution, the proportion of pathways where the patient has yet to receive treatment and is actively waiting. For these pathways the national standard requires that no more than 8% of patients should be waiting longer than 18 weeks for treatment i.e. 92% should be waiting less than 18 weeks.

As shown in the chart below, the trust returned to compliance against the incomplete pathway standard in June 2016 and continues to maintain compliance (Data source: National Health Service England).

Performance in 2015/16 is shown in the chart below.

Data source: National Health Service England)
The accident and emergency department is often the patient's point of arrival. The graph summarises the Royal Free's performance in relation to meeting the 4-hour maximum wait time standard set against the performance of London A&E departments. The national waiting time standard requires trusts to treat, transfer, admit or discharge 95% of patients within four hours of arrival. A higher percentage in the graph is indicative of shorter waiting times.

During the period April 16 to March 17 the Royal Free London NHS Foundation Trust achieved 87.47% compliance against the 95% 4 hour standard. Pressure on A&E has been increasing with more people than ever before selecting accident and emergency as their preferred means of accessing urgent healthcare.

This is a worsening of performance compared to the previous year. During the period April 2015 to March 2016 the trust achieved 93.44% compliance against the 95% four hour standard. Over this period, the trust's three emergency departments recorded the fourth highest performance against the standard when compared with the 18 London non-specialist acute providers.

In response the trust has invested heavily in modernising and extending its emergency service, this includes completely rebuilding the Royal Free hospital site A&E department now well underway (Data source: National Health Service England).
Day cases are procedures that allow a patient to come to hospital, receive 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.

During the period covering April 2016 to February 2017, the Royal Free London NHS Foundation Trust treated 84.73% of elective admissions as day cases; this was the highest proportion across the group of large teaching providers (Data source: Dr Foster Intelligence Ltd).

Across the full year 2016-17, the proportion of elective cases treated in the daycase setting was 84.58%.

Day case rate

The figures quoted above represent an improvement on the previous reporting period (calendar year 2015) where 83% of elective admissions were day cases. These figures represent a continuation of the trend over the last 3 years whereby Royal Free London NHS Foundation Trust has reported the highest daycase rate across the peer group.
In-patient length of stay

Length of stay is also an important efficiency indicator with, in most cases, a shorter length of stay being indicative of well organised and effective care. A shorter length of stay can also result in better outcomes with a reduced infection risk.

We can analyse our actual length of stay against an expected value once our acuity and patient demographic are taken into account. This is called our casemix adjusted and expected length of stay and over the period 2016/17 our length of stay was 4.61 days against an expected 5.5 days. It is important to note that when producing comparative data of this type a variety of data quality issues will influence all trusts data and operational models will differ significantly between trusts as well as between trust sites (Data source: Dr Foster Intelligence Ltd). From April 2016 to February 2017, the trust reported the 7th lowest average length of stay across the large teaching provider peer group. Data is not presented for the full reporting period as this is currently not available.

Between January and December 2015 the trust reported the fifth lowest average length of stay across the large teaching provider peer group.

It is important to note that when producing comparative data of this type a variety of data quality issues will influence all trusts’ data and operational models will differ significantly between trusts as well as between trust sites. (Data source: Dr Foster Intelligence)
Clinical evidence demonstrates that the sooner patients urgently referred with cancer symptoms are assessed, diagnosed, and treated, the better the clinical outcomes and survival rates. National targets require 93% of patients urgently referred by their GP to be seen 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.

For 2016/17 as a whole, the Royal Free London saw 93.9% of patients on a two-week wait pathway within 14 days. However, the trust did fail the two-week wait standards in quarter 4 (January to March 2016). The main factors influencing performance included reduced capacity over Christmas and New Year as well as patients declining appointments during this period. Benchmarked data is provided for the period October to December 2016, the most recent available. Over this time series the Royal Free London NHS Foundation Trust was 17th when compared to the 26 benchmark providers in relation to the two-week wait standard.

This performance is similar to 2015-16, where, at 94.7% the trust performed better than the national targets in relation to the two-week standards.
Breast Urgent referral two week waits

In 2016/17, the trust saw 95.1% of patients on an urgent breast referral pathway within two weeks, meeting the national standard.

This is similar performance to 2015/16, where 95.0% of patients on this pathway were seen within two weeks.
First definitive treatment within 31 days

In 2016/17, the trust saw 98.6% of patients within 31 days for their first definitive treatment for cancer, meeting the national standard. This placed us 4th against our 26 benchmark comparators.

This is similar performance to 2015/16, where 98.9% of patients met the standard.
The trust underperformed against the 62 day standard in 2016/17 with 80.5% of patients receiving first treatment within 62 days of a GP referral. Underperformance this year has been driven by a build-up of breach backlog pathways across a number of tumour sites, most notably Urology where there have been significant capacity issues in the diagnostic and tertiary centre surgical stages of treatment.

Specific issues in both the urology and skin pathway, such as imaging and biopsy diagnostic clinics, have been addressed, as have extended waiting times at tertiary treatment centres. Waiting times at the front end of tumour site pathways, such as initial referral to first appointment two week waits and waits for diagnosis are improving as a result. However the trust is still working through improvement actions across all tumour site pathways and will look to improve performance back to delivering against the national standard in 2017/18.

This still represents an improvement on performance in 2015/16 where 72.7% of patients met the standard. The Royal Free London has also improved its position relative to its 26 benchmark providers, moving from 24th place to 14th.
Readmissions

The Royal Free London NHS Foundation Trust carefully monitors the rate of emergency readmissions as a measure for quality of care and the appropriateness of discharge. The hospital is working with commissioners, GPs and local authorities to provide enablement 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 below presents the rate over the 12 month period shown; over this period the Royal Free London NHS Foundation Trust had the third lowest relative risk of readmission across the English teaching hospital peer group of 25 providers (Data source: Dr Foster Ltd). Data is not presented for the full reporting period as this is currently not available.

The chart below illustrates the historical trend and evidences that the Royal Free London NHS Foundation Trust has consistently recorded a low relative risk of readmission.

Patient experience indicators

Last minute cancellations

Cancelling operations on the day of, or following admission, is extremely upsetting for patients and results in longer waiting times for treatment.

For the current financial year reported, from April 2016 to March 2016, the trust cancelled admission for 431 patients at the last minute for non-clinical reasons. This translates into a rate of 2.8 cancellations per 1,000 admissions. As a ratio, the trust rate of 0.28% is the eighth lowest rate of cancellations across the English teaching hospitals peer group (data source: NHS England).

For the 12 months reported, from January to December 2015, the trust cancelled admission for 471 patients at the last minute for non-clinical reasons. This translates into a rate of seven cancellations per 1,000 admissions. As a ratio, the trust rate of 0.7% was the fifth lowest rate of cancellations across the English teaching hospitals peer group. Internal analysis shows that the cancellation rate was highest at the Royal Free Hospital at 0.9% and lowest at Barnet and Chase Farm hospitals (0.5%).

(Data source: NHS England)
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 patient's transfer.

This results in the waste of hospital resources and inappropriate care for the patient, the aim therefore is to reduce the rate of delayed transfers. 30% of the delayed transfers of care observed across Royal Free London NHS FT were attributable to social care delays (Data source: NHS England).

For the period April 15 to March 16, the trust recorded a delayed transfer rate of 2.2% resulting in a ranking of 13th when compared to the 128 London acute provider trusts.

(Data source: NHS England)
Friends and family test (patients)

The Friends and family test (FFT) was introduced in April 2013. Its purpose is to track and so improve patient experience of care. FFT aims to provide a simple, headline metric which, when combined with follow-up questions, can be used to drive cultural change and continuous improvements in the quality of care received by NHS patients. Across England the survey covers 4,500 NHS wards and 144 A&E services.

We are not commissioned to provide community services under the auspices of a community services contract or any of those services that are associated with a community provider. However, we do provide services in the community, largely out-patient and ambulatory care based across Camden, Barnet and Enfield.

The data below shows our performance from April 2015 to February 2017 with regards to our A&E (AE) and Inpatient (IP) FFT scores.
Performance against key national indicators

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

<table>
<thead>
<tr>
<th>Monitors indicators of governance</th>
<th>Target</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E Maximum waiting time of four hours from arrival to admission/transfer/discharge</td>
<td>&gt;=95%</td>
<td>90.93%</td>
<td>89.61%</td>
<td>84.46%</td>
<td>84.87%</td>
<td>87.47%</td>
</tr>
<tr>
<td><strong>C.difficile number of cases against plan</strong></td>
<td>Q1&lt;=17</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td><strong>Maximum time of 18 weeks from point of referral to treatment in aggregate for patients on an incomplete pathways (arithmetic average of monthly performance)</strong></td>
<td>&gt;=92%</td>
<td>91.49%</td>
<td>92.09%</td>
<td>92.10%</td>
<td>92.18%</td>
<td>91.97%</td>
</tr>
<tr>
<td><strong>Cancer: two week wait from referral to date first seen</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All cancers</td>
<td>&gt;=93%</td>
<td>93.0%</td>
<td>94.3%</td>
<td>94.5%</td>
<td>93.7%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Symptomatic breast patients</td>
<td>&gt;=93%</td>
<td>94.5%</td>
<td>93.8%</td>
<td>96.0%</td>
<td>96.0%</td>
<td>95.1%</td>
</tr>
<tr>
<td><strong>All cancers: 31 day wait from diagnosis to first treatment</strong></td>
<td>&gt;=96%</td>
<td>97.6%</td>
<td>96.6%</td>
<td>99.3%</td>
<td>98.6%</td>
<td>98.6%</td>
</tr>
<tr>
<td><strong>All Cancer 31 day second or subsequent treatment - surgery</strong></td>
<td>&gt;=94%</td>
<td>98.9%</td>
<td>98.8%</td>
<td>99.1%</td>
<td>99.2%</td>
<td>99.0%</td>
</tr>
<tr>
<td>drug</td>
<td>&gt;=98%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>radiotherapy</td>
<td>&gt;=94%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>99.3%</td>
<td>100.0%</td>
<td>99.9%</td>
</tr>
<tr>
<td>**All Cancer 62 days wait for first treatment:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>from urgent GP referrals:</td>
<td>&gt;=85%</td>
<td>82.03%</td>
<td>77.84%</td>
<td>79.32%</td>
<td>82.6%</td>
<td>80.45%</td>
</tr>
<tr>
<td>from a screening service</td>
<td>&gt;=90%</td>
<td>94.9%</td>
<td>94.9%</td>
<td>89.6%</td>
<td>86.8%</td>
<td>84.2%</td>
</tr>
</tbody>
</table>

External testing on two national indicators

Our external auditors PricewaterhouseCoopers LLP (PwC) are required under NHS Improvement requirements for quality reports; Detailed guidance for external assurance on quality reports’ to perform testing on two national indicators.

The indicators tested for 2016-17 were:
- Incomplete pathways within 18 weeks
- Total time in A&E of four hours or less

A detailed definition and explanation of the criteria applied for the measurement of the indicators tested by PwC is included below.

Incomplete pathways within 18 weeks

The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways:

**Descriptor:** The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.

**Numerator:** The number of patients on an incomplete pathway at the end of the reporting period who have been waiting no more than 18 weeks.

**Denominator:** The total number of patients on an incomplete pathway at the end of the reporting period.

**Indicator format:** The indicator is calculated as the arithmetic average for the monthly reported performance for April 2016 to March 2017 and is reported as a percentage.

The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the year was: 92.4%. The arithmetic average of monthly performance for the period of April 2016 to March 2017 was 91.97%. ☑
The reported indicator performance has been calculated based on all patients recorded as having been referred to Royal Free London NHS FT for consultant led services and who are on an incomplete pathway at the end of the period, consistent with the national indicator guidelines.

Completeness of this information is therefore dependent on the complete and accurate entry of data at source (referrals received for consultant led services) and the complete recording of all those on incomplete pathways at period end.

It is not possible to check completeness to source because referrals may be received through different routes, for example, by letter, fax or via the live ‘choose and book’ system or may have been received in a prior period.

Patients who have not been identified within the population will therefore not be included in the indicator calculation. To the best of our knowledge, this information is complete.

**Total time in A&E of four hours or less**

<table>
<thead>
<tr>
<th>Percentage of patients with a total time in A&amp;E of four hours or less from arrival to admission, transfer or discharge:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Descriptor</strong></td>
</tr>
<tr>
<td><strong>Numerator:</strong></td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
</tr>
<tr>
<td><strong>Indicator format:</strong></td>
</tr>
</tbody>
</table>

The percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge for the period of April 2016 to March 2017 is: 87.48% 😷

The reported indicator performance has been calculated based on all patients recorded as having an unplanned attendance at our A&E departments and urgent care centre. Completeness of this information is therefore dependent on the complete and accurate entry of data at source (in our A&E departments and urgent care centre) and the complete recording of those patients who breached the four hour standard.

The clock start for ambulance arrivals to Barnet Hospital is the time of patient offload or 15 minutes after the patient arrives at the hospital, whichever is sooner. The clock start for ambulance arrivals to the Royal Free Hospital is the time of patient registration. To the best of our knowledge, this information is complete.
Our local improvement plans

This section contains additional areas of our local improvement plans.
This also includes:
• Chase Farm Redevelopment
• Care Quality Commission (CQC)
• Patient safety (including safeguarding)
• NHS staff survey (KF21 and KF26)
• Complaints

Throughout 2016/17 we have undertaken additional measures to support our delivery of world class expertise and local care and plans are in place to drive this.

Chase Farm redevelopment—health and wellbeing programme

The acquisition of Chase Farm hospital site by the trust gave us an opportunity to help promote the health and wellbeing of the patients using our services, the staff working on the site and the local community.

The Public Health White Paper (2010) stressed the importance of joined up services and tackling the major causes of health and disability in our community. We are committed to working with partners not only to treat people in poor health but look at ways we can prevent ill health and improve health outcomes for people.

We have developed a health and wellbeing plan for Chase Farm setting out our approach to improving the health and wellbeing of the population using Chase Farm Hospital and the community living around it.

To help deliver the plan we set up a multi-agency group with the following aim:

To oversee implementation and delivery of the health and wellbeing programme including joint working with partner agencies.

This includes the following:

1) The trust has a role to promote the health of the local population; its patients and staff.
2) A healthier environment is good for patients, staff and communities.
3) Working in partnership with the local council and NHS and third sector partners to ensure our programme of work reflects and supports local health need.

This group has membership from Chase Farm staff, the London Borough of Enfield public health team, a local councillor, and local charity groups including the London Borough of Enfield Carers group, healthwatch Hertfordshire and Macmillan Cancer Charity.

Outcomes achieved in 2016:

For patients:

• A stop smoking advisor for patients, staff and construction workers is in place. So far they have seen 288 referrals – 83 were Enfield residents and seven members of staff (three of whom are also Enfield residents).

• An independent domestic and sexual violence advisor (IDSVA) is in place and training is taking place with staff to encourage them to ask about domestic abuse and refer patients. The service for Chase Farm has been in place since October 2016. Since then there have been 15 referrals from Chase Farm Hospital directly but in total 14% (525) of the services referrals are Enfield residents.

• The highest proportion of referrals comes from the Trust’s main catchment areas: Barnet, Camden, Enfield and Hertfordshire. Three in four of all referrals (75%) reside in one of these areas. 37% of referrals were from Barnet, 14% from Camden, 14% from Enfield and 9% from Hertfordshire.

Graph: Proportion of DV referrals by borough of residence: Q2 2015/16 to Q3 2016/17
(Source: Royal Free Trust)
Staff health Initiatives:

- Initial discussions have begun on training staff on ‘making every contact count’ and introducing a social prescribing pilot at Chase Farm where people are linked up with support within the community.
- Weekly walk now in place for staff organised by Tottenham Hotspur and Macmillan (free piece of fruit for all walkers)
- Weekly on site discounted yoga classes for staff – average of 14 participants per class.
- Weekly discounted pilates class now on site.
- Health checks for staff – 85 participants seen so far for checks BMI, cholesterol, glucose and blood pressure. A health trainer who is present every Thursday and has set a programme in place for 12 staff.
- New Year event was held on 31 January 2017 where staff were able to sign up for a boot camp, Shape Up with Spurs, Slimming World vouchers, a free health check, the Royal Free Step Challenge and a walking trip to Mount Snowden.
- Healthy Café offering free fruit if you spend £4 or more.

In September, as part of the NHS Healthy Living Week, an outdoor green gym and café was opened at Chase Farm for patients, staff and visitors.

Service moves and improvements

Through working with healthwatch we have significantly improved disabled access for patients and carers at Chase Farm. In addition we have moved cardiology and echo services so they are now side by side. Our preoperative assessment area has been moved from a building in a poor state of repair to the Highlands building which is within the main body of the hospital.

Our very busy phlebotomy service has not only moved to much better facilities but has started an appointment service. For patients attending, waiting times are now much reduced leading to a far more responsive service which in turn has reduced complaints.

The endoscopy service has moved to a brand new building in order to be able to take on the additional demands created by the implementation of new screening programmes.

We have been limited in our improvement within the constraints of an old hospital site, but the new hospital build will enable care to be provided within first class facilities by 2018.

Community involvement

Throughout the year we have continued to reach out to community groups across Enfield and Hertfordshire in particular, in order to keep individuals informed around the developments at Chase Farm. We have engaged with ‘Love Your Doorstep Enfield’ who connect with thousands of local residents through social media and updated twitter feeds, we have gone out to community patient groups, held Chase Farm stakeholder events, ensured the communication hub on site is well manned and produced a quarterly newsletter. In September we were represented at the Enfield show and many local residents visited our stand to find out more about the new hospital and the improvements underway at Chase Farm.

In addition the Royal Free Charity has been engaged in order to increase the number of volunteers on site and has been successful in fundraising to provide a dementia garden and rehab garden facilities for patients. The mayor of Enfield took a particular interest and gave support to this work.

Our contractor, IHP, responsible for the new building is working with local schools regarding art projects connected with the new build. In addition we are involved with the open doors construction scheme when young people who are considering a career in the construction industry and able to register an interest to visit the site to learn more about opportunities available.

Lastly we have been working with a small local social enterprise company who are working with us to promote communication further and to capture a record of the facilities provided on site and the progress of the new build throughout the seasons.
Care Quality Commission

The CQC undertook a full comprehensive hospital inspection during the week 1-5 February 2016. The trust is rated good overall as a provider and rated good at each hospital site and for each core service at all sites an unprecedented rating for a London trust.

The trust was rated requires improvement for the safety domain, in addition to “requires improvement” rating for specialist community mental health services for children and young people (CAMHS) for the safe and responsive domains.

The trust have developed and submitted a responsive action plan in relation to the regulatory breaches which relates to the suitability of the premises from which the current CAMHS are provided and issues regarding privacy and dignity notably inadequate soundproofing of consultation rooms.

NHST is responsible for oversight of the provider’s improvement actions and will monitor the implementation through a quarterly forum. The responsive action plan is reported and monitored at the trusts patient safety committee.

Our intended actions to improve our services for children and young people within our Children and Adolescent Mental Health services (CAMHS) is to move this service to an alternative site within Hampstead which will enable the provision of care to meet the needs of our users providing appropriate privacy and dignity during their consultation. The new service will be located at Queen Mary House site from May 2017.
**Action planning for improvement:**

The trust historical CQC self-assessment process initially introduced in 2010, has been a key driver earlier in the year in raising the awareness of the trust comprehensive hospital inspection and was instrumental in the preparation for inspection as well as connecting the core service teams with their identified areas of improvement across services.

The quarterly self-assessment process is informed by the new model of inspection and is designed to encourage services to assess themselves and understand their compliance for their services. These arrangements require each clinical division to lead and embed assessing compliance for their core services across all trust locations. It also provided the opportunity for the core services to lead and develop responsive quality improvement initiatives across sites which further spreads and shares knowledge in areas of best practice amongst services in response to quality and safety outcomes.

Action planning following self-assessment enables the opportunities for teams to work collaboratively between operational and clinical intentions in order to drive the implementation of quality improvements as well as share ideas and best practice particularly amongst cross-site clinical teams.

Percentage scores are derived from the number of green scores identified for each of the eight core services reported throughout the 2015/16 and 16/17 quarterly self-assessment executive panel review meetings.

**Improving patient safety**

As shown through our quality account priorities, patient safety remains integral to the delivery of safe and effective care for our patients. The quality accounts patient safety priorities are based on our phased clinical patient safety programme workstreams. Our patient safety programme sets out the actions that we will undertake in response to the five ‘sign up to safety pledges’ via our local safety improvement plan. We also fully appreciate that staff safety is important, and while not directly addressed within patient safety, is actively reviewed by the trust both at serious incident review panels and via the Health and Safety Committee.
Patient safety programme

The patient safety programme includes the development of improving patient safety capability, capacity and culture across the trust over the three years from April 2015 to March 2018.

We have identified new pilot wards/areas for improvement work on falls, sepsis, deteriorating patient, diabetes, acute kidney injury, safer surgery and pressure ulcer prevention. Alongside this the trust is starting to implement the quality strategy to develop capacity and capability in quality improvement training for frontline staff. We know that in the recent staff survey on quality (December16), patient safety was identified as a key area to enable quality improvement. With investment in staff and training via the quality strategy we expect there to be a significant improvement in this area over the next few years.

Implementing the duty of candour (DoC)

We have implemented the ‘being open’ policy across the trust for many years, and approved our duty of candour policy in November 2014, to clarify the updated processes for staff. We have developed a monthly training package aimed at all staff that has been delivered across all sites.

We have set up our incident reporting system (Datix) to enable us to monitor duty of candour compliance for those incidents that have resulted in moderate harm or above. We provide monthly reports to the patient safety committee and our commissioners, detailing our compliance with duty of candour.

All incidents which meet the duty of candour criteria are reviewed at our serious incident review panel, where assurance is provided that this duty has been met. For serious incidents, the duty of candour compliance is reported as part of the monthly quality report that is shared with our commissioners, this includes details as to the reason compliance with DoC is sometimes not possible, such as for a deceased patient with no next of kin.

For non-serious incidents (those graded moderate or above harm) we record whether DoC was met within 10 days, was not breached (i.e. it was not possible to meet DoC in 10 days due to a patient being unconscious), or was possibly breached. This information is available on Datix and reviewed each month, where assurance is sought from our divisional quality managers.
Patient safety improvement plan as part of the ‘sign up to safety’ campaign

The trust formally signed up to NHS England’s ‘sign up to safety’ campaign in April 2015 to develop our patient safety programme. We have committed to deliver a detailed improvement plan through building strong organisational relationships and engaging clinical and non-clinical staff to work together for a shared purpose.

The patient safety programme holds monthly collaborative meetings where clinical leads and safety champions come together to share learning and experiences around driving safety improvements.

As part of this work we are actively involved in our academic health science network UCL Partners’ safety collaborative, where we contribute to sharing and learning around safety issues with many other organisations.

‘Never events’

‘Never events’ are extremely serious and largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place. The trust takes never events seriously and a full investigation is undertaken with the final report discussed at the serious incident review panel where final actions are agreed.

Unfortunately, we reported four never events during 2016/17, two of which relate to surgery. On April 1st 2017, it was 158 days since the Trust last reported a never event.

<table>
<thead>
<tr>
<th>ID</th>
<th>Date reported</th>
<th>Never Event Description</th>
</tr>
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<tbody>
<tr>
<td>2016/11937</td>
<td>03/05/2016</td>
<td>Misplaced NG Tube</td>
</tr>
<tr>
<td>2016/15049</td>
<td>02/06/2016</td>
<td>Misplaced NG Tube</td>
</tr>
<tr>
<td>2016/16373</td>
<td>16/06/2016</td>
<td>Wrong tooth removed</td>
</tr>
<tr>
<td>2016/27784</td>
<td>25/10/2017</td>
<td>Unnecessary endoscopy procedure</td>
</tr>
</tbody>
</table>

In May 2016, the trust-wide never event; never again symposium was held. With over 70 participants, teams shared local ‘never event’ stories and lessons learnt, through presentations, storyboards, case studies and personal accounts.

By incorporating the findings of root cause analysis (RCA) of previous never events and conducting a literature search of the relevant evidence base, the team have commenced observational data collection of distractions and interruptions in theatres. We are now collaborating with Loughborough University Human Factors team on the processes that influence distractions and interruptions.

All incidents resulting in moderate or severe harm, or death are reviewed at our twice-weekly review panels where serious incidents, reports and actions are discussed with all divisions, so that the information can be shared at divisional...
quality meetings. We publish a weekly précis of serious incidents as they are reported, and share further general and speciality specific newsletters online and by email. We also hold learning events, seminars and workshops in order to disseminate lessons learnt.

All serious incidents are reviewed at our board level patient safety committee, chaired by one of our non-executive directors where we triangulate serious incidents with incidents, complaints, PALS and litigation to identify themes which might require system-wide work.

**Safeguarding**

The trust has adopted an integrated approach to safeguarding which brings together a range of specialist professionals ensuring the statutory requirements for safeguarding adults and children are delivered.

Over the last year the integrated safeguarding team has strengthened and developed. The team has a full establishment of staff to provide advice, support and training to staff across the trust as well as strategic leadership. The team includes independent domestic violence advisors.

The trust has in place a robust governance structure to ensure that safeguarding activity, audit and training is monitored and reviewed by the relevant internal committees as well as the local safeguarding boards, the clinical commissioning groups and the Care Quality Commission. The team have continued to develop the reporting templates to enable trend analysis.

In 2016/17 the safeguarding team have improved the identification of vulnerable people who access our services. We have seen an increased number of referrals for patients with a learning disability and patients who are victims of domestic abuse.

Our training programme continues to receive excellent evaluation and is regularly reviewed to include national and local priorities and reflect feedback. The training programme is well supported by our external partners who contribute to delivery.

We are able to demonstrate where learning from case review has been achieved.

**NHS staff survey results 2016**

This section outlines the most recent NHS staff survey results for indicators KF21 and KF26 as requested by NHS England (medical directorate).

- KF21 (percentage believing that the trust provides equal opportunities for career progression or promotion)
- KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months)

The 2016 survey also outlines the trusts Workforce Race Equality Standard (WRES) position compared with other acute trusts and differences from the previous year as below:

<table>
<thead>
<tr>
<th></th>
<th>Your trust in 2016</th>
<th>Average (median) for acute trusts</th>
<th>Your trust in 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KF26</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>White: 30%</td>
<td>24%</td>
<td>32%</td>
</tr>
<tr>
<td></td>
<td>BME: 35%</td>
<td>27%</td>
<td>36%</td>
</tr>
<tr>
<td><strong>KF21</strong></td>
<td>Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>White: 85%</td>
<td>88%</td>
</tr>
<tr>
<td></td>
<td>BMS: 66%</td>
<td>76%</td>
<td>65%</td>
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</tbody>
</table>

The patient and staff experience committee (being replaced by the leadership for quality Improvement committee) reviewed the staff survey results in January (pre-publication of the national picture) and a programme of engagement with staff, trade unions and others is underway that will inform changes to the trust’s staff experience and retention plan (SERP).
We are committed to improving staff experience as we are aware that good patient experience goes hand in hand with good staff experience. We introduced our five-year plan in 2015 with a number of initiatives to improve staff engagement, appraisals and development, bullying and harassment, equality and diversity and health and wellbeing.

As evident in the 2016 national staff survey results, we have made improvements in a number of areas and we are continuing to build on this through the development of further actions. Following various engagement events, we have agreed that the three key areas listed below should be our focus in our five-year plan in order for us to achieve continued improvement:

1. Participation and leadership for improvement,
2. Inclusion and diversity and staff health,
3. Wellbeing and support.

The trust has identified a number of actions in the areas where our performance in this year’s survey results have been below the national average; these areas are: equality, diversity and inclusion—equal opportunities and health and wellbeing—experience of stress and harassment.

Equality, diversity & inclusion - equal opportunities

The leadership with the trust is committed to ensuring that every staff is treated fairly with equal opportunities being available to all. Within the last 12-18 months BME staff listening sessions have taken place, the trust policy has been reviewed, and there have been small improvements against some of the WRES indicators.

With regards to ensuring transparency and fairness the survey results for discrimination and perceptions of equal opportunities suggest we still have some way to go in order to make tangible improvements. As a result, a number of actions under equality, diversity and inclusion have been identified and it is anticipated this will be an area that shows improvement within the next year.

Some of these actions are:

- senior leadership engagement and mentoring of BME staff,
- championing equality and establishing group mechanisms for measurement and progress (to hold others to account).
- Recruitment and selection training mandatory for managers.
- Diverse panels for job interviews
- BME staff listening sessions
- Promoting and raising awareness of trust LGBT staff network & BME staff network
- Non-exec BME board appointment
- Trust signed up to “disability confident committed employer” to support existing employees with disability.
- Promote awareness of discrimination when it is high amongst particular minority groups, and train other staff to act as allies for these groups.
- Enable staff from these groups to be involved in developing and evaluating strategies to reduce discrimination.
- Ensure appropriate diversity training is not only carried out regularly, but is also conducted effectively, so that staff engage with it and it does not become a ‘tick-box’ exercise.

Health and wellbeing - experience of stress and harassment.

This trust is committed to providing services which promote staff wellbeing: below are some of the actions which have been implemented a year ago together with new initiatives which will be continued:

Staff health & wellbeing:

- MSK – Needs assessment/cost effective of fast track access to physiotherapy services for staff.
- Mental Health – Care First, OH clinical psychologist, stress and mental Health awareness sessions.
- Physical activities – Netball, football, walking groups, and cycling.
- Staff Engagement – Staff health and wellbeing days, ‘new year new you’ events across the year.
• Flu vaccination – achieved 61%, increase of 27% on 2015 figures.
• Healthy workplace charter – achievement level.
• Identify the ten worst performing services in relation to manager support and roll out ‘feedback’ questionnaires for staff to be given the opportunity to provide real time feedback on how they are supported by their manager – to help formalise specific actions.

**Bullying and harassment (B&H)**

• Executive ‘champions’ identified to lead on addressing B&H
• B&H activity data collated and monitored
• Survey of staff who raised B&H complaint undertaken
• Workshop materials reviewed and sessions undertaken
• Increase in mediation service capacity
• Refresh of B&H policy and procedure

Our objective is to reach the national average in these areas of concern within the period of our five year-plan, i.e. by the end of 2020. Since the plan started in 2015, we have noticed marginal improvements in these areas, and we expect yearly improvement to increase as our initiatives gather momentum. The marginal level of improvement so far results from the initial effort needed to get things moving as a process of change in culture and practice.

**Complaints**

The trust recognises that in the majority of instances it is best to resolve issues as soon as possible. Our patient information leaflets and posters encourage concerns to be raised immediately with the person in charge of a patient’s care. Alternatively, contact details are provided for PALS and complaints teams.

Complaints data is reviewed monthly by the trust executive committee alongside other data, including patient surveys, infection, falls, pressure ulcers and incidents. Complaints data, including lessons learnt and actions taken is included in:

• The divisional monthly quality & safety boards.
• The quarterly report taken to the patient and staff experience committee.
• An annual complaints report taken to the July trust Board.

The quarterly CLIPS (complaints, litigation, incidents, PALS and safety) report taken to the patient safety committee.
Annex 1. Statements from commissioners, local Healthwatch organisations, overview and Scrutiny committees and council of governors

Commissioners:

Barnet Clinical Commissioning Group (CCG)

Barnet Clinical Commissioning Group (CCG) welcomes the opportunity to comment on the quality account for the Royal Free London NHS Foundation Trust. The CCG are the lead commissioners responsible for the commissioning of health services from the Royal Free Trust, this includes, Royal Free, Barnet and Chase Farm Hospitals.

The CCG confirms that it has reviewed the quality account and makes comments where it feels appropriate. The CCG team can confirm that the data contained within the annual account has been checked and is correct.

This quality account has been reviewed by the quality team within Barnet CCG, the commissioning support unit and other associate commissioners, it should be noted that some associate commissioners will provide individual feedback to the trust regarding the quality account.

We can confirm that the content of the account complies with the prescribed information and guidance as set out by the Department of Health or where the information is not yet available a placeholder was inserted. The quality account is a fair and balanced record and overview of the quality of care and services delivered by the Royal Free London NHS Foundation Trust.

The CCG continues to meet with the trust on a monthly basis at its Clinical Quality and Review Meetings (CQRG) this forum is where the commissioners are provided with assurance regarding the quality of care and services provided by the trust. The meeting received a quality report from the trust and there is robust discussion with the trust regarding the targets it has met and those that require further work.

The CCG welcomes the continued focus on patient safety within the trust and the introduction of the five steps to safer surgery and should be commended on this piece of work to ensure the safety of surgical patients within the trust.

It is highly commended that the trust has taken part and submitted data to over 50 national audits and patient confidential enquiries. The CCG would ask that the trust look into the data quality issues that has come to light in a number of audits and seek to improve these.

In relation to the national audits, the CCG would like to see some improvements in the diabetes data that is submitted as part of the National Diabetes Audit.

The trust needs to continue to focus on the accident and emergency performance which has been declining over the year and a continued focus on the improvement of these standards is required by the trust. The CCG, trust and NHS England continue to focus on this important aspect of care provided by the trust.

In support of this achievement the CCG will continue to support and work with the Trust in reducing the number of delayed transfers of care within the trust to ensure that patients are in the most appropriate location for their care needs to be met.

The CCG would also like to see continued focus in the improvement of the trust 62 day cancer targets and the plans it has to ensure these meet the targets as set out. In those areas where the targets have not been met the CCG will work collaboratively to ensure improvement targets are in place in support of the trust.

NHS England have recently completed a cancer patient experience survey and the CCG would like to see the trust undertake this piece of work internally, to demonstrate improvements against the national averages. The trust has provided evidence in relation to the patient experience agenda that has been taken forward and looks forward to continued development of this agenda within the trust.

The CCG would like to continue to work collaboratively with the trust in agreeing, setting and monitoring of the quality issues and priorities during this year.

The final element the CCG would like to have seen as part of this quality account would have been information in relation to the safeguarding procedures and how the trust has met its responsibilities in relation to this important area.

The CCG would like to commend the trust on its high achievements in a number of specialities that have produced higher than the national average in relation to patient outcomes and its continued improvements in those areas that didn’t meet the required levels identified.
Herts Valleys Clinical Commissioning Group’s Response to the Quality Account provided by the Royal Free Hospitals London NHS Foundation Trust

As the host commissioner for the Hertfordshire contract with the Royal Free Hospital London NHS Foundation Trust (RFL), Herts Valleys Clinical Commissioning Group (HVCCG) welcomes the opportunity to review the Trust’s Quality Account and to provide a statement on behalf of both our population and East and North Herts CCG (ENCCG).

We have undertaken the review of this Quality Account in collaboration with Enfield and Barnet CCGs and would like to echo our support of the comments and recommendations made within the Barnet CCG statement.

The information provided within this Quality Account presents a balanced report of the quality of healthcare services that RFL provides and is, to the best of our knowledge, accurate and fairly interpreted. The Quality Account clearly evidences the improvements made and importantly where improvements are still required.

In addition to the comments made by the two London CCGs aforementioned, HVCCG and ENHCCG would also like to make the following observations and recommendations:

Firstly HVCCG would like to acknowledge the outcome of the Care Quality Commission’s inspection of the Trust during in February 2016 and the ‘good’ rating they were given later that year. It was positive to note that in his report, the Chief Inspector of Hospitals commented that the staff across the Trust acted with compassion and kindness to patients. The report also highlighted areas of improvement such as the handling of complaints and patient safety. The Trust has plans in place to ensure improvements are made in these areas. Regular updates on the progress of those plans will be seen by commissioners.

The Trust has had another challenging year in ensuring patients are seen within the targets set nationally around cancer care. The Trust continues to respond to these performance issues positively and has conducted thorough investigations to ensure current patients on their waiting lists are safe and have not suffered harm. Improvements have been seen in many of the cancer target areas but the Trust has been unable to achieve the national 62 day cancer target. HVCCG and ENHCCG expects the Trust’s continued focus and drive in achieving this specific national target during 2017/18 and will monitor the improvements made during the monthly Quality Review Meetings to ensure the people of west Hertfordshire who choose RFL for their cancer treatment are receiving timely care.

Further challenges were experienced during the year for the Trust to deliver the national 4 hour A&E target of 95%. Although not referred to in the Trust’s Quality Account the performance at the Barnet Hospital has been poor throughout the year and this is a particular concern for the CCGs. The hospital site finished the year at a compliance rate of 80.6%. Improvements must be delivered in 2017/18 to ensure that the 95% target is met on a consistent basis. The CCGs acknowledge that the Trust cannot meet this target alone and this is an issue for the whole system to resolve. In order to work together collaboratively and with the vigour that is required, the health and social care partners across the health economy internal and external to Hertfordshire will be focussing on key areas of work in order to work with the Trust to support them in achieving the 95% target.

The Trust’s previous priority relating to reducing the number of Never Events was welcomed in light of the 10 Never Events declared by the Trust during 2015/16. The CCGs are pleased to see the patient safety initiatives put in place by the Trust during 2016/17 to reduce the number the Never Events have been successful and that a significant reduction has been seen, with a total of 3 Never Events being declared. The CCGs would now like to see that the Trust continues their focus in this area to further drive down the number of Never Events declared, in order to achieve the national ambition of zero.

The Trust achieved its Clostridium difficile targets in 2016/17, which the CCGs would like to acknowledge.
We note that no reference was made in the Trust’s Quality Account regarding safeguarding adults or children and how the Trust has met its responsibilities in this key area. The CCGs expects this to be included in future Quality Accounts.

Both Hertfordshire CCGs are keen that the Trust continues to take note of the interests of the Hertfordshire population in which they serve. We will therefore continue to work with the Trust to maintain that focus, including ensuring that data is provided by hospital site and population.

We look forward to working with the Royal Free Hospital London NHS Foundation Trust, in collaboration with Barnet and Enfield CCGs, in developing and monitoring the quality of services it provides for all patients, which includes more Quality Assurance Visits to the Trust during the year. We hope the Trust finds these comments helpful and we look forward to continuous improvements in 2017/18.

Kathryn Magson  
Chief Executive Officer  
Herts Valleys CCG  
May 2017

Beverley Flowers  
Accountable Officer  
East and North Herts CCG  
May 2017
Response from Healthwatch Camden and Camden Health and Adult Social Care Scrutiny Committee

We welcome the opportunity to comment on the detailed draft Quality Account. Overall, we felt that the Trust have picked the right priorities and have well thought-out measurements to ensure they can monitor and feedback effectively.

We have some comments on specific aspects of the report:

**Introduction:** We would have liked to have seen further information on the Royal Free’s achievements, success and areas of improvement for the year.

**Priority areas:** It wasn’t clear how these were identified and we would have liked to have seen further information on the aims and outcomes. In addition, it was unclear why the priorities for clinical effectiveness had been identified and how they would increase or improve clinical effectiveness.

**Patient safety and complaints:** We would have liked to have seen further information on how many incidents had occurred and their resulting impact and the process around complaints including how they can be made and how they are reviewed and what learning has been shared and/or acted upon for both incidents and complaints. We would also like to have seen further information on primary care voluntary and community sector engagement including how this is being undertaken in the different boroughs.

**Patient experience:** We would have liked to have seen further information about how patient experience around end of life is working within the Cancer setting.

**Clinical effectiveness:**
We would have liked to have seen further information on the metrics in dementia and when these will be in place to measure any improvement in dementia care.

In addition, we would have liked to have seen further clarity on the following:

**Falls:** it was not clear what number of patients this percentage equated to;

**Deteriorating patient:** what are the current number of deaths per thousand;

**Safer surgery:** how you intend to reach a target of 100% compliance of maternity counting of swabs and needles - currently shown as having risen from 65% to 85%.

**Foot care:** What options are available to improve foot care if the NHS England funding bid for a multidisciplinary Diabetes Foot Team is not successful.

**Cancer referrals:** How many patients are waiting longer than 104 days and how many patients fall outside national cancer referral to treatment guidelines (p.73)

**Audit tables:** We would have liked to have seen further information on the purpose/intended outcomes from each audit and the actions the Royal Free intends to take to improve quality of care for their patients.

Feedback on style and content

We know that the content of the Quality Account is mandated nationally. However, we did feel that the document was very technical and not easily readable for the public e.g. full of medical jargon, acronyms and the content and some tables are not easy to fully understand. From a Camden point of view, it was not always clear in the report whether information related specifically to the Royal Free, Barnet or Chase Farm, or all three e.g. in the audit tables.

Healthwatch Barnet response to Royal Free London Quality Account 2016-17

This is Healthwatch Barnet’s response to Royal Free London’s Quality Account for 2016-17. Thank you for providing the opportunity for local Healthwatch to respond to this Account.

We welcome the clear lay out and glossary that is provided. However, in some sections, whilst there are targets and aims, there is no corresponding information on whether targets have been met or are on track. There is information on action in progress, but this means that the Quality Account is in some sections less meaningful and may cause confusion or anxiety with readers.

In some sections we have focused on services about which local residents have provided with feedback. In some sections, we have amalgamated our comments on a number of services into one. We do recognise that the
quality of all these services is of the utmost importance. However, we did this where the issues were similar across the services and to make our comments as succinct and clear as possible.

2016-17 Quality Improvement Priorities

We were pleased to see that the Trust agreed an overarching quality priority, which included reference to building capabilities and equipping front line for greater control of systems. We understand that the 2016 NHS Staff Survey showed that whilst staff experience was higher than the national average for job satisfaction, the quality of non-mandatory training, appraisals and belief that their role makes a difference, the responses were below the national averages for equal opportunities and experiences of stress and harassment. We find this of concern and request that RFL provide further details of their action to improve performance in these areas.

Priority 1 Improving patient experience: delivering excellent experiences

Dementia: We were pleased to see that dementia was a key priority for 2016-17, including improving the experience of carers. We are pleased that 71% of wards are now practising ‘John’s Campaign’ and look forward to receiving the dementia annual report which can provide more details on RFL’s current delivery in this area.

Priority 2 Improving clinical effectiveness: delivering excellent outcomes

Dementia: Healthwatch Barnet has worked with RFL in the past to provide feedback from patients and carers, including around hospital discharge. Some more recent anecdotal feedback suggests that there were issues with medication at discharge. We welcome the National Audit of Dementia’s commendation for RFL questionnaire for carers and look forward to seeing the full report when published in May 2017. We welcome the additional support for carers of people with dementia, such as reduced parking costs but would raise as a separate point, that the limited car-parking and costs at the Barnet site still raises significant problems for patients and carers.

Priority 3 Improving patient safety: delivering safe care

Falls chosen priority. It is not clear whether the 12% reduction in the number of falls links directly with the 25% target (per 1000 occupied bed days). If so, it is of concern to learn of the low achievement and lack of explanation. Although it is positive to see a 73% reduction in those that experience moderate harm or above, the overall rates are still a concern, considering the physical effects of falls and the potential damage to patients’ sense of confidence, wellbeing and safety.

Acute Kidney Injury. We would like to see the data to show whether RFL is on target to meet its overall aims for this priority. Although the activity may be in relatively early stages to meet the aims, the Quality Account is the document in which any progress towards the targets and challenges should be documented.

Safety Surgery. We are pleased to see the actions for the “Buy-In” and although the data is concerning, endorse the action to improve the “De-brief” and the escalation tool. We request that further data is provided for all theatre sites, in addition to Maternity.

Deteriorating unborn baby, deteriorating patient and sepsis

We value the detailed information provided on the actions to reduce incidence and the effect of these issues and also support these priorities for 2017-18. We also recommend that patients’ and carers’ feedback can be of crucial importance in identifying key points of deterioration.

Priorities for improvement 2017-18

Priority 1 Improving patient experience: delivering world class experience

We endorse the priorities for the coming year, particularly in relation to patient engagement. However, Healthwatch Barnet has always recommended that some of this engagement takes place in community settings, to enable as diverse a range of local people to participate. We would also like to see a diversity analysis of patient and carer engagement to help ensure that feedback from a range of communities is in place.

Priority 2 Clinical effectiveness

We note the development of Clinical Practice Groups and Quality Improvement and endorse this and the aim to reduce variation. Healthwatch Barnet has on-going feedback on referral management with patients being “lost in the system” which has delayed care. This is an area about which Healthwatch Barnet plans further projects, reviewing and recording patient feedback and experiences at the point of care, in the specific departments and we will liaise with RFL to help improve the service.

Priority 3 Safety

We note that this is a continuation of a three year plan and support the continuing priorities on Falls, Acute Kidney Injury, Safer Surgery, Deteriorating Patient and Sepsis.
Quality achievements made during 2016-17

We are encouraged to note that Royal Free London NHS Foundation Trust has made progress in achieving targets against number of priority areas for 2016/2017. Disappointingly, the Quality Account includes only limited information on patient experience initiatives and how feedback from people using the Trust’s services informs Quality Improvement initiatives.

2016/17 quality improvement priorities

(1) Priority one: Delivering world-class experience

We welcome the publication of the Trust’s annual report, which included a statement on progress against the Trust dementia strategy.

We are disappointed to learn that the Trust did not achieve the target of allowing flexible visiting times for carers of people living with dementia on 100% of inpatient wards. We would urge the Trust to take a firm stance on ensuring all wards achieve the target for the well-documented benefits of patients with dementia. We are concerned that the Trust “has taken a non-prescriptive approach to implementing” compliance with the target as this may result in delays and have negative impact on health outcomes for patients.

We note the progress Royal Free London NHS Foundation Trust has made towards achieving certification for ‘The Information Standard’ by 2018; we would suggest that the Trust involves patients and their carers in work on developing materials that are clear and balanced way.

Unfortunately, the Quality Account does not include sufficient data that would enable us to comment on performance against the target to ensure that 95% of patients (identified as end of life) have an end of life care bundle in place.

(2) Priority Two: Clinical effectiveness

We would like to recognise the Trust’s performance on introducing initiatives that support the carers of people living with dementia and participating in the National Audit of Dementia. We note that the Trust developed metrics, which will enable the organisation to measure improvements in dementia care however, we would suggest that these are considered with patients and carers to ensure the metrics are aligned with needs and expectations of people using services.

(3) Priority Three: Patient safety

We would like to congratulate Royal Free London NHS Foundation Trust on reducing the number of Never Events (from 10 to 3) and significantly exceeding its target to reduce by 20% the proportion of patients that experience moderate harm or above from falls.

Healthwatch Enfield is registered as a Community Interest Company no 8484607 (under the name Enfield Consumers of Care and Health Organisation). Registered address: Community House, 311 Fore Street, London N9 0PZ

Regrettably, the Quality Account does not include sufficient data that would enable us to comment on performance against all targets for: Acute Kidney Injury, Safer Surgery, Deteriorating unborn baby, Deteriorating Patient and Sepsis.

Action planning for improvement

We are concerned about the deterioration in performance on the Trust’s self-assessment tool through quarters two and three following the Care Quality Commission’s comprehensive inspection carried out in early 2016/2017.

Accessibility

Having reviewed the document, we are disappointed to note that the Quality Account is not as accessible as the document produced to highlight the Trust’s performance in 2015/2016. The Account is lengthy and includes clinical terms and jargon making it less comprehensible or engaging for the general population.

We would welcome the Trust developing a public-facing version of the document that enables residents of Barnet, Camden and Enfield to understand the Trust’s priorities and challenge the performance against these, where appropriate. We would be happy to support this work.

Site-specific data

We encourage the Trust to include presentation of site-specific data for Quality Account going forward as Royal Free London NHS Foundation Trust develop its Group model. This would enable local stakeholders and patients to monitor, understand and support quality improvement initiatives within local services as patients’ experience can vary across Trust’s sites and divisions.

Priorities for Improvement 2017-18

We are pleased to note that some of the suggestions from the stakeholder group meeting have been included in the plans for the current year.


Healthwatch Enfield supports majority of the Royal Free London NHS Foundation Trust’s priorities for 2017/2018 however we are disappointed that dementia will not be retained as a key focus area; particularly when considering that focus on improving dementia care brings better health outcomes for individuals whilst also saving money for the health and care system.

We also encourage the Trust to develop its work on patient involvement to improve patient experience across Royal Free London NHS Foundation Trust with a view to co-design solutions, pathways and mechanisms that better meet the needs of patients and carers utilising services across the Trust. Considering our experience and expertise in supporting implementation of co-production, we would be more than happy to discuss ways of working with the Trust to support this.

The Quality Account certainly provides a comprehensive study of the many national and local clinical audits that the RFL is participating in, with key actions detailed. A few of the audits demonstrate the use of patient experience and involvement such as the renal dialysis audit and it would have been good to have a few more examples of where the feedback of patients, carers and their families has had an impact on service improvement.

We are pleased to see that the dementia care initiatives have progressed well over the year and that the Trust has supported ‘John’s Campaign’ for flexible visiting times for carers of patients with dementia and published a statement on progress against the Trust dementia strategy. It is good to see that this focus will continue for 2017/18.

Our Healthwatch Hertfordshire representative attends the Chase Farm redevelopment meetings and Trust Board meetings and we receive email updates on new initiatives but we would welcome a closer working relationship in conjunction with other local Healthwatch to ensure that Hertfordshire patients who access services at the Trust’s hospitals are fully represented.

The Royal Free London NHS Foundation Trust

Barnet Health Overview and Scrutiny Committee scrutinised the Draft Royal Free London NHS Foundation Trust Quality Account 2016-17 and wish to put on record the following comments:

- The Committee was pleased that the Trust had been rated ‘Good’ in most areas by the CQC.
- The Committee complimented the Trust on their continuing progress on its Dementia Strategy in particular the introduction of a Passport for Carers.
- The Committee congratulated the Trust on the list of its key achievements over the year.
- The Committee noted the Trust’s participation in national clinical audits which it found most informative. Whilst this is prestigious, it is recognised that there is considerable additional work for practitioners. However, the Committee was pleased that the results of the audit are being used to improve local practice.
- The Committee acknowledged the efforts made by the Trust to make the data clearer in this year’s report and found the statistics suggested that the Trust was doing well when its performance is compared with the national average.
- The Committee commented that lower levels of diabetes were reported at Chase Farm than expected and queried the reasons behind this. The Trust said there had been an improvement in in-patient foot surveillance, in addition to projects on improved interventions in order to alert staff to dangerous changes in glucose levels. The Trust explained that at any one time up to 20% of patients at the Royal Free can be diabetic and it is a great challenge for the diabetic team to manage all of these.
- The Trust explained they were looking into an alerting system for pre-diabetics and this would be the focus for the next few years. The Committee requested that the Trust bring an update on this back to a future meeting.

Michael Downing, Chair Healthwatch Hertfordshire, May 2017
However:

- The Committee noted that the number of reported incidents at the Trust had risen since last year. The Trust explained this was viewed as a positive sign that members of staff were reporting more incidents and the number of serious incidents resulting in harm had actually gone down.

- The Committee queried the accuracy of the figures on Sepsis. The Committee suggested these figures be investigated before the final version of the report is published. The Committee also queried whether a Sepsis intervention programme was currently in place in order to educate all staff about the signs and seriousness of Sepsis. The Committee were assured that all staff were trained to look for signs of Sepsis, especially at the triage stage of care.

- The Committee noted that the C.difficile key performance indicator on page 85 of the Royal Free report did not make sense, as it appeared that the Trust was performing better than the highest national performing trust. The Committee suggested these figures were also checked. The Chairman commented that she found last year’s table easier to understand.

- The Committee commented that the C.diff figure was not clear, making it difficult to understand if the Trust was doing well when compared with its own previous year’s figures as well as other hospitals. The Committee asked that the table be made clearer and the figures checked.

- The Committee felt that being ranked 23rd out of 25 hospitals for C.diff indicated this was an issue the Trust should look into further. The Trust explained that C.diff is measured in a number of ways and cannot be avoided in all cases, however the aim was to get the number as close to zero as possible. The Trust stated that they needed to do some work comparing its numbers of C.diff cases with other hospitals with similar complex cases.

- The Committee acknowledged that A&E had experienced a challenging winter which had been affected by social care provision issues, not necessarily caused by the five NCL Boroughs but often by Hertfordshire, which had led to difficulties with discharging patients. The Committee asked whether there appeared to be a trend whereby patients preferred to seek treatment from A&E rather than via other methods of accessing urgent care. The Trust said it was not able to comment on what was causing the trend but there had definitely been an increase in the number of patients attending A&E. The Trust suggested it could be due to the increasing and changing demographics in the population. The Trust explained it was working closely with colleagues in Primary Care and the CCG, as well as local councils, to try to co-ordinate responses across the system in order to ensure patients do not have to wait more than four hours when possible. The Trust also stated work was needed to encourage patients to go to the most appropriate place for care, but did not anticipate this being an easy issue to resolve.

- The Committee questioned the number of ‘Never Events’ and how these were being managed to prevent reoccurrence. The Trust explained these were mainly incidents in surgery and one was currently under review to establish whether it met the criteria to be classified as a never event. The Committee did however acknowledge there had been a big reduction in these events over the year and encouraged the Trust to ensure these numbers remained as low as possible. The Committee were pleased to hear a surgical safety programme would be continuing and patient safety meetings were due to be held throughout the year.

- The Committee commented that no section had been included in regard to any compliments or complaints. The Committee suggested that a number of these are included in the final report.

- The Committee wished to put on record again their concern regarding the insufficient amount of parking at Barnet Hospital for both patients, visitors and staff. The Committee had mentioned this issue at last year’s Quality Account meeting and were disappointed that the Trust had done nothing to improve matters since then. The Committee also expressed its concern that a quarter of the visitor/patient car park had been re-designated as staff parking and that a portacabin was also taking up 18 patient/visitor spaces.

- The Committee asked specifically about whether the hospital had received complaints in regard to the lack of parking. The Committee explained that at previous Health Overview and Scrutiny meetings suggestions had been made to extend the current car park on the east side of the hospital. The Trust said it would have to look into this. The Committee also suggested the Trust look into the possibility of installing a camera at the exit of the car park which would inform the driver whether they had paid for their parking or not. This would give the person the opportunity to return to the car park and pay for their parking rather than being fined.

- The Committee asked about whether there was a strategy for parking at the Royal Free Hospital, whilst acknowledging that the site was very restricted for space.
The council of governors reviewed the draft quality account and is assured that the report provides a comprehensive summary of the work undertaken by the trust in 2016/17 to improve services for patients. Much of this information has been shared with the council of governors during the year by:

- Presentation and feedback session at council by Professor Stephen Powis – medical director
- Copies of the minutes of the trust board.
- Updates in the chief executive’s briefing to the council.
- Briefings from non-executives on individual board committee work programmes.
- Quality Account consultation stakeholders event held in January 2017
- Regular provision of the trust performance report.

The governors are clear in their responsibility to hold to account the non-executive directors, collectively and individually, for the performance of the board, and focus their attention on ensuring that high quality services are available both for the local population and for patients from further afield requiring specialist services.

To help them carry out their statutory responsibilities, governors attend each of the three quality focused board committees and provide challenge to the trust in the robustness and timeliness of improvement plans to enhance both patient and staff experience.

The governors particularly liked the showcasing quality event that was held in January 2017 and expressed that the consultation process was very clear. The quality objectives outlined for 2017/18 are and are linked to each domain for quality – it will be important that progress against these is reported regularly; the areas chosen are of national and local importance.

Overall the governors welcome the opportunity to comment on the quality account 2016/17 and look forward to further engagement and monitoring of progress made during 2017/18 to improve our services and the outcomes for our patients.

25/5/17
Annex 2: Statement of directors’ responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare quality accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance
- the content of the quality report is consistent with internal and external sources of information including:
  - board minutes and papers for the period April 2016 to 30 May 2017
  - papers relating to quality reported to the board over the period April 2016 to 30 May 2017
  - feedback from commissioners dated 4 May 2017, 9 May 2017
  - feedback from governors dated 24 May 2017
  - feedback from local Healthwatch organisations dated 3 May 2017, 4 May 2017, 12 May 2017
  - feedback from overview and scrutiny committee dated 12 May 2017, 23 May 2017
  - the trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated 27 July 2016
  - the latest national patient survey dated 8 June 2016
  - the latest national staff survey dated 7 March 2017
  - the head of internal audit’s annual opinion over the trust’s control environment dated 23 May 2017
  - CQC inspection report dated 15 August 2016
- the quality report presents a balanced picture of the RFL’s performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions and is subject to appropriate scrutiny and review and
- the quality report has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the board

Sir David Sloman
Chief executive
30 May, 2017

Dominic Dodd
Chairman
30 May, 2017
Annex 3. Limited assurance statement from external auditors

Independent auditors’ limited assurance report to the council of governors of Royal Free London NHS Foundation Trust on the Annual Quality Report

We have been engaged by the council of governors of Royal Free London NHS Foundation Trust to perform an independent assurance engagement in respect of Royal Free London NHS Foundation Trust’s quality report for the year ended 31 March 2017 (the ‘quality report’) and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance (the “specified indicators”) marked with the symbol @ in the quality report, consist of the following national priority indicators as mandated by Monitor (operating as NHS Improvement (“NHSI”)):

<table>
<thead>
<tr>
<th>Specified Indicators</th>
<th>Specified indicators criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways.</td>
<td>Page 293 of the quality report</td>
</tr>
<tr>
<td>Percentage of patients with a total time in A&amp;E of four hours or less from arrival to admission, transfer or discharge.</td>
<td>Page 294 of the quality report</td>
</tr>
</tbody>
</table>

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the specified indicators criteria referred to on pages of the quality report as listed above (the “criteria”). The directors are also responsible for the conformity of their criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual (“FT ARM”) and the “detailed requirements for quality reports for foundation trusts 2016/17” issued by NHSI.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report does not incorporate the matters required to be reported on as specified in the FT ARM and the “detailed requirements for quality reports for foundation trusts 2016/17”
- the quality report is not consistent in all material respects with the sources specified below; and
- the specified indicators have not been prepared in all material respects in accordance with the criteria set out in the FT ARM and the “detailed requirements for external assurance for quality reports for foundation trusts 2016/17”.

We read the quality report and consider whether it addresses the content requirements of the FT ARM and the “detailed requirements for quality reports for foundation trusts 2016/17”; and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with the following documents:

- board minutes for the financial year, April 2016 and up to the date of signing this limited assurance report (the period)
- papers relating to quality report reported to the Board over the period April 2016 to the date of signing this limited assurance report;
- feedback from NHS Barnet Clinical Commissioning Group dated 04/05/2017
- feedback from NHS Herts Valley Clinical Commissioning Group and NHS North Herts Clinical Commissioning Group dated 09/05/2017
- feedback from Governors dated 24/05/2017
- feedback from Healthwatch Enfield dated 04/05/2017
- feedback from Healthwatch Barnet dated 04/05/2017
- feedback from Healthwatch Hertfordshire dated 03/05/2017
- feedback from Healthwatch Camden and Camden Health and Adult Social Care Scrutiny Committee dated 12/05/2017
- feedback from Barnet Health Overview and Scrutiny Committee dated 23/05/2017
- the trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 15/07/2016
• the latest national patient survey dated 08/06/2016
• the latest national staff survey dated 07/03/2017
• Care Quality Commission inspection, dated 15/08/2016
• the head of internal audit’s annual opinion over the trust’s control environment dated 23/05/2017; and

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the “documents”). Our responsibilities do not extend to any other information.

Our independence and quality control

We applied the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.

We apply International Standard on Quality Control (UK & Ireland) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Use and distribution of the report

This report, including the conclusion, has been prepared solely for the council of governors of Royal Free London NHS Foundation Trust as a body, to assist the council of governors in reporting Royal Free London NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the annual report for the year ended 31 March 2017, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the council of governors as a body and Royal Free London NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’ issued by the International Auditing and Assurance Standards Board (ISA 3000 (Revised)). Our limited assurance procedures included:

• reviewing the content of the quality report against the requirements of the FT ARM and the “detailed requirements for quality reports for foundation trusts 2016/17”
• reviewing the quality report for consistency against the documents specified above
• obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding
• based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures
• making enquiries of relevant management, personnel and, where relevant, third parties
• considering significant judgements made by the NHS foundation trust in preparation of the specified indicators

• performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
• reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the quality report in the context of the assessment criteria set out in the FT ARM and “detailed requirements for quality reports for foundation trusts 2016/17” and the criteria referred to above.

The nature, form and content required of quality reports are determined by NHSI. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS foundation trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the quality report, which have been determined locally by Royal Free London NHS Foundation Trust.
Basis for adverse conclusion – percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

The 18 week indicator is calculated each month based on a snapshot of incomplete pathways and reported through the Unify2 portal. The data reported is subsequently updated by the Royal Free London NHS Foundation Trust for any identified errors through a monthly validation process. The process is however not applied to the whole data set, as it focuses only on cases which have breached the indicator.

In our testing, we found an unacceptable level of errors. For four out of fifteen incomplete pathways tested it was noted that the patients included in the indicator did not meet the inclusion criteria as a referral for consultant-led services.

Basis for qualified conclusion – percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

The A&E attendances and emergency admissions monthly return definitions require that for ambulance cases, arrival time is when hand over occurs or 15 minutes after the ambulance arrives at A&E, whichever is earlier.

Through discussions with management and our review of individual case records, it was noted that this rule is applied inconsistently across the Royal Free London NHS Foundation Trust. At Barnet and Chase Farm A&Es this rule is applied using documentation provided by the relevant ambulance trust, whereas at the Royal Free A&E this rule is not applied and all clocks are started at the point of handover irrespective of arrival time. It is further noted that for one such case tested at Barnet Hospital, sufficient documentation was not retained to demonstrate the application of this rule.

Ambulance cases represent 19.0% of all A&E attendances at the Trust and in particular ambulance cases at Royal Free Hospital at which the handover rules are not currently being applied represent 7.9% of the total population.

In addition to the above, when the 15 minute handover rule is not applicable, the clock start in all cases should reflect the patient’s arrival time at A&E as recorded by the clinician carrying out initial triage, or A&E reception, whichever is earlier. However, through sample testing performed, it was found that the time of the clock start per the indicator was later than initiation of the automated visit date and time field within the patient’s record on the Royal Free London NHS Foundation Trust’s Cerner system. The differences noted were minimal, ranging from one to six minutes and only impacted the breach status of one of forty cases tested, however management were not able to extract a report to quantify the exact number of attendances impacted.

Conclusion (including adverse opinion on the incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period and qualified opinion on the percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge)

Because of the significance of the matters described in the basis for adverse conclusion, the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period indicator has not been prepared in all material respects in accordance with the criteria.

In addition, except for the matters described in the basis for qualified conclusion paragraph above relating to A&E wait time, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the quality report does not incorporate the matters required to be reported on as specified in the FT ARM and the “Detailed requirements for quality reports for foundation trusts 2016/17”
- the quality report is not consistent in all material respects with the documents specified above; and
- the percentage of patients with total time in A&E of four hours or less from arrival to admission, transfer or discharge indicator has not been prepared in all material respects in accordance with the criteria set out in the FT ARM and the “Detailed requirements for external assurance for quality reports for foundation trusts 2016/17”.

PricewaterhouseCoopers LLP
London
31 May 2017

The maintenance and integrity of the Royal Free London NHS Foundation Trust’s website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.
Appendices

Appendix a: Quality improvement driver diagram: toward 50 initiatives by end April 2018

Overall aim:
At least 50 QI projects across RFL by end April 2018 which exhibit 5 core features
• Clear aim
• Change logic
• Ongoing PDSAs
• Measurement linked to learning
• Spread plan

Communications and engagement

1. Listening events/survey to determine high-level focus and themes
2. Communication strategy developed
3. Narrative developed and cascaded through teams
4. Formal launch event, QI conference – May/Jun 2017
5. Establish QI champions identity and network
6. Establish regular peer-learning forum, share ongoing work
7. Freenet/Internet site developed
8. Learning visits to leading sites in UK/internationally
9. Participate in key national/international networks
10. Strong presence at major forums, eg London April 2017

Creating Capacity

1. Visibly stop lower value activities to create time for staff
2. QI embedded into formal trust mechanisms, incl: quality account, service reporting, job planning, appraisal, revalidation, professional development

Building Capacity

1. Refresh skills and experience mapping
2. Practitioner & coaching applied learning offers developed
3. Capability “Bench strength”
   • 10 improvement advisors trained by Dec 2017
   • 50 improvement coaches trained by Dec 2017
   • 120-150 QI practitioners trained by Mar 2018
4. Establish RFL faculty, supported by QI partner
5. Self-serve online training open to all (staff, pts, volunteers)
6. Drop-in/introductory learning modules available to all

Leadership and alignment

1. Strong patient/carer/family input into all QI work
2. Board visibility champion QI as an enduring way of working at RFL (not just a project) eg GoSee visit, CEO brief
3. Continuing development and strategic advice for board
4. QI emphasised in service/divisional/committee agendas
5. Full alignment with RFL leadership/OD offerings
6. Joint strategy and initiatives agreed with RFL Charity, eg events, visits, training/projects for volunteers
7. Repeat QI diagnostic by end 2017

Supporting infrastructure

1. Support team in place by Mar/Apr 2017 with required links to adjacent skills, eg analytics, communications
2. Analytic capacity in situ (support measurement, track RoI)
3. Strategic partner procured by Apr 2017
4. QI project tracking: ‘library’ of projects developed on SeeData; all projects use SeeData for tracking and measures
5. Standard QI tools available via Freenet and widely utilised
Appendix b: Changes made to the quality report

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

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

1. The presentation of full data for the year (2016/17)
2. Overview of quality of care in 2016/17 against key indicators and performance against NHS improvements indicators.

In addition, the report contains changes made as a result of stakeholder feedback which is summarised below.

Responses to stakeholder comments

In response to comments received from commissioners, local healthwatch organisations and overview and scrutiny committees we have outlined our responses in the following table:

<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Comments</th>
<th>RFL response or changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet Health Overview Scrutiny Committee (BHOSC)</td>
<td>The committee queried the accuracy of the figures on Sepsis. The committee suggested these figures be investigated before the final version of the report is published.</td>
<td>The data in our quality account has been reviewed and additional data was presented, illustrating our sepsis survival to discharge data for patients on the sepsis bundle.</td>
</tr>
<tr>
<td></td>
<td>The committee noted that the C.difficile key performance indicator (on page 85) of the Royal Free report did not make sense, as it appeared that the trust was performing better than the highest national performing trust. The committee suggested these figures were also checked.</td>
<td>We have reviewed our data and changes made accordingly.</td>
</tr>
<tr>
<td></td>
<td>The committee commented that no section had been included in regard to any compliments or complaints. The committee suggested that a number of these are included in the final report.</td>
<td>We have included information on our complaints and full details are presented in our annual report.</td>
</tr>
<tr>
<td>Barnet Clinical Commissioning Group (CCG)</td>
<td>The CCG would like to have seen as part of this quality account would have been information in relation to the safeguarding procedures and how the Trust has met its responsibilities in relation to this important area.</td>
<td>We have agreed to include information on safeguarding in section 3.3 of this report.</td>
</tr>
<tr>
<td>Healthwatch Camden and Camden Health and Adult Social Care</td>
<td>Introduction: We would have liked to have seen further information on the Royal Free London achievements, success and areas of improvement for the year.</td>
<td>We have agreed to include additional information on our achievements, success and areas of improvement for the year. This is included in section 2.1 of this report.</td>
</tr>
<tr>
<td></td>
<td>Priority areas: It wasn’t clear how these were identified and we would have liked to have seen further information on the aims and outcomes. In addition, it was unclear why the priorities for clinical effectiveness had been identified and how they would increase or improve clinical effectiveness.</td>
<td>We have amended our information presented and in particular we have included additional data for our patient safety priorities.</td>
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<td><strong>Patient safety and complaints:</strong> We would have liked to have seen further information on how many incidents had occurred and their resulting impact and the process around complaints including how they can be made and how they are reviewed and what learning has been shared and/or acted upon for both incidents and complaints. We would also like to have seen further information on primary care voluntary and community sector engagement including how this is being undertaken in the different boroughs.</td>
<td><strong>Our annual report contains further information on patient safety and complaints.</strong> We have included information on our Chase Farm redevelopment which presents information on our health and wellbeing programme. In future we will consider including additional information on primary care voluntary and community sector engagement.</td>
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<td><strong>We would have liked to have seen further information on the metrics in dementia and when these will be in place to measure any improvement in dementia care.</strong></td>
<td><strong>We have agreed to include additional information on the metrics for dementia. This is reported in section 2.1 of this report.</strong></td>
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<td><strong>Falls:</strong> it was not clear what number of patients this percentage equated to;</td>
<td><strong>We have revised the information presented and included several charts to illustrate our falls data.</strong></td>
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<td><strong>Deteriorating patient:</strong> what are the current number of deaths per thousand;</td>
<td><strong>Our deteriorating patient priority aims to reduce cardiac arrests, not deaths. However the number of deaths per year is just over 2000, which will include patients who arrive at ED in resus and die.</strong></td>
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<td><strong>Safer surgery:</strong> how you intend to reach a target of 100% compliance of maternity counting of swabs and needles - currently shown as having risen from 65% to 85%.</td>
<td><strong>Counting swans needles and instruments compliance will be improved through PDSA cycles and standardisation of current processes, as demonstrated through 65% to 85% improvement.</strong></td>
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<td><strong>Foot care:</strong> What options are available to improve foot care if the NHS England funding bid for a multidisciplinary diabetes foot team is not successful?</td>
<td><strong>If the bid is not successful then our clinical division (SAS) will explore other ways to deliver the service.</strong></td>
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<td>We know that the content of the quality report is mandated nationally. However, we did feel that the document was very technical and not easily readable for the public eg full of medical jargon, acronyms and the content and some tables are not easy to fully understand. In addition, it was not always clear in the report whether information related specifically to the Royal Free, Barnet or Chase Farm Hospitals, or all three eg in the audit tables.</td>
<td>We will be working with Healthwatch Enfield to produce an easy to read version and will consider how the data could be presented more clearly.</td>
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<td><strong>East and North Hertfordshire and Herts Valley clinical commissioning groups</strong></td>
<td>We note that no reference was made regarding safeguarding adults or children and how the trust has met its responsibilities in this key area. The CCGs expect this to be included in future quality accounts. We have agreed to include information on safeguarding in section 3.3 of this report.</td>
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<td>Healthwatch Barnet</td>
<td>We understand that the 2016 NHS Staff Survey showed that whilst staff experience was higher than the national average for job satisfaction, the quality of non-mandatory training, appraisals and belief that their role makes a difference, the responses were below the national averages for equal opportunities and experiences of stress and harassment. We find this of concern and request that RFL provide further details of their action to improve performance in these areas.</td>
<td>We have agreed to include additional information on actions taken in section 3.3 of this report.</td>
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<td>Falls chosen priority. It is not clear whether the 12% reduction in the number of falls links directly with the 25% target (per 1000 occupied bed days). If so, it is of concern to learn of the low achievement and lack of explanation. Although it is positive to see a 73% reduction in those that experience moderate harm or above, the overall rates are still a concern, considering the physical effects of falls and the potential damage to patients’ sense of confidence, wellbeing and safety.</td>
<td>We have revised the information presented and included several charts to illustrate our falls data.</td>
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<td>Acute kidney injury. We would like to see the data to show whether RFL is on target to meet its overall aims for this priority. Although the activity may be in relatively early stages to meet the aims, the quality report is the document in which any progress towards the targets and challenges should be documented.</td>
<td>We have revised the information presented and included several charts to illustrate our AKI data.</td>
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<tr>
<td>Regrettably, the quality report does not include sufficient data that would enable us to comment on performance against all targets for: Acute kidney injury, safer surgery, deteriorating unborn baby, deteriorating patient and sepsis.</td>
<td>We have revised the information presented and included several charts to illustrate our Acute kidney injury, safer surgery, deteriorating unborn baby, deteriorating patient and sepsis performance.</td>
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<td>We are disappointed that dementia will not be retained as a key focus area; particularly when considering that focus on improving dementia care brings better health outcomes for individuals whilst also saving money for the health and care system.</td>
<td>Whilst we have not retained our focus on dementia within our clinical effectiveness priority; we will continue to focus on dementia within our patient experience priorities for 2017/18,</td>
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</table>
### Five steps to safer surgery

<table>
<thead>
<tr>
<th>Steps</th>
<th>Timings of intervention</th>
<th>What is discussed at this step</th>
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</table>
| 1. Briefing | Before list of each patient (if different staff for each patient e.g. emergency list)   | • introduction of team/individual roles  
 • list order  
 • concerns relating to equipment/surgery  
 • anaesthesia |
| 2. Sign in  | Before induction of anaesthesia                                                          | • confirm patient/procedure/consent form  
 • allergies  
 • airway issues  
 • anticipated blood loss  
 • machine/ medication check |
| 3. Time out (stop moment) | Before the start of surgery:  
 Team member introduction,  
 Verbal confirmation of patient information  
 Surgical/anaesthetic/nursing issues,  
 Surgical site infection bundle,  
 Thromboprophylaxis,  
 Imaging available | In practice most of this information is discussed before, so this is used as a final check.  
 Surgeons may use this opportunity to check that antibiotics prophylaxis has been administered. |
| 4. Sign out | Before staff leave theatre                                                               | Confirmation of recording of procedure:  
 • instruments, swabs and sharps correct  
 • specimens correctly labelled.  
 • equipment issues addressed  
 • Post-operative management discussed and handed over |
| 5. Debriefing | At the end of the list                                                                  | Evaluate list  
 Learn from incidents  
 Remedy problems, e.g. equipment failure  
 Can be used to discuss five–step process |
### Glossary of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Explanation</th>
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<tr>
<td>ASA</td>
<td>The ASA physical status classification system is a system for assessing the fitness of patients before surgery adopted by the American Society of Anesthesiologists (ASA) in 1963</td>
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<td>CQC: Care Quality Commission</td>
<td>The independent regulator of all health and social care services in England</td>
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<td>C-diff: Clostridium difficile</td>
<td>A type of bacterial infection that can affect the digestive system</td>
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<td>Clinical Practice Group (CPG)</td>
<td>Permanent structures which the trust is developing to address unwarranted variation in care.</td>
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<td>CQUIN: Commissioning for Quality and Innovation</td>
<td>CQUIN is a payment framework that allows commissioners to agree payments to hospitals based on agreed improvement work</td>
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<td>DeepMind</td>
<td>DeepMind is a technology company that is working in partnership with the Royal Free London NHS Foundation Trust to create a new app called Streams. The app detects early signs of kidney failure and is now being used to improve care for some of the Royal Free London most vulnerable patients by directing clinicians to patients who are at risk of or who have developed a serious condition called acute kidney injury (AKI).</td>
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<td>MDT: multi-disciplinary team</td>
<td>A team consisting of staff from various professional groups i.e. nurses, therapist, doctors etc.</td>
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<td>NHS NCL</td>
<td>NHS north central London clinical network</td>
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<td>NICE: National Institute of Clinical Excellence</td>
<td>An independent organisation that produces clinical guidelines and quality standards on specific diseases and the recommended treatment for our patients. The guidelines are based on evidence and support our drive to provide effective care.</td>
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<td>Patient at Risk &amp; Resuscitation Team (PARRT)</td>
<td>The Patient at Risk &amp; Resuscitation Team (PARRT) is a combined nursing service to provide 24/7 care to patients at risk, including attending medical emergency calls (2222) and reviewing all patients post discharge from intensive care. The team members provide education, training and support to manage life-threatening situations, including in-hospital resuscitation, care of the patient with a tracheostomy and CPAP.</td>
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<td>PEWS: paediatric early warning score</td>
<td>A scoring system allocated to a patient’s (child’s) physiological measurement. There are six simple physiological parameters: respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness.</td>
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<td>SBAR: situation, background, assessment, recommendation</td>
<td>SBAR is a structured method for communicating critical information that requires immediate attention and action contributing to effective escalation and increased patient safety. It can also be used to enhance handovers between shifts or between staff in the same or different clinical areas.</td>
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<td>SHMI: summary hospital-level mortality indicator</td>
<td>The SHMI is an indicator which reports on mortality at trust level across the NHS in England using a defined methodology. It compares the expected mortality of patients against actual mortality.</td>
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<td>UCLP: University College London Partners</td>
<td>UCLP is organised around a partnership approach. It develops solutions with a wide range of partners including universities, NHS trusts, community care organisations, commissioners, patient groups, industry and government. (<a href="http://www.uclpartners.com/">http://www.uclpartners.com/</a>).</td>
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<tr>
<td>VTE: venous thromboembolism</td>
<td>A blood clot that occurs in the vein</td>
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