MEETING
HEALTH OVERVIEW AND SCRUTINY COMMITTEE
DATE AND TIME
WEDNESDAY 25TH MAY, 2022
AT 7.00 PM
VENUE
HENDON TOWN HALL, THE BURROUGHS, LONDON NW4 4BQ

TO: MEMBERS OF HEALTH OVERVIEW AND SCRUTINY COMMITTEE (Quorum 3)

Membership to be appointed at Annual Council, Tuesday 24th May 2022.

In line with the Constitution's Public Participation and Engagement Rules, requests to submit public questions or comments must be submitted by 10AM on the third working day before the date of the committee meeting. Therefore, the deadline for this meeting is Friday 20th May at 10AM. Requests must be submitted to tracy.scollin@barnet.gov.uk Tel 020 8359 2315

You are requested to attend the above meeting for which an agenda is attached.

Andrew Charlwood – Head of Governance

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Media Relations Contact: Tristan Garrick 020 8359 2454 Tristan.Garrick@Barnet.gov.uk

ASSURANCE GROUP

ORDER OF BUSINESS

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1.	Minutes	5 - 12
2.	Absence of Members	
3.	Declaration of Members' Interests	
4.	Report of the Monitoring Officer	
5.	Public Question Time (If Any)	
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7.	Minutes of the North Central Sector London Joint Health Overview and Scrutiny Committee To follow	
8.	Covid-19 and Flu Vaccination update	
9.	NCL Healthwatch Long Covid update	13 - 78
10.	Finchley Memorial Hospital, Edgware Walk-In Centre and APMS Cricklewood Update	
11.	NHS Trust Draft Quality Accounts 2021-22 • Appendix 1a – Minute extract, QA, Royal Free London (RFL) NHS Foundation Trust • Appendix 1b - mid-year QA, Royal Free London (RFL) NHS Foundation Trust • Appendix 1c – RFL NHS Foundation Trust Draft QA 2021/22 • Appendix 2a – Minute extract, QS Central London Community Healthcare (CLCH) NHS Trust • Appendix 2b mid-year QA, CLCH • Appendix 2c – CLCH Draft QA 2021/22 • Appendix 3a – Minute extract, QA North London Hospice • Appendix 3b, mid-year QA, North London Hospice • Appendix 3c – North London Hospice Draft QA 2021/22	79 - 314
12.	Health Overview and Scrutiny Forward Work Programme	

	To follow	
13.	Any Other Items that the Chairman Decides are Urgent	

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Decisions of the Health Overview and Scrutiny Committee

10 February 2022

AGENDA ITEM 1

Members Present:-

Councillor Alison Cornelius (Chair)

Councillor Saira Don	Councillor Anne Hutton
Councillor Lisa Rutter	Councillor Geof Cooke
Councillor Alison Moore	Councillor David Longstaff (Substitute for Councillor Golnar Bokaei)

Apologies for Absence

Councillor Linda Freedman	Councillor Golnar Bokaei

1. MINUTES

Corrections to the Minutes of the meeting held on 7 December 2021:

Agenda Item 11, Page 7 of the Minutes of the meeting held on 7 December 2021- Accessing GPs remotely. The Chairman wished to insert the following paragraph at the beginning of the item: 'At the previous Committee Meeting held on 12 October 2021, the Chairman had asked Cllr Lisa Rutter if she could bring a couple of carers from Dementia Club UK to the meeting to be held on 7 December 2021 to provide an account of their experiences with accessing GPs remotely. Cllr Rutter brought two carers and also read out an account from another carer who was unable to attend'.

Matters arising from the Minutes of the meeting held on 7 December 2021:

- Agenda Item 8, Page 4 of the Minutes of the meeting held on 12 October 2021 - Uptake of the 'flu vaccination. The Chairman noted that the data was circulated on 10 February and Dr Djuretic apologised for the late circulation. A Member noted that it was pleasing to see a small uplift in uptake.

- Agenda Item 5, Page 2 of the Minutes – Public Question Time. A question had been received from a member of the public. The Chairman reported that the Royal Free London NHS Foundation Trust had responded to the resident and that their response had also been circulated to the Committee as follows:
'Royal Free London NHS Foundation Trust (RFL) is committed to ensuring staff and patients receive the best possible experience. The Trust has prioritised capital investment in digital transformation and IT infrastructure. In October 2021, a new Electronic Patient Record (EPR) was launched. Staff at Barnet Hospital and Chase

Farm Hospital had been using EPR since 2018. In October, we upgraded the system across all of our hospitals, and introduced it to the Royal Free Hospital.

EPR is an innovative new system that has replaced paper records at the Royal Free London. It means staff caring for patients always have access to accurate and up-to-date information to ensure patients get the best care. With all healthcare information in one place, it means staff can access patients' test results, and details of their care, more quickly. There are no longer paper records and our staff are now using computers and laptops to input information directly.

The Trust also has a patient portal, (My RFL Care), with approximately 160,000 patients registered. This is web-based and enables patients to view their appointments and letters online in one place, anytime and anywhere.'

A Member commented that it could be difficult to get information about loved ones, as often Trusts do not have the information to hand. She hoped this would help staff to access information when relatives request it. The Chairman noted that this could be discussed when the Quality Accounts are discussed at the HOSC in May.

- Agenda Item 8, Page 3 of the Minutes – Covid Update and Flu Vaccination Verbal Update. The Chairman reported that an apology had been received from Ms Vishram about the late response to a query on access to lateral flow tests. The Chairman read out the response:

    - 'We escalated the issue with the Department of Health and Social Care (DHSC) and HSC and UK Health Security Agency (UKHSA). They confirmed clearly with us and pharmacies, that pharmacies should still give out tests even if people do not have a code.
    - We increased the number of community sites as an alternative if people do not want or cannot get a code
    - We put out social media comms
    - We changed our testing factsheet to say that you can pick up a test kit without a code and shared this with Health Champions.'

A Member reported that they had been dealing with residents who were struggling to get booster vaccines and thanked officers as this had been resolved.

Another Member noted that there appeared to be problems obtaining lateral flow tests. The Chairman suggested that the Member contact Dr Djuretic if there are problems with a particular pharmacy.

RESOLVED that the Committee approved the Minutes of the Meeting held on 7 December 2021 as an accurate record.

2. ABSENCE OF MEMBERS

Apologies were received from Councillor Golnar Bokaei, who was substituted by Councillor David Longstaff.

Apologies were received from Councillor Linda Freedman.

3. DECLARATION OF MEMBERS' INTERESTS

Cllr Cornelius and Cllr Longstaff declared an interest by virtue of being Trustees of Eleanor Palmer Trust.

Cllr Hutton declared an interest by virtue of being a Trustee of Barnet Carers' Centre.

4. REPORT OF THE MONITORING OFFICER

None.

5. PUBLIC QUESTION TIME (IF ANY)

None.

6. MEMBERS' ITEMS (IF ANY)

None.

7. MINUTES OF THE NORTH CENTRAL SECTOR LONDON JOINT HEALTH OVERVI AND SCRUTINY COMMITTEE

A Member enquired whether there had been an update at the recent JHOSC meeting on support for GP Practices with online booking systems. The Chairman suggested that Cllr Moore email Councillor Connor, the Chairman of the JHOSC for an update. The Chairman noted that two GP Surgeries had thanked her for bringing this matter to the HOSC as they had changed to the PATCHES system from eConsult, which was more user friendly for the public.

A Member enquired whether there were any plans to make changes to the form that had to be completed by the patient, as it contained many irrelevant questions. The Chairman responded that Dr Charlotte Benjamin had noted that the individual Surgeries could choose their system and could change it if patients complained that it was not working well.

Another Member asked why all GP Practices didn't use a single system. Dr Djuretic, Director of Public Health, responded that GP Practices operate as private businesses, so they purchase a licence for what they think will be the most appropriate system for their Practice.

The Minutes of the meeting of the North Central London Joint Health Overview and Scrutiny Committee held on 26 November 2021 were noted.

8. CHILDREN'S ORAL HEALTH REPORT

The Chairman invited Dr Djuretic to speak on the item.

Dr Djuretic presented the report on Children's Oral Health. She noted that Barnet has had a stubborn rate of tooth decay in children under five years of age which had not changed over many years, despite efforts to improve this. A needs assessment would be undertaken to review the current offer and to find out where additional interventions would need to be introduced, including a review of best practice in other local authorities.

Dr Djuretic reported that details of the Young Brushers' Project were provided in the report. Barnet had successfully bid for funding from the North Central London Integrated Care Partnership Inequalities Fund for the project, which is targeting 40 Early Years settings,

involving up to 3200 children, and has so far agreed a commitment with 11 Early Years settings, reaching 317 children. Dr Djuretic noted that the provider had received a good response so far and was chasing the remaining settings. She added that this was also providing an opportunity to train people and was focusing on more deprived areas where rates of tooth decay are much higher.

Dr Djuretic reported that CLCH already trains all Early Years staff, who then train parents, and CLCH has been commissioned to take part in the project. Packs with brushes are provided for families but also education from breastfeeding onwards, improvement of access to dental services and food intake are also important. The Healthy Early Years London Award has a component on tooth brushing and oral health and Barnet has carried out initiatives with schools so that they offer water only and no fizzy drinks.

A Member asked whether childminders are also educated as part of the contact with the 40 Early Years settings and suggested distributing tooth brushing packs at food banks.

The Member also enquired about the metrics, baseline, and methodology to be used as part of the mini oral health needs assessment, and how Solutions 4 Health could be used to enable the implementation of changes. They felt it would be helpful to have more information after the meeting if possible.

Dr Djuretic agreed to take back the helpful suggestion about food banks as this would not be difficult to implement.
Action: Dr Djuretic

Dr Djuretic stated that her team had been chasing Public Health England (PHE) for six months to try to get data on children's oral health across the whole of Barnet and had also been trying to get data from NHS England (NHSE) on equalities in access to dental services in Barnet, ideally from before the pandemic as the pandemic data would not be typical. Dr Djuretic added that then an evidence review would be carried out on interventions that work best, as well as discussions on best practice with other local authorities. Additional support would then be provided for those with the poorest outcomes.

A Member stated that for those families in dire circumstances, their situation is likely to get worse over the coming months due to the economic situation. It would be helpful to have Ward data to be able to target the areas most in need, but she was aware that Childs Hill, Burnt Oak, and Colindale have active food banks.

Another Member noted that, whilst educating parents, it is important to inform them about gingivitis and its links with dementia in later life.

It was hoped that Dental Awareness Days in schools could take place more often as a way of informing people.

Dr Djuretic noted that there would be an evaluation of current interventions to try to find out why they are not improving the situation.

A Member noted that in Section 5.11 the report references an-out-of-date corporate plan. Dr Djuretic apologised and would correct this.
Action: Dr Djuretic

The Member also enquired where the figure of 'one third' came from (page 19) for the number of children in Barnet suffering from tooth decay. At the Children's Partnership

Board, the figure given was 25% i.e. one quarter. Dr Djuretic would check this but agreed the figure was about 25%.
Action: Dr Djuretic

The Member stated that if after teaching parents and undertaking other work had still not improved the situation, the study should look into why this had not worked and what happened to make the parents forget the importance of looking after children's teeth. He also enquired whether having to wear a face mask for eight hours a day would make a difference to bacteria build-up in children's mouths leading to an increase in tooth decay. Dr Djuretic noted that there was no evidence to the best of her knowledge, and that she is not aware of this subject being researched. She added that 0-5-year-olds were not required to wear masks.

Dr Djuretic agreed that some qualitative research with parents could be carried out on what are the barriers to oral health and why some children still develop tooth decay despite all the interventions.
Action: Dr Djuretic

A Member reported that she was aware of a Primary School in another Borough that had set up sessions of tooth brushing in schools which included all children, due to the reports of children having teeth removed at an early age. She added that the idea of providing toothbrushes and toothpaste in food banks was a good one, noting that there are two strategically placed food banks in Woodhouse Ward.

Another Member asked whether details on the 40 settings for the project could be provided, including whether any of these are private nurseries. Dr Djuretic offered to forward the details to the Committee.
Action: Dr Djuretic

A Member suggested looking at the drivers for why some families were not prioritising children's oral health in Barnet, as part of the research. Dr Djuretic responded and said this could be considered but the cause of tooth decay also included food and liquid intake, for example a large proportion of some cultures are giving young children fruit juices rather than water. Barnet uses brushing as a 'hook' to also teach parents and teachers on other aspects.

Another Member stated that deprivation is one of the factors, but not the only factor, so the project should not exclude groups of society who are seen as unlikely to suffer from tooth decay. Parental neglect could occur in any family.

The Chairman noted that it had been reported at a previous meeting of the HOSC that fizzy drinks had been removed from school meals and replaced by water with fruit slices. She enquired whether this was still the case. Dr Djuretic responded that some children probably do bring in packed lunches with fruit juice and, although Barnet Council could advise schools, it is the school's choice whether to ban fizzy drinks on site. The Healthy School Initiative should be addressing this issue.

Cllr Moore made a declaration of interest by virtue of the fact that she is a School Governor and she was aware of chocolate and juice packs being banned in one school.

A Member reported that the Prevention Team in the Council tries to highlight healthy lifestyles and the same could happen with oral health. Dr Djuretic noted that booklets are already being circulated on this.

Dr Djuretic reported that she would bring an update with a detailed plan when the needs assessment is completed in the second half of the year.
Action: Dr Djuretic

RESOLVED that:

1. **the Committee noted the report and progress made in Oral Health Promotion services, especially the additional supervised toothbrushing intervention in the most deprived areas of Barnet.**

2. **the Committee noted that the Public Health team is planning to conduct a mini oral health needs assessment in 2022. The findings would be reported to the Committee in the second half of the year.**

9. UPDATE ON CORONAVIRUS AND 'FLU VACCINATION

The Chairman invited Dr Djuretic to speak on the item.

Dr Djuretic spoke to her slides, which had been circulated to the Committee, and to a written update on 'flu vaccination that she had received from Colette Wood, Director, Barnet Clinical Commissioning Group (Barnet CCG).

Dr Djuretic reported that Covid testing had been decreasing due to there being fewer cases of Covid-19. Hospital admissions had also decreased with currently 130 patients in hospital with illness related to Covid-19, and 16 patients at the Royal Free Hospital requiring mechanical ventilation. Dr Djuretic noted that cases were decreasing slowly with a few in Care Homes but with schools in particular being hit the hardest. There are currently 61 reported Covid-19 cases in Barnet Schools, though Dr Djuretic noted that reporting lines to the Department for Education had recently changed, so there may be more.

She reported that the Covid-19 vaccination uptake is currently 74.4% in Barnet, with 'flu vaccination uptake at 45%. There appear to be fewer inequalities than at the beginning of the programme. A Vaccine Clinic for people with learning disabilities had also been set up in Barnet.

A London Draft Strategy for living with Covid-19 had been produced and would be published by the end of March. Local contract tracing was likely to stop and testing would also be reduced from June. She noted that it was not yet clear whether local authorities would have additional health protection responsibilities in the future. When the National Strategy is published, the Barnet website would be updated with new policies for Care Homes and hospitals.

A Member stated that the current policies were out of date on the Barnet website as residents had informed her that they did not know that they could visit relatives in hospital, as hospitals themselves were not aware of the policies. Dr Djuretic asked the Member to send her specific details and she would check this. She added that Care Homes are open for visits.

The Member enquired about the number of patients requiring mechanical ventilation currently and whether they were vaccinated. Dr Djuretic noted that anecdotally two-thirds of patients who were hospitalised with Covid-19 were unvaccinated. She was unable to provide more information due to data protection given that the numbers were small and so

individual identities might be revealed by discussing this. However, she added that the evidence suggests that those vaccinated and having had a booster jab typically experience very mild illness with Covid-19. Also, nine out of ten Covid-19 patients who die with any of the variants, have underlying health conditions.

RESOLVED that the written and verbal updates were noted.

10. LONG COVID UPDATE

10. LONG COVID UPDATE (AGENDA ITEM 10)

The Chairman invited Dr Djuretic to speak on the item and on a Paper entitled 'Health needs assessment of post Covid-19 syndrome in London' which had been published with the Agenda.

Dr Djuretic reported that Barnet has the highest rate of Long Covid in London. The highest-risk members of the population are middle-aged working-class females and people with pre-existing conditions such as obesity, hypertension and poor mental health. She added that only around half of the patients with Long Covid have been seen by a clinician.

Dr Djuretic noted that she would be looking into the implications for Barnet of Long Covid and would be in contact with the Royal Free London NHS Foundation Trust (RFL), to find out where the gaps in care are and whether improvements can be made. She would report back to the Committee when she has had further discussions with the Royal Free.
Action: Dr Djuretic

The Chairman suggested that it might be useful to invite a service lead on Long Covid from the RFL to the May meeting (as a representative would be attending to present the Quality Account) or the July meeting.

A Member asked what the definition of Long Covid is. Dr Djuretic responded that the National Institute for Health and Care Excellence provides guidelines on this.

Another Member enquired whether there is evidence that the Omicron variant results in fewer cases of Long Covid than other variants. Dr Djuretic responded that it is too early to know but she would report back when evidence emerges.

RESOLVED that the written and verbal updates were noted.

11. HEALTH OVERVIEW AND SCRUTINY FORWARD WORK PROGRAMME

The Chairman introduced the Forward Plan which had been published with the Agenda,

25 May 2022:

- Covid-19 and 'flu vaccination Update
- Quality Accounts – Royal Free London NHS Foundation Trust, Central London Community Healthcare and the North London Hospice

- Edgware Walk In Centre, APMS Cricklewood and Finchley Memorial Hospital Update
- Long Covid Update

6 July 2022

- Barnet Healthy Child Programme Update
- Solutions4health

To be allocated:
Suicide Prevention Strategy Update
Mini Oral Needs Assessment (during the second half of 2022)

RESOLVED that the Forward Plan was noted.

12. ANY OTHER ITEMS THAT THE CHAIRMAN DECIDES ARE URGENT

The Chairman reported that she had had an update on the Edgware Walk In Centre from Beverley Wilding and Colette Wood, Barnet CCG.

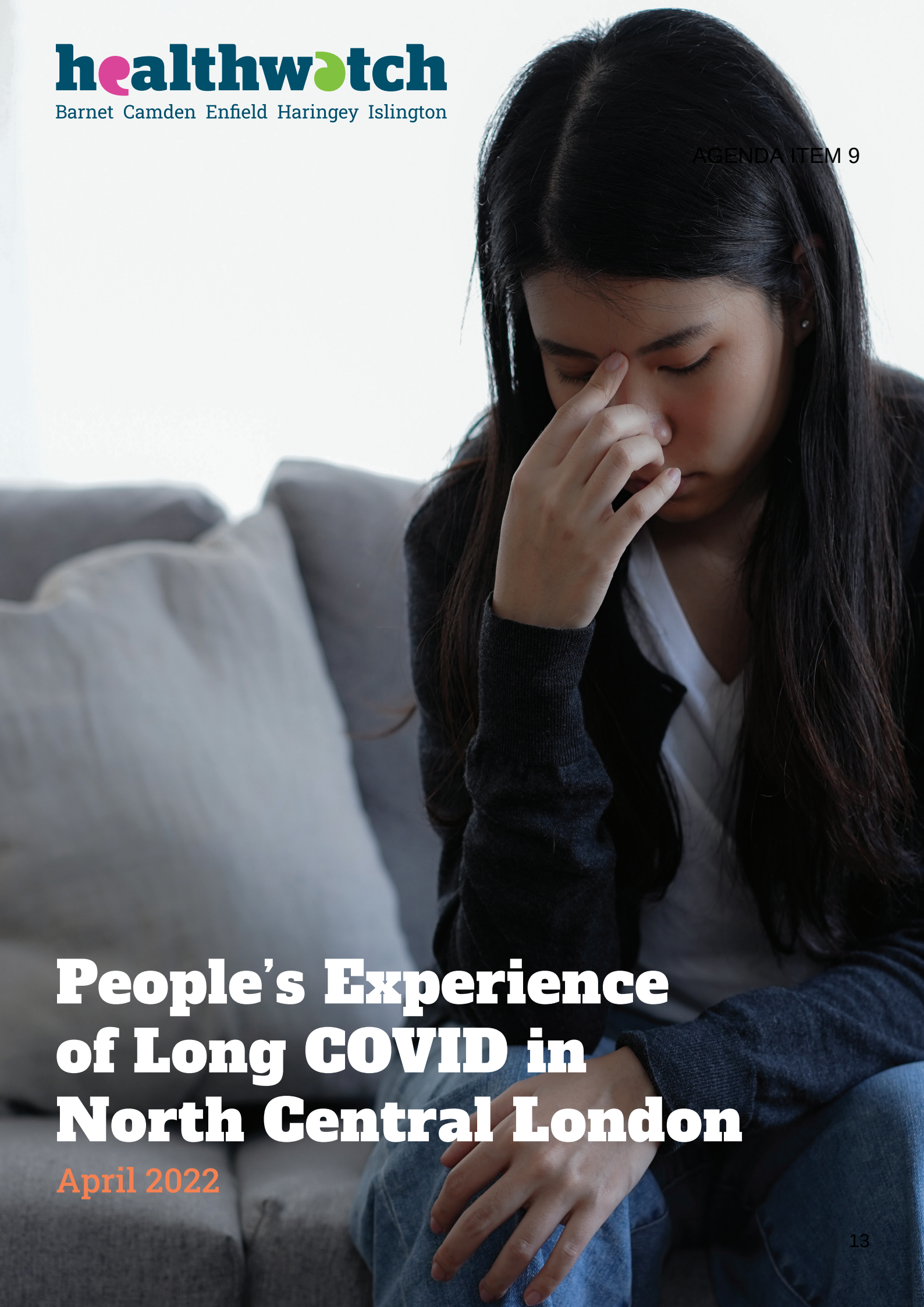
The Walk In Centre had been closed on 26 December 2021 because of omicron. The decision was taken by North Central London GOLD and the Staff had been redeployed to administer booster vaccinations to the housebound.

On 10 February 2022, the date of the HOSC meeting, NCL GOLD had met to discuss the date of reopening the Walk In Centre and redeploying the staff. The Centre is currently due to reopen on 28 February 2022, at the latest. Beverley Wilding and Colette Wood would confirm the exact date as soon as they know.

They also informed the Chairman that they will attend the HOSC on 25 May, together with a representative from Central London Community Healthcare (CLCH), in order to give a further update to the Committee.

The meeting finished at 8.30 pm

healthwatch
Barnet Camden Enfield Haringey Islington



People's Experience of Long COVID in North Central London

April 2022

Contents

Healthwatch Barnet

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healthwatchbarnet.co.uk

Healthwatch Camden

85-87 Bayham Street
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London
NW1 0AG

020 7383 2402

healthwatchcamden.co.uk

Healthwatch Enfield

Community House
311 Fore Street
Edmonton, London
N9 0PZ

020 8373 6283

healthwatchenfield.co.uk

Healthwatch Haringey

Tottenham Town Hall
Town Hall Approach Road
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N15 4RX

020 8888 0579

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Healthwatch Islington

6-9 Manor Gardens
Islington
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N7 6LA

07538 764436

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Background

Long COVID is a new and evolving condition that can greatly impact the health and quality of life of many people. The precise causes of Long COVID are not yet known and the recovery time varies for each patient. More research is required to develop a standardised treatment pathway from diagnosis to treatment and management of the condition.

There is currently no agreed clinical definition, however the National Institute for Health and Care Excellence recommendation is that 'Ongoing symptomatic COVID-19' be used when symptoms continue after 4 weeks of contracting COVID-19 and are not explained by an alternative diagnosis; and 'Post-COVID-19 syndrome' is used when symptoms continue beyond 12 weeks or newer symptoms develop. Both are commonly called Long COVID by laypeople.

Long COVID presents itself through a wide range of clustered symptoms. A study conducted by University College London[1] identified Long COVID patients self-reported over 200 symptoms across 10 organ systems[2]. The most recent data from the Office for National Statistics show that an estimated 1.5 million people self-reported experiencing Long COVID symptoms as of 31st January 2022[3].

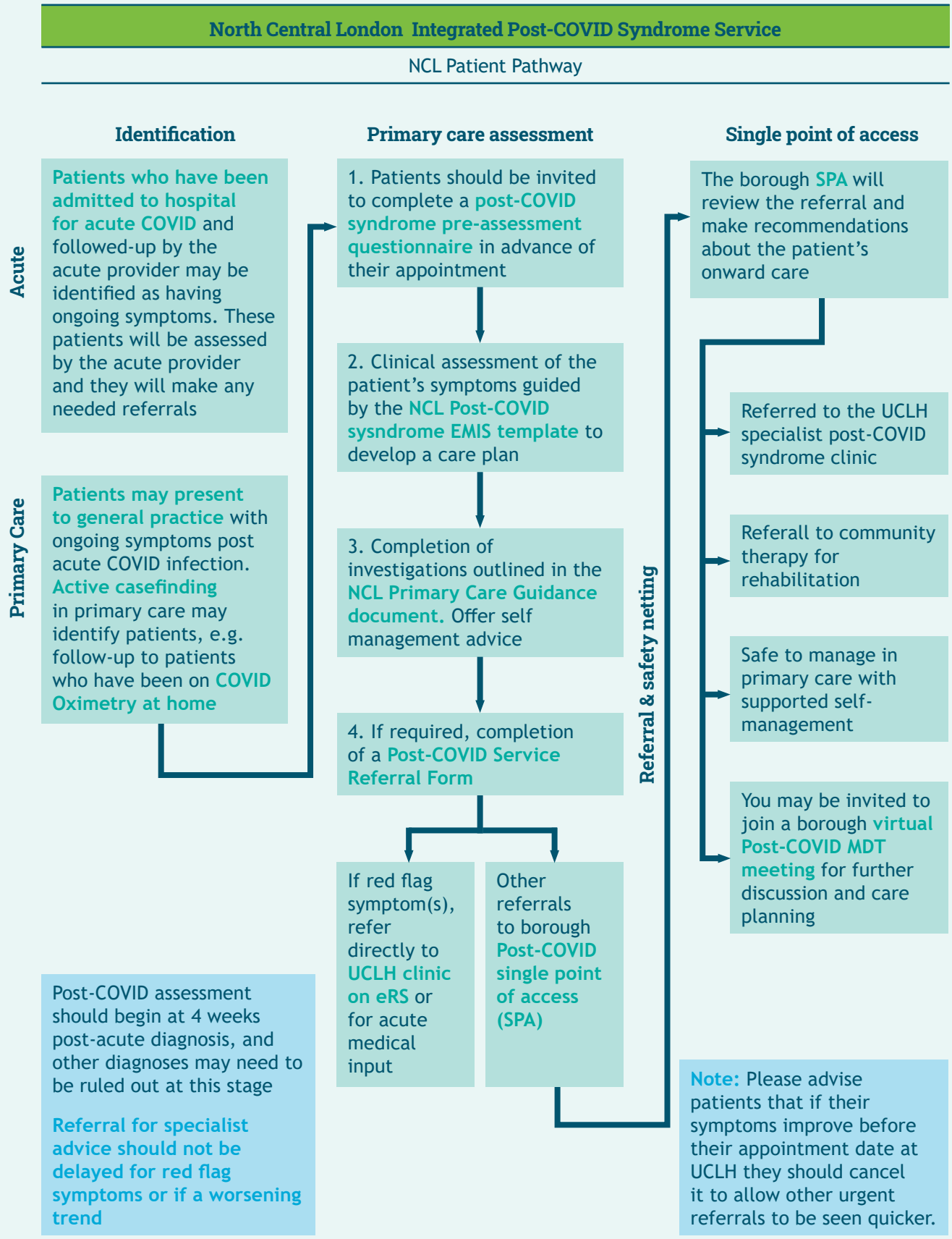
To tackle the debilitating impact of the condition, the Long COVID NHS Plan for 2021/22 outlined an investment of £100 million to support patients. There are now approximately 90 Post-COVID Specialist Clinics across England that support patients where previous medical care did not aid their recovery. These specialist clinics provide physical, cognitive and psychological treatment. The plan also outlines the establishment of paediatric hubs to support children and young people suffering from Long COVID.

University College London Hospitals (UCLH) provides the Post-COVID Specialist Clinic service for residents across North Central London (NCL). The chart below shows the Long COVID patient pathway.

[1] www.nice.org.uk/guidance/ng188/resources/COVID19-rapid-guideline-managing-the-longterm-effects-of-COVID19-pdf-51035515742

[2] www.ucl.ac.uk/news/2021/jul/identification-over-200-long-COVID-symptoms-prompts-call-uk-screening-programme

[3] www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/3march2022


North Central London Integrated Post-COVID Syndrome Service
NCL Patient Pathway
Identification
Primary care assessment
Single point of access
Acute
Primary Care
Patients who have been admitted to hospital for acute COVID and followed-up by the acute provider may be identified as having ongoing symptoms. These patients will be assessed by the acute provider and they will make any needed referrals
Patients may present to general practice with ongoing symptoms post acute COVID infection. Active casefinding in primary care may identify patients, e.g. follow-up to patients who have been on COVID Oximetry at home
1. Patients should be invited to complete a post-COVID syndrome pre-assessment questionnaire in advance of their appointment
2. Clinical assessment of the patient's symptoms guided by the NCL Post-COVID sysndrome EMIS template to develop a care plan
3. Completion of investigations outlined in the NCL Primary Care Guidance document. Offer self management advice
4. If required, completion of a Post-COVID Service Referral Form
If red flag symptom(s), refer directly to UCLH clinic on eRS or for acute medical input
Other referrals to borough Post-COVID single point of access (SPA)
Referral & safety netting
The borough SPA will review the referral and make recommendations about the patient's onward care
Referred to the UCLH specialist post-COVID syndrome clinic
Referall to community therapy for rehabilitation
Safe to manage in primary care with supported self-management
You may be invited to join a borough virtual Post-COVID MDT meeting for further discussion and care planning
Post-COVID assessment should begin at 4 weeks post-acute diagnosis, and other diagnoses may need to be ruled out at this stage
Referral for specialist advice should not be delayed for red flag symptoms or if a worsening trend
Note: Please advise patients that if their symptoms improve before their appointment date at UCLH they should cancel it to allow other urgent referrals to be seen quicker.

What we did

The five Healthwatch organisations across NCL (Healthwatch Barnet, Healthwatch Camden, Healthwatch Enfield, Healthwatch Haringey, and Healthwatch Islington) agreed in the summer of 2021 to work in partnership together on a joint NCL Long COVID project.

The core aims of this project were:

- To capture local people's experiences of Long COVID in order to identify any gaps in current provisions.
- To support the better development of services and systems to help local people to manage their symptoms.

To gather insight on local NCL residents' experiences of living with Long COVID, we jointly agreed on a hybrid methodology: an anonymous online survey, 1-2-1 interviews and community focus groups.

Survey respondents had the option to participate in a follow-up 1-2-1 interview to enable us to gather detailed in-depth qualitative data.

We also shared our draft survey with the North Central London Clinical Commissioning Group, who developed the local patient pathway, and we implemented their feedback in our online survey.

Each Healthwatch worked with local voluntary sector organisations to broaden their reach and gather robust responses, and we entered every person who took part into a prize draw to win one of five £50 gift vouchers to increase engagement.

We also engaged and shared our survey with local press and statutory healthcare services that support people with Long COVID.

We aimed to gather experiences of people across the whole treatment pathway, from those seeking support in primary care from their GP, those receiving support in the community, those who required support from a specialist Long COVID clinic, and those who had never reached out for help and were managing symptoms on their own.

The survey covered the impact of Long COVID on patients' lives, their physical and mental health, access to NHS treatment, experience with healthcare professionals and suggestions for improvement. Subsequent 1-2-1 interviews and focus groups loosely followed a similar structure of questions. In total, we gathered 300 local peoples' experiences of Long COVID across NCL. The data from this report was collected from September 2021 to February 2022.

Local Healthwatch	Survey Reponse	1-2-1 Interviews	Focus Groups	Community Event/Others
Healthwatch Barnet	63	18	2	1
Healthwatch Camden	79	5	0	3
Healthwatch Enfield	53	0	0	0
Healthwatch Haringey	21	4	0	0
Healthwatch Islington	38	14	1	0

Respondent profiles

For our online survey, we provided an option for the respondent to contribute additional information if they wished to share their details or they could skip this section. We gathered demographic data from approximately 190 of 254 respondents.

A full breakdown of the demographic data can be found in the appendix 2.

- **87%** of people surveyed answered on their own behalf, **2%** on behalf of a child under 18, **2%** for an adult they are caring for and **7%** for others, which includes local organisation partners, staff members and family.
- More than half (**51%**) of the people surveyed were aged 45 to 64.
- **79%** of the people surveyed were female, **20%** were male and **1%** were non-binary.
- **43%** of people surveyed were from ethnic minorities.
- **24%** of people surveyed said English was not their first language.
- More than half (**54%**) of people surveyed have a long-term condition.
- One-quarter (**25%**) of people surveyed considered themselves to have a disability.

Summary of findings

Impact on Health

Physical Health

Mental Health & Wellbeing

Impact on Life

Employment & Job Security

Home Life

Experiences with the Health Care System

Accessing the Long COVID Pathway

Healthcare Support & Referrals

Useful Interventions

Diagnosis

GP Knowledge

Moving Forward

Improve GP's Knowledge

Recognise Patients' Symptoms and their Impact

Improve Awareness of the Support Already Available

Improve Access to Primary Care

Improve Access to Specialist Care Where Needed

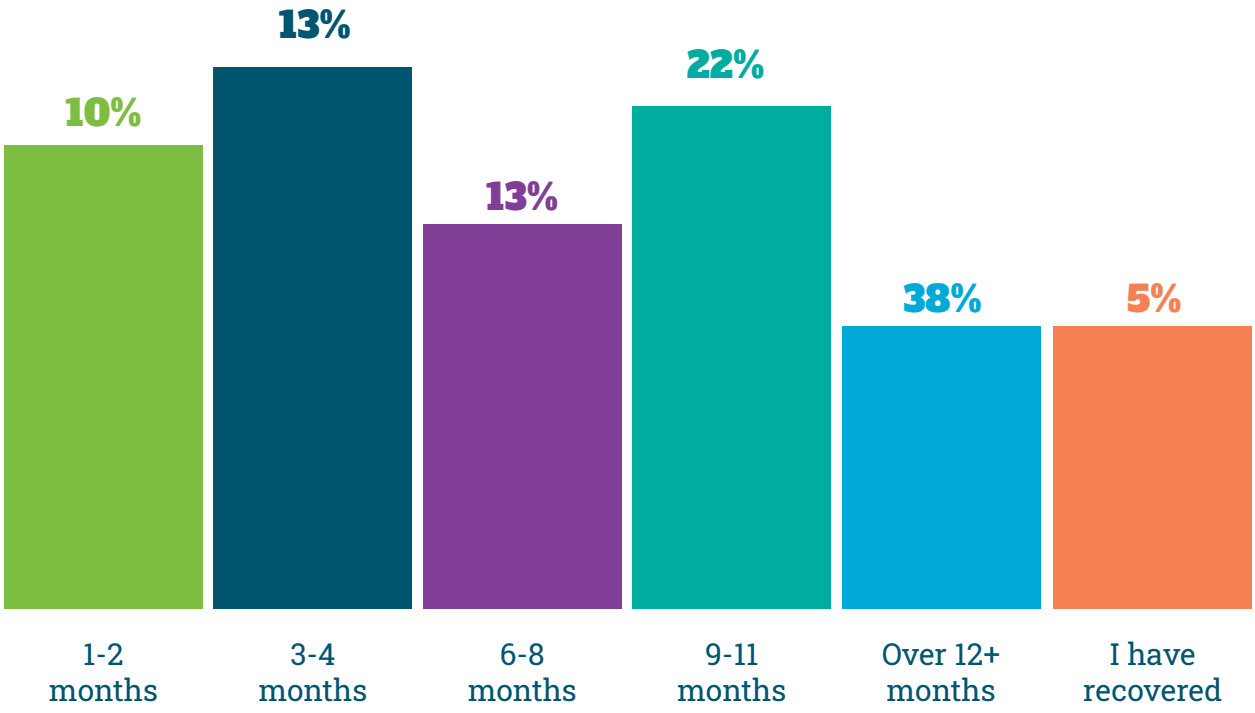
Enable Continuity of Care

Share Self-Management Techniques Early

Peer Support Groups

What we found

Almost three quarters (73%) of respondents reported that they had been living with Long COVID for 6 months or more, with various symptoms affecting their physical and mental health. People who have been long-term Long COVID sufferers describe different phases of the illness, where symptoms might change, be less frequent or more severe and where symptoms may not present during the transition from acute COVID to Long COVID.



Physical Health

Patients described an array of physical symptoms, most of which are in line with the current understanding of Long COVID symptomatology, such as fatigue, tiredness, muscle and joint aches, coughing, 'brain fog', shortness of breath, general pain, pins and needles, dizziness, gastric distress, sleeping difficulties, tinnitus and rashes.

Recurring earache, mucus at the back of throat, tiredness, headaches, sore throat, wheezing/shortness of breath.
Islington Resident

Fatigue, poor concentration, insomnia, impaired taste and smell, abnormal toes.
Camden Resident

Severe pins and needles in my arm which was so painful that I went to A&E as I couldn't walk without extreme pain. This lasted nearly 6 months. Additionally fatigue and sleep problems for 6 months.
Barnet Resident

Breathlessness and other respiratory difficulties, severe fatigue, muscle pain, fever, severe loss of taste/smell, severe problems with memory and concentration, severe anxiety, chest tightness/heart palpitations, headache, mild insomnia, moderate memory loss, Low mood anxious/fear. Fever, tightness in the chest, headache, and breathlessness - has improved. Fatigue. Tiredness, little appetite, anxiety, brain fog has continued.
Barnet Resident

I am tired all the time. I am breathless, have palpitations chest pains, pain in muscle and bones. I suffer from brain fog and forget all the time. Mentally and physically I am tired I am stuck in this nightmare can't make plans and don't know when it will end.
Haringey Resident

The symptoms make me tired and brain fog, random spasms aches and pains stiff joints. Palpitations. Insomnia. Migraine. Chest and thought tightness/ feels like blocked. Reoccurring coughs with mucus.
Camden Resident

I am constantly tired and need to sleep more, my joints hurt, I still have a persistent dry cough which wakes me so my sleep at night is disturbed every night. It's difficult to explain but my bones hurt I have headaches and earaches which is making me feel useless like I can't do anything anymore as every time I start to do anything I cannot finish it because I get too tired and I have to stop and sit down. Enfield Resident

I have been unable to smell at all for months and my taste has been affected by a bad aftertaste on everything I eat. Islington Resident

Body aches, have to make a real effort to do things. Headaches. Difficulties concentrating. Loss of taste. General lethargy. Enfield Resident

I felt exhausted. Had no energy and couldn't walk very far. I had digestive problems such as severe stomach acid. I felt nauseous after eating. My chest hurt. I couldn't smell anything. Barnet Resident

I wake up EVERYDAY with a splitting migraine. Although I did get migraines, they were perhaps once a quarter or so. I also get random bouts of nausea. The feeling is strong and very sudden. So I have to lock myself in a toilet and just heave. I get fatigued for no reason. It's not like being just tired- it's the inability to get up and take care of yourself. I often have to lie down or drink something sugary. Barnet Resident

I cannot smell and taste which affects my enjoyment. I now have developed Parosmia and so things that should smell nice, perfume, shampoo, and certain foods make me feel ill and are so overpowering. They do not smell as they should. Enfield Resident

At the age of 35, I'm not able to live a normal life. I'm in so much pain and I'm so exhausted that all I can do is force myself to work from home and stay in bed. All the joy is gone, there is only pain, exhaustion and anticipation of more pain. I used to be an active smart person now due to the brain fog I feel like an idiot most of the time. Haringey Resident

Mental Health & Wellbeing

A secondary impact of developing Long COVID is the effect it can have on a person's mental health. Respondents often reported struggling, particularly compared with who they were before to who they are now. Effects on patients' wellbeing include: lower self-esteem and confidence, reduction in engagement with their family, friends and other social activities, increased anxiety and low mood, as well as depression.

> This has had a knock-on effect on my mental health. Not being able to work, take care of my household or family is very frustrating and relying on others is demeaning.
> Barnet Resident

> My mental health has been bad as a result. I've been depressed and anxious, started self-harming a bit, have given up on trying to look after my physical health at times. I feel like my physical and mental health has been really low. And that there is very little support. I am lucky to have some friends even if they are not close by. One tried to phone the local mental health crisis team for me.
> Enfield Resident

> Confidence and self-esteem are low. GP didn't believe me.
> Barnet Resident

> I have never been diagnosed with depression or anxiety, I have always been really positive and energetic. This whole year however I have viewed things really differently I have looked at things really negatively and have had really intrusive bad thoughts, obsessive thoughts. I have been really down (this is not due to lockdown as I have continued to work through the pandemic as frontline staff for a homeless charity) so I have kept active but I have become a shell of a person.
> Camden Resident

All of these physical health symptoms have impacted my mental health. I get really down from not being able to do as much as I'd like with my son, or have to be really picky on what plans I make with friends. I get really anxious and stressed about how much I am behind in work and other aspects of life, which then impacts my relationships with friends and family. Long COVID has crept into every aspect of my life in silent, insidious ways - it's debilitating & demoralising.
Camden Resident

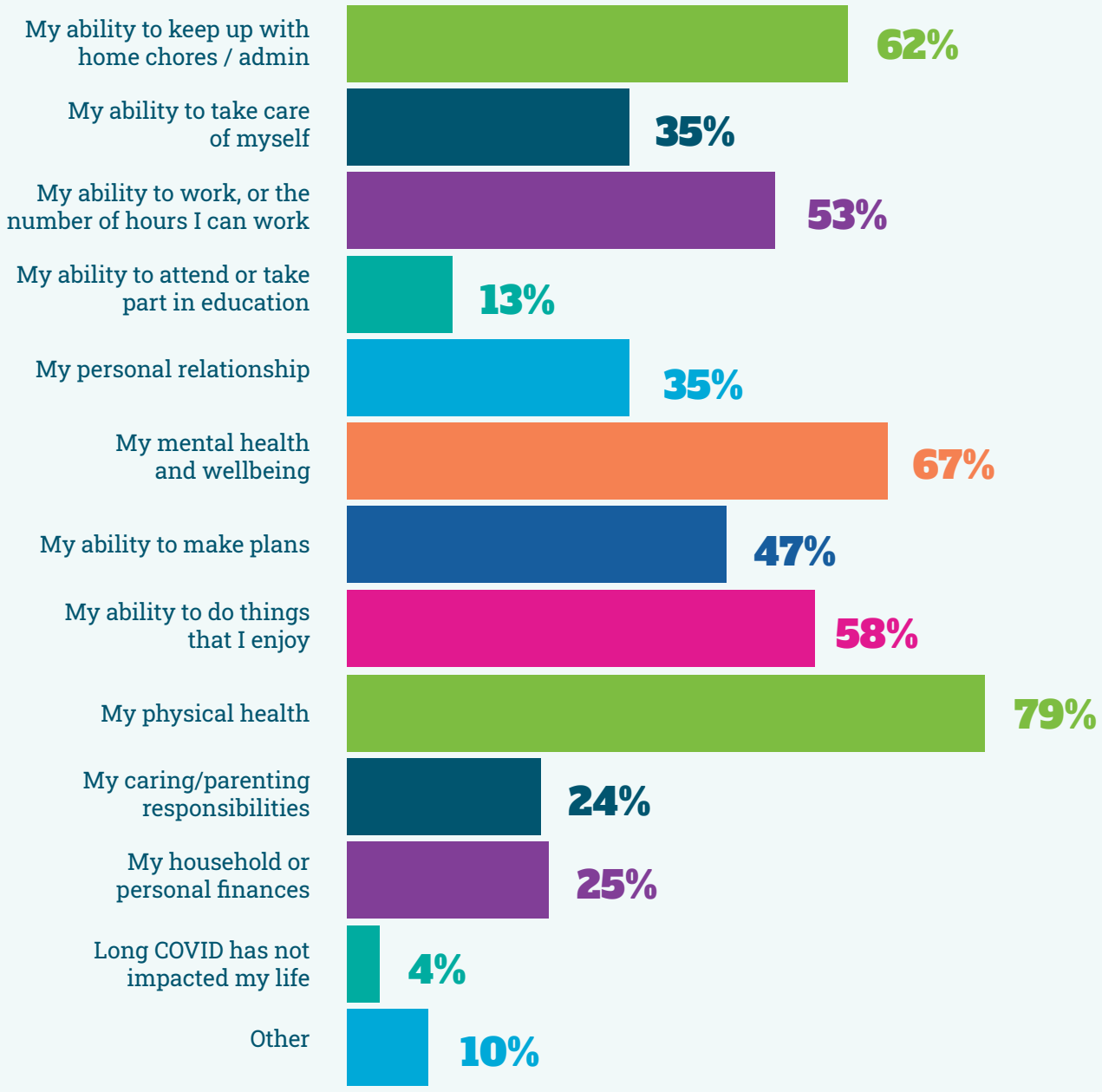
All these of course have had an impact also for my mental health made me feel depressed. Because Long COVID is a relapsing illness, it is extremely hard to mentally cope with a relapse in the symptoms after a better period (when I have thought that finally I am almost back to normal and then the daily pains and exhaustion are back again).
Barnet Resident

It's a yo-yo: anxiety is there all the time but I never know what else I'm going to feel eg anger/irritation/depression/ gnawing anxiety/irritation/apathy/ bouts of crying etc.
Haringey Resident

My mental well-being is pretty bleak because of the gaslighting and lack of support I received. I can manage mentally with the ups and downs of Long COVID but being denied adequate support is hard to bear. I feel useless and hopeless.
Camden Resident

Impact on Life

Long COVID has negatively impacted patients' lives, from their employment status, job security, finances, relationships with the family and friends, to their home life completely debilitating some patients' lives.



Employment & Job Security

The various symptoms patients experienced caused challenges in their ability to work, leading to some respondents having to reduce their working hours, voluntarily stop working or be made redundant. Consequently, this had an adverse impact on some respondents' household finances.

Those in active employment have felt pressured to return to work due to the lack of understanding of the challenges Long COVID can present. Many also worried about the number of days which they have taken off work, which for some could result in disciplinary action.

Furthermore, respondents whose job relied on skills that Long COVID particularly impacts, such as memory, cognitive skills, or strong physical strength, found it more difficult to go back to work or maintain their employment. Examples included acting, DIY/handyman, medical professionals and interpreters. Those who were on a zero-hour contract were impacted the most as they only get paid for the days they have worked and do not receive the wider benefits associated with a permanent role.

> Yes, I lost my job after 25 years.
> Islington Resident

> I was unable to work for 40 days.
> Camden Resident

> Too many sick days and fear of being replaced.
> Barnet Resident

> I have had to drop down my hours at my job due to COVID.
> Camden Resident

> It has put me on universal credit. I am self-employed and having Long COVID meant that I accrued a work debt that I am still trying to pay off. I was unable to claim for a self-employment grant or anything similar because I didn't fit the narrow criteria.
> Haringey Resident

> Long COVID has badly affected the organisation I used to work for and I, along with many others, accepted voluntary severance.
> Haringey Resident

> I was a sign language interpreter so I'm not able to process two languages at once at the moment and because I suffer from chronic fatigue, I just don't have the energy to be processing.
> Barnet Resident

> I work as a nurse but I'm on a zero-hour contract so I only get paid for the days I work and I can't always manage much.
> Islington Resident

Notwithstanding, not all respondents experienced negative concerns about their employment and job security. Some were retired, on furlough or in receipt of welfare benefits. A few found their employer to be understanding and made accommodations to enable them to work flexibly.

> It hasn't impacted my job as such, because my job is quite flexible. Some days my productivity is very low because my energy and mood are low, but I can make it up out of hours or not do lower priority tasks. In another job, I might well have had to stop working or reduce my hours.
> Enfield Resident

> I'm new in my post, I've only been in my job for like a couple of months. And I didn't tell them immediately. But obviously, I had to tell them that, I didn't have to, but I decided to because they are so nice. And they've been really supportive and understanding.
> Barnet Resident

> I'm very lucky as I work 2-night shifts a week and I can spread them out if I have a bad spell.
> Islington Resident

> Work has been very understanding as I have been able to work from home.
> Haringey Resident

Home Life

Participants described struggling with a range of activities in their home life. These included personal care, leisure activities, maintaining a healthy lifestyle including regular exercise, life planning, relationships, caring responsibilities and education.

> I've had to move home, I was in rented accommodation. I couldn't afford to stay there, I also couldn't look after myself and remain independent. So around the house, I rely on other people to help me like they do the shopping, cooking cleaning. I have help washing as well, sometimes on bad days. So it's been a huge life change from being very independent to relying on people around me for support.
> Barnet Resident

> Not being able to work, take care of my household or family is very frustrating and relying on others is demeaning.
> Barnet Resident

> I now have limited mobility I use a stick or a wheelchair to get around for longer distances. I've had to move home. This is a huge life change to rely on family members so in turn has affected my mental well-being. Barnet Resident

> I can't exercise as my heart rate goes up and I get chest pain and then so exhausted after a short amount of slow walking. I'm gradually building this up but over 5 months I can still only walk for 30-40 minutes. I'm gaining weight. I am so down a lot of the time, feel guilty for not working and sad about missing so many of my usual social activities. My relationship is suffering as I'm so down and not at all fun. Haringey Resident

> Can't do the things I used to be able to do - even though I was young, fit and healthy before catching COVID.
> Enfield Resident

> I've been exhausted for 11 months and it has been a struggle to do daily life maintenance tasks such as cleaning, changing the duvet covers, hoovering. My normally very active social and cultural life has been reduced enormously and I have become somebody who watches TV most nights having not watched TV for 30 years! Camden Resident

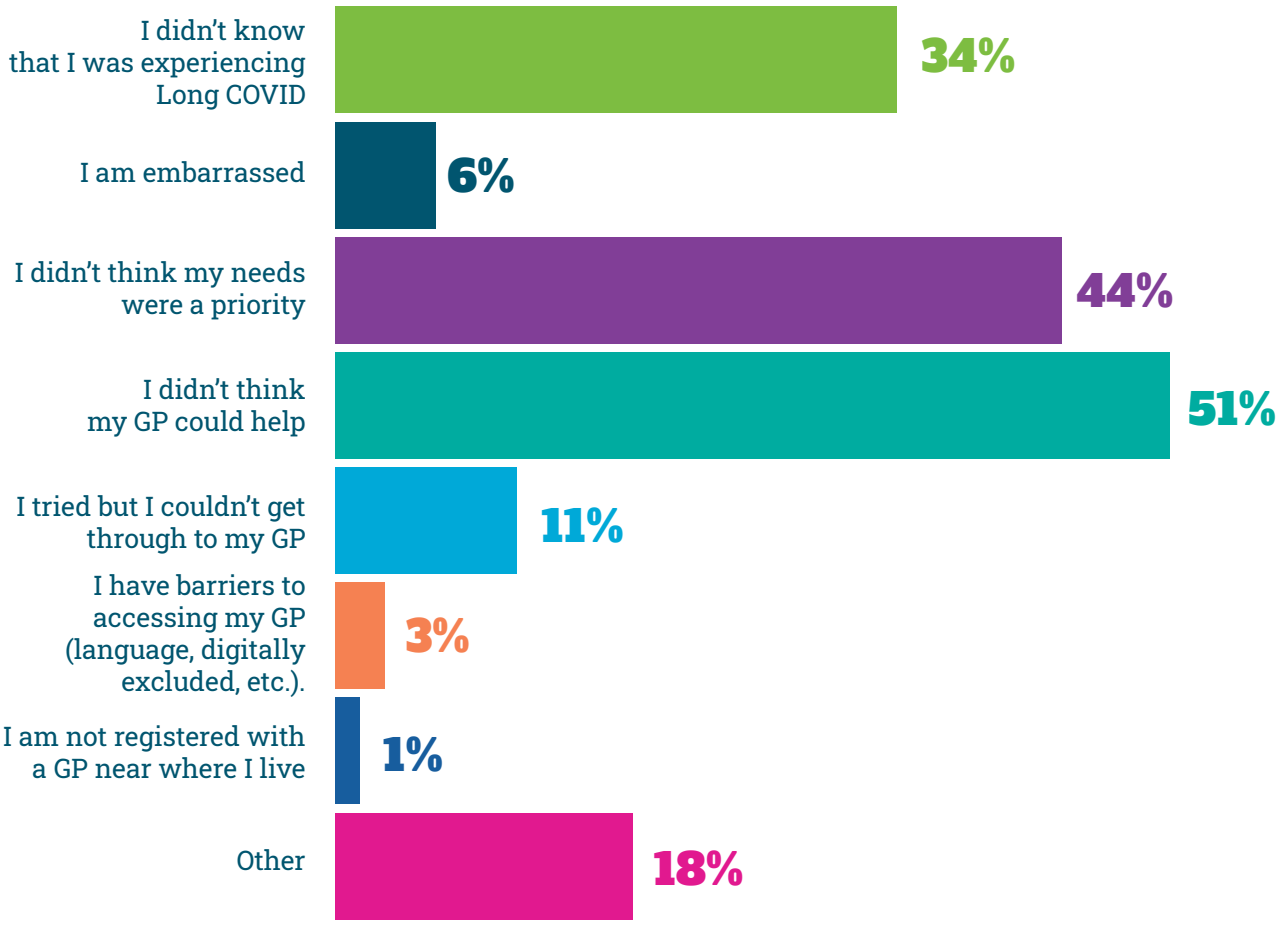
Experiences with the Healthcare System

Respondents described their experience of accessing and using the healthcare system, with challenges in receiving a diagnosis and referral and a lack of knowledge of Long COVID among GPs, causing low satisfaction rates amongst patients. Respondents also discussed interventions that had helped their condition and any self-management techniques they had used.

Accessing the Long COVID Pathway

67% of respondents went to see their GP or other health care professional about their Long COVID symptoms.

33% of respondents did not see their GP or other health care professional about their Long COVID Symptoms. A breakdown for the reasons why these people did not contact their GP is below, with **51%** of respondents reported that they did not think their GP could help them followed closely by respondents reported they did not think their needs were a priority, which was common amongst most of the nation during the initial lockdowns when people otherwise would have sought medical help.



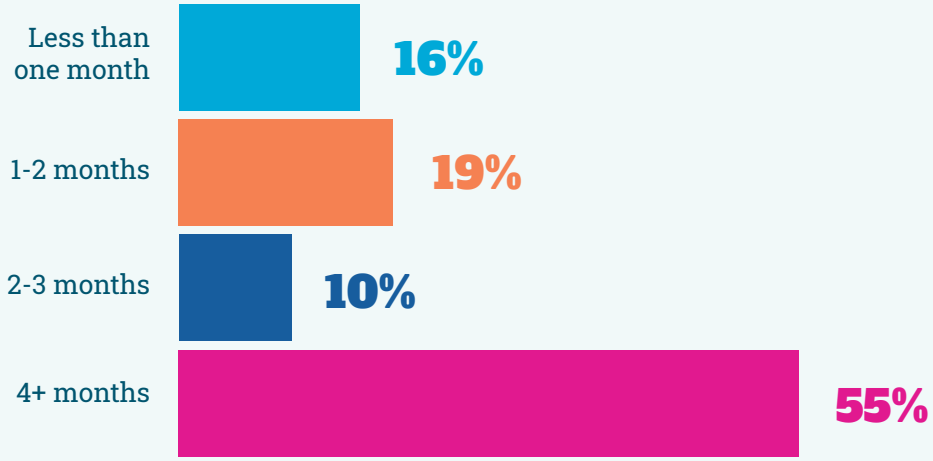
Diagnosis

Of those who went to their GP or other health care professionals, **61%** of respondents were formally diagnosed with Long COVID.

Some of our one-to-one interviews showed that those who got COVID early in the pandemic, 'first-wavers', had difficulty getting COVID-19 tested. For some, this has caused an extra barrier to diagnosis and help, which left them feeling forgotten.

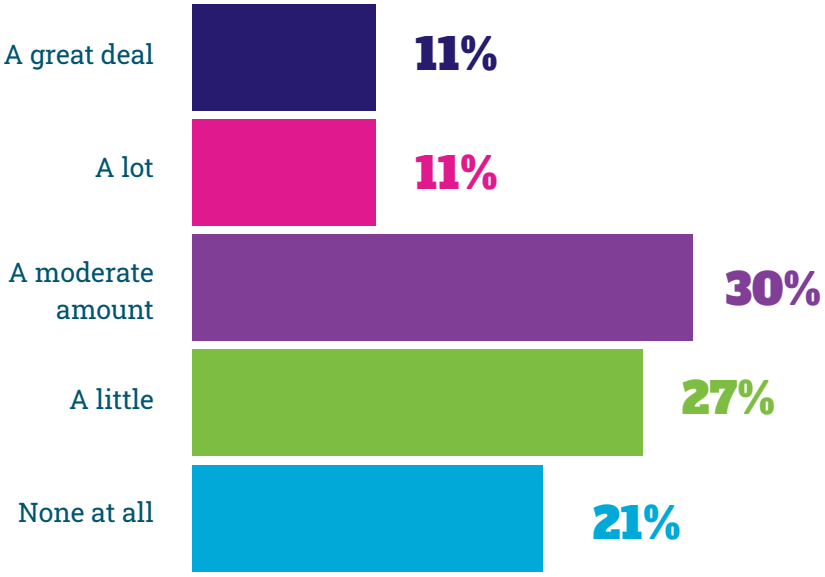
More than half (**55%**) of the respondents who have gone to their GP and been diagnosed with Long COVID reported it took 4 months or more to receive the diagnosis.

The lack of a timely diagnosis has contributed greatly to many peoples' negative experiences. Better processes and systems need to be put in place to enable diagnosis of Long COVID for patients.



GP Knowledge

A common theme that was repeated by respondents was the feeling that GPs lacked the knowledge to help patients with Long COVID. **27%** of respondents said they think GPs had 'a little' knowledge about the symptoms and effects of Long COVID, and **21%** of respondents said they think GPs had 'none at all' about the symptoms and effects of Long COVID.



Consequently, almost three quarters (**73%**) of respondents reported they had to conduct their own research into Long COVID. There were multiple reasons why people felt the need to conduct their own research which include experiencing symptoms unaccounted for; not having been given sufficient information about their condition from their GP; taking ownership of one's own health needs, looking for treatment options; an awareness of the novelty of the condition and therefore cognisance that medical professionals may not have all the answers; looking for other people with similar experiences for support and sharing of treatment and self-management ideas.

> Initially, there was limited support from the GP practice. I 'saw' three different doctors until one understood what I was experiencing.
> Camden Resident

> Complete lack of advice and support on how to manage my symptoms. I've been told to rest, to drink lots of water and eat well. This is advice you'd give anyone and isn't at all helpful. I haven't got a clue what to do - should I try to exercise more? How to manage breathing problems? Is chest pain a concern?
> Camden Resident

> I feel very unsupported and alone and need to manage the 20 plus symptoms endured in some way during the past 20 months.
> Camden Resident

> As no local support groups offered and I felt just left to my own after hospitalisation.
> Islington Resident

> My GP is unaware of Long COVID and where to refer me to, and they have yet to tell me my symptoms are actually Long COVID. So I have been researching online to find out more information and see if there are other people like me. I also wanted to find out what I could do to help myself. GPs really lack knowledge here and need training by the NHS.
> Barnet Resident

> I work in a medical setting so this has been easier for me. I have been struck by the lack of knowledge re Long COVID and the lack of compassion shown by some GPs. They have been dismissive, lacking in any management plan and keen to psychologise my symptoms. I've had to push for the referrals. I worry about those patients who are not able to advocate for themselves.
> Haringey Resident

> I had several visits to the GP but did not improve or receive any diagnosis. The GP advised there was nothing they could identify and I had to contact them again if symptoms persisted. It was only after approx 6-9 months that a rheumatology referral was made following repeated visits to the GP. During this time I had to research chronic fatigue & Long COVID myself for further information.
> Barnet Resident

> I wanted an NHS self-help type of leaflet you get for medical problems but my GP said she didn't have one so I started to look online for advice.
> Barnet Resident

> When I spoke with my GP she didn't have much to offer me. So I went online and found support groups like the Long COVID support network where I've learned so much.
> Barnet Resident

> Not much help from NHS until 10 months in.
> Islington Resident

Healthcare Support & Referrals

Respondents described difficulties in accessing healthcare support and referrals:

- Half (51%) of the respondents had difficulties in getting appropriate healthcare support for Long COVID such as referral to the specialist Post COVID Clinic, Community Teams, diagnostic testing within primary care, or being informed of general self-guided support.
- Respondents not being made aware of the available support.
- Reluctance to recognise and poor understanding of Long COVID by GPs.
- Significant delays in referral acceptance from primary care to secondary care.
- Poor communication between the Long COVID Clinic, GP services and other secondary care providers that left patients without adequate support resulting in the patients needing to chase up for results and follow-up appointments.
- Pre-existing challenges with patients trying to book appointments with their GPs.
- Lack of treatment options once patients are at the Long COVID Clinic because unlike other conditions managed in secondary care by Consultants who have access to treatment not available at primary care, the Long COVID Clinic Consultants have limited options and resources to treat Long COVID.

> "I didn't get referred to that long COVID unit until I think maybe March 2021. I spent a whole year until I got any kind of real support. That November 2020 when they discussed Long COVID, I got referred to respiratory but I've never ever been seen by respiratory because my referral, in the end, got cancelled. It kept getting moved due to the lockdowns and I just got a letter saying that has been cancelled. I didn't bother to chase it because I was under Long COVID unit and I just was a bit tired of chasing everything myself." Barnet Resident

> "I had to speak to 3 GPs at my practice before I was referred to the Long COVID clinic (roughly 5-6 months after suspected onset). Since being referred to the Long COVID clinic I have had to self-initiate follow up during a serious relapse and self-initiate treatment options which I had been refused by my GP. I am also still yet to hear from the community team that I had supposedly been referred to in March 2021 by the clinic." Camden Resident

> I had to wait 3 months to be referred by my GP to Long COVID clinic and then another 2 months before a call/appointment. After the excitement of being finally seen by the 'experts' and a few tests being organised (and a lot of signposting for me to do), there was nothing for months. No feedback on test results, I did message and got another phone appt. 10 months in and feel completely despondent with the clinic in so many ways.
> I need someone to help me with the physicality of Long COVID not just the emotional aspects of Long COVID.
> Haringey Resident.

> I contacted Queen Square over a year ago - 'Brain Fog' focus as long COVID clinic opens at London hospital' an article by Ross Lydall Health Editor but was told I did not qualify for enrolment.
> Camden Resident

> I had a fairly quick referral to the Long COVID clinic at UCLH, but when the results did not show any issues, I was left to find ways to manage the recurring symptoms myself.
> Islington Resident

> My first two referrals were turned down by the hospital but my GP never did anything to address this. So after 7 months of waiting for someone from the Long COVID clinic to contact me, I found out by myself that the referrals had never been accepted. My GP left me without any care. They did however prescribe medication for depression after asking 10 questions about my mood over the phone while I was suffering from terrible pain and high fever. I was recently referred to the clinic by a new GP, however, I don't actually believe anything will happen. I also got referred to have blood test done however that was cancelled too, due to a shortage of the testing tubes.
> Haringey Resident.

> The whole Long COVID clinic experience has been almost non-existent and has had a terrible effect on my mental health.
> Barnet Resident

> I have seen my husband struggle for over a year to get his referral to the Post COVID clinic. I didn't even want to attempt to tell them about me because of all the extra barriers. I haven't got the energy to fight to be seen.
> Islington Resident

> Such a nightmare getting a referral to cardiology for my heart problems. Numerous phone appointments were made and then after waiting at home all day for a call, I never received one. Then I got a call at 8 am unexpectedly so wasn't prepared with what I wanted to say and didn't mention all my symptoms - I'm more confused and foggy in the morning. Feels so unfair not to have a warning. Waiting for months still for an appointment at Long COVID clinic, still no news on that - I first saw my GP in July.
> Haringey Resident.

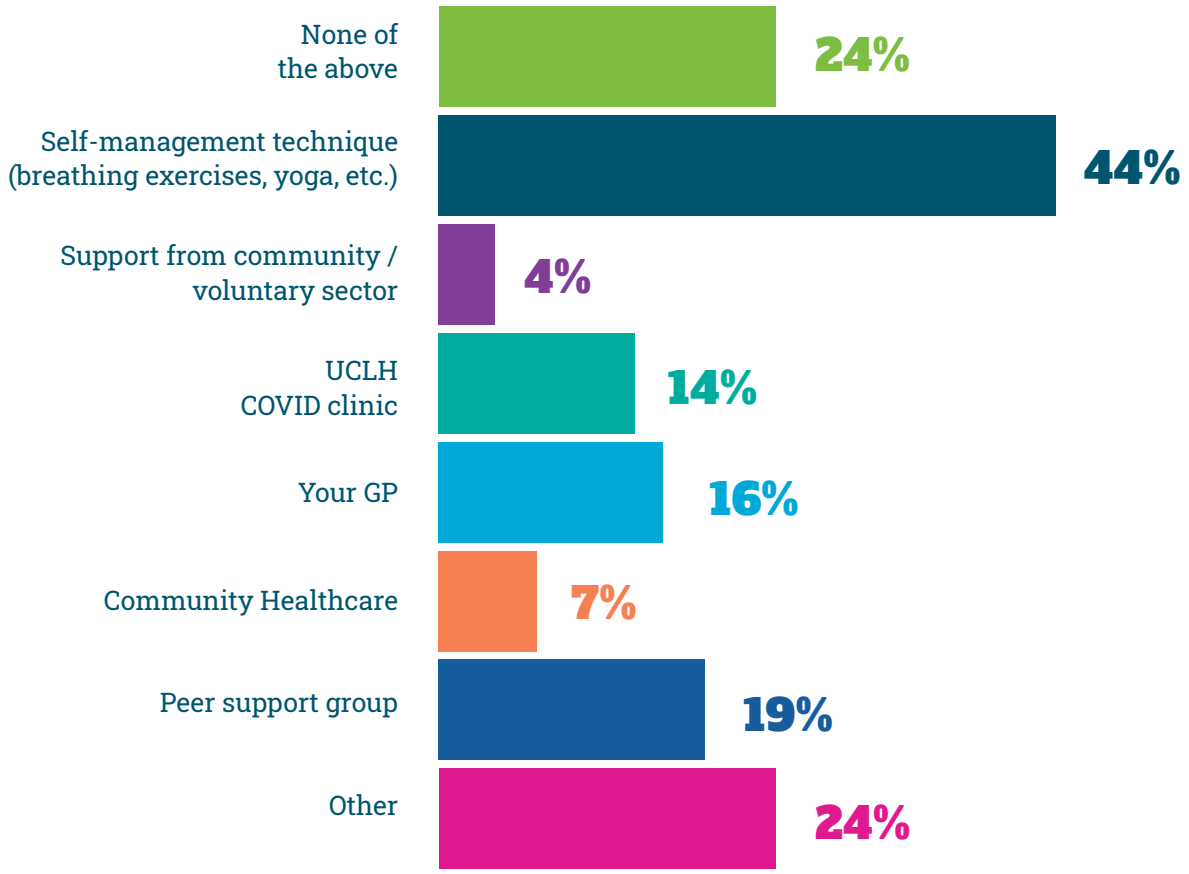
Useful Interventions

44% of respondents said the most helpful intervention to support their Long COVID recovery was self-management techniques, and **61%** of respondents found out about the self-management techniques themselves. People were desperate for answers, for coping strategies, and to understand how long this condition might last. Many patients, desperate for relief, paid large sums out of pocket for additional services such as acupuncture, supplements, massage and more. This further exacerbates health inequalities as not all people can afford such additional treatment.

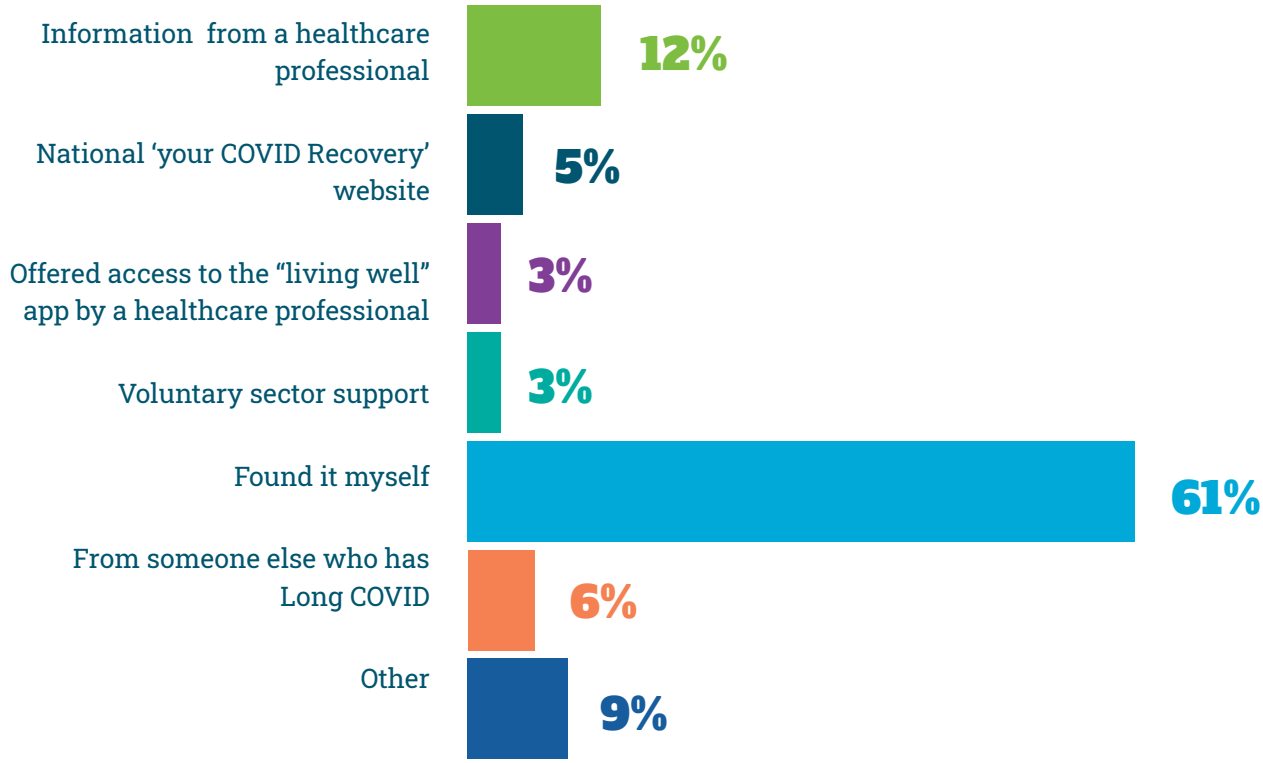
> I was desperate to make progress... Didn't want to just sit around being helpless.
> Camden Resident

> There are long gaps between having COVID, seeing GP, referral bloods & x-ray, being seen etc so I carried out my own research to try and plug the gap. It helped me get a rough idea of what type of things I could / should do at home to help manage the condition.
> Camden Resident

What interventions have helped the most with your Long COVID recovery?



How did you access and learn about self management techniques?

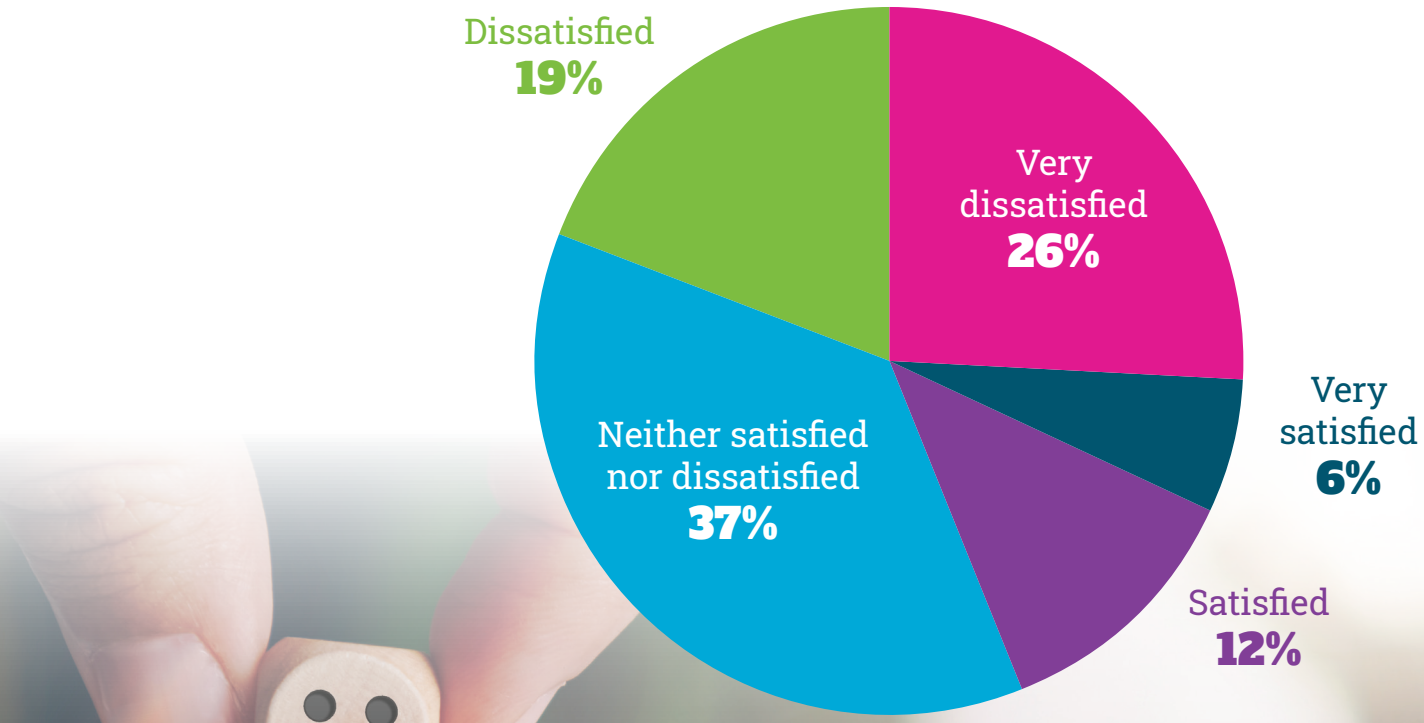


Moving Forward

Overall Sentiment

Of respondents:

- 18% were satisfied or very satisfied with the local Long COVID support.
- 37% were neither satisfied nor dissatisfied with the local Long COVID support.
- 45% were dissatisfied or very dissatisfied with the local Long COVID support.



Respondents were given the opportunity to provide suggestions that could improve their experience and recovery. The most common themes were:

- Primary care clinicians to be more knowledgeable about the symptoms so they can identify them better in patients.
- Recognise patients' symptoms and their impact immediately as patients were often not believed or the condition was considered psychosomatic, which only extended patients' suffering in isolation.
- Improve awareness of the support that is available so people can begin their recovery journey early.
- Recognise that existing support is only as useful as the strength of the communications, e.g. some patients only discovered what is available by attending a Healthwatch event.
- Improve access to primary care and its service model as already reported by all NCL Healthwatch
- Improve access to specialist care as many reported slow referrals and long waiting times.
- Ensure continuity of care with regular follow up appointments to assess progression but also to reduce the isolation felt by many, and especially those with support groups.
- Share self-management techniques early, such as support groups, yoga, breathing exercises, digital apps, living a healthy lifestyle etc, resources that do not need to be confined only to secondary care.

Improve GP's Knowledge

> GPs need to be more aware of the impact and know where to signpost.
> Camden Resident

> A better understanding for GPs.
> Barnet Resident

> GPs to have more information on symptoms, recovery and make suggestions.
> Enfield Resident

> GP to pay more attention to patients and when something is asked it is because they want to feel safe and if they do research is because they need to understand the symptoms and by asking other people, friend specialists or by eliminating every issue of them thinking.
> Barnet Resident

> Please make sure GP practices are informed of the latest research.
> Camden Resident

> It would be great if GPs were a bit more knowledgeable about Long COVID so that they could advise on how patients can support themselves whilst waiting for further help.
> Barnet Resident

> For GPs to be fully aware of Long COVID symptoms and not just brush them off, this type of behaviour makes me feel even more worthless.
> Enfield Resident

Recognise Patients' Symptoms and their Impact

> Long COVID is very real I can assure you. Treatment needs to come or further testing for people like me who don't fit the traditional box. I'm not wasting GPs time on purpose. Barnet Resident

> We should be made aware that we are not alone and we are not pretending the symptoms. More media coverage from the government.
> Enfield Resident

> Take an interest in people with mild symptoms because fatigue ruins your life... Even though you cannot see it or prove it!
> Camden Resident

> I know that it's a new illness and it's so difficult to know what to do, but I am so frustrated and upset, it feels hopeless as I've not been offered anything that's helped me so far. One doctor told me it's all psychological and it's down to the patient to figure out what to do for themselves.
> Haringey Resident

> Ultimately if my GP as my first point of contact had shown support and interest I wouldn't have felt so alone but there is also a lot of harm being done to those with Long COVID in the community by the perpetuated belief that unless you die from COVID you have nothing to complain about. The fact that you are conducting this survey gives me hope, so thank you!
> Camden Resident

> Contact from my local healthcare providers informing myself and others that the condition is real and that help is available.
> Enfield Resident

> Doctors to recognize that Long COVID exists, and for GPs to pay attention to the patients' complaints, and acknowledge it and recognize the feelings of the patient with empathy. Not dismiss it as imaginary.
> Camden Resident

Improve Awareness of the Support Already Available

> It was clear from your webinar that a lot of work IS going on, but not so clear as to how to access it, I'm sure that there is some help 'out there', it's a question of how to access it.
> Camden Resident

> Would have been good to know help is available.
> Enfield Resident

> Healthwatch could provide a summary of what support opportunities are currently on offer to Camden residents. There seemed to be lots of people/agencies doing something that could help me but there was no time to make a note of their contact details during the event.
> Camden Resident

> Some support for people in my situation would be good. I feel very alone with it.
> Enfield Resident

> Access to the Living Well with COVID app ASAP - from the initial consultation with GP instead of after months and months of waiting. It's a great app and it would have been great to have that virtual support while waiting for appointments to come through. ENO Breathe is fantastic - really pleased I was referred to that.
> Camden Resident

> Be more clear that help is available and from where.
> Islington Resident

> Have teams that offer breathing work and information on pacing etc early on. I could have possibly improved months earlier if this information was public. I believe it is now.
> Camden Resident

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Improve Access to Primary Care

> Being able to get a GP appointment would be helpful.
> Enfield Resident

> Doctors should see patients face to face instead of telephone consultations. Not months down the line when the situation got worse. Referrals should have been made to the relevant specialist.
> Camden Resident

> It would be better to be seen in person and not online. It would also double up as a day out that would force me to get ready and fight the fatigue. Also, much quicker and regular access to specialists.
> Barnet Resident

> I don't know what would help. Having a GP that you can see face to face would help to start with. I had a host of other medical problems during the pandemic like a broken foot that was misdiagnosed and couldn't see anyone about that until many weeks after where it was getting worse.
> Islington Resident

> Make it easier to access primary healthcare resources, not necessarily a GP. The fatigue management that helped me was written by an OT.
> Haringey Resident

> Getting help from my GP early. The government not changing the rules all the time. Local support groups. A special NHS service for sufferers.
> Barnet Resident

Improve Access to Specialist Care When Needed

> The GP service was extremely slow to make a referral for clinical support and appeared to just hope my symptoms would improve on their own without medical intervention. When this didn't happen it left me feeling very isolated without support. It should not require repeated visits to the GP to prompt further action.
> Barnet Resident

> Immediate referral and regular access and checks from a specialist clinic that looks at all the symptoms being experienced together. Online or telephone at least. Advice and tests for really debilitating and scary unusual symptoms. Physical overall check-in at the specialist clinic.
> Camden Resident

> Access to specialist support for advice and reassurance. Recognition at an earlier stage and placed on my records at an earlier stage so I could have had access to research projects.
> Barnet Resident

> Easier to be referred to the Long COVID team.
> Enfield Resident

> Better information to GPs on how to refer. 'Being the only child at the surgery with Long COVID and not knowing what to' is not a valid reason to do nothing.
> Barnet Resident

> I have had no support or guidance just advised to take paracetamol.
> Camden Resident

Continuity of Care

> Since everyone is so different, and everyone suffers from different ailments as well as the well-known Long COVID symptoms, a regular phone call, email, or even questionnaire would be so supportive to those suffering. It would help map symptoms and also help health providers know who is still suffering and who still needs referrals and who would just benefit from a friendly call to let a patient know they are still being cared for and looked after.
> Barnet Resident

> There needs to be regular examinations of how we're doing - just to check that our cognitive skills are still intact. I haven't had any support with coping with brain fog, anxiety, tearfulness and worry etc.
> Enfield Resident

> A point of contact that 24 hours after release from hospital contacts you and assesses the situation, you have weekly contact and a separate unit to deal with Long COVID patients and this is not going away and needs urgent attention.
> Islington Resident

> I would welcome some follow up after the initial diagnosis.
> Barnet Resident

> Try and keep in touch with people suffering. It feels very lonely trying to deal with it on your own.
> Enfield Resident

Sharing Self-Management Techniques Early

> Staying safe and eating healthily and taking some vitamins.
> Camden Resident

> Helping people with breathing exercises.
> Camden Resident

> NHS to get Long COVID persons more ideas to help them. Lists of breathing apps/videos. Mediation/ mindfulness app/ video. Give Long COVID app earlier in their journey.
> Islington Resident

Peer Support Groups

> I think having some sort of support group would be just fantastic. Because you really just want to be able to speak to someone who's going through the same thing as you and can, you know, you can just talk to them. I think will be immensely helpful.
> Barnet Resident

> Long COVID groups so you can share stories with other people as many people around you don't believe in your symptoms. You don't feel alone is good for mental health.
> Haringey Resident

> Additional resources need to be put into support groups and services, as it appears very little is available even after a GP referral.
> Barnet Resident

Conclusions

We recognise that NHS services across North Central London, as well as nationally, have been exceptionally busy during the COVID-19 pandemic. This has placed NHS staff under a considerable amount of pressure and has been compounded by the additional challenge of Long COVID, requiring NHS staff to learn about this new condition quickly under incredibly difficult circumstances. The Long COVID patient pathway developed by the NCL CCG, whilst dealing with these unprecedented challenges, has aided the recovery of many patients experiencing this debilitating illness.

From the data we have gathered, there are many lessons to be learnt from the experiences of Long COVID patients, who have had to become experts by experience, in helping them on the road to recovery. Like with any new condition or service, there is great room for improvement in aiding patients to access the treatment they require which we outline in our recommendations in this report. We believe our report accurately reflects the challenges faced by Long COVID patients in North Central London and we hope they can be mitigated by implementing our recommendations.

Recommendations

NHS

Primary Care

- Improve access to GP services and face-to-face appointments, for which for there are already existing reports and insight from all five NCL Healthwatch.
- Increase training and support for primary care clinicians so they can be better informed on Long COVID and its symptoms. This will also help identify patients with potential Long COVID.
- Build awareness of local support and treatment already available for patients through multi-platform communications campaign.

NCL CCG

- Ensure there is more consistency in people's experiences accessing the Long COVID pathway taking into account patients' physical, mental and social needs.
- Ensure at the point a patient is referred for Long COVID support the Long COVID Pathway is explained and communicated to them in an accessible method.
- Ensure all patients on the Long COVID pathway are clear about how they will be followed up after their first appointment, including planned and patient-initiated options.
- Patients who are diagnosed with Long COVID or referred for further support should be given immediate access to applicable self-care and self-management resources regardless of the 12-week NICE guidance.
- Invest in the development of local peer support groups for Long COVID.

Long COVID Clinic & Community Teams

- Ensure all patients on the Long COVID pathway understand how to contact the clinical team responsible for their care accurately through telephone and email.

Councils

- Local Education Authorities should work proactively with teachers through education and training to support families whose children are absent from school due to Long COVID.
- Local Public Health teams should continue to monitor data and conduct an ongoing needs analysis of Long COVID in communities to inform how NCL CCG can make the Long COVID services more equitable and address inequalities.
- Local Public Health teams should publish their data on Long COVID to make it more visible.

Employers

- Human resource departments of employers in North Central London statutory services, such as NHS Trusts, Councils and the NCL CCG, working with the NCL's Long COVID Vocational Rehab Service, should recognise and adequately accommodate employees diagnosed with Long COVID through flexible working policies.

North Central London Clinical Commissioning Group Response

We would like to thank our Healthwatch colleagues for their work to produce such a comprehensive picture of the experience of people living with Long Covid in NCL. Hearing feedback from our communities and their personal stories is vitally important to help us reflect on the care we offer. This report and its recommendations will help us to better understand what our residents need from us, and how we can improve access to services, experience of care, and clinical outcomes for everyone.

There is still much we don't understand about Long Covid, and we know that for people affected, this uncertainty can be hard to deal with. We also recognise that for many, getting access to support, a diagnosis and clinical care, at a time when clinicians are still learning about this new condition themselves, has been difficult. For health and care staff, the uncertainties of Long Covid, how many people it affects, and how to best care for them, has also been challenging. Many staff themselves have also been personally affected by Long Covid.

We are proud of the work that our colleagues across NCL have done to set up holistic Long Covid services in such a short space of time, and of the commitment to patient care shown by staff working in these new services. However, as this report reminds us, we have more work to do to make sure we provide the best possible care for all NCL residents. The feedback and the recommendations in this report will be an important tool to help us do this.

NCL's Long Covid clinical and operational leads are committed to working in partnership with Healthwatch and other health and care organisations across NCL to implement the recommendations in this report. As our knowledge of the clinical aspects of Long Covid continues to develop, the services we offer will also need to change to accommodate this. We are also committed to continue listening to patient and resident voices to make sure that we are also continuously improving services to best meet their needs.

Dr Katie Coleman, Clinical Lead for Primary Care Network Development

Sarah Mansuralli, Executive Director of Strategic Commissioning

On behalf of NCL CCG.

Appendix 1

Full Demographic Data

Age Group	Number	Percent
18 - 24	4	2%
25 - 34	19	10%
35 - 44	37	19%
45 - 54	48	25%

Age Group	Number	Percent
55 - 64	49	25%
65 - 74	25	13%
75+	8	4%

Gender Identity	Number	Percent
Male	38	20%
Female	151	79%
Non-binary	1	1%

Gender Different from Birth	Number	Percent
No	180	93%
Yes	12	6%

Ethnicity	Number	Percent
Arab	1	1%
Asian / Asian British: Bangladeshi	17	9%
Asian / Asian British: Indian	7	4%
Asian / Asian British: Pakistani	2	1%
Asian / Asian British:		
Any other Asian / Asian British background	3	2%
Black / Black British: African	9	5%
Black / Black British: Caribbean	8	4%
Black / Black British:		
Any other Black / Black British background	1	1%
Mixed / Multiple ethnic groups: Black African and White	1	1%
Mixed / Multiple ethnic groups: Black	1	1%
Mixed / Multiple ethnic groups: Any other Mixed / Multiple ethnic background	2	1%
White: British / English / Northern Irish / Scottish / Welsh	79	41%
White: Irish	2	1%
White: Any other White background	31	16%
Polish	2	1%
Romanian	1	1%
Turkish	3	2%
Another ethnic background	2	1%

Sexual Orientation	Number	Percent
Asexual	2	1%
Bisexual	3	2%
Gay	5	3%
Heterosexual / Straight	153	82%
Lesbian	2	1%
Pansexual	1	1%
Others	4	2%
Prefer not to say	16	9%

Disability	Number	Percent
Yes	47	25%
No	131	69%
Prefer not to say	12	6%

Religion	Number	Percent
Buddhist	2	1%
Christian	46	24%
Hindu	2	1%
Jewish	14	7%
Muslim	32	17%
No religion	66	35%
Other	12	6%
Prefer not to say	14	7%

English as First Language	Number	Percent
Yes	142	75%
No	46	24%
Prefer not to say	2	1%

Carer Status	Number	Percent
Yes	37	19%
No	148	78%
Prefer not to say	5	3%

Long Term Health Condition(s)	Number	Percent
Yes	101	54%
No	74	40%
Prefer not to say	11	6%

COVID Vaccination Status	Number	Percent
Yes - 1 dose	24	10%
Yes -2 dose	185	80%
No	23	10%

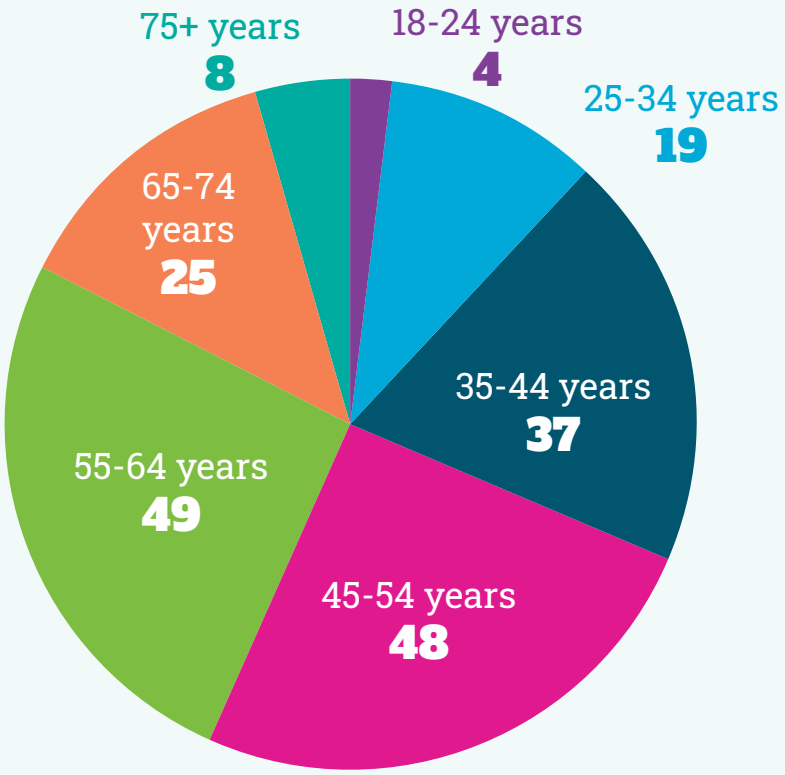
Highest Level of Qualification	Number	Percent
GCSE	21	11%
A Level	19	10%
Bachelor's degree	52	28%
Master's degree	44	24%
PhD or higher	10	5&
I'd prefer not to say	14	8%
Other	14	8%
None of the above	11	6%

Annual Household Income	Number	Percent
Under £15,000	39	21%
Between £15,000 and £29,999	23	12%
Between £30,000 and £49,999	23	12%
Between £50,000 and £74,999	21	11%
Between £75,000 and £99,999	12	6%
Between £100,000 and £150,000	7	4%
Over £150,000	2	1%
I'd prefer not to say	58	31%

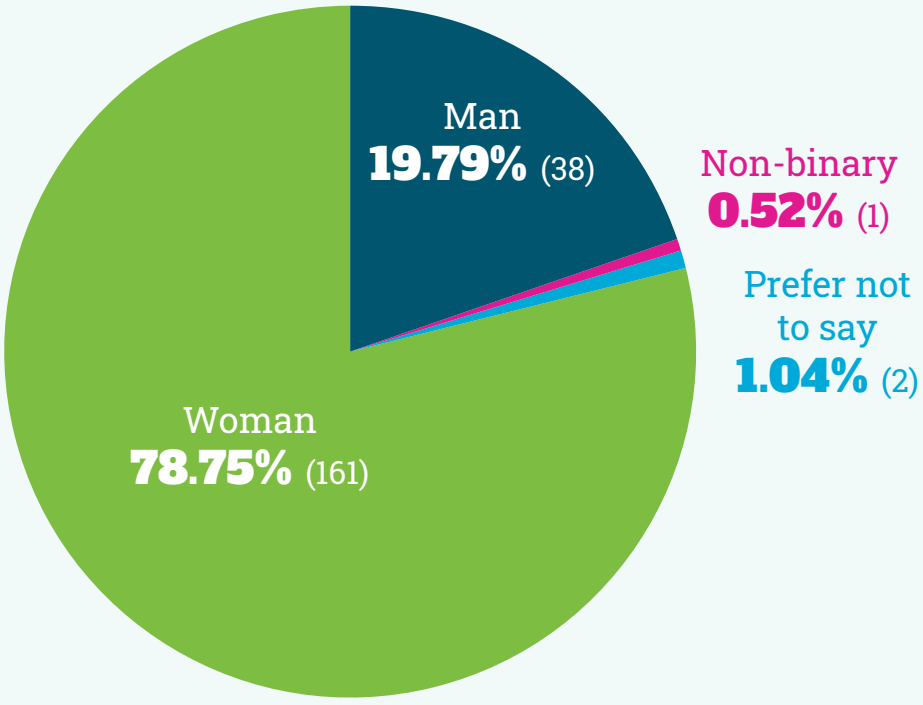
Appendix 2

Respondent profile

Age



Gender



Ethnicity

Arab	1
Asian / Asian British: Bangladeshi	17
Asian / Asian British: Indian	7
Asian / Asian British: Pakistani	2
Asian / Asian British: Any other Asian / Asian British background	3
Black / Black British: African	9
Black / Black British: Caribbean	8
Black / Black British: Any other Black / Black British background	1
Mixed / Multiple ethnic groups: Black African and White	1

Mixed / Multiple ethnic groups: Black Caribbean and White	1
Mixed / Multiple ethnic groups: Any other Mixed / Multiple ethnic background	2
White: British / English / Northern Irish / Scottish / Welsh	79
White: Irish	2
White: Any other White background	31
Polish	2
Romanian	1
Turkish	3
Another ethnic background	2

Word Cloud of Commonly Used Phases for Long Term Health Conditions

heart disease
long term health
problem
diabetes
hypertension
high blood pressure
long covid damage
asthma
arthritis
hypothyroidism

Healthwatch Barnet

Barnet & Southgate College
7 Bristol Avenue, Colindale
London NW9 4BR

020 3475 1308

healthwatchbarnet.co.uk

Healthwatch Camden

85-87 Bayham Street
Camden
London NW1 0AG

020 7383 2402

healthwatchcamden.co.uk

Healthwatch Enfield

Community House
311 Fore Street, Edmonton,
London N9 0PZ

020 8373 6283

healthwatchenfield.co.uk

Healthwatch Haringey

Tottenham Town Hall
Town Hall Approach Road
London N15 4RX

020 8888 0579

healthwatchharingey.org.uk

Healthwatch Islington

6-9 Manor Gardens
Islington
London N7 6LA

07538 764436

healthwatchislington.co.uk

healthwatch

Barnet Camden Enfield Haringey Islington

healthwatch
Barnet Camden Enfield Haringey Islington

People's Experience of Long COVID in North Central London

Background

- Long COVID is a new and evolving condition that can greatly impact the health and quality of life of many people.
- Long COVID presents itself through a wide range of clustered symptoms.
- Data from the Office for National Statistics show that an estimated 1.7 million people self- reported experiencing Long COVID symptoms as of April 2022.
- University College London Hospitals (UCLH) provides the Post-COVID Specialist Clinic service for residents across North Central London (NCL).

What We Did

- Five Healthwatch organisations across NCL worked in partnership together on a joint NCL Long COVID project.
- **Aims of the project:**
  - To capture local people's experiences of Long COVID in order to identify any gaps in current provisions.
  - To support the better development of services and systems to help local people to manage their symptoms.
- **Hybrid methodology:**
  - Anonymous online survey
  - 1-2-1 interviews
  - Community focus groups
  - Survey respondents had the option to participate in a follow-up 1-2-1 interview to enable us to gather detailed in-depth qualitative data.

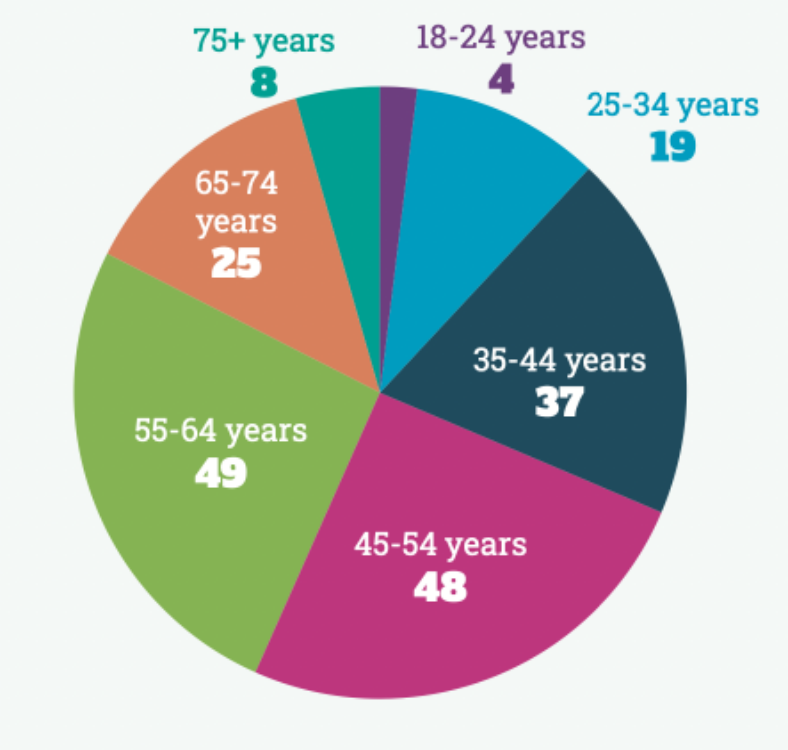
What We Did

- Each Healthwatch worked with local voluntary sector organisations to broaden their reach.
- In total, we gathered 300 local peoples' experiences of Long COVID across NCL.
- Data was collected from September 2021 to February 2022.

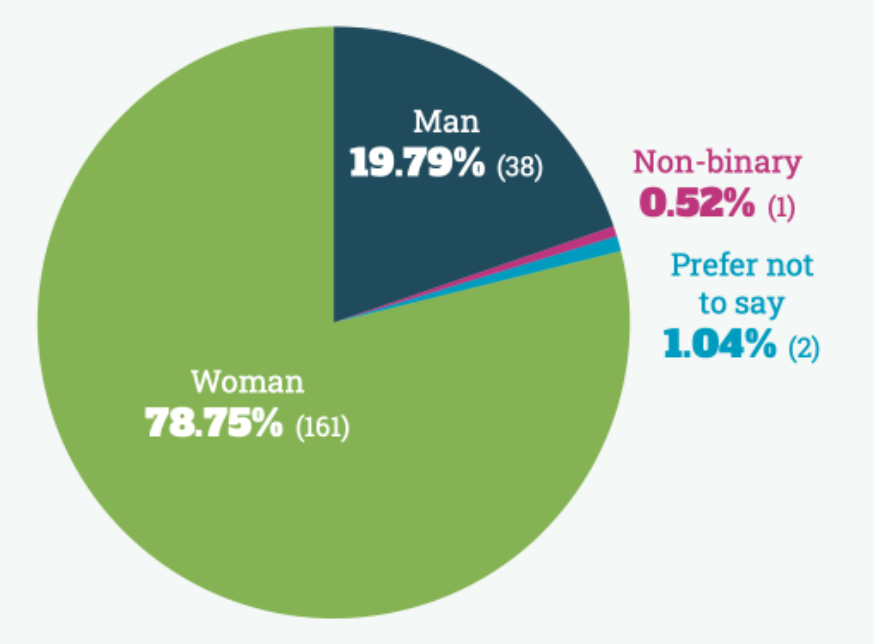
Local Healthwatch	Survey Reponse	1-2-1 Interviews	Focus Groups	Community Event/Others
Healthwatch Barnet	63	18	2	1
Healthwatch Camden	79	5	0	3
Healthwatch Enfield	53	0	0	0
Healthwatch Haringey	21	4	0	0
Healthwatch Islington	38	14	1	0

Respondent Profiles

- We gathered demographic data from approximately 190 of 254 respondents.



Age



Gender

Respondent Profiles

Ethnicity

Arab	1
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Asian / Asian British: Any other Asian / Asian British background	3
Black / Black British: African	9
Black / Black British: Caribbean	8
Black / Black British: Any other Black / Black British background	1
Mixed / Multiple ethnic groups: Black African and White	1

Mixed / Multiple ethnic groups: Black Caribbean and White	1
Mixed / Multiple ethnic groups: Any other Mixed / Multiple ethnic background	2
White: British / English / Northern Irish / Scottish / Welsh	79
White: Irish	2
White: Any other White background	31
Polish	2
Romanian	1
Turkish	3
Another ethnic background	2

Disability	Number	Percent
Yes	47	25%
No	131	69%
Prefer not to say	12	6%

healthwatch
Barnet Camden Enfield Haringey Islington

What We Found

Key Findings

- **Theme 1 – Impact on Health**

  - Physical health
  - Mental health and wellbeing
  - 73% of respondents reported that they had been living with Long COVID for 6 months or more, with various symptoms affecting their physical and mental health.

My mental well-being is pretty bleak because of the gaslighting and lack of support I received. I can manage mentally with the ups and downs of Long COVID but being denied adequate support is hard to bear. I feel useless and hopeless.

Camden Resident

Key Findings

- **Theme 2 – Impact on Life**
  - Employment and job security
  - Home life
  - Symptoms caused challenges in ability to work, leading to some respondents having to reduce their working hours, voluntarily stop working or be made redundant.
  - This had an adverse impact on some respondents' household finances.

I've had to move home, I was in rented accommodation. I couldn't afford to stay there, I also couldn't look after myself and remain independent. So around the house, I rely on other people to help me like they do the shopping, cooking cleaning. I have help washing as well, sometimes on bad days. So it's been a huge life change from being very independent to relying on people around me for support.

Barnet Resident

Key Findings

- **Theme 3 – Experiences With the Health Care System**
  - Accessing the Long COVID Pathway
  - Healthcare support and referrals
  - Useful interventions
  - Diagnosis
  - GP knowledge

I have been struck by the lack of knowledge re Long COVID and the lack of compassion shown by some GPs. They have been dismissive, lacking in any management plan and keen to psychologise my symptoms. I've had to push for the referrals. I worry about those patients who are not able to advocate for themselves.

Haringey Resident

Key Findings

- **Theme 4 – Moving Forward**
  - Improve GP's knowledge
  - Recognise patients' symptoms and their impact
  - Improve awareness of the support already available
  - Improve access to primary care
  - Improve access to specialist care where needed
  - Enable continuity of care
  - Share self-management techniques early
  - Peer support groups

There needs to be regular examinations of how we're doing - just to check that our cognitive skills are still intact. I haven't had any support with coping with brain fog, anxiety, tearfulness and worry etc.

Enfield Resident

healthwatch
Barnet Camden Enfield Haringey Islington

Recommendations

Recommendations - NHS

Primary Care

- Improve access to GP services and face-to-face appointments, for which there are already existing reports and insight from all five NCL Healthwatch.

- Increase training and support for primary care clinicians so they can be better informed on Long COVID and its symptoms. This will also help identify patients with potential Long COVID.

- Build awareness of local support and treatment already available for patients through a multi-platform communications campaign.

Recommendations - NHS

NCL CCG

- Ensure there is more consistency in people's experiences accessing the Long COVID pathway taking into account patients' physical, mental and social needs.
- Ensure at the point a patient is referred for Long COVID support the Long COVID Pathway is explained and communicated to them in an accessible method.
- Ensure all patients on the Long COVID pathway are clear about how they will be followed up after their first appointment, including planned and patient-initiated options.
- Patients who are diagnosed with Long COVID or referred for further support should be given immediate access to applicable self-care and self-management resources regardless of the 12-week NICE guidance.
- Invest in the development of local peer support groups for Long COVID.

Recommendations - NHS

- **Long COVID Clinic & Community Teams**

- Ensure all patients on the Long COVID pathway understand how to contact the clinical team responsible for their care accurately through telephone and email.

Recommendations - Councils

- Local Education Authorities should work proactively with teachers through education and training to support families whose children are absent from school due to Long COVID.

- Local Public Health teams should continue to monitor data and conduct an ongoing needs analysis of Long COVID in communities to inform how NCL CCG can make the Long COVID services more equitable and address inequalities.

- Local Public Health teams should publish their data on Long COVID to make it more visible.

Recommendations - Employers

- Human resource departments of employers in North Central London statutory services, such as NHS Trusts, Councils and the NCL CCG, working with the NCL's Long COVID Vocational Rehab Service, should recognise and adequately accommodate employees diagnosed with Long COVID through flexible working policies.

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The Committee wished to put on record its thanks to all staff, across the Trust, who had gone above and beyond and coped incredibly well during the pandemic and also having to try to facilitate 'virtual' visits in place of families and carers being able to visit 'in person'. The Committee put on record the following comments on the Draft Quality Account:

The Committee would like to congratulate and compliment the Trust on the following:

- that staff across all departments have coped to the best of their abilities in very difficult circumstances over the past year
- that the Trust was at the forefront of Covid 19 related research and had also hosted the world-first 'human challenge trials' aimed at understanding infection transmission
- that the triaging or research streams was impressive
- their participation in rolling out various vaccination centres most efficiently including the StoneX Centre
- that the Trust's REST (Resilience and Emotional Support Team) hub provided psychological support to airline flight crews after stressful shifts: Project Wingman
- that the health and wellbeing of staff is vitally important as it also has an impact on patient care. The Committee is pleased to see that 'Joy in Work' remains a priority
- that one of the four delivery priorities is to reduce the number of patients who are waiting a long time to be seen, and that the Trust recognises the tenacity that achieving this will require from staff
- that digital infrastructure and solutions are in place to improve patient and staff experience as their third priority
- its Research and Development Team having its first Covid 19 research study approved and its participation in the world's largest Covid 19 treatment trial which is estimated to have saved over one million lives globally
- for developing a 'proning board' which reduces the number of staff necessary to turn patients over to help with better ventilation, especially those in Intensive Care Unit with Covid 1
- the excellent and informative TV documentary on the care it has given since the pandemic. This included details of the delicate work of recruiting patients onto studies for treatments for Covid-19
- Its bereavement work especially where staff had listened to families, looked at processes and improved them
- the use of artwork to design a bereavement card
- the work of the property team in trying to make sure that all patients property was safe and secure
- instigating training to help staff examine the root causes of episodes of violence and aggression perpetrated by people with dementia or delirium, particularly against staff
- their achievement of 22 places in the national scoreboard for the National Cancer Patient Experience
- the development of digitised patient pathways to improve care and noted that this piece of work is ongoing
- for participating in 100% of national confidential enquiries and 97% of national clinical audits, and noted the actions to improve its national and local audits

- reducing the delayed transfers of care which was previously rated ‘bad’ and reducing these down to zero which was impressive. However, the Committee expressed its concerns regarding the following:
- the Trust’s failing which resulted in a maternal death, but was pleased that the Group Chief Executive acknowledged this in her Foreword
- That there is only a single shared Electronic Patient Record (EPR) within the RFL Group. This is a disappointment as ideally patients’ records should follow the patient as they move to different Trusts
- that in the Mid-year Quality Account update, it was noted that data would be presented more clearly for the layperson in future. However, this was not felt to be the case of the 2020/21 Quality Account, which still appeared to be aimed at professionals
- that the Trust had failed to achieve its target of zero ‘never events’ by March 2021 and instead had had five
- that there had been 68 incidents of avoidable harm by the end of Quarter 3, with one quarter remaining for the year
- that the number of inpatient falls at the end of the third quarter of the year was already well above the Trust’s target for the whole year that there had been six cases of MRSA when the aim had been to have zero cases in the Trust
- there had been 70 cases of C Difficile in the current year, against a target of zero
- that the Trust had hoped to reduce incidents of Gram negative bacteraemias in line with the mandated threshold by 2021/22 but they had increased from 145 cases in 2020 to 170 in 2021, although it was noted that this had been an exceptional situation due to the pandemic
- that there had been an increase in emergency readmissions within 28 days since the previous year
- that more training is required for nurses and doctors to fully understand about dementia and requested more details on the new plans for dementia care
- that the percentage of staff who would recommend the Trust to families and friends was down to 68% from 71% in the previous year and continuing a downward trend
- that the Trust ranked low across London in overall performance compared with comparable NHS Acute Trusts
- the number of patients who had waited over 52 weeks for Referral to Treatment (RTT) had increased from last year
- that the Trust’s performance against the four-hour A&E standard was lower than the target
- that the number of patients waiting over 62 days following a GP referral to start cancer treatment was higher than previous years
- that feedback from patients on how well they felt looked after by staff, including non-clinical staff, was disappointing
- that some of the KPIs were disappointing, such as only 0.5868 against a target of 0.90 for less than a 62-day way for referral for first treatment for cancer screening referrals
- that the In-Patient surveys were rated worse than most other transfers of care. A Member asked whether Jane Hawdon would kindly send the Committee the plans for dementia care from the new Nurse Consultant, both during the pandemic and in the future. The Member offered to forward papers that she had received and Jane Hawdon agreed to go through any further concerns. A Member asked whether there is any data on the length of time between death and the funeral of religious patients, who don’t need a post mortem, but would normally be buried within 24 hours. Dr Greenberg replied that the RFH does not collect this data but makes every attempt to facilitate funerals within this time frame, as far as possible.

Royal Free London NHS Foundation Trust Quality Account 20/21 Update – November 2021

Ref	Barnet HOSC Comment/Query	Response
1	Variations in electronic patient record (EPR) within the RFL Group	RFL now have a shared EPR deployed since October 2021. This has allowed the Trust to start addressing the issue of fragmented clinical and administrative workflows and has enabled digitised records to be shared across RFL and the NCL ICS.
2	Data should be presented more clearly for the layperson - not felt to be the case in the 2020/21 Quality Account which appeared to be aimed more at professionals	We apologise that the representation of data was not adequately explained in the 2020/21 report. We will be mindful to improve our commentary and clarity in the 2021/22 report to ensure the language of the report is more accessible.
3	Failed to achieve its target of zero 'never events' by March 2021	We will continue as part of our Safety Strategy 2020 - 2025, to work towards zero never events by decreasing our avoidable harm score to 49 and becoming a zero-harm organisation by 2025. Currently for the first 2 quarters of 2021/22, the Trust has reported 1 never event which is down on the previous year to date position, reflecting a steady improvement in line with our safety strategy.
4	More details on the new plans for dementia care	Currently working on the delivery of a Dementia CPG which consists of 5 focussed workstreams: Delirium, Distressed behaviour, Assessment-based care, Discharge and Carers. Please see dementia strategy and activity summary that was shared by the RFL lead for dementia in Sept 2021 with HOSC.

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Royal Free London
NHS Foundation Trust

The next chapter:
Improving quality of care

Royal Free London NHS Foundation Trust

Comprising of:

Barnet Hospital, Chase Farm Hospital, Royal Free Hospital

Quality Account 2021/22

Quality Account 2021/22

Part one: Achievements in quality

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

Part three: Overview of the quality of care in 2021/22

Annexes

Appendices

Part One: Achievements in quality

1.1 Statement on quality from the chief executive

We would like to open this Quality Account publication with a huge thank you to our staff and everyone who has supported them, and for their incredible efforts over 2021-2022.

We would like this report to give you an idea of what we have achieved over the last year and our priorities for the period ahead, including some of the activities that we believe will yield further improvements in the quality of care we offer going forward.

Although we cannot cover every detail of our achievements in quality from the past year in this report, we hope this account gives a faithful impression of the journey we have travelled and the key next steps along the road to delivering excellence.

Achievements to highlight

Collaboration across the Royal Free London Group through operating at scale has been key to reducing unwarranted variation and waste in the organisation whilst coping with the unprecedented increase in demand after the pandemic. Building on clinical partnerships and developing shared protocols across the group has also allowed us to provide more effective and personalised responses to population health needs across North Central London. This has been largely achieved through the introduction and use of digital systems across the group thereby releasing time for staff to focus on delivery of high quality patient care.

The Royal Free London Group is therefore making a difference to patients through evolving our clinical pathways and involving nearly 400 clinicians in the design of new pathways through the digitisation, implementation and embedding of Clinical Practice Groups which is covered in greater detail in subsequent sections of this account. One of the benefits of this programme of improvement includes the ability to maximise the number of patients that we can safely treat to better tackle the national growth in waiting lists for diagnosis and treatment.

As an organisation we are also working with our partners in integrated health care provision to better deliver consolidated services across North Central London through implementing clinical networks and creating diagnostic hubs in order to reduce health inequalities and improve equity of access. The ability to develop good working relationships with our partners means that patients will benefit from improved outcomes and reduced variation in their patient experience of service provision between the most and least deprived wards in North Central London.

In looking ahead to the future, it will be important for us to balance ongoing preparation for any future waves of the pandemic with the urgent and ongoing need to recover our clinical performance and re-focus on the delivery of all our services. We are therefore reminded of the trust's governing objectives which are the means by which we hold ourselves to account for progress against our mission of world class expertise and local care. The objectives act as our primary decision-making criteria and have guided the development of our quality priorities for the coming year.

Our objectives

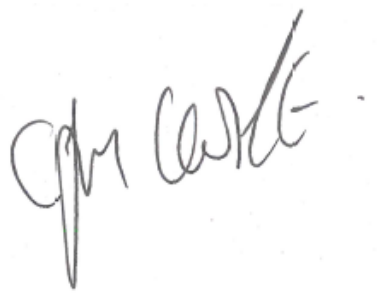
	Excellent health outcomes	Outstanding experience of care	Outstanding experience for our people	Be a sustainable organisation
Five-year goal	Achieve an overall 'Outstanding' CQC rating	The experience that our patients and carers have is amongst the best in the world	Joy at work - shared decision making between patients and staff, who are enabled to deliver the standard of work they aspire to	• *Financial:* the group achieves balanced budgets and the trust has an overall surplus • *Environmental:* reduction in carbon emissions towards net zero by 2040
Two/ three-year goal	Delivering fundamental quality standards	Transform the relationships we have with our patients and carers	Belonging and inclusion - staff have a sense of belonging and inclusion, and feel supported by their immediate team and wider trust	• *Financial:* 50% reduction in the underlying deficit • *Environmental:* reduction in carbon emissions towards net zero by 2040
Year one goal (2022/23)	Improvement in health outcomes across the group	Understand and improve the experience for our patients and carers	Health and wellbeing - build on the health and wellbeing provision in place at the trust to support staff members' mental health	• *Financial:* meet our system financial plan • *Environmental:* reduction in carbon emissions towards net zero by 2040
Underpinning strategies	Health and care strategy	Patient experience strategy	People strategy	Green plan Finance strategy

Enablers: Digital / Partnerships / Integrated Care / Research / Royal Free Charity / Data

You will note in Part 2 of this report that each of the quality priorities identified for 2022/23 has been aligned to one of the relevant goals in the table above in order to support the delivery of the trust's overall strategic framework.

Part 3 of this report describes performance against selected and key indicators and also gives examples of some of the improvement plans we have put in place across the trust.

Finally, it remains to say that I hope you find this Quality Account enlightening and interesting. I am confident that the information in this report accurately reflects the services we provide to our patients and the quality of care delivered by the Royal Free London Group.



Caroline Clarke
Group Chief Executive
Royal Free London NHS Foundation Trust

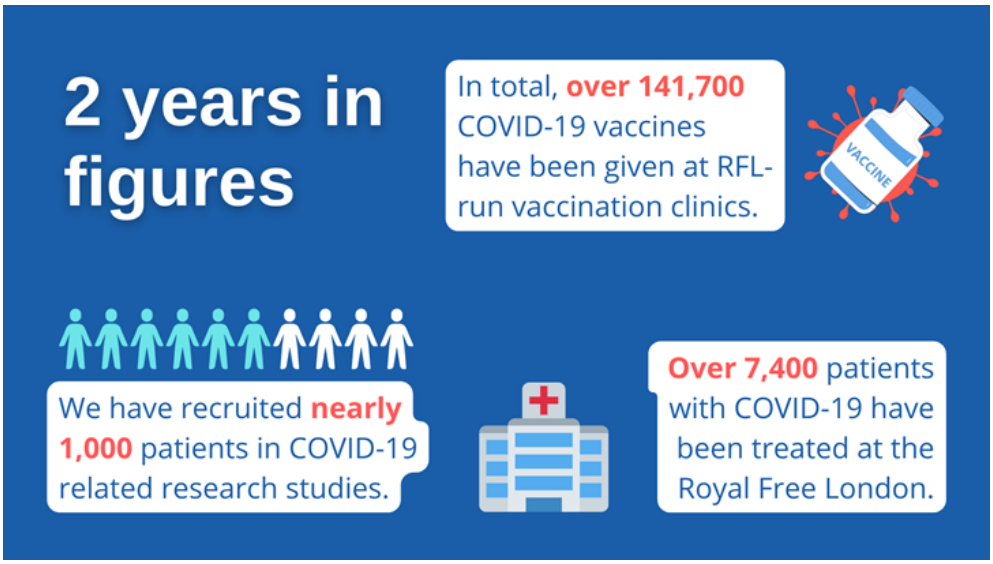
1.2 Recovery from the pandemic

Two years on from the start of the pandemic, the NHS does feel different. We have learnt about how to work in systems across organisations. We have learnt about reimagining and reinventing many of our services. We have learnt how important we all are to each other – no matter what our role, or in which department we work.

We know that staff who are cared for are better able to care for others, so there can be no NHS recovery without staff recovery. This is why we continue to highlight staff wellbeing in our quality account because of its direct impact on the quality of care we deliver. The wider theme of staff inclusion and wellbeing is also included in our governing objectives and the goals associated with achieving the aims of the trust's people strategy.

Whilst part of 2021/22 was dominated by the ongoing pandemic response, the focus had shifted to the recovery of planned (elective) care and accelerated recovery of services where possible as well as to treating the many patients who have been waiting longer for their care because of the pandemic. Some of our achievements in light of the pandemic and what we have done during 2021/22 include:

- Caring for over 7,400 patients with COVID-19.
- Setting up vaccination centres which have given over 141,000 COVID-19 jabs to protect healthcare workers, patients, and members of the public.
- Innovating at a scale and pace never seen before to care for patients in different ways.
- Using technology to put loved ones in touch on screen, at a time when they could not do the simple things we take for granted, like share a hug or a moment of human contact.
- Establishing vaccine and treatment trials that have changed the course of the pandemic so that we can live with COVID-19 rather than in fear of COVID-19.
- Working with an incredible sense of common purpose to provide the best possible patient care, reorganising services often at the drop of a hat.
- Using data and science to ensure that our patients are treated with the best possible regimes.
- Forging incredible relationships with NHS partners and others, including the military, which will endure forever.
- Continuing to work across the health and social care system to make sure that we provide the best services for our local communities.



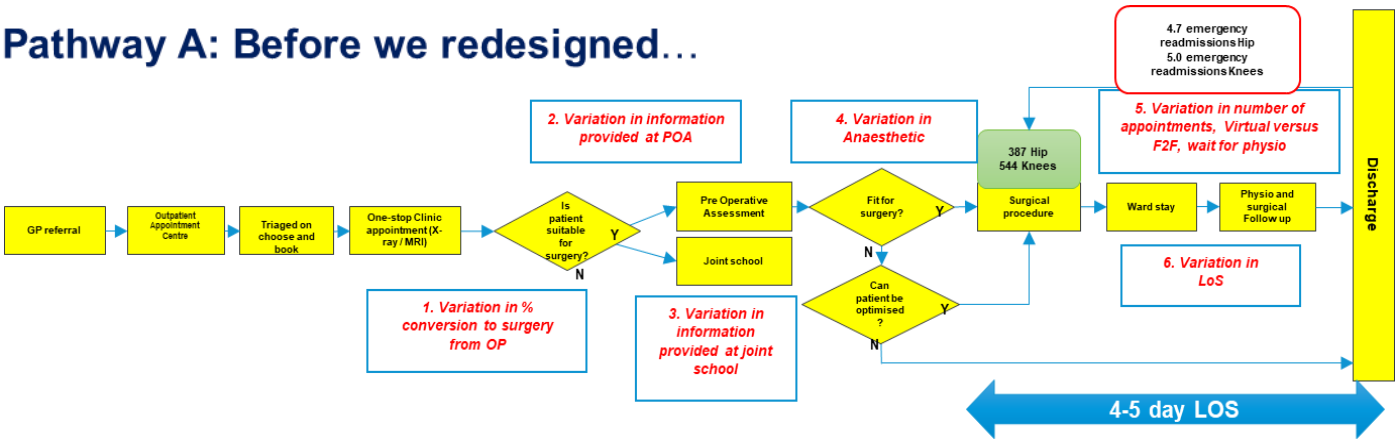
This year's Quality Account highlights the work done across the organisation to move on from the pandemic using the lessons learnt over the past year by staff at the Royal Free London.

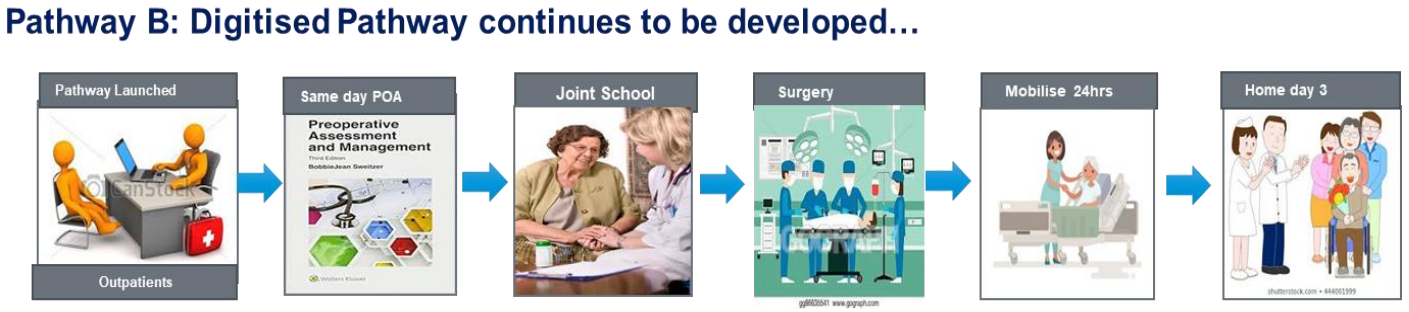
1.3 Delivering high quality care

Clinical Practice Groups

This programme is based on reducing unwarranted variation to improve clinical outcomes by design pathways that are evidence based. Of the 54 Clinical Practice Group (CPG) pathways identified at the start of the programme, 38 have been digitised so far since 2018 using patient co-design and engaging with multi-disciplinary clinical teams.

The pathway to digitisation involves multiple steps including understanding current pathways, reviewing the workforce model and designing a digital solution that can be tested and used to improve the service before going live. An example of this systematic approach to care re-design is the work completed by the CPG for the elective hip and knee pathway as explained in the below diagrams:





CPG activity now accounts for approximately 52-59% of all admitted activity in the trust and we are working in close partnership with our partners at North Middlesex University Hospital, West Herts and across the integrated care system.

The benefits from the first 20 pathways to be digitised include:

- 30,800 fewer pathology tests
- 2,944 fewer radiology exams
- 18,800 fewer bed days used across the frailty and inpatient pathways
- 10,900 fewer outpatient attendances and procedures
- 17,600 more non face to face outpatient appointments
- Reduction in unit cost for 16 of the 20 pathways

The data that we can now collate from the digital pathways demonstrates how we are able to capture patient level data to understand the impact of the care we deliver. This has helped support the organisation's case for HIMSS Analytics Electronic Medical Record Adoption Model (EMRAM) Stage 7 which is an international benchmark for the use of advanced IT to improve patient care.

Research and Development

After the colossal clinical research year of 2020/21 which saw the Trust recruit its highest ever number of patients into the National Institute for Health and Care Research (NIHR) portfolio, including a spectacular contribution to COVID-19 studies, 2021/22 has been the year of recovery, re-start and planning for an even more successful clinical research future post-pandemic.

The challenge has been great, with the concurrent priorities of permanently un-pausing the many clinical research studies that were paused, restarted, and paused again; securing staff and patient safety amid the pandemic; ensuring that COVID-19 research continued to flourish; enabling new non-COVID-19 research to resume, and formulating the next 5-year clinical research and development strategy. The Quality Account priorities set for the past year were intentionally focussed on recovery and we are pleased to report being well on course to have delivered both priorities of 'reviewing 100% of paused studies and restarting 70% of those deemed eligible to restart' and 'achieving a 10% increase in the number of patients recruited into NIHR portfolio research'.

Over 300 studies we paused in March 2020 because of the first COVID-19 surge. This was under the direction of the NIHR and necessary in order to preserve the safety of our patient research participants and research delivery staff, to grant our patients and staff access to participate in COVID-19 research and, for Research and Development (R&D) clinical staff to support colleagues in delivering front-line care. Overall, since April 2021, 67% of the entire paused portfolio has been granted permission to restart.

The need to persevere with important COVID-19 research has remained with us throughout the year and once again the R&D delivery teams and research investigators continued to make a vital contribution to this Global effort. The Trust opened its second COVID-19 vaccine trial recruiting 166 patients. Some of our investigators have made important strides towards understanding long-COVID whilst others continued to contribute to COVID-19 treatment trials. In total 1,809 patients were recruited into COVID-19 related research at the Trust in 2021/22 (figure as of the 11th March 2022).

The Royal Free Hospital Clinical Research Facility (CRF) opened its doors on 31st March 2021. It, for the first time, offers a dedicated clinical research space at the trust for researchers to undertake ground-breaking early-phase and experimental medicines research. This year, the CRF began to build its portfolio of studies and grow its operational capability. A full complement of staff is now in post and the CRF has already adopted around 50 studies. Moreover, the CRF has now been awarded £4.9 million in prestigious NIHR funding over the next 5 years which will allow the CRF to continue to drive forward innovation in experimental medicine and support the translation of exciting discoveries into new treatment for patients.

This year also saw the formulation of the trust's 5-year clinical R&D strategy. Between September and December 2021, the R&D team embarked on a project to develop and set up delivery of an equitable, patient-centred, and enduring clinical research strategy that enables the Trust to become an excellent clinical research hospital. Our approach was to embark on an extensive programme of stakeholder consultation by running a series of workshops, surveys and commissioning an independent external review of clinical research at the trust. Patients and members of the public were invited to contribute to both the surveys and workshops.

This led to the development of an ambitious vision for the future of clinical research at RFL in that 'By 2027, RFL will be a top 10 research hospital through all staff and patients having excellent access, experience, and outcomes by virtue of world class clinical research'. The strategy has been used to inform the 2022/23 quality priority for R&D.

The last two years have underscored the importance of clinical research in improving patient outcomes. As we recover from the aftermath of the pandemic, the R&D department is committed to ensuring that clinical research remains an integral part of the delivery of care across the Royal Free London Group.

We have made excellent ground in restarting research during 2021/22 and the focus for this year will be to continue with recovering our clinical research activity and growing further.

Maternity Services

Following the Section 29A warning notice issued by the CQC in November 2020, an un-announced CQC inspection was carried out in May and June 2021 of the maternity services at both the Royal Free Hospital and Barnet Hospital sites. This was to review the improvement actions undertaken by the trust since the notice and to provide assurance to the CQC that we had begun the process of addressing their specific concerns. The CQC welcomed the improvements made across the trust's maternity services and were re-assured by the ongoing monitoring of the improvement plans by the maternity services senior management teams and the trust executive.

Improving how the Trust engages with staff and patients has been vital to the improvement work carried out by the maternity service and accessibility of information via the service website has played an important role in ensuring we can offer the best care to women who chose to have their babies with us.

Further details of the improvement work carried out are included in subsequent sections of this report.

In addition, the CPG pathway development has been influential in promoting the safety of mothers and babies in maternity and reducing the numbers of neonatal admissions to the neonatal unit by 24% (300 babies) in 2021/22. This has been done through engaging women and clinicians alike to co-design pathways and ensure that there is a clear governance structure in place to improve the quality of the service being delivered.

For example, the 'keeping mothers and babies together' pathway developed a standardised risk assessment for all babies immediately following delivery. Those babies categorised as 'at risk' follow a standardised pathway; including timely observations and respiratory risk assessments.

The 'induction of labour' pathway introduced a mechanical form of inducing labour through immediate irradiating hyper stimulation of the uterus and reducing the need for emergency transfer of patients to the labour ward. This has vastly improved user experience with women confirming that the procedure is less uncomfortable. Women can also return home until the next stage of the induction of labour which has led to an overall reduction in length of stay by approximately two days. The neonatal unit admission rate has in turn been reduced by 2% when compared with the pharmaceutical form of inducing labour.

The maternity services will continue to ensure that going forward into 2022/23 they have a clear, consistent and transparent approach to the provision of accessible, inclusive information to women including communication support for all women accessing maternity care in accordance with the accessible information standard.

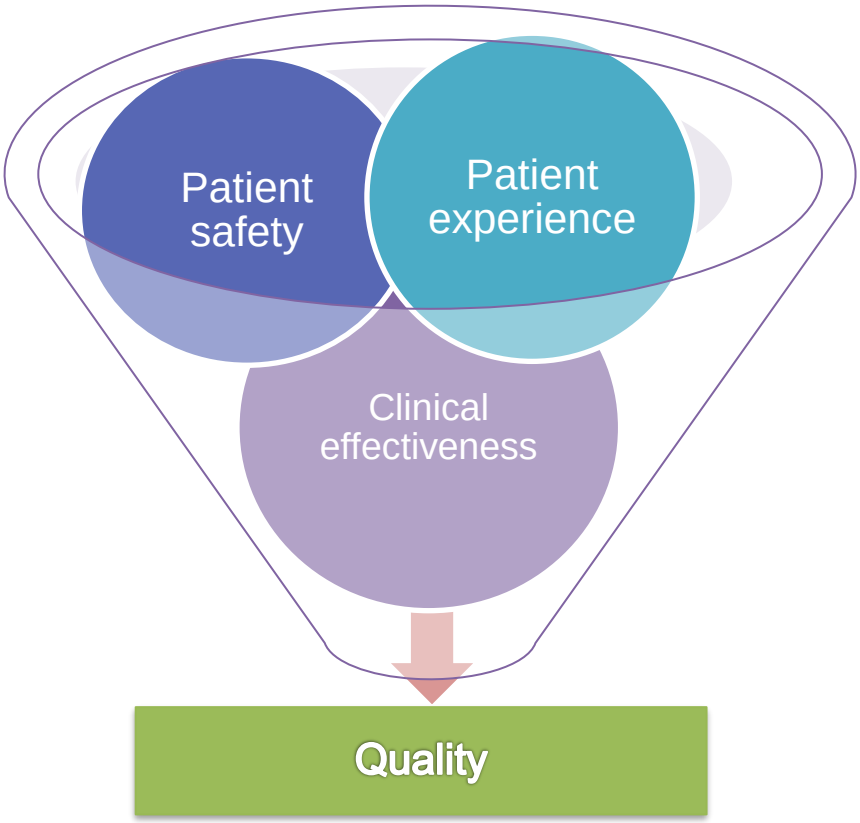
Part two: Priorities for improvement and statements of assurance from the board

Every year all NHS hospitals are required to produce a quality account report for their stakeholders detailing the quality of their provision of care and outlining their priorities for the year ahead.

The report allows us to be more accountable and helps us to drive improvement in how patients experience our services as well as support the overall strategic objectives of the Royal Free London Group by underpinning the quality goals with principles of safety and effectiveness.

Within this quality report we will review our performance over the previous year, identify areas for improvement and publish that information. These areas include the three key indicators of quality:

- **Patient experience** – meeting our patients' emotional needs as well as their physical needs.
- **Clinical effectiveness** – providing the highest quality care with world-class outcomes whilst also being efficient and cost effective.
- **Patient safety** – having the right systems and staff in place to minimise the risk of harm to our patients, being open and honest, and learning from mistakes if things do go wrong.



This section describes the following:

- Progress made against our priorities during 2021/22
- Outlines our quality priorities chosen for 2022/23
- Provides feedback and assurance statements in relation to key quality measures

2.1 Priorities for improvement

What were our quality priorities for 2021/22 and how did we do?

Improving Patient Experience: delivering excellent experiences

Priority 1: Deliver Dementia Clinical Practice Group which consists of 5 focussed workstreams; Delirium, Distressed behaviour, Assessment, Discharge and Carers.

The following actions have been completed over the last year in relation to the Dementia Clinical Practice Group (CPG):

Delirium

- A comprehensive delirium review was undertaken across both the Royal Free and Barnet Hospital sites in order to get an accurate post-COVID picture of the rate of delirium incidence, its prevalence and associated patient outcomes.
- There was a roll-out of the 'delirium bundle' across the Trust with diagnostic protocols implemented in partnership with the Frailty CPG.

Distressed behaviour

- A new behavioural intervention tool has been designed and tested across multiple care of the elderly sites at RFL.
- A new education and awareness session was developed and delivered to promote the understanding of behavioural changes and the importance of de-escalation across RFL.
- A de-escalation checklist produced in partnership with the Trust security services was produced to encourage a ward-based de-escalation approach and reduce unnecessary use of security resource in managing patient behaviour.

Assessment

- The team took a care redesign approach to the existing tool "8 important things about me" in order to incorporate "what matters to you" principles and improve the way assessment is carried out in the Trust.
- There was a Trust launch of the updated tool with the associated protocols across both the Royal Free and Barnet Hospital sites.
- The team worked on embedding the new process and tool on all elderly care wards in the Trust.
- Discussion has taken place around building in additional tools (4AT, Abbey Pain Scale, etc.) to further develop a more comprehensive multi-specialty dementia bundle.

Discharge

- Data analysis of people with dementia experiencing high volume of readmissions has been carried out with a thematic review of the common causes of readmissions completed.
- Opportunities for additional support/ signposting/ resource materials have been identified and offered to this patient group and their supporters.
- A resource pack is currently in the co-design phase with active involvement from both carers and third sector stakeholders.

Carers

- A cross-borough carer steering group (Camden and Barnet) has been set up and members have been appointed to the existing CPG leadership team.
- A carer story training package was developed, filmed and produced for use in staff training.
- There is an ongoing dissemination plan in place to ensure it reaches all those affected.
- A carer's resource pack to improve signposting and support is in the co-design phase and is being done in collaboration with our integrated care partners.

Priority 2: Patients who are recognised as being likely in the last year of life are offered a conversation recognising this. In this conversation their wishes and preferences will be assessed, there will be negotiation of treatment plans, and a comprehensive discharge summary will be written.

In completing the actions associated with this priority, the trust has committed to ensuring that patients over the age of 65 are screened for the possible need for conversations about the future (advance care planning) using the Clinical Frailty Scale. The clinical frailty score is a validated score for people over the age of 65 that assesses a person's overall condition. It can provide a reference point for the introductions of conversations about what matters to the person, thinking through which treatments are clinically indicated, and making arrangements to meet psychological, social and spiritual needs.

The importance of these conversations and thinking about how to live well until we die is that patients receive treatment in the most appropriate place, spend less of the last 90 days of their life in hospital, unless care needs cannot be met elsewhere, and those important to them are prepared as best they can for care at end of life and bereavement.

From the National Audit of Care at the End of Life (2021) we can see that 25% of patients at Barnet Hospital (more than national average) and 5% of patient at the Royal Free Hospital (less than national average) had participated in advance care planning prior to their last admission to hospital, and 11% (Barnet Hospital) and 15% (Royal Free Hospital) took part whilst they were in hospital.

Working with therapy partners we have generated a trust intranet site has been developed to guide patients and families as to the conversations they can expect and also provide additional resources https://www.royalfree.nhs.uk/patients-visitors/advance-care-planning-and-end-of-life-care/

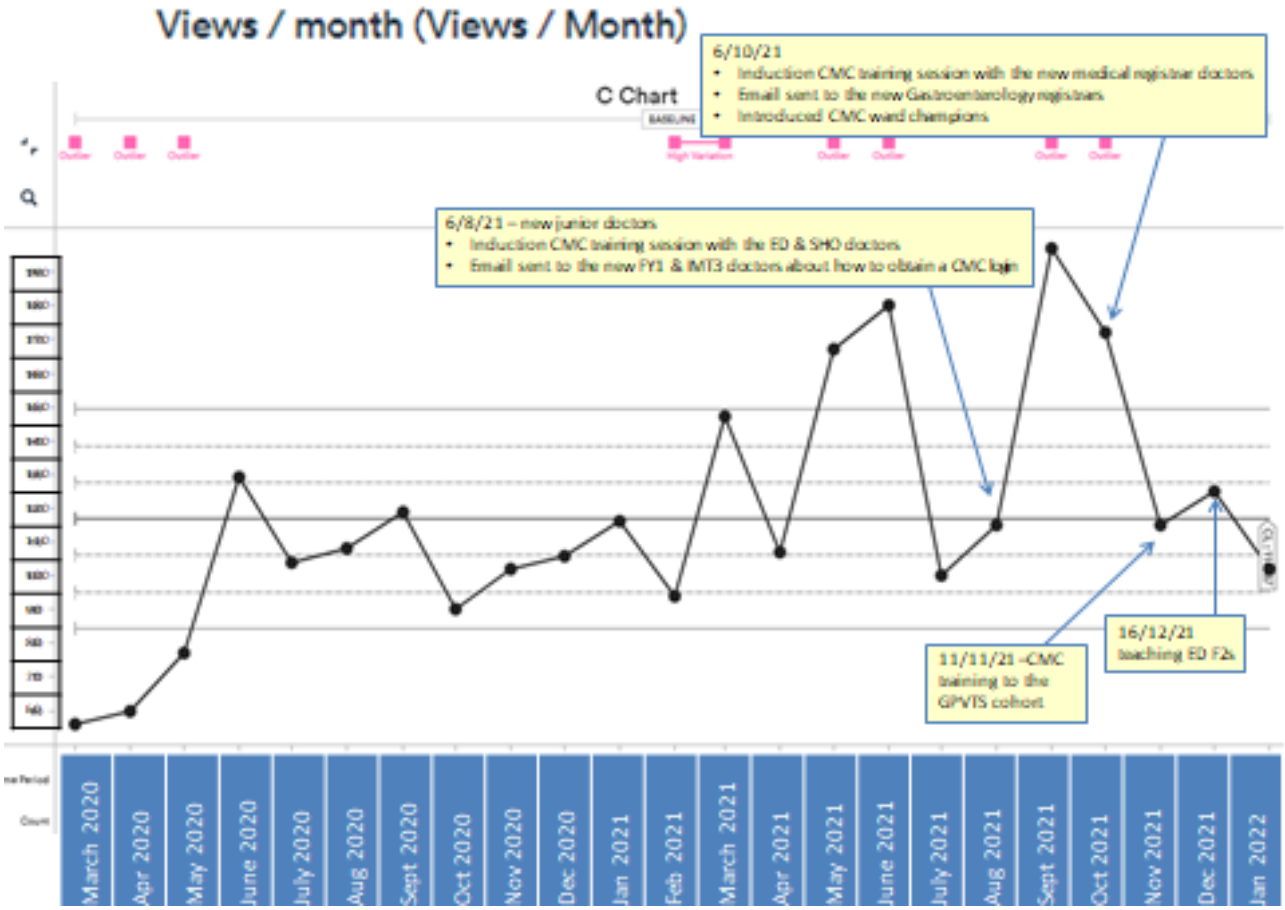
The advance care planning work also links to good patient and family communication, the care of the dying, and excellent discharge planning. In 2021-2022 we have provided seven, two day advance communications skills courses for nearly 80 senior clinicians. These courses have been well evaluated. On average, 88% clinicians have reported increased confidence in handling conversations, 87% have reported improved skills in conversations, 69% better patient experience, 66% more insight / self-awareness, 51% increased job satisfaction and 46% have insight into how health inequalities may affect communication.

We have updated the new electronic patient record to ensure there is clear and easy access to documentation for clinicians. We are utilising the London Urgent Care Record – Co-ordinate My Care (CMC) – to understand patient's previously articulated wishes and to update them. (See graph below)

In November 2021 we held a half away day where we shared and celebrated the good practice occurring at Barnet Hospital in elderly care, and at the Royal Free Hospital in stroke and renal medicine and elderly care. The Barnet Hospital junior doctors won a pan-London quality improvement prize for the work they have done to increase access to Co-ordinate My Care.

Doctors, senior nurses and therapists have been surveyed to understand what they find challenging about advance care planning conversations and teaching has been provided to doctors about ensuring the outputs of such conversations are covered in discharge and clinic letters. All of this work will be continued in 2022-2023.

Graph demonstrating the number of views per month of CMC by Barnet clinical teams



Priority 3: Establish a role for the hospital in supporting, educating and signposting for carers of people with dementia and the use of co-design as a model of support to enable the participation of carers in the hospital process.

In achieving this priority the team have produced **CAPER** which is a framework developed to support and up-skill staff working with patients experiencing dementia and provide support to carers. It stands for:

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

Assessment – understanding behaviour as a form of communication and understanding reversible causes of distressed behaviour; pain and delirium

Partnership – working alongside patients, families and carers

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

Role-modelling – using your own skilled practice to inspire cultural change

Carers have been involved in the design of a resource bundle which includes a video detailing the 'carer experience' for use in staff training as well as for dissemination across dementia carer groups in North Central London.

Priority 4: Improve our administrative support for patients through the non-clinical practice group by reviewing baseline data, scoping and improving the referral letter process to patients as part of their non-clinical interactions with the trust. This is a 5 year target.

In order to meet the requirements of this priority, the Non-Clinical Practice Group (NCPG) Programme seeks to reduce waste and unwarranted variation in the patient administrative pathway, resulting in improved patient experience, quality of care, and staff satisfaction. As part of this programme, there are multiple workstreams which have been setup to improve patient appointment and referral communications.

The development of digital appointment management in the trust means that as of February 2022, 174,000 patients have signed up to My RFL Care to benefit from this service which enables patients to opt out of paper appointment letters and provides patients with digital access to other types of letters, including clinical letters and discharge summaries.

Since the launch of My RFL Care, we have directly engaged patients through a number of channels, including Equal Access Groups, to get their input on how the introduction of new features can make positive difference to patients' lives.

This has simplified patient interactions with the trust when cancelling or rescheduling appointments, and their updated letters are available automatically via the portal. Further benefits include patients having more control over their care and being able to manage their appointments around other commitments like work and childcare.

In addition, services are able to recycle cancelled appointment slots enabling patients to reschedule their appointment to an earlier date should a slot become available and allowing us to reduce waste across the trust and improve efficiency.

Priority 5: Ensure Royal Free London is a welcoming and supporting trust for patients, their carers', families and friends and that kindness is at the centre of improving and sustaining their experience across the trust.

In order to deliver a comprehensive Patient Experience strategy, a multi-faceted approach was taken to gathering information from our service users across all sites of the Royal Free London Group during 2021/22. Many of these tools have been embedded and will continue to be used to ensure we remain an engaged trust. They include:

- The installation of a compliments and patient experience information board in main corridors to make the environment more welcoming and reassuring to visitors.
- Launching site specific twitter patient experience accounts to engage better with the public.
- Introducing a patient experience walkabout programme whereby the team can speak to patients and/or their loved ones about their experience. Areas visited include inpatients, maternity, outpatients, and will soon rollout to paediatrics.
- A ward pledge poster was rolled out across inpatient areas to demonstrate staff commitment to patients. Each poster is co-signed by the ward manager and matron.
- An information and communication audit was conducted across the trust to obtain an understanding of where the trust is in terms of implementing the Accessible Information Standard and accessibility for patients and carers whose first language is not English.
- A survey was conducted on 'My RFL Care' patient portal to ascertain how accessible it has been for people with disabilities. The report highlighted areas for improvement and the trust will be addressing these next year to ensure we are meeting patient needs on all our digital portals.

COVID-19 shone a very bright light on inequalities that already existed for many people including our staff. We have seen everyone continue to rise to the challenge and work towards decreasing the impact the pandemic has had on service delivery and health and wellbeing of our patients and our people. During 2021/22 the trust held 'what matters to you?' events whereby we engaged with patients and carers to identify what matters to them and to address areas for improvement.

Much of the feedback will inform the actions we take in 2022/23 to ensure we deliver on our promises to patients and staff alike.

Improving Clinical Effectiveness: delivering excellent outcomes

Priority 6: Deploy Quality Improvement (QI) methodology, projects and programmes towards at least two of RFL's four delivery priorities. This will be evidenced by QI programmes, projects or methods being established in the overall work programme focused on [at least two of] those delivery priorities.

The QI team have successfully rolled out virtual training in QI methodology across the trust from 'Bitsize' to 'Practitioner' level with up to 500 staff engaging with the team during 2021/22 with further work to commence around a competency framework during 2022/23.

Project	Aim	Progress Score	Update
QI Sponsor Learning Programme	A process will be developed that ensures our QI sponsors have the capability, capacity and clarity to perform their role at Royal Free London.	2.0	Capabilities for QI sponsors have been developed. A programme of learning will be developed based on these. This is due to commence in Q2 22/23.
QI Practitioner Training	Develop a learning programme to create QI Practitioners who can lead improvement in their own area.	2.0	Capabilities for QI Practitioners have been developed. A programme of learning is in development for these. This is due to commence in Q2 22/23.
QI Measurement Training	We will develop learning and reference materials that create an accurate and consistent approach to measurement for improvement in RFL.	3.5	Both the Intermediate and Advanced Measurement Master classes are live. Work is underway across QI and Info & Analytics to create consistency in measurement across the Trust.
QI Coach Quality Assurance	A process will be developed that ensures our QI coaches have the capability, capacity and clarity to perform their role at Royal Free London. (Coach QA)	2.0	Capabilities for QI Coaches have been developed. Assessing capability against these competencies is due to commence in Q2 22/23.

In supporting the workstreams for reducing the number of patients facing long waits and building an inclusive workforce whilst improving the wellbeing of our staff, the QI Team has been involved in the following improvement programmes, projects and activities that has supported delivery of these priorities:

- Barnet Hospital Flow
- Chase Farm Hospital theatre productivity
- Chase Farm UTC (Urgent Treatment Centre) triage times
- Royal free Hospital site plan – enabling staff and patients to feel 'Included', 'Safe' and 'Supported'
- Royal Free Hospital – violence and aggression in the Emergency Department

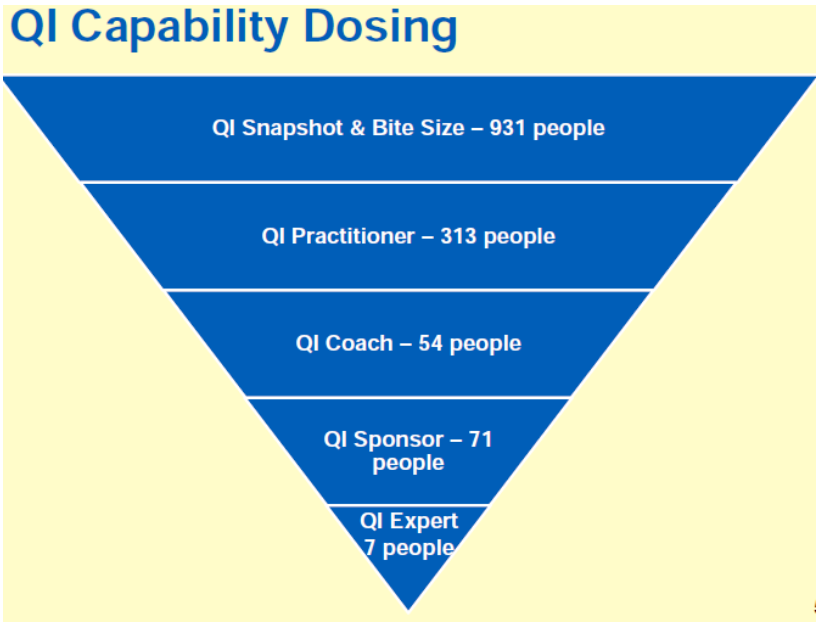
- Group-wide – Equitable Access programme
- Group-wide – Vanguard 2 programme, aimed at improving health and wellbeing of staff in [Agenda for Change] Bands 1 to 5

The QI team takes a more active role in leading improvement where a project or programme is a significant priority for the group or a site. For example, the 'Front Door Flow Collaborative' at Barnet Hospital is looking at improving patient experience in Emergency Departments and aligning with processes across the North Central London sector to better manage demand.

Priority 7: Embed quality improvement expertise, methodology and approaches in RFL's approach to achieving improved CQC ratings. This will be evidenced by QI team members being involved in the relevant governance forums for this work and also through QI methods being adopted in priority improvement areas.

The team are working towards building capability for QI which can be defined as: "The organisational ability to intentionally and systematically use improvement approaches, methods and practices, to change processes and products/services to generate improved performance." (Furnival et al., 2017)

The following diagram shows the number of individuals trained in the QI method during 2021/22.



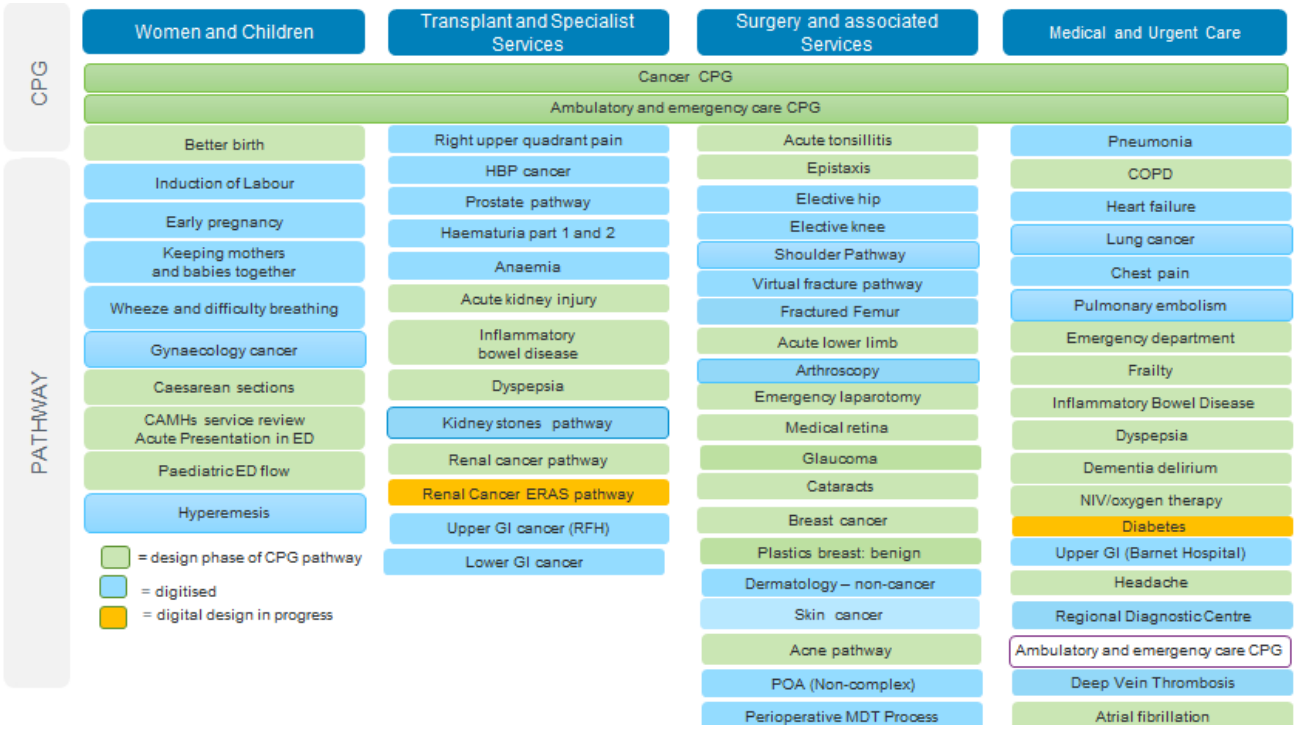
The QI Team is currently actively involved in the following forums and programmes:

- CQC Steering Group
- CQC Maternity Services Action Plan
- Royal Free Hospital – improving MAST (Mandatory and Statutory Training) compliance
- Group-wide – improving shared learning following serious incidents

All active projects support the trust's strategic priorities and comprise of delivering established business as usual programmes and the development of new programmes.

Priority 8: The CPG programme will develop and implement an additional 14 digital pathways with particular focus on Trust priority areas in Cancer, Emergency and Ambulatory Medicine, Maternity and Surgery Clinical Practice Groups.

During 2021/22 all digitised pathways were made live across all hospital sites, and the programme team have digitised a further 15 pathways in addition to the 14 completed in achieving this priority.



Priority 9: Develop and embed a clinical pathway group which aims to improve safety and quality of diabetes management both within hospital and in primary care.

This CPG has been setup and is developing its agenda to improve the safety and quality of the management of diabetes care across the Trust. This has been included as an action to take forward in our 2022/23 priorities.

Priority 10: We will establish a population based approach to improve outcomes for patients with heart failure by developing a fully integrated pathway with our partners in primary and community care.

In completing this priority, the trust started to use CPG methodology for integrated care pathways across the integrated care system (ICS) for Camden and Barnet in heart failure through introducing a new heart failure hub at the Royal Free Hospital. This was a great example of delivering care in a different way and will pave the way to improve patients' experience and outcomes.

The hub acts as a 'one-stop-shop' for cardiology patients to receive their results and treatment plan on the same day. It has also meant closer working with the local primary care network and community heart failure team to truly integrate patients' care.

In 2022/23 the programme team will also be expanding their work on integrated pathways to include Wheezy Child, Frailty and Cancer.

Priority 11: Increase in patient recruitment to NIHR portfolio studies by 10%.

The year 2021/22 saw the resumption of non-COVID research following the successful restart work of the R&D office. By mid-March 2022, the trust had recruited at total of 8,748 patients into NIHR portfolio research with almost 80% being into non-COVID research.

The GRAIL (also known as SYMPLIFY) study for example, exploring the use of rapid blood testing to diagnose an array of cancers recruited 307 patients across all 3 RFL sites. In partnership with our local North Central London collaborators the Trust contributed to 20% of the national recruitment into this exciting study.

Elsewhere, colleagues at Edgware exploring the use of novel 3D imaging technology to screen women for breast cancer have enrolled 1,384 patients. The Trust recruited the first patient globally into the PHYOX7 trial, exploring a new treatment for primary hyperoxaluria and the first patient in the UK into the ONWARDS trial, investigating a potential new treatment for osteoarthritis of the knee.

Hundreds of other non-COVID research studies are also once again actively recruiting patients. All of this has meant that the trust was able to meet its priority of increasing patient recruitment into NIHR portfolio studies by 10% for the period 2021/22.

Priority 12: Review 100% of studies paused as a result of Covid-19, restarting 70% of those deemed eligible for restart.

This priority has been met for the period 2021/22 with 100% of paused studies having been reviewed and 89% of those eligible to restart having been restarted.

Following a brief attempt to restart paused studies prior to the second major surge in January 2021, when studies had to go back into a state of hibernation, the R&D office team began the work of permanently reviewing and restarting 351 studies in April 2021. This has been an extensive exercise requiring careful prioritisation of research and balancing of demands.

As of January 2022, the team had successfully reviewed all 351 studies and restarted 232 of the 262 studies that were deemed eligible to restart.

Improving Patient Safety: delivering safe care

Priority 13: As part of our Safety Strategy 2020-2025, have zero never events, decrease our Avoidable Harm Score to 49 by 2021/22, and become a zero harm organisation by 2025.

The first measure of success for this patient safety priority was to achieve zero never events by the end of March 2022. 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.

Unfortunately, we reported one never event during 2021/22, this represented a significant improvement on five never events reports in 2020/21. All never events are investigated as serious incidents and reviewed at our Board level Clinical Standards and Innovations Committee (CSIC), chaired by one of our Non-Executive Directors where we triangulate serious incidents with incidents, complaints, PALS and litigation to identify themes which might require system-wide work.

We publish a weekly summary of serious incidents as they are reported and share learning further general and speciality-specific newsletters online and by email. We also hold learning events, seminars and workshops in order to disseminate lessons learnt.

Never Event reported in 2021/22

Steis	Site	Type	Incident date	Harm
2021/9173	RFH	Retained tampon	23/04/2021	None

The key actions taken to prevent recurrence include:

- Reviewed the perineal suturing packs in use across all sites to ensure consistency across all sites
- All tampons and gauze swabs smaller than 45cm by 45cm removed from the perineal suturing packs and replaced with large swabs 45cm by 45cm.
- Revision of the Maternity guideline and proforma: Perineal Trauma and Repair Including 3rd and 4th Degree Tears to reflect the agreed change in practice.

The second measure of success for this patient safety priority was to decrease our Avoidable Harm Score to 49 by the end of the 2021/22 financial year.

Since June 2017 the Trust has used the Likert definitions of avoidability in order to assist in determining our level of response in the investigation of incidents. Taking a risk-based approach we have created the RFL Avoidable Harm Score (AHS) for each incident that is moderate harm or above and has a Likert score of 1-3:

1) Definitely avoidable
2) Strong evidence of avoidability
3) Probably avoidable - more than 50:50

The total AHS for each month is then used as the indicator, with the median used as a baseline indicator. The trust recognises that the determination of level of harm and level of avoidability are subjective and so our decisions are based on the consensus opinion of the multi-disciplinary Safety Incident Review Panels (SIRP), chaired by the respective site Medical Directors.

The Trust's average AHS for the financial year 2021/22 was 107 which means that we have not achieved our target of 49.

Whilst the avoidable harm score has proved useful when discussing the level of investigation, it has not proved an effective measure of the work done by the trust in safety learning. And the "NHS Patient Safety Strategy: Safer culture, safer systems, safer patients" published in July 2019, clarifies that for effective safety measurement the terms 'avoidable' and 'unavoidable' are unhelpful for patient safety. The trust will review the priority to measure patient safety.

Priority 14: Decrease the number of falls incidents with moderate or more harm reported by 5% by March 2022.

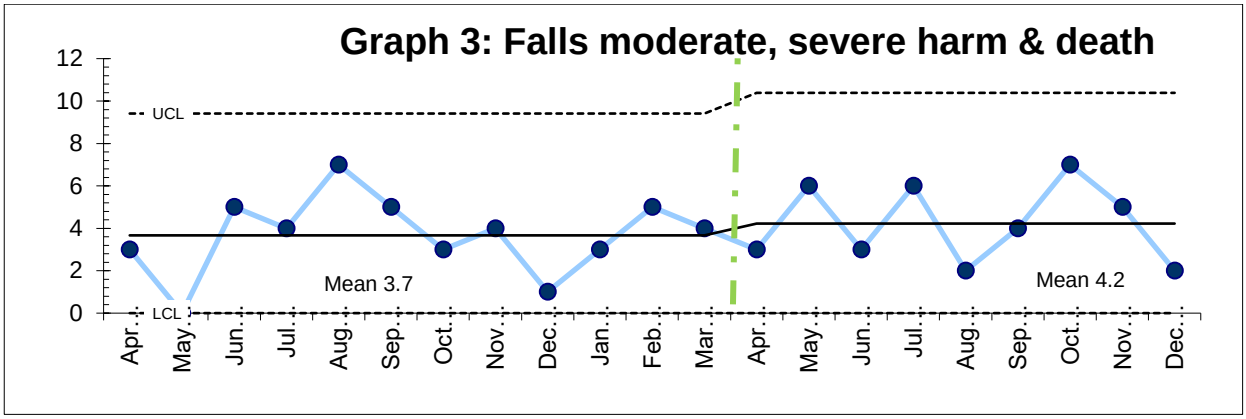
The measure of success for this patient safety priority was to reduce the number of inpatient falls resulting in moderate, severe harm or death by 5% by the end of the 2021/22 financial year.

In the 2020/21 financial year, the average monthly number of moderate or greater harm inpatient falls was 3.66. To achieve a 5% reduction the average monthly number for the 2021/22 financial year would need to be 3.47.

As shown in the graph below, as at the end of Q3 2021/22, the average monthly number of moderate plus inpatient falls was 4.2 for the 2021/22 financial year, which unfortunately represents an increase and means that we have not achieved this target.

The falls that result in moderate or more harm are reviewed regularly at our safety incident review panels, fall panels, Trust-wide nursing and midwifery committee and matron's meetings.

Further information to be included once Q4 data has been reviewed



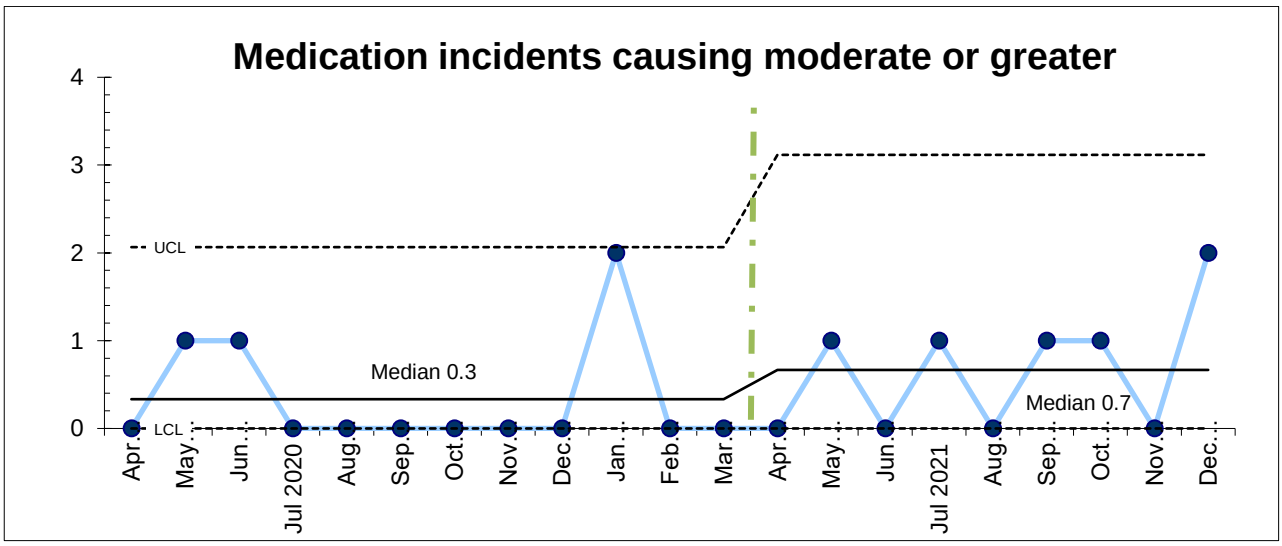
Priority 15: Decrease medication incidents with moderate or more harm reported by 5% by March 2022.

The measure of success for this patient safety priority was to reduce the number of medication incidents resulting in moderate, severe harm or death by 5% by the end of the 2020/21 financial year.

In the 2020/21 financial year, the average monthly number of moderate or greater harm medication incidents was 0.25 (there were 3 such incidents during that year). To achieve a 5% reduction the average monthly number for the 2021/22 financial year would need to be 0.2375.

As shown in the graph below, at the end of Q3 2021/22 the average monthly number of moderate plus medication incidents was 0.7 for the 2021/22 financial year, which means that we have not met the objective of a 5% reduction this financial year.

Work will continue at the Trust to reduce all medication incidents, with the introduction of EPR (Electronic Patient Records) across the Trust in 2021 allowing greater system controls to prevent harm.



Further information to be included once Q4 data has been reviewed

Priority 16: Achieve zero trust attributed meticillin-resistant Staphylococcus aureus bacteraemia (MRSA) cases.

During the period 2021/22 there have been 7 attributed cases of MRSA bacteraemia since April 2021, 4 attributed to RFH and 3 attributed to BH.

All MRSA bacteraemia infections have been subject to a post infection review (PIR). Outcome, learning and action plans are shared at monthly divisional leads meeting and monthly Clinical Performance and Patient Safety (CPPS) committee.

Further information to be included once Q4 data has been reviewed

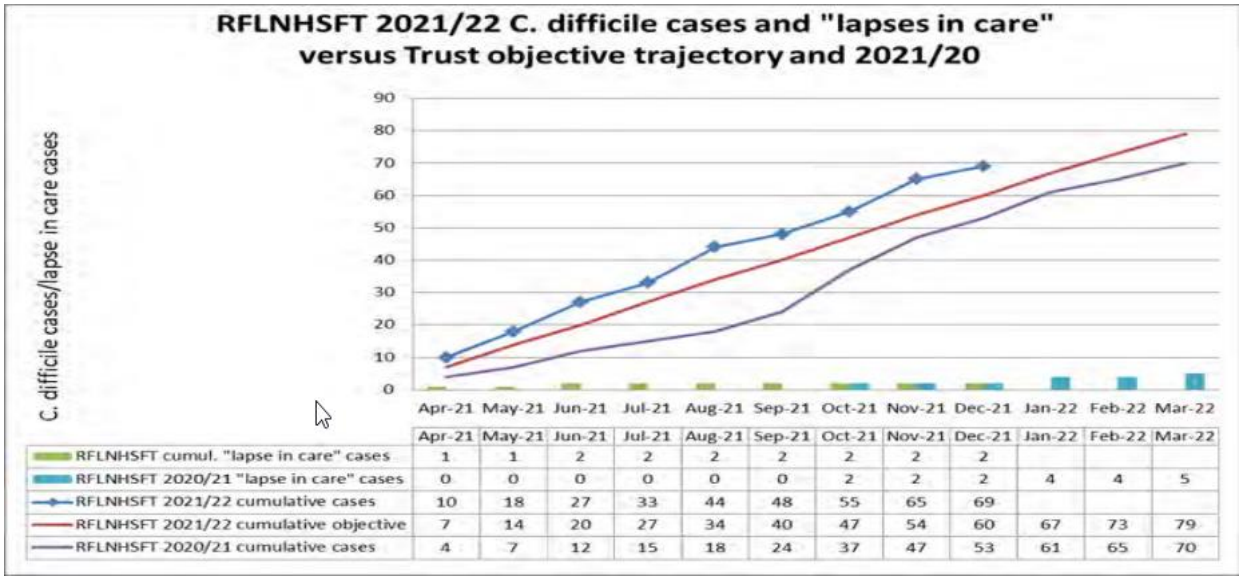
Priority 17: Achieve zero trust attributable Clostridium difficile (C. diff.) infection cases with a lapse in care.

The threshold for the trust for 2021/22 set by UKSHA was 79 cases. During the period 2021/22 69 cases have been reported since 1st April 2021, two of which were lapses in care due to delayed patient isolation.

In order to better understand lapses in care, acute provider objectives are set using these two categories:
• HOHA: hospital onset healthcare associated: cases that are detected in the hospital three or more days after admission
• COHA: community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

The Trust reported a total of 69 C. diff. cases in 2021/22, down from 70 in 2020/2021. Two cases with lapses in care were identified. All cases have a Root Cause Analysis (RCA), with learning fed back through the monthly IPC Divisional Leads group and monthly Clinical Performance and Patient Safety (CPPS) committee.

Following the two identified and confirmed lapses in care, the RCA process was completed and the learning shared suggested that early identification, timely isolation, and sampling can be improved.



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
RFLNHSFT cumul. "lapse in care" cases	1	1	2	2	2	2	2	2	2			
RFLNHSFT 2020/21 "lapse in care" cases	0	0	0	0	0	0	2	2	2	4	4	5
RFLNHSFT 2021/22 cumulative cases	10	18	27	33	44	48	55	65	69			
RFLNHSFT 2021/22 cumulative objective	7	14	20	27	34	40	47	54	60	67	73	79
RFLNHSFT 2020/21 cumulative cases	4	7	12	15	18	24	37	47	53	61	65	70

This Action Plan has been developed following a rise in C. diff. cases in the first quarter at Royal Free hospital. An external review was requested by DIPC and director of nursing for RFH site. It should be noted that some recommendations have already been previously identified as part of the Trust-wide on-going plan to reduce C. diff. infections:

- External review to get a fresh perspective on the environment and practice
- Audits on commodes, mattress and pillows
- Audit C. diff knowledge and practice amongst staff
- Revitalise the deep cleaning programme across all sites
- Review of all cleaning audit reports at site divisional lead meetings
- C diff road show
- EPR – IT integration: stool chart/algorithm, antibiotic stewardship, patient tracking and isolation
- Clinical audit programme – Tenable audit
- Clinical team engagement in RCA process

Further information to be included once Q4 data has been reviewed

Priority 18: Achieve zero hospital onset definite healthcare associated COVID-19 infections.

COVID-19 outbreaks for Q3 – Oct to Dec:

Barnet: 13 wards declared covid19 outbreaks

CFH: nil declared

RFH : eight wards declared covid19 outbreaks

Further information to be included once Q4 data has been reviewed

Priority 19: Reduce Gram negative bacteraemias in line with NHS Long Term Plan reduction objective of 50% by 2024/25.

Attribution: Gram negative blood stream infections due to E. coli, Klebsiella species, and Pseudomonas aeruginosa are assigned to the Trust when the specimen is taken on the third day of admission onwards (e.g. day 3 when day 1 equals day of admission) and classified as hospital-onset, healthcare-associated cases (HOHA).

Following a decrease in 2020/21 there was an increase in 2021/22. Awaiting 21/22 data for table.

RFLNHSFT hospital-onset, healthcare-associated Gram negative blood stream infections			
Organism	**2018/19**	**2019/20**	**2020/21**
Escherichia coli	75	88	83
Klebsiella species	49	38	47
Pseudomonas aeruginosa	27	19	40
Financial year total	**151**	**145**	**170**

Where there were increased cases of Gram negative blood stream infections, regular infection prevention and control (IPC) audits and teaching were undertaken to monitor IPC practice compliance, such as hand hygiene, line care management (insertion and on-going) and documentation. Post infection review (PIR) will be carried out where learning needs are identified from initial review.

Our priorities for improvement for 2022/23

The priorities chosen for 2022/23 remain within the quality domain and are drawn from the group leadership aims, local intelligence, previous CQC inspections and feedback following consultation with key stakeholders.

Progress in achieving these priorities will be monitored at our strategic committees and reported to the Trust Board, as illustrated in Figure 1.

Additionally, reports are sent to Trust Infection Prevention and Control Committee (chaired by the Director for Infection Prevention and Control) and the business unit level Clinical Performance and Patient Safety committees which are chaired by the respective medical directors.

Updates on progress will be sent to our commissioners via the Clinical Performance and Patient Safety Committees and the Clinical Standards and Innovation Committee.

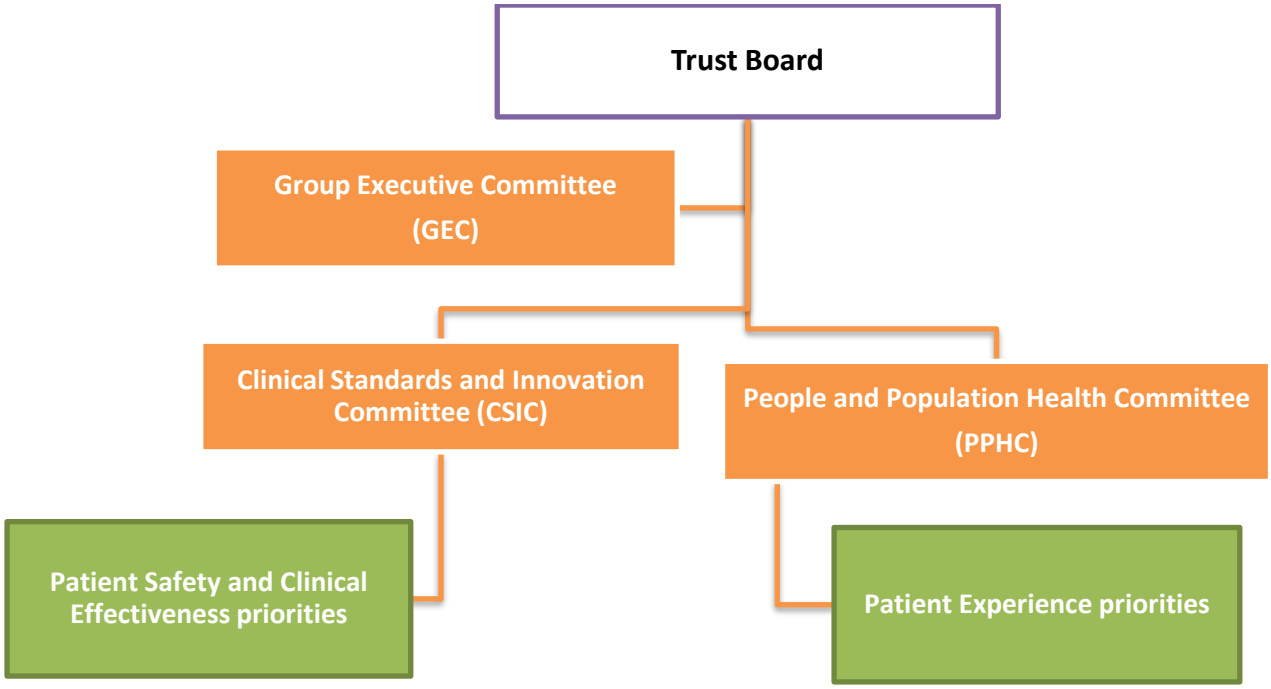


Figure 1: Strategic committees reporting to the Trust Board

Some of the priorities from 2021/22 have been carried over as proposed priorities for the new financial year 2022/23 as they form part of a longer plan or strategy within the Trust. Some have been adapted and reworded to make them more current to the teams committing to delivery of them.

In addition, all the quality priorities have been linked to the trust's governing objectives as described in Part 1 of this report so as to align our quality performance aims with the overall strategic ambitions of the trust.

Patient Experience	
Our quality priorities and why we chose them:	**What success looks like:**
1. Establish shared principles for involving patients and carers in our services to better monitor their experiences and make relevant improvements **NEW** This priority supports delivery of our year two/three quality goal to transform the relationships we have with our patients and carers	We will build a framework to facilitate and embed high quality, diverse involvement work across the Trust. We will work collaboratively with patients to identify and act on areas for improvement and better understand health inequalities through changes in service utilisation. We will develop clear processes to better understand the experience of patients with learning disabilities and work with patients and carers in the co-production and design of our services. We will Make Every Contact Count by supporting the prevention of poor health across the North Central London patch.
2. Establish a world class dementia care service operating across inpatient settings Trust wide **NEW** This priority supports delivery of our year one quality goal to understand and improve the experience for our patients and carers	We will ensure we remain a 'dementia friendly' hospital through ongoing delivery of the Dementia Clinical Practice Group five workstreams: Delirium, Distressed behaviour, Assessment, Discharge and Carers. We will measure the impact of the service on critical outcomes through collection of patient and carer feedback and use this to identify areas for improvement.
3. Patients who are recognised as likely to be in the last year of life will be offered a conversation about their personal preferences and priorities for their future care **Continue from 21/22, wording adapted in light of new national guidance** This priority supports delivery of our year one quality goal to understand and improve the experience for our patients and carers	We will ensure that in these conversations patients' wishes, preferences and priorities for their future care will be explored. These are likely to be a number of conversations and with whomever the person wishes to involve. We will ensure that there will be agreement of treatment plans, and a comprehensive discharge/clinic summary will be written so the person can review their own care plan.
4. Keep patients informed and regularly updated about waiting times in outpatient clinics **NEW** This priority supports delivery of our year one quality goal to understand and improve the experience for our patients and carers	We will identify the best methods to keep patients informed and updated of any delays. We will monitor our progress using outpatient surveys to collect patient and carer feedback.

Clinical Effectiveness	
Our quality priorities and why we chose them:	**What success looks like:**
5. Implement a systematic approach to align the following activities at group and business unit levels: planning and prioritisation; progress and performance tracking; quality improvement activity **NEW** This priority supports delivery of our year two/three goal to achieve fundamental quality standards	This will be evidenced by: • The Annual Planning process identifying priority themes and areas for improvement; • Performance data, implementation updates (e.g. CQC) and other sources of insight being used regularly to understand the extent to which progress is being made in key areas of improvement; • Quality Improvement projects and activities being aligned to the themes and areas of improvement identified from annual planning.
6. Systematically spread learning from Quality Improvement activity across teams, services and sites and, where appropriate, scale effective interventions across the RFL group **NEW** This priority supports delivery of our year two/three goal to achieve fundamental quality standards	This will be evidenced by: • QI governance structures being updated to reflect this objective (e.g. in their Terms of Reference); • Broaden involvement of colleagues across the organisation in relevant QI governance forums; • A comprehensive set of processes and activities to spread learning being established.
7. Over the next year the Clinical Practice Group (CPG) programme will embed a further 17 pathways and develop a training package to increase knowledge, skills and capabilities across operational and clinical teams. **NEW** This priority supports delivery of our year one quality goal to improve health outcomes across the group	We will have 54 CPG pathways completed, 44 of which will be built within our EPR. We will work on developing an end-to-end patient care pathway across the integrated care system which targets existing health care inequalities whilst making sure every contact counts. We will give priority to improving emergency flow, elective recovery, cancer care and inpatient enhanced recovery pathways. We will monitor the safety and quality of diabetes care through the digital pathway for inpatient adult diabetes patients.
8. Increase patient recruitment by a further 10% into National Institute for Health Research portfolio to build on achievements of 2021/22 and increase RFL led research (target to be confirmed) **NEW** This priority supports delivery of our year two/three goal to deliver fundamental quality standards	We will provide rapid, responsive, cost effective and transparent clinical research support. We will improve clinical research infrastructure to enable the best possible clinical research opportunities and experience to staff/ patients. We will ensure all of our staff have the opportunity to be part of clinical research regardless of their role or site. We will ensure optimal and equitable access to

*The measures for success detailed in the adjacent column are the strategic objectives of the 5-year Clinical Research and Development strategy and the intention is to achieve them all by 2027 and establish RFL as a top-10 NHS research hospital	excellent clinical research to all patient groups across our local populations. We will work with our partners to maximise the opportunities for clinical research for RFL patients and staff. We will ensure that digitally enhanced and data driven clinical research is enabled throughout our clinical research endeavour.
Patient Safety	
Our quality priorities and why we chose them:	**What success looks like:**
9. As part of the RFL Safety Strategy 2020-2025 to make improvements and to keep patients and staff safe, we will aim to have zero never events this year and ensure that we learn from patient safety incidents **NEW** This priority supports delivery of our year one quality goal to improve health outcomes across the group	We will do this through implementation of the new national Patient Safety Incident Response Framework and ensuring smooth transition to the new processes across the organisation by June 2023. We will embed a culture of learning from incidents through ensuring that 95% of Serious Incident actions are completed and evidenced by the deadline. We will improve our completion rate of open incident investigations. We will appoint a minimum of two 'patient safety partners' by July 2022 and ensure that they are fully trained by July 2023.
10. Improve medicines optimisation ensuring the right patient gets the right medicine at the right time **NEW** This priority supports delivery of our year one quality goal to understand and improve the experience for our patients and carers	We will reduce medicines-related problems at transfer including admission to hospital, discharge from hospital and during internal transfer. Awaiting Medical Safety Board to nominate a few time critical medications to reduce the missed doses as measure of success
11. Improve the way in which we manage violence and aggression from patients **NEW** This priority supports delivery of our year one quality goal to support staff members' mental health and wellbeing	We will ensure staff who are in patient-facing roles receive conflict resolution training and are offered appropriate support following any incidents of violence and aggression. We will ensure all staff who are involved in patient restraint roles have a complete understanding of safe restraint techniques, the legal frameworks and legislation that applies to its use.

12. Achieve zero trust attributed Methicillin-resistant Staphylococcus aureus bacteraemia (MRSA) cases **Continue from 21/22** This priority supports delivery of our year two/three goal to deliver fundamental quality standards	We will do this through continuing to action recommendations from the Trust Infection Prevention and Control Committee (IPCC) including: • Post Infection Reviews (PIR) to be carried out to identify and act on key areas of improvement • Implementing education training plan to improve line care practice
13. Achieve zero trust attributable Clostridium difficile (C. diff.) infection cases with a lapse in care **Continue from 21/22** This priority supports delivery of our year two/three goal to deliver fundamental quality standards	We will do this through continuing to action recommendations from the Trust IPCC including: • Audits on commodes, mattress and pillows • Audit C. diff. knowledge and practice amongst staff • Revitalise the deep cleaning programme across all sites • Review of all cleaning audit reports at site divisional lead meetings • Root cause analysis (RCA) to be carried out in order to identify what changes would prevent reoccurrence • Develop robust and practical action plan with clinical team to reduce rates of C. diff. infection
14. Reduce Gram negative bacteraemias in line with NHS Long Term Plan objective of 50% by 2024/25 **Continue from 21/22** This priority supports delivery of our year two/three goal to deliver fundamental quality standards	We will do this through continuing to action recommendations from the Trust IPCC including: • Regular audits and teaching to monitor practice compliance • PIR to be carried out to identify and act on key areas of improvement • Implementing education training plan to improve line care practice

2.2 Statements of assurance from the board

This section contains the statutory statements concerning the quality of services provided by Royal Free London NHS Foundation Trust. These are common to all quality accounts and can be used to compare us with other organisations.

A. Review of services

During 2021/22 the Royal Free London NHS Foundation Trust provided and/or subcontracted 42 relevant health services.

The Royal Free London NHS Foundation Trust has reviewed all the data available to them on the quality of care in 42 of these relevant health services.

The income generated by the relevant health services reviewed in 2021/22 represents 100% of the total income generated from the provision of relevant health services by the Royal Free London NHS Foundation Trust for 2021/22. The actual income from relevant health services is below plan due to the COVID pandemic, with fixed payments to ensure the Trust meets COVID patient demands and business as usual for the relevant services.

B. Participation in clinical audits and national confidential enquiries

During 2021/22 54 national clinical audits and 5 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 97% national clinical audits and 100% national confidential enquiries for which it was eligible to.

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

The national clinical audits and national confidential enquiries that the Royal Free London NHS Foundation Trust was eligible to participate in during 2021/22 are detailed in Tables 1 & 2 below.

The national clinical audits and national confidential enquiries that the Royal Free London NHS Foundation Trust actually participated in during 2021/22 are also detailed in Tables 1 & 2 below.

The national clinical audits and national confidential enquiries that Royal Free London NHS Foundation Trust participated in, and for which data collection was completed during 2021/22, are listed in Tables 1 & 2 below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

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

Where 2021/22 data is not yet published, the previous year’s reported participation and ascertainment rates are recorded as an indicator.

Key for Table 1 & 2 below:
* = Timeframe for data collection
RFH = Royal Free Hospital
BH = Barnet Hospital
CFH = Chase Farm Hospital

Table 1: Name of audit, eligibility and participation

Name of Audit	Data collection completed in 2021/22	Trust Eligibility to participate	Participation 2021/22	Case ascertainment
Transurethral REsection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment	Yes	Yes	RFH	RFH: N=33 *2022
Cancer: National bowel cancer audit (NBOCA)	Yes	Yes	Reported at trust level, data collected RFH and BH	RFL: N=271 (>80% of expected cases) *2019/20
Cancer: National lung cancer audit (NLCA)	Yes	Yes	Reported at trust level, data collected at RFH and BH CFH service not available	RFL: N =327 *2020/21
Cancer: National oesophago-gastric cancer audit (NOGCA)	Yes	Yes	Reported at trust level, data collected RFH and BH CFH service not available	RFL: 69% (61/88) *2019/20 N=74 *2020/21 (awaiting HES data)
Cancer: National prostate cancer audit	Yes	Yes	RFH, BH and CFH	RFL: N=687 *Apr 21 to 16 Mar 22
Chronic obstructive pulmonary disease (COPD) audit programme: Secondary care	Yes	Yes	Reported at trust level, data collected RFH and BH CFH service not available	RFH: N=25 *Apr 21 to 16 Mar 22 BH TBC
COPD audit programme - Adult Asthma	Yes	Yes	Reported at trust level, data collected RFH and BH CFH service not available	RFH: N=48 *Apr 21 to 16 Mar 22 BH TBC
COPD audit programme - Paediatric asthma	Yes	Yes	BH RFH and CFH service not available	No report was published in 2021/22.
Diabetes: National foot care in diabetes audit (NFCA)	Yes	Yes	RFH and BH CFH service not available	No report was published in 2021/22.
Diabetes: National diabetes in-patient audit (NaDIA)	N/A	Yes	Not undertaken 20/21	N/A

Name of Audit	Data collection completed in 2021/22	Trust Eligibility to participate	Participation 2021/22	Case ascertainment
Diabetes: NaDIA -Harm	Yes	Yes	RFH, BH and CFH	RFL: N=6 *2021/22 (up to 16/03/21)
Diabetes: National pregnancy in diabetes audit (NPID)	Yes	Yes	RFH and BH CFH service not available	BH: N=100 RFH: N=50 * Jan 2018-Dec. 2020
Diabetes: National diabetes Core audit	Yes	Yes	RFH, BH and CFH	N=1300 Type 1 *2019/20 N=935 Type 2 *2019/20
Diabetes: National paediatric diabetes audit (NPDA)	Yes	Yes	RFH, BH and CFH	BH: N = 110 CFH: N = 62 RFH: N= 54 *2019/20
BAUS Cytoreductive Radical Nephrectomy Audit	Yes	Yes	N/A (audit complete)	RFH: N= 2 *2020/21
BAUS Management of the Lower Ureter in Nephroureterectomy Audit	Yes	Yes	RFH	RFH: N=137 *2020/21
Elective surgery -National PROMs programme	No	Yes	RFH, BH and CFH	No contracted PROMs provider in 2021/22. Quality Health is being approved as the new provider.
Falls and fragility fractures audit programme (FFFAP): Fracture liaison service database (FL-SD)	Yes	Yes	BH RFH and CFH service not available	BH: N= 486 *2020
FFFAP: Inpatient falls	Yes	Yes	RFH and BH Reported at trust level	RFL: N= 8 *2020/21 (up to 31/10/2021)
FFFAP: National hip fracture database (NHFD)	Yes	Yes	RFH and BH CFH service not available	BH - 88.7% RFH - 63.4% *2020
Heart: Cardiac rhythm management (CRM)	Yes	Yes	BH RFH and CFH service not available	TBC
Heart: Myocardial infarction national audit project (MINAP)	Yes	Yes	RFH and BH CFH service not available	RFH: N=728 BH: N=185 Total N=913/943 (96.82%) *2019/20
National audit of cardiac rehabilitation (NACR)	Yes	Yes	RFH and BH CFH service not available	RFH: 1/7 KPIs submitted BH: 5/7 KPIs submitted *2020

Name of Audit	Data collection completed in 2021/22	Trust Eligibility to participate	Participation 2021/22	Case ascertainment
Heart: National audit of percutaneous coronary interventions	Yes	Yes	RFH BH and CFH service not available	RFH: N= 1043 (Minimum required is 400) *2019/20
Heart: National heart failure audit (NHFA)	Yes	Yes	RFH and BH CFH service not available	RFH: N=93 BH: N=587** Overall – 52.8% *2019/20
Intensive Care National Audit and Research Centre (ICNARC): Case mix programme (CMP)	Yes	Yes	RFH and BH CFH service not available	RFH: N=1498 BH: N= 749 *2020/21
ICNARC: National cardiac arrest audit (NCAA)	Yes	Yes	RFH and BH CFH service not available	RFH: N=140 BH: N=49 *2020/21
Inflammatory bowel disease (IBD) registry: Biological therapies audit (Adult)	Yes	Yes	RFH and BH CFH service not available	RFH: N=57 (adult) * up to Oct 2021 Children & Young People: RFH and BH non participation during 2021/2022
National audit of breast cancer in older people (NABCOP)	Yes	Yes	Reported at trust level, data collected RFH and BH	RFL: 50-69 years N=768 RFL: 70+years N=243 *2021/2022
National audit of dementia	N/A	Yes	RFH and BH CFH service not available	2020 Data collection suspended due to COVID 19 until 2022
National audit of pulmonary hypertension audit (NAPH)	Yes	Yes	RFH BH and CFH service not available	RFH: N=815 – Minimum required is 300 *2020/21
National audit of seizures and epilepsies in children and young people (Epilepsy 12)	Yes	Yes	RFH and BH CFH service not available	RFL: N = 26/50 (52%) *2020/21
National clinical audit of care at the end of life (NACEL)	N/A	Yes	RFH and BH CFH service not available	Case note review RFH: N=40 BH: N=38 Staff Survey RFH: N=26 BH: N=24
National early inflammatory arthritis audit (NEIAA)	Yes	Yes	RFH, BH, CFH submission data available National report only includes Trust level data	Number of patients recruited. RFH: N=18 BH: N=5 CFH: N=63 *1 Mar 21 - 28 Feb 22
National emergency laparotomy audit (NELA)	Yes	Yes	RFH and BH CFH service not available	RFH: N=136 (94.45) BH: N=25 (16%) *1 Dec ‘19 & 30 Nov ‘20

Name of Audit	Data collection completed in 2021/22	Trust Eligibility to participate	Participation 2021/22	Case ascertainment
National joint registry (NJR)	Yes	Yes	RFH BH and CFH	BH completed ops= 67 (NJR consent rate= 55% CFH completed ops= 399 (NJR consent rate=83% RFH completed ops= 26 (NJR consent rate= 88% *2020
National maternity and perinatal audit (NMPA)	Yes	Yes	RFH and BH CFH service not available	2021 is the first year the NMPA used MSDS (Maternity Services Dataset).No report was available for RFL.
National neonatal audit programme (NNAP)	Yes	Yes	RFH and BH CFH service not available	RFH: N= 8 -100% BH: N= 80 -100% *2020
National vascular registry (NVR)	Yes	Yes	RFH BH and CFH service not available	AAA N=30 *2019/2021 Carotid Endarterectomy N=19 *2020 Lower Limb Angioplasty/Stent N=299 *2018/20 Lower Limb bypass N=126 *2019/2020 Lower Limb Amputation N=54 *2020
RCEM: Pain in children	Yes	Yes	RFH and BH CFH service not available	Still on-going: Data collection is from 4 October 2021 – 3 October 2022.
Sentinel stroke national audit programme (SSNAP)	Yes	Yes	RFH and BH CFH service not available	RFH: Clinical audit: 90%+ (Level A) BH: Clinical audit:98.8% (Level A) *2020/21
Trauma audit research network (TARN) –Major trauma audit	Yes	Yes	RFH and BH CFH service not available	RFH: = 49% BH: 100% *2021
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	Yes	RFH BH and CFH	RFL: N=45 total reports *2020
NCA of Blood Transfusion programme: 2021 Audit of Blood Transfusion against NICE Guidelines QS138	Yes	Yes	RFH and BH	RFH and BH submitted the required data.
National Smoking Cessation 2021 Audit	Yes	Yes	RFH and BH	TBC
Society for Acute Medicine Benchmarking Audit (SAMBA) study	Yes	Yes	RFH and BH CFH service not available	RFH: N=27 *17 June 2021 BH: N= 58 *2021

Name of Audit	Data collection completed in 2021/22	Trust Eligibility to participate	Participation 2021/22	Case ascertainment
Chronic Kidney Disease registry	Yes	Yes	RFH BH and CFH	RFL: N=264 (98% completeness) RRT Patients *2019
LeDer: Learning disability review programme	N/A	Yes	RFH, BH and CFH	No cases have been allocated in 2020/2021
MBRRACE-UK: Perinatal Mortality and Morbidity Confidential Enquiries	Yes	Yes	RFH and BH CFH service not available	100%
MBRRACE-UK: Perinatal Mortality Surveillance	Yes	Yes	RFH and BH CFH service not available	100%
MBRRACE-UK: Maternal Mortality surveillance and mortality confidential enquiries	Yes	Yes	RFH and BH CFH service not available	100%
Perinatal Mortality Review Tool	Yes	Yes	RFH and BH CFH service not available	100%
National Child Mortality Database (NCMD)	Yes	Yes	RFH and BH CFH service not available	100%

Table 2: National confidential enquires: participation and case ascertainment

Name of Programme	Data collection completed in 2020/21	Trust Eligibility to participate	Participation 2021/22	Case ascertainment
National Confidential Enquiry into Patient Outcome and Death (NCEPOD				
Physical health in mental health hospitals	Yes	Yes	RFH and BH CFH service not available	The trust involvement with this study is submission of a data collection spreadsheet to identify patients who have been transferred from a mental health hospital to our services.
Transition from child to adult health services	Underway	Yes	RFH and BH CFH service not available	Clinical questionnaire: In-progress Case notes: In-progress Organisational questionnaire: 1/1
Epilepsy	Underway	Yes	RFH and BH CFH service not available	Clinical questionnaire: In-progress Case notes: 10/10 Organisational questionnaire: 2/2
Crohn's disease	Underway	Yes	RFH and BH CFH service not available	Enquiry in development
Community Acquired Pneumonia	Not started	Yes	RFH and BH CFH service not available	Enquiry in development

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 business unit and group levels.

The reports of TBC **national clinical audits** were reviewed by the provider in 2021/22 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 committees (Clinical Performance and Patient Safety committee and Clinical Standards and Innovation Committee).
- We will use outcomes from national clinical audits to help us prioritise pathway work in our Clinical Practice Groups across our group of hospitals.
- We will continue to make improvements to our clinical processes where national clinical audits suggest care could be improved.

Specific actions undertaken to improve quality	
National clinical audit	**Actions to improve quality**
Falls and Fragility Fractures Audit programme (FFFAP): Inpatient falls	• Falls prevention initiatives that are ongoing within Barnet and the Trust at present are: ○ a weekly Stop the Pressure Falls prevention panel, all patient falls with harm are discussed to identify areas of learning and put actions in place to prevent future falls with harm ○ Falls Steering group, ○ RCP falls audit relating to the recording of lying and standing BP ○ Reducing in-patient falls across Barnet Hospital - QIP programme ○ Frailty group work
Society of acute medicine benchmarking audit (SAMBA)	• A second medical registrar supporting the night time acute medical take from August 2021 to equal the current level of extended daytime registrar cover has been added so we will be able to measure any benefits at the next audit. • There is work to be done on timing of NEWS scores– Matron has shared the report findings with ED, AAU and AEC, highlighting the need for clinical observations on all patients to obtain a NEWS score upon arrival.
National Emergency Laparotomy Audit (NELA)-Barnet Hospital	• Job planning for a new Surgical NELA lead • Case ascertainment to be increased via education and reminders of inclusion criteria displayed in theatres • Preoperative input by a consultant surgeon, intensivist and anaesthetist when documented risk of death >=5% as a local standard of care and documented • Mean post-op length of stay in patients surviving to hospital

Specific actions undertaken to improve quality	
National clinical audit	**Actions to improve quality**
	discharge or alive in hospital at 60 days (days) - The emergency laparotomy CPG is working to include more frailty assessment and input from Medicine for the Elderly team
Epilepsy 12	• Consider the use of screening tools in conjunction with the epilepsy clinical nursing team (when staffing is at capacity) • Team to review consistency of care plan for all patients once epilepsy clinical nurse specialist is at capacity. • Benchmarking exercise with NCL colleagues and other DGH teams • Gather figures from other NCL hospitals
National Asthma and COPD Audit Programme (NACAP) - Adult Asthma (Royal Free)	• The asthma service continues to perform well, with NACAP national audit figures generally better than national medians • We continue to provide severe asthma service as part of regional network, including provision of biologic medications (omalizumab, mepolizumab, benralizumab) on site and via homecare, with rapid increase in Homecare provision in response to COVID pandemic allowing our patient cohort to safely continue their treatment. • We will actively review case ascertainment for the NACAP audit using Trust data on asthma admissions • Business cases for additional CNS and pharmacy support have been submitted or are in development. We have applied for temporary additional industry funding to try and mitigate current staffing problems.
Sentinel Stroke National Audit Programme (SSNAP) - Clinical Audit and Organisational Audit (Royal Free)	• Levels of therapy input have remained high throughout the year. • Transfers from the HASUs have continued in a prompt and timely fashion. • SSNAP scoring has been maintained through the year. • This coming year we will aim the re-establish our outreach working and look to start up again our carers groups. • We continue to work closely with our community team colleagues in order to further promote the best outcomes and on-going treatment pathways for our patients as they move from the acute setting onto the rehabilitation phase of their recovery.
Sentinel Stroke National Audit Programme (SSNAP) - Post Acute Organisational Audit (Neurological rehabilitation centre)	• Increase access to research and patients being recruited to studies across NCL • Training for nurses and rehab assistants – to access weekly MDT training from RFL 6S and to explore options for further stroke education at the NRC • To re -establish NRC training programme to include stroke • To establish medical training from consultant neurologist to MDT • Progress business case for neuro psychology wokforce • Progress business case for therapy workforce • Liaison with stroke association for support / carer support across NCL

Specific actions undertaken to improve quality	
National clinical audit	**Actions to improve quality**
	• Liaison with NCL CCG for access to SW for all NCL patients • Equipment : to progress RFL charity application for balance training to support patients with complex needs
National Emergency Laparotomy Audit (NELA) (Royal Free)	• Maintain mortality rate below national levels • High risk patients assess by Consultant team (surgeon and Anaesthetic) • Input by consultant care of elderly (dedicated surgical HSEP service) • Funding to NELA and ERAS programme , currently there is not nurse support • Discuss the need for dedicated emergency theatre in view of increase demand (not shared with transplant services) • Dedicated time to present audit results, the current audit timetable is not sufficient.
National Vascular Registry	• We have significantly improved the percentage of non-elective lower limb revascularisations treated within 5 days, from 38% in 2019 (national average 50%) to 70% in 2020 (national average 58%). • Our in hospital mortality for elective open infra-renal aortic aneurysm repair is 0%. • Only 47% of our carotid endarterectomy patients are operated on within the 14 days guidelines. The National (England) average is 62%. However, UCLH patients are within our envelope and 86% of those patients were operated on within 14 days. • This may reflect that more complex patients are operated upon at RFH, or else that they have come to RFH because there was no theatre availability at UCLH. • These figures represent a period of time before PACU was opened. • There are plans to increase theatre access at the RFH site so that robust pathways can be adhered to for these patients.
RCEM Care of Children (Care in Emergency Departments) (Royal Free)	• Standard 1 (developmental) – Infants at high risk of potential safeguarding presentations reviewed by a senior (ST4+) clinician whilst in the ED: RFH average 88%, national average 79%. • Standard 4 – Policies are in place to review cases where an infant, child or adolescent either leaves or absconds from a department unexpectedly prior to discharge, or when they do not attend for planned follow up: YES [National 94% of 106 EDs] • Standard 5 – Systems are in place to identify children and young people who attend frequently: YES [National 97% of 106 EDs] • Standard 6 – Policies are in place to identify and review children at high risk of potential safeguarding: YES [National 99% of 106 EDs] • Standard 2 All self-discharged patients have their notes reviewed by the child safe guarding team on next working day. However, for those who leave on a Friday this could be more problematic.

Specific actions undertaken to improve quality	
National clinical audit	**Actions to improve quality**
	Therefore, we have introduced a tray where notes requiring review are placed for Registrars to review at the beginning or end of their shift. • Standard 2 may also reflect lack of documentation. Most Registrars did review the patient notes and discuss with nursing staff that had triaged to identify if patients needed to be contacted but this was rarely recorded. Importance of documentation highlighted to registrars. This is also affected if nursing staff remove self d/c patient from the screen – this has been highlighted to paeds nursing staff also. • Standard 3 – Introduce HEADSSS screening tool for relevant patient cohort. Including staff education and sticker to attach to notes once done. • We are currently in the process of introducing a new EPR in Sep '21. There is a HEADSSS proforma available within the EPR and we are exploring the possibility of triggering an automatic prompt for children aged 12-17 to consider a HEADSSS assessment
RCEM Assessing Cognitive Impairment in Older People (Care in Emergency Departments) (Royal Free)	• Cognitive impairment could be incorporated into the new EPR Cerner transformation as a mandatory component, which could then be relayed to the GP. • An assessment of cognition using AMT4 has been included in the AAU admission proforma. • The AAU discharge form could be upgraded to include TREAT/HSEP style discharge points – to include frailty score, cognitive assessment and advanced care planning notification (for all aged >65).

C. Participating in clinical research

The number of patients receiving NHS services provided or sub-contracted by Royal Free London NHS Foundation Trust in 2020/21 that were recruited during that period to participate in research approved by a research ethics committee was 11137.

D. CQUIN payment framework

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

The CQUIN framework has been suspended for the past two years owing to the COVID-19 pandemic and therefore there is no reporting against CQUINs in this year's report. CQUINs have returned for 2022/23 and the Trust will be able to report on its participation in next year's quality account report.

E. Registration with the Care Quality Commission (CQC)

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

The Care Quality Commission has not taken enforcement action against Royal Free London NHS FT during 2021/2022 reporting period.

The Royal Free London NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during 2021/22.

The Royal Free London NHS Foundation Trust was subject to a CQC un-announced follow up inspection in May and June 2021 of the maternity services at both Royal Free Hospital and Barnet Hospital respectively. The inspection was to follow up on the improvements undertaken to our maternity services in order to assure the regulator that our improvement actions had addressed the concerns identified by the Section 29A warning notice issued in November 2020.

The maternity service at the Royal Free Hospital site was given a rating of requires improvement for Safe and Well Led in August 2021 as a result of the inspection in May. The service was previously rated as inadequate and issued a section 29A notice following the inspection in October 2020. Barnet Hospital maternity service has retained its 'good' rating following the CQC's inspection in June 2021.

The CQC welcomed the improvements in the Trust's maternity services. The August inspection report made a total of fourteen recommendations that required action to be taken across both sites to ensure the areas requiring improvement were met.

The on-going monitoring of the improvement plans by the maternity service senior management team report progress to Barnet Hospital Local Executive Committee. The Clinical Standards and Innovation Committee, who have delegated board oversight of the improvement actions performance and completion, receives a monthly update on the progress of the improvement actions from Barnet Hospital executive team.

To date a significant amount of improvement work has been undertaken across those areas identified by the CQC and this will continue. We have shared the details of our action plan and its current completion status as part of Appendix A. In addition we have continued to focus on the historical improvement requirements as identified from our 2019 comprehensive CQC inspection report.

Details of our on-going improvement outcomes can be found in Appendix B of these accounts.

F. 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.

I. 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.

II. General Medical Practice Code

The percentage of records in the published data which included the patient's valid General Medical Practice Code was: Awaiting 21/22 data

	2018/19	2019/20	2020/21
For admitted patient care	99.8%	99.9%	99.9%
For outpatient care	100%	99.9%	99.9%
For accident & emergency care	100%	100%	100%

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

- The Data Quality team will be working with underperforming teams to ensure agreed KPIs are being met. Action plans will be put in place to resolve issues and any issues will be escalated to divisional management if required.
- The data quality dashboard will continue to be monitored and new KPIs will be added to ensure that we detect early any issues with our internal and external submissions.
- The Data Quality will support the data migration into our new PAS.
- Audits will take place to ensure data is being captured correctly and workflows will be provided to staff to help them get it right first time.

III. Information Governance (IG)

The Data Security and Protection Toolkit (DSPT) is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. It is a statutory requirement to comply with the DSPT as it is an information standard published under section 250 of the Health and Social Care Act 2012. All organisations that have access to NHS patient data and systems must use the DSPT to provide assurance that they are practising good data security and that personal information is handled correctly. The requirements of The Network & Information Systems (NIS) Regulations also align to DSPT standards. The DSPT is an annual assessment. As data security standards evolve, the requirements of the Toolkit are reviewed and updated to ensure they are aligned with current best practices.

The 2019/20 DSPT incorporated additional requirements into the standards. This was to provide comparable assurance to that of Cyber Essential. NHS Digital's strategy is to gradually raise standards across NHS trusts in regards to cyber security.

The Royal Free London NHS Foundation Trust is working towards the 2021/22 DSPT submission deadline of June 2022 and is expected to reach a status of 'approaching standards'. Where partial or non-compliance is identified, the trust will take appropriate measures. The trust has an action plan in place which it will continue to complete to ensure that 'standards met' is reached prior to NHS Digital's remediation deadline of December 2022.

G. 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 2021/22 by the Audit Commission.

H. Learning from deaths

Hundreds of patients come through our doors on a daily basis. Most patients receive treatment, get better and are able to return home or go to other care settings. Sadly, and inevitably, some patients will die here - this is approximately 1% of all admissions.

Whilst most deaths are unavoidable and would be considered to be 'expected'; there will be cases where sub-optimal care in hospital may have been a contributory factor. The trust is keen to take every opportunity to learn lessons to improve the quality of care for other patients and families.

During 2021/22, 1429 of the Royal Free London NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 433 in the first quarter; 483 in the second quarter; 513 in the third quarter.

Further information to be included once Q4 data has been reviewed

Due to differences in the reporting periods for Learning from deaths (LfD) reviews and the Quality Accounts, for completeness data is included here for 2020/21 quarters 3 and 4, as these were not included in last year's Quality Accounts. Likewise review data for 2021/22 quarters 3 and 4 are not available for inclusion in this year's Quality Accounts. The complete data presented in the tables covers the period from October 2020 to September 2021.

Table Summary of Learning from deaths (LfD) reviews

Reporting period		**Number of deaths**	**Number of reviews completed**	**Number of serious incident investigations**	**Number of the patient deaths considered likely to be avoidable**	**Percentage of the patient deaths considered likely to be avoidable**
Third quarter	October 2020 to December 2020	541	34	4	2	0.36%
Fourth quarter	January 2021 to March 2021	889	42	6	1	0.11%
Total		**1430**	**76**	**10**	**3**	**0.21%**
First quarter	April 2021 to June 2021	433	29	7	3	0.69%
Second quarter	July 2021 to September 2021	483	22	1	0	0.00%
Total		**916**	**51**	**8**	**3**	**0.33%**

Reporting period		Number of deaths	Number of reviews completed	Number of serious incident investigations	Number of the patient deaths considered likely to be avoidable	Percentage of the patient deaths considered likely to be avoidable
Third quarter	October 2021 to December 2021	513	Not yet completed	Not yet completed	Not yet completed	Not yet completed
Fourth quarter	January 2022 to March 2022		Not yet completed	Not yet completed	Not yet completed	Not yet completed
Total						

Reporting period 2020/21 (Q3 and Q4) 2021/22 (Q1 and Q2) – October 1st 2020-September 30th 2021

By 31/03/22, 127 case record reviews and 18 serious incident investigations have been carried out in relation to 2346 of the deaths included in the information presented in the table.

Further information to be included once Q4 data has been reviewed

In 18 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out is shown in the table.

6 representing 0.26% of patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

These numbers have been estimated using the Likert avoidability scales in line with the Learning from Deaths (LfD) policy and the Incident management policy. Scores of 1-3 indicate those deaths considered likely (i.e. over 50%) to be avoidable. These scores are determined by the Safety incident review panel (SIRP).

Likert avoidability Scale:

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

Summary of lessons learnt

The themes of lessons learnt summarised below relate to all patient deaths which were reviewed as part of this process. We have included examples of good practice and areas for improvement. We share the learning from deaths, serious incidents and near misses throughout our organisation as part of our on-going efforts to improve the consistency and quality of the care provided to our patients.

Good practice	Areas for improvement

• Discussions with multi-disciplinary teams (MDT)
• DNAR (Do Not Attempt Resuscitation) fully documented
• Patients treatment 'best interest' led to swiftly provide excellent care
• Compassionate care and discussions with family
• Impartial learning from deaths reviews
• Appropriate investigations ordered and reviewed in a timely manner
	• Earlier recognition of dying
	  ○ care planning
	  ○ management
	  ○ communication with patients and their families;
	  ○ referral to palliative care
	• Documentation,
	  ○ including outcomes from morbidity and mortality meetings
	  ○ risk assessments
	• backlog of learning from deaths to review

The 18 incidents below relate to those patient deaths which were considered likely to be avoidable were identified and reported as serious incidents:

Further information to be included once Q4 data has been reviewed

Incident	FinYear	Quarter	Likert Avoidability
2020/21146	2020/21	Q3	4 Possibly avoidable but not very likely, less than 50/50
2021/3880	2020/21	Q3	4 Possibly avoidable but not very likely, less than 50/50
2020/23168	2020/21	Q3	6 Definitely not avoidable i.e. unavoidable
2021/362	2020/21	Q3	2 Strong evidence of avoidability
2021/2686	2020/21	Q4	4 Possibly avoidable but not very likely, less than 50/50
2021/3866	2020/21	Q4	4 Possibly avoidable but not very likely, less than 50/50
2021/4458	2020/21	Q4	5 Slight evidence of avoidability
2021/6305	2020/21	Q4	4 Possibly avoidable but not very likely, less than 50/50
2021/6738	2020/21	Q4	4 Possibly avoidable but not very likely, less than 50/50
2021/7290	2020/21	Q4	2 Strong evidence of avoidability
2021/15304	2021/22	Q1	3 Probably avoidable, more than 50/50
2021/11759	2021/22	Q1	2 Strong evidence of avoidability
2021/13287	2021/22	Q1	6 Definitely not avoidable i.e. unavoidable
2021/12188	2021/22	Q1	
2021/13298	2021/22	Q1	1 Definitely avoidable
2021/14813	2021/22	Q1	3 Probably avoidable, more than 50/50
2021/14325	2021/22	Q1	4 Possibly avoidable but not very likely, less than 50/50
2021/17982	2021/22	Q2	3 Probably avoidable, more than 50/50

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

These actions are logged in our Risk Management system Datix, and are monitored by our hospital Clinical performance & patient safety committees and Clinical standards and innovations committee (CSIC) to ensure completion and compliance.

In addition, a number of actions are also reviewed by our commissioners, providing external assurance of our processes. This ongoing external review has been completed to the satisfaction of our commissioners.

I. Seven day hospital services

The seven day services programme is designed to ensure patients that are admitted as an emergency, receive high quality consistent care no matter which day they enter hospital. Providers have been working to achieve all these standards, with a focus on four priority standards:

Standard 2 - Time to first consultant review

Standard 5 - Access to diagnostic services

Standard 6 - Access to consultant-led interventions

Standard 8 - Ongoing review by consultant daily for all patients admitted as an emergency

In November 2019, the Trust submitted its 2019/20 self-assessment to NHSE/I. This self-assessment described our compliance with the four priority standards. During the pandemic no self-assessments were carried therefore the Trust did not submit data in relation to seven day services in 2020/21 and has not collected any relevant audit data during 2021/22.

In February 2022 NHSE/I updated the guidance in recognition of the internal data collection burden placed on trusts and has moved away from clinical audit to measuring operational performance against the standards. This can now be measured using the Trust's newly implemented EPR and will be reported on in next year's account.

Further information to be included once annual report has been reviewed

2.3 Reporting against core indicators

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

Areas covered will include:

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

This information is based on the most recent data that we have access to from NHS Digital and the format is presented in line with our previous annual reports.

1) Summary hospital-level mortality Indicator (SHMI)

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

Royal Free Performance Oct 17 to Sep 18	Royal Free Performance Oct 18 to Sep 19	Royal Free Performance Oct 19 to Sep 20	Royal Free Performance Oct 20 to Sep 21	National Average Performance Oct 20 to Sep 21	Highest Performing NHS Trust Performance Oct 20 to Sep 21	Lowest Performing NHS Trust Performance Oct 20 to Sep 21
0.8270 (lower than expected)	0.8207 (lower than expected)	0.8501 (lower than expected)	0.8192 (lower than expected)	1.0 (as expected)	0.7132 (lower than expected)	1.1909 (higher than expected)

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 SHMI score published in this report has been calculated by NHS Digital and uses finalised HES data.

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.

The Royal Free London NHS Foundation Trust considers that this data is as described as it has been sourced from NHS Digital.

The latest data available covers the 12 months October 2020 to September 2021. During this period the Royal Free had a mortality risk score of 0.8192, which represents a risk of mortality lower than expected for our case mix. This represents a mortality risk statistically significantly below (better than) expected with the Royal Free ranked 7th out of 124 non-specialist acute trusts, an improvement of three places compared to the same position last year.

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

Royal Free Performance Oct 17 to Sep 18	Royal Free Performance Oct 18 to Sep 19	Royal Free Performance Oct 19 to Sep 20	Royal Free Performance Oct 20 to Sep 21	National Average Performance Oct 20 to Sep 21	Highest Performing NHS Trust Performance Oct 20 to Sep 21	Lowest Performing NHS Trust Performance Oct 20 to Sep 21
40.8%	35%	37%	40%	39%	63%	12%

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 considers that this data is as described for the following reasons; the data has been sourced from NHS Digital.

2) Patient reported outcome measures scores (PROMS)

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. The difference between the two sets of responses is used to determine the outcome of the procedure as perceived by the patient.

PROMS measure health gain in patients undergoing hip replacement, knee replacement and up to September 2017, varicose vein and groin hernia surgery in England, based on responses to questionnaires. Clinicians are required to regularly review scores at a service and Trust level to ensure that what we learn from patient feedback is incorporated into our quality improvement programmes.

The Trust is currently out to tender for a PROMS provider and has no data for 2021/22.

3) Emergency readmissions within 28 days

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. Internally, the trust review its 30-day emergency readmission rates for elective patients as part of its board key performance indicators.

Royal Free Performance 2017/2018	Royal Free Performance 2018/2019	Royal Free Performance 2019/2020	Royal Free Performance 2020/2021	National Average Performance 2020/2021	Highest Performing NHS Trust Performance 2020/2021	Lowest Performing NHS Trust Performance 2020/2021
Patients aged 0 to 15 years old						
10.5%	9.4%	9.1%	**9.2%**	11.9%	2.8%	64.4%
Patients aged 16 years old or over						
12%	13.2%	13.9%	**13.3%**	15.9%	1.1%	112.9%

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 Royal Free carefully monitors the rate of emergency readmissions as a measure for quality of care and the appropriateness of discharge. A low, or reducing, rate of readmission is seen as evidence of good quality care. The table above demonstrates that the 28 day readmission rate at Royal Free London NHS Foundation Trust continues to perform strongly, with lower than average readmission rate in paediatric cohorts and for adult patients.

We also undertake detailed enquiries into patients classified as readmissions with our public health doctors, working with GP's and identifying the underlying causes of readmissions.

4) Responsiveness to the personal needs of our patients

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

Royal Free Performance 2016/2017	Royal Free Performance 2017/18	Royal Free Performance 2018/19	Royal Free Performance 2019/20	National Average Performance 2019/20	Highest Performing NHS Trust Performance 2019/20	Lowest Performing NHS Trust Performance 2019/20
68.3	67.1	64	**66.7**	67.1	84.2	59.5

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

The NHS has prioritised, through its commissioning strategy, improvement in hospital responsiveness to the personal needs of its patients. Information is gathered through patient surveys. There were significant changes made to the adult inpatient questionnaire for 2020/21 including the way in which it is scored therefore no data is available for comparison to the previous years above.

5) Staff recommendation to friends and family

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 is represented in the below table.

Royal Free Performance 2018	Royal Free Performance 2019	Royal Free Performance 2020	Royal Free Performance 2021	National Average Performance 2021	Highest Performing NHS Trust Performance 2021	Lowest Performing NHS Trust Performance 2021
73%	71%	77%	**71%**	67%	90%	44%

The Royal Free London NHS Foundation Trust considers that these data are as described for the following reasons; the data have been sourced from the official NHS Staff Survey.

Each year the NHS surveys its staff and one of the questions looks at whether or not staff would be happy with the standard of care provided by their organisation if they had a relative or friend who needed treatment. Trust performance is above the national average for acute trust providers on this measure. The Royal Free London NHS Foundation Trust performed marginally worse than in previous years and just below average compared to Acute NHS providers.

6) Venous thromboembolism (VTE)

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

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

Royal Free Performance Oct 18 to Dec 18	Royal Free Performance Oct 19 to Dec 19	Royal Free Performance Oct 20 to Dec 20	Royal Free Performance Oct 21 to Dec 21	National Average Performance Oct 19 to Dec 19	Highest Performing NHS Trust Performance Oct 19 to Dec 19	Lowest Performing NHS Trust Performance Oct 19 to Dec 19
96.5%	96.9%	N/A	**N/A**	95.0%	100.0%	71.6%

VTE is a significant international patient safety issue. Clinicians and pharmacists must assess all patients to identify their risk of VTE and bleeding as soon as possible after admission or by the time of the first consultant review. As part of the National VTE Prevention Programme, all Trusts should have a **95% compliance** of VTE risk assessment on admission for all inpatients aged 16 and over.

The VTE data collection and publication is currently suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic. This was communicated via this letter on 28th March 2020.

7) Clostridium difficile (C. diff.)

The rate per 100,000 bed days of C. diff. infection cases that have occurred within the trust amongst patients aged 2 or over are demonstrated in the table below.

Royal Free Performance 2017/2018	Royal Free Performance 2018/2019	Royal Free Performance 2019/2020	Royal Free Performance 2020/2021	National Average Performance 2020/2021	Highest Performing NHS Trust Performance 2020/2021	Lowest Performing NHS Trust Performance 2020/2021
24.7	16	14.6	16.1	15.4	0	80

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

C. diff. is an infection which can cause severe diarrhoea and vomiting and has been known to spread within hospitals, particularly during the winter months. Reducing the rate of C. diff. infections is a key government target. Royal Free London NHS Foundation Trust performance was better than the national average during 2020/21 and showed an improvement on 2019/20 rates.

8) Patient safety incidents

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

	Royal Free Performance 1st April 2020 – 31st Mar 2021	National Average NHS Acute Hospitals Performance	Range across NHS Acute Hospitals
A	47.6	58	27.2 - 118.7
B	0.4%	0.49%	0 - 2.8%

Every 12 months, NHS Improvement publishes official statistics on the incidents reported to the National Reporting and Learning System (NRLS). These reports give NHS providers an easy-to-use summary of their current position on patient safety incidents reported to 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 to support the NHS to deliver improvements in patient safety.

NHS Improvement regards the identification and reporting of incidents as a sign of good governance with organisations reporting more incidents potentially having a better and more effective safety culture. The trust reported a similar volume of incidents per 1,000 bed days between April 2020 and March 2021 (47.6) as other organisations, improving our reporting from 37.6 in the previous year's data.

The trust has taken the following actions to improve this percentage, and so the quality of its services, by launching our Safety Strategy (2020-2025) with six key drivers that are in line with the National Patient Safety Strategy published in July 2019.

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

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

Further information to be included once Q4 data has been reviewed

Part three: Overview of the quality of care in 2021/22

This section of the quality report presents an overview of the quality of care offered by the Trust based on performance in 2021/22 against indicators and national priorities selected by the board in consultation with our stakeholders.

The charts and commentary contained in this report represent the performance for all three of our main hospital sites. This approach has been taken to ensure consistency with the indicators the trust is required to report on by the NHS Improvement Single Oversight Framework and to show key performance indicators that are requested by the Royal Free London NHS FT Board.

Where possible, performance is described within the context of comparative data which illustrates how the performance at the trust differs from that of our peer group of English teaching hospitals. The metrics reproduced in this section are a list of well-understood metrics that help measure clinical outcomes, operational efficiency, waiting times and patient safety.

Relevant quality domain	Quality performance indicators
Section 1: Patient safety	• Methicillin-resistant staphylococcus aureus (MRSA) • C. difficile Infections
Section 2: Clinical effectiveness	• Referral to treatment (RTT) • A&E performance • Cancer waits • Average length of stay (elective and non-elective) • 30-day emergency readmission rates for elective patients
Section 3: Patient experience	• National surveys • Friends and Family Test • Volume of cancelled operations

Definitions

The following table sets out the definition for each performance measure. These are, to the best of our knowledge, consistent with standard national NHS data definitions.

Indicator / Metric	Description / Methodology	Source
MRSA	The count of meticillin resistant Staphylococcus aureus (MRSA) bacteraemias attributed to the trust.	Datix system
C. Difficile infections	Number of Clostridium Difficile infections reported at the trust	Datix system
C. Difficile lapses in care	Number of Clostridium Difficile infections due to lapses in patient care	Datix system
RTT Incomplete Performance - % waiting less than 18 weeks	Percentage of patients on the incomplete RTT patient tracking list waiting 18 weeks or less for treatment or discharge from referral.	Cerner system
Accident and Emergency – 4hr standard	Percentage of A&E attendances where the patient was admitted transferred or discharged within 4 hours of their arrival at an A&E department.	Cerner system
2 Week Wait - All Cancer	Percentage of patients referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment or diagnostic.	Infoflex system
2 Week Wait - symptomatic breast	Percentage of patients referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for their first outpatient appointment.	Infoflex system
31 day wait diagnosis to treatment	Percentage of patients waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers.	Infoflex system
62 day wait - from urgent GP referral	Percentage of patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer. There are new reallocation rules which have been in place since April 2019. These affect pathways which are shared between providers, and allocate breaches based primarily on: a) whether the referring provider has sent the appropriate referral within 38 days and b) whether the treating provider has started treatment within 24 days	Infoflex system
Average length of stay (non-elective and elective)	Mean length of stay for all inpatients based on whether their mode of admission was elective or non-elective. This includes patients with a 0-day length of stay.	Stethoscope
30-day re-admission rate following elective or non-elective spell	Number of emergency re-admissions within 30 days of discharge as proportion of total discharges following an elective admission; and Number of emergency re-admissions within 30 days of discharge as a proportion of number of discharges following an elective admission.	Stethoscope
Cancelled operations	Volume of last minute (on the day of surgery or following admission) cancellations for non-clinical reasons as a proportion of all elective inpatient and day-case operations.	Cerner system

Notes on the charts

Performance over time is presented in a control chart with benchmarking presented as bar charts.

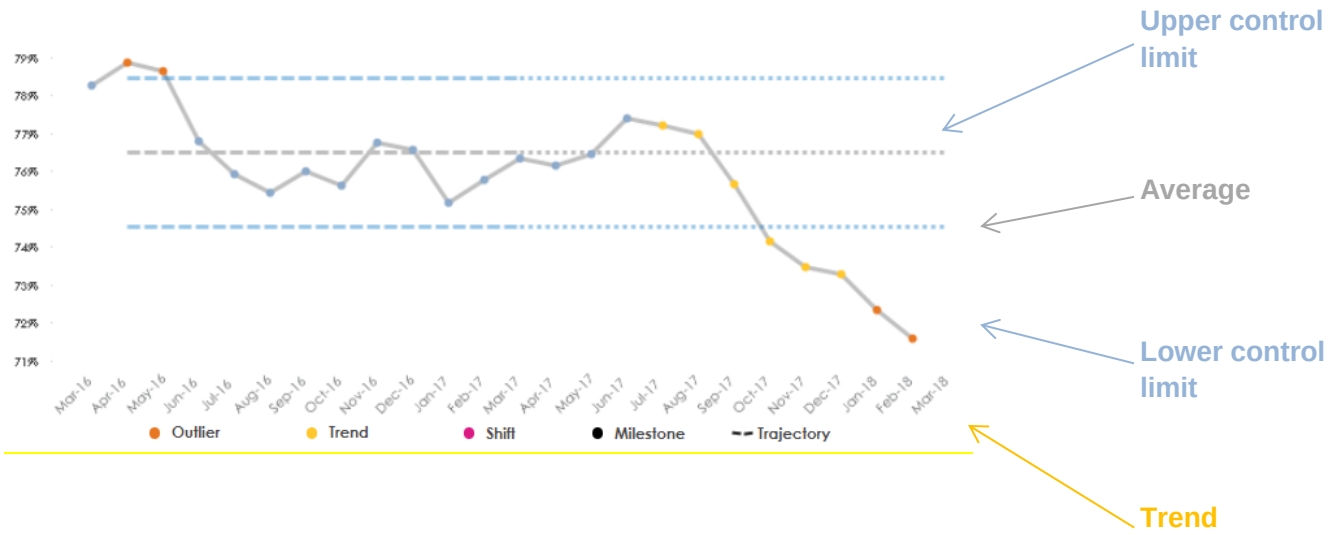
Control charts

The control chart is a graph used to study how a process changes over time. Data are plotted in time order. A control chart always has a central line for the average, an upper line for the upper control limit and a lower line for the lower control limit. These lines are determined from historical data. By comparing current data to these lines, you can draw conclusions about whether the process variation is consistent (in control) or is unpredictable (out of control, affected by special causes of variation).[1]

Where there has been variation that signals a change in the underlying process, this is marked on the chart as:

- Outlier - data points either above the upper control limit or below the lower control limit
- Trend - 6 or more points either all ascending or all descending
- Shift - 8 or more points either all above or all below the average line

Example control chart



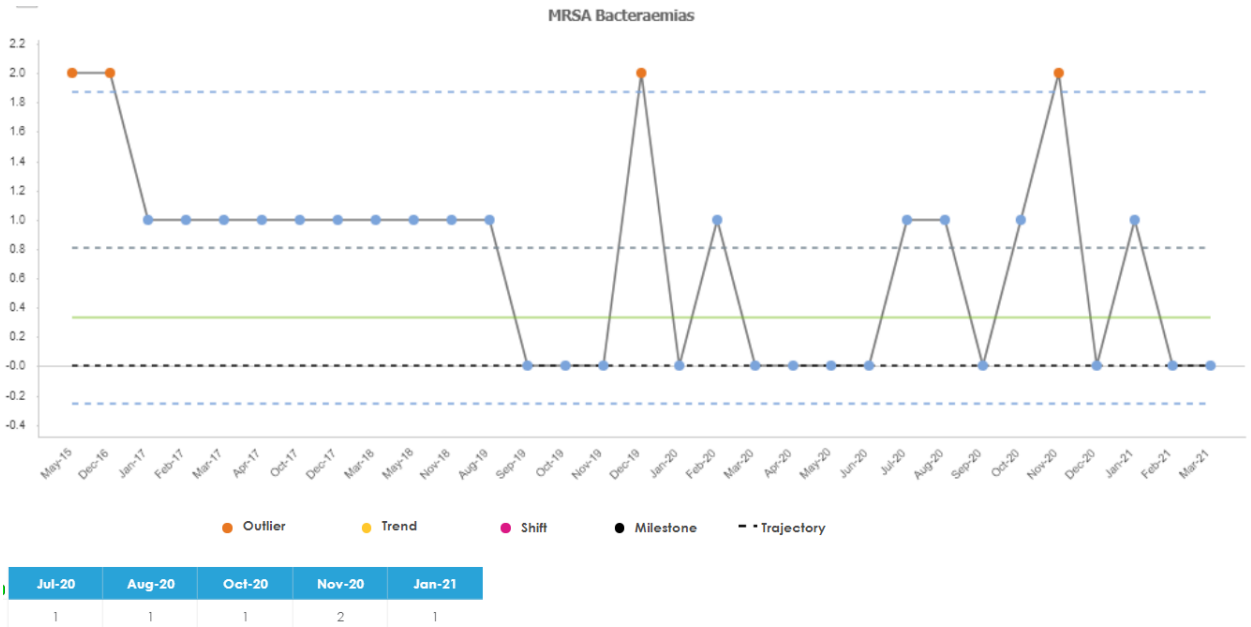
[1] http://asq.org/learn-about-quality/data-collection-analysis-tools/overview/control-chart.html

3.1 Performance against nationally selected indicators

Section 1: Patient Safety

Methicillin-Resistant Staphylococcus Aureus (MRSA)

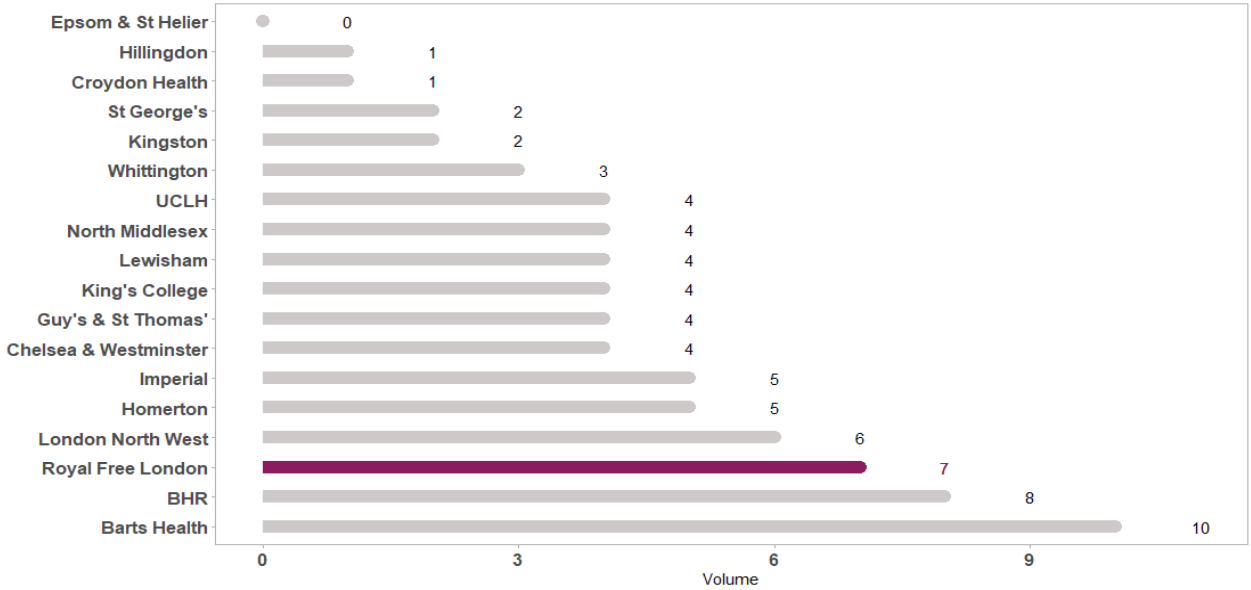
MRSA is an antibiotic resistant infection associated with admission to hospital. The infection can cause an acute illness, particularly when a patient's immune system may be compromised due to an underlying illness. Reducing the rate of MRSA infections is vital to ensure patient safety and is indicative of the degree to which our hospitals prevent the risk of infection by ensuring cleanliness of their facilities and good infection control compliance by their staff.



Source: Royal Free London NHS FT 2015-2021

Further information to be included once 2021/22 data has been reviewed.

Chart: Total volume of MRSA bacteraemias, March 2020 - March 2021

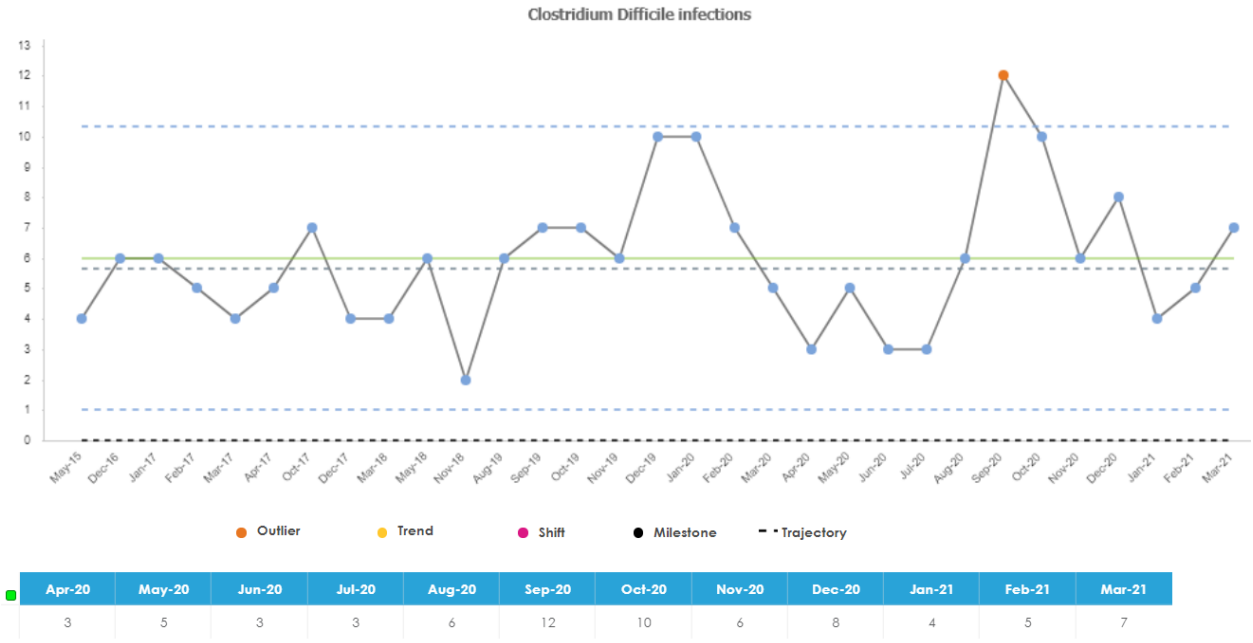


Source: https://www.gov.uk/government/statistics/mrsa-bacteraemia-monthly-data-by-location-of-onset

C. difficile

In relation to C. difficile the trust saw stable performance throughout 2020-21 with the exception of one negative outlier in September 2020.

Further information to be included once 2021/22 data has been reviewed

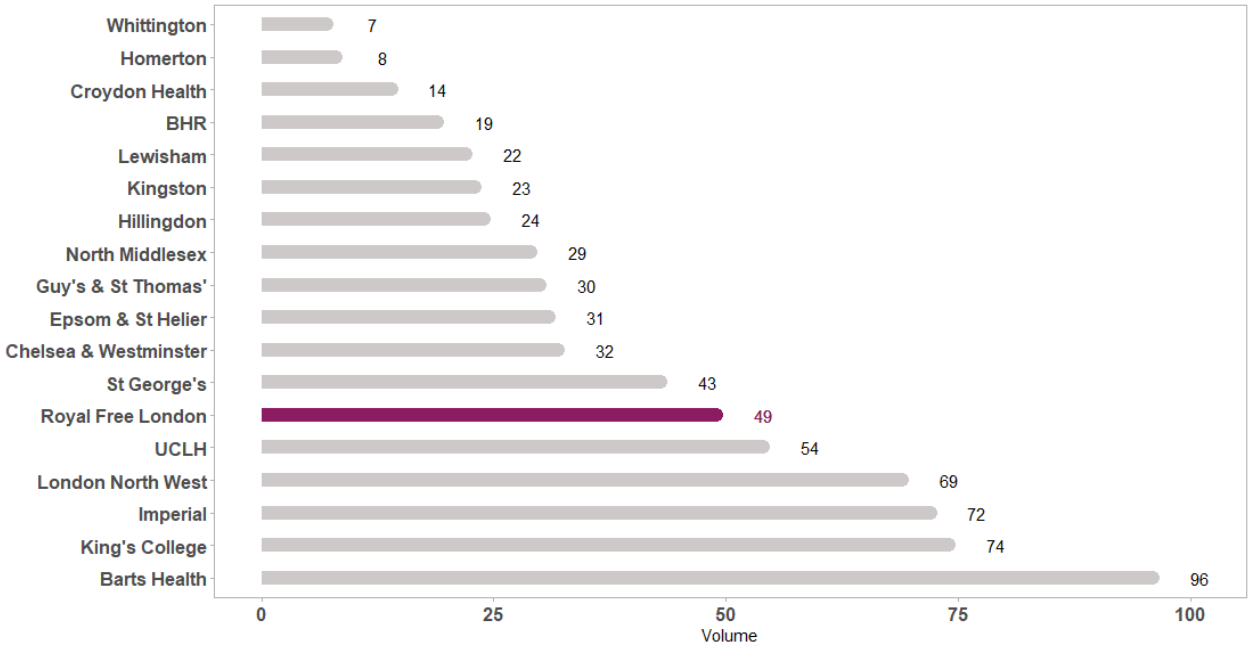


Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
3	5	3	3	6	12	10	6	8	4	5	7

Source: Royal Free London NHS FT 2015-2021

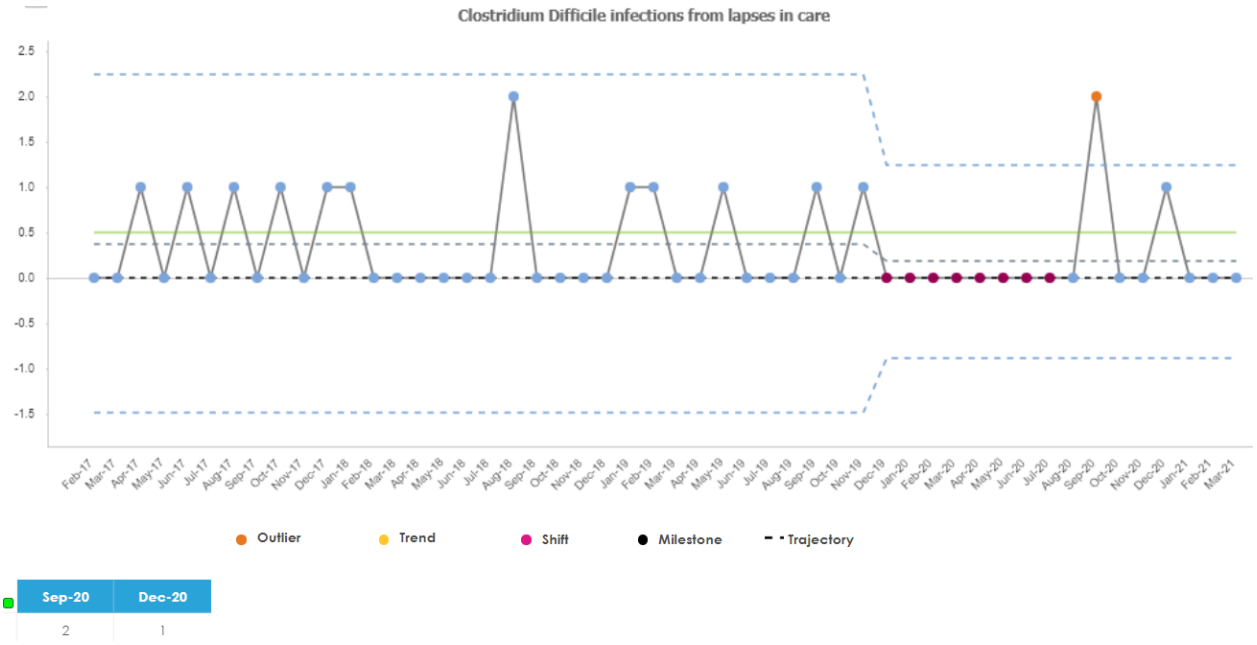
Benchmarking data is available only up to March 2019. Over this time period, the Royal Free London reported 49 infections, the 4th highest compared to the 10 benchmark providers.

Chart: Total volume of c. difficile infections, April 2020 – March 2021



Source: https://www.gov.uk/government/statistics/c-difficile-infection-monthly-data-by-prior-trust-exposure

However, of the c. diff. volumes that can be attributed to “lapses in case” by the trust are significantly lower. Against this measure of performance the trust has seen 3 incidents in the 12 months prior to March 2021.



Source: Royal Free London NHS FT 2017-2021

Section 2: Clinical Effectiveness

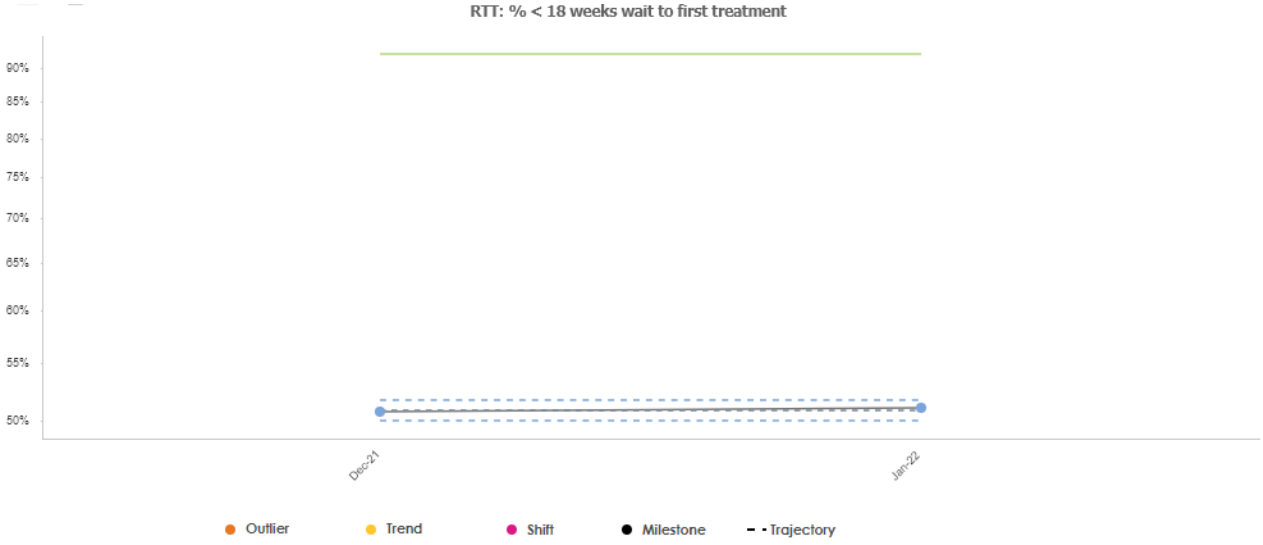
Referral to treatment (RTT)

18-week waiting times

The Trust returned to national reporting in March 2021 following a period of over 2 years of non-reporting due to concerns about the quality and accuracy of data. The decision to report to national reporting was jointly made by the Trust and commissioners (North Central London (NCL). The Trust returned to national reporting with the highest volume of patients waiting over 104+ weeks for first definitive treatment and the highest volume of patients waiting over 52+ weeks for first definitive treatment. Since then, the trust has reduced the volume of patients waiting more than 52 weeks from 14,962 in March 2021 to 6,730 in February 2022 (not yet finalised) a reduction of 8,232 / 55%. The Trust has also seen a reduction in the volume of patients waiting more than 104 weeks from a 402 in March 2021 to 176 in February 2022 (not yet finalised) a reduction of 226 / 56%. Whilst there is still some way to go in eradicating all long waits the Trust is making rapid and sustained progress against a backdrop of an increasing volume of long waits when benchmarking nationally.

Key improvements made include:

- EPR migration
- A large-scale validation programme to ensure all patients are being accurately recorded.
- A full suite of updated data quality reports available centrally for operational use
- Re-launch of RTT training following disruption caused by COVID-19
- A revised referral to treatment governance structure launched.

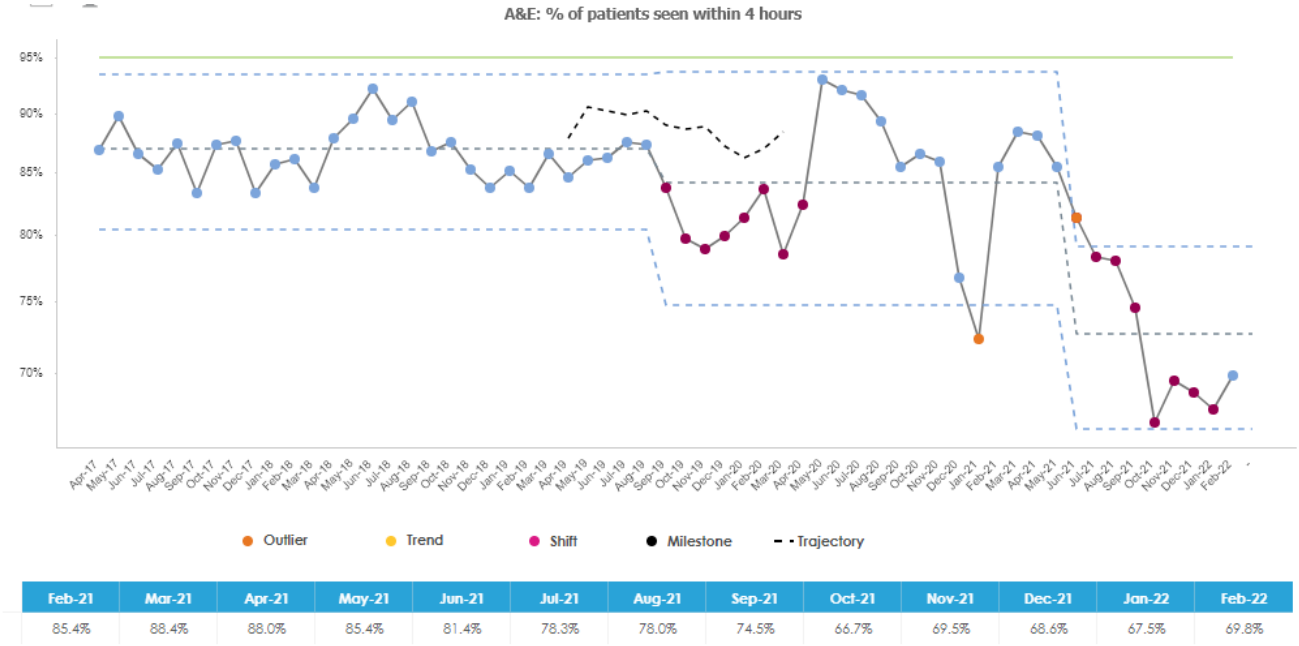


Dec-21	Jan-22
50.7%	51.1%

Accident and Emergency performance

The Accident and Emergency Department is often the patient's point of arrival. The graph below summarises the Royal Free London's performance in relation to meeting the 4-hour maximum wait time standard set against the performance of A&E departments. The national waiting time standard requires trusts to treat, transfer, admit or discharge 95% of patients within 4-hours of arrival.

During the period Feb 2021 to Feb 2022, the Royal Free London NHS FT achieved an average monthly performance of 75.2%, lower than 2020/21 which averaged at 85.8%.

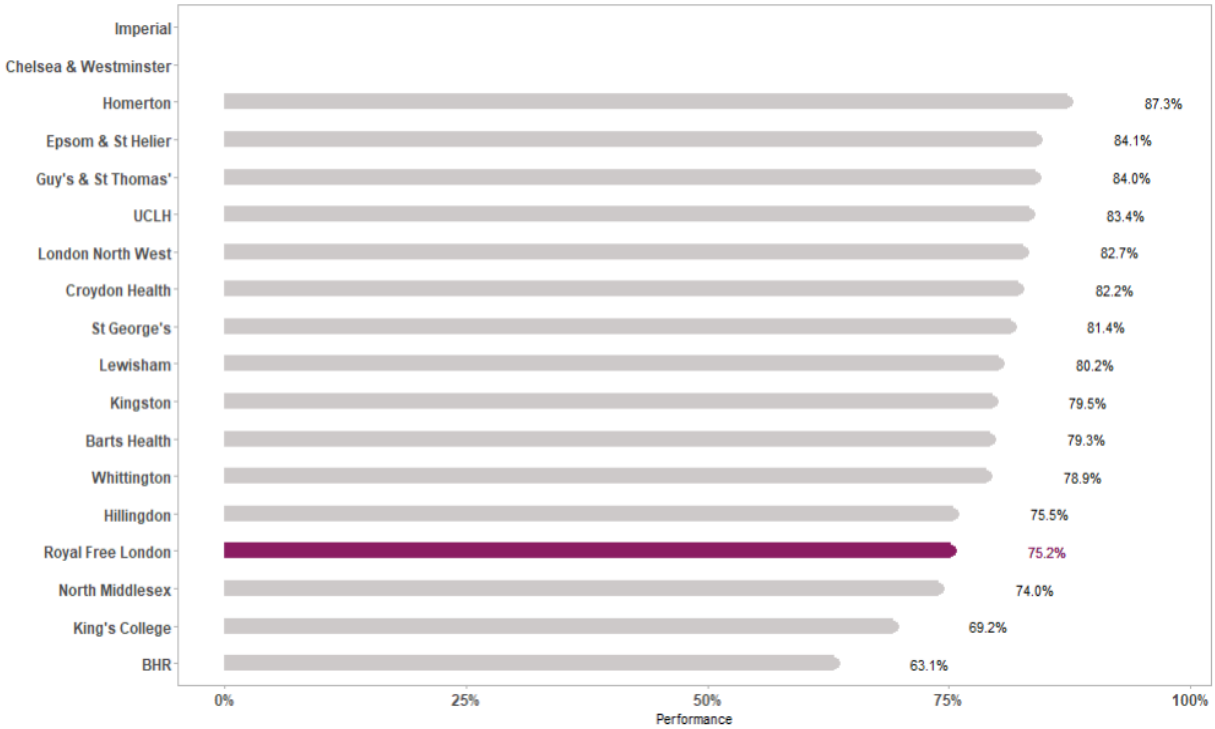


Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
85.4%	88.4%	88.0%	85.4%	81.4%	78.3%	78.0%	74.5%	66.7%	69.5%	68.6%	67.5%	69.8%

Source: Royal Free London NHS FT 2015-2022

The chart below shows the Royal Free London performance for April 21 – Feb 2022 benchmarked against 16 peer providers. This shows that our performance was 13th out of 16 peer providers. Two peer trusts, Imperial College and Chelsea & Westminster, ceased reporting in June 2019 due to participation in the waiting times standards review.

Chart: Mean performance against 4 hour A&E standard 21/22



Source: NHS Digital, 2021

Cancer waits

Our focus this year has been to ensure the continuity of cancer services throughout the pandemic and through the transitional recovery period. We have worked with clinical teams to capture changes to pathways and document learning from new ways of working, facilitated the roll out of virtual cancer multi-disciplinary team meetings, developed infection prevention and control compliant procedures, helped to co-ordinate the transfer of cancer services across the trust in response to the pandemic and developed plans to cope with the impact of any surge in COVID-19.

NHS England set three key performance indicators for cancer:

- restoring 31-day first cancer treatment numbers to pre-pandemic volumes
- reducing the backlog of patients waiting more than 62 days for cancer treatment following a GP Urgent referral for suspected cancer
- the achievement of 75% of patients to be given either a diagnosis of cancer or the ruling out of cancer within 28 days of referral

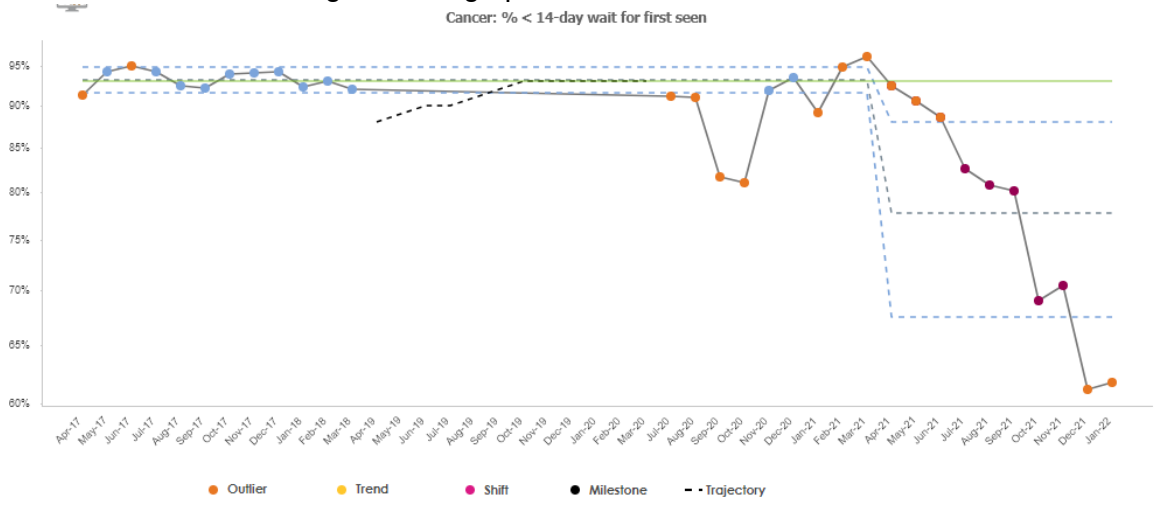
Royal Free London is one of the largest providers of cancer care in the NHS, receiving the second highest suspected cancer referrals (two-week wait) in England.

This year the trust has focused on repatriating cancer surgical services back to the trusts acute hospital sites from the independent sector. Systemic treatments (chemotherapy and immunotherapy) have re-commenced at Royal Free Hospital and Chase Farm Hospital although some continue to take place at Finchley Memorial Hospital. Diagnostic capacity that was heavily impacted during the pandemic is largely recovered with more capacity available for suspected and confirmed cancer patients.

All cancer 2 week waits

Clinical evidence demonstrates that the sooner patients urgently referred with cancer symptoms are assessed diagnosed and treated the better the clinical outcomes and survival rates. National targets require 93% of patients urgently referred by their GP to be seen for an outpatient or diagnostic appointment within 2 weeks, 96% of patients to have begun first definitive treatment within 31 days of the decision to treat and 85% of patients to have begun first definitive treatment within 62 days of referral.

For 2021/22, the trust has failed to meet the standard to see at least 93% of patients within 2 weeks from GP referral, achieving an average performance of 80.6%.

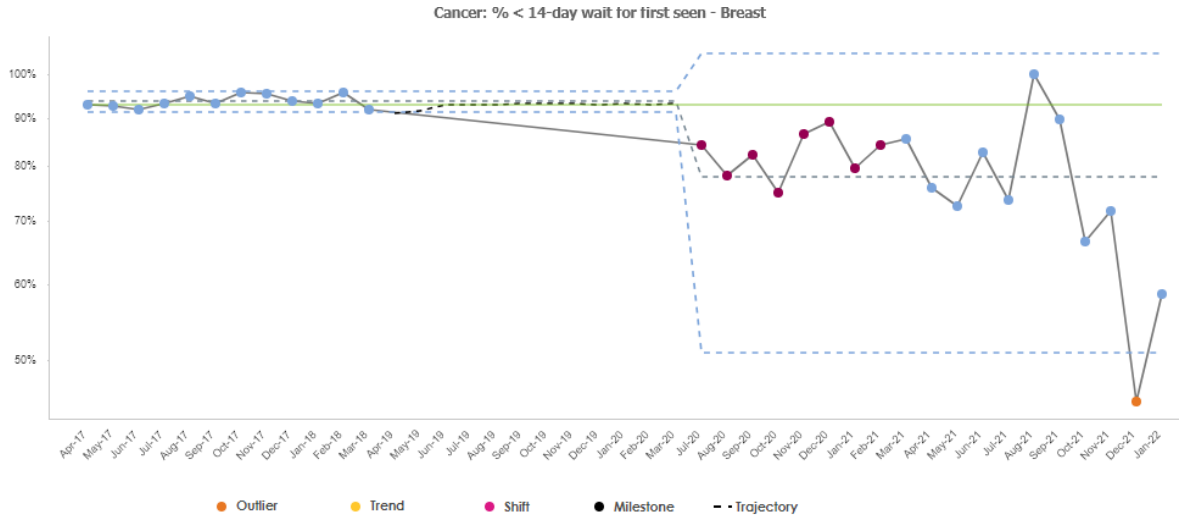


Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
94.86%	96.14%	92.38%	90.54%	88.59%	82.56%	80.81%	80.16%	68.97%	70.41%	61.18%	61.70%

Source: Royal Free London NHS FT 2017-2022

Breast urgent referral 2 week waits

In 2021/22 the trust saw 75.5% of patients on an urgent (symptomatic) breast referral pathway within 2 weeks, below the national standard.

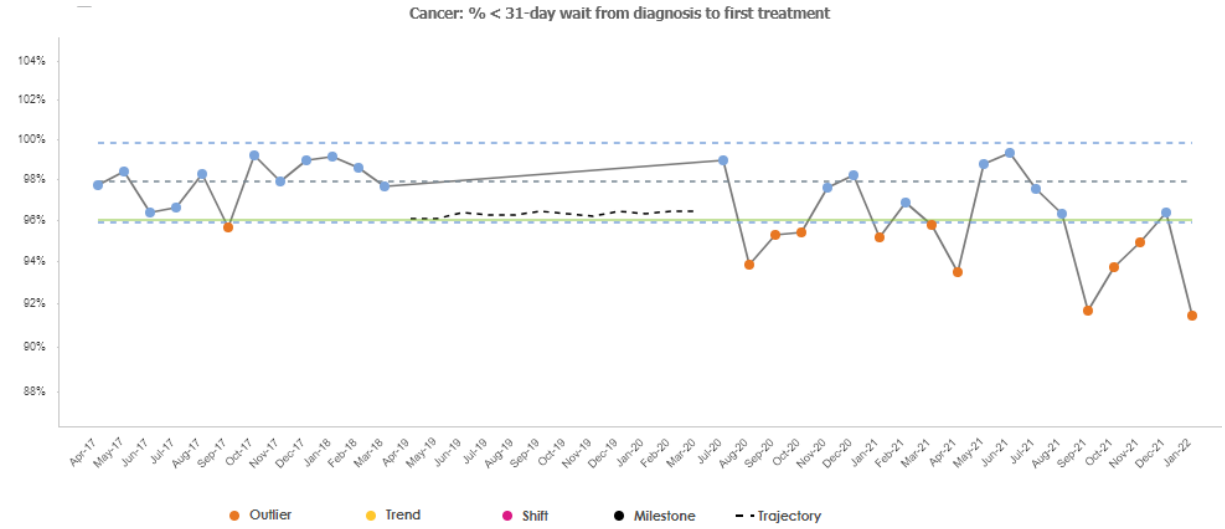


Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
84.21%	85.40%	75.90%	72.66%	82.86%	73.68%	100.00%	89.80%	66.67%	71.83%	45.16%	58.62%

Source: Royal Free London NHS FT 2017-2022

First definitive treatment within 31 days

In 2021/22, the trust was below the standard to see 96% of patients within 31 days for their first definitive treatment for cancer, with an average of 95.5%.

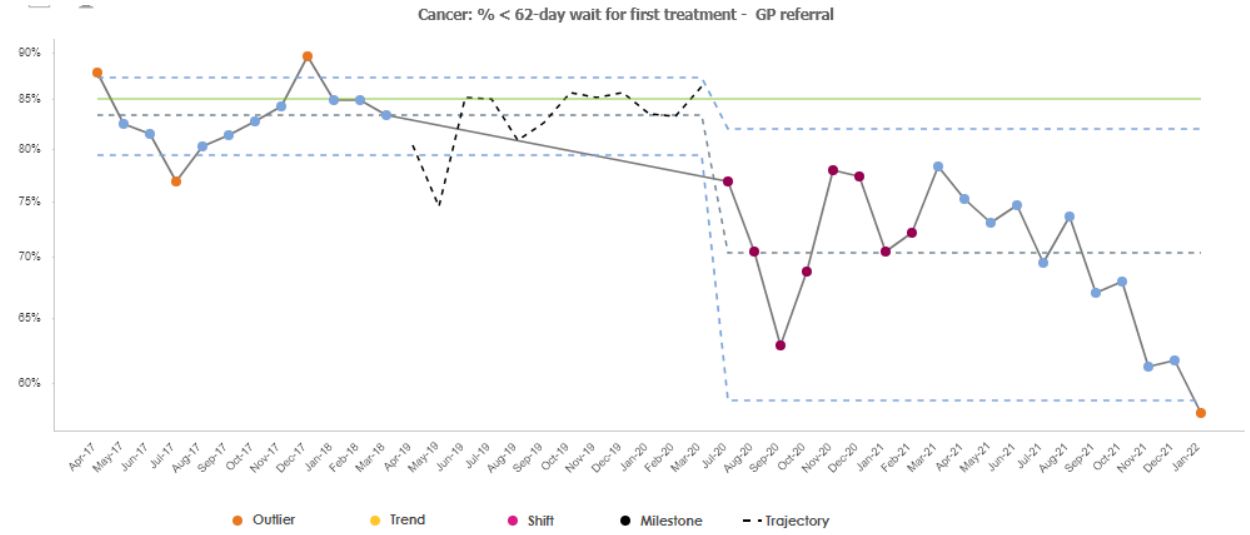


Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
96.85%	95.71%	93.48%	98.75%	99.26%	97.53%	96.28%	91.64%	93.70%	94.88%	96.32%	91.41%

Source: Royal Free London NHS FT 2017-2022

First definitive treatment within 62 days of an urgent GP referral

The trust did not meet the 62 day standard in 2021/22, with an average of 69.3% patients receiving first treatment within 62 days of a GP referral. Performance had stabilised since October 2020 but has shown a continuing decrease from April 2021.



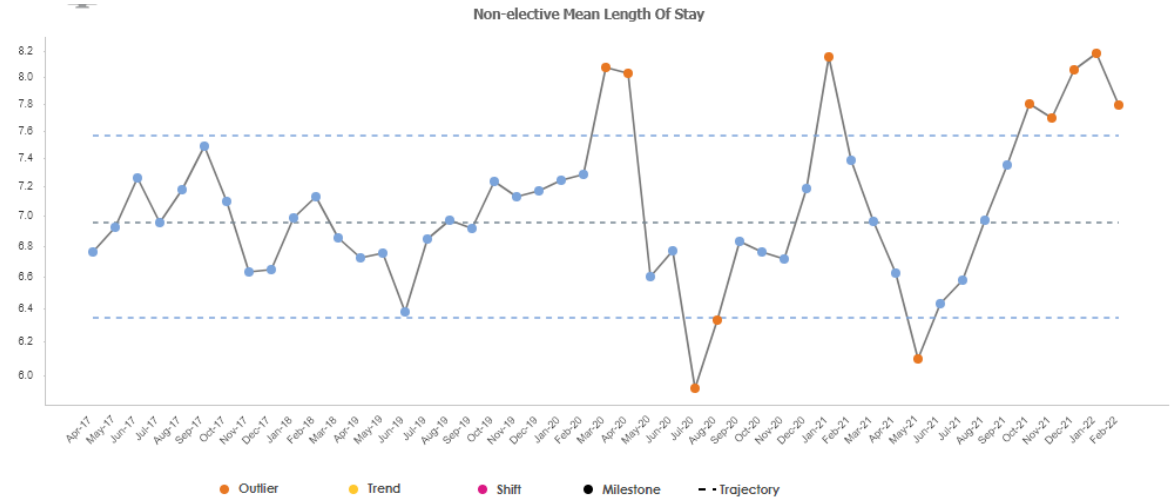
Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
72.10%	78.25%	75.19%	73.05%	74.55%	69.49%	73.57%	66.99%	67.95%	61.21%	61.69%	57.84%

Source: Royal Free London NHS FT 2015-2021

Benchmark information is not available for this measure

Average length of stay: Non-elective mean length of stay

The trust average inpatient length of stay for patients admitted as non-elective from Feb 2021 to Feb 2022 shows that the trust average length of stay was 7 days. Variation has been much greater than previous years and is due to an unusual case-mix of COVID-19 patients mixed with the usual emergency cases we would admit throughout the year.



Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
7.4	7.0	6.6	6.1	6.4	6.6	7.0	7.4	7.8	7.7	8.1	8.2	7.8

Source: Royal Free London NHS FT 2017-2022

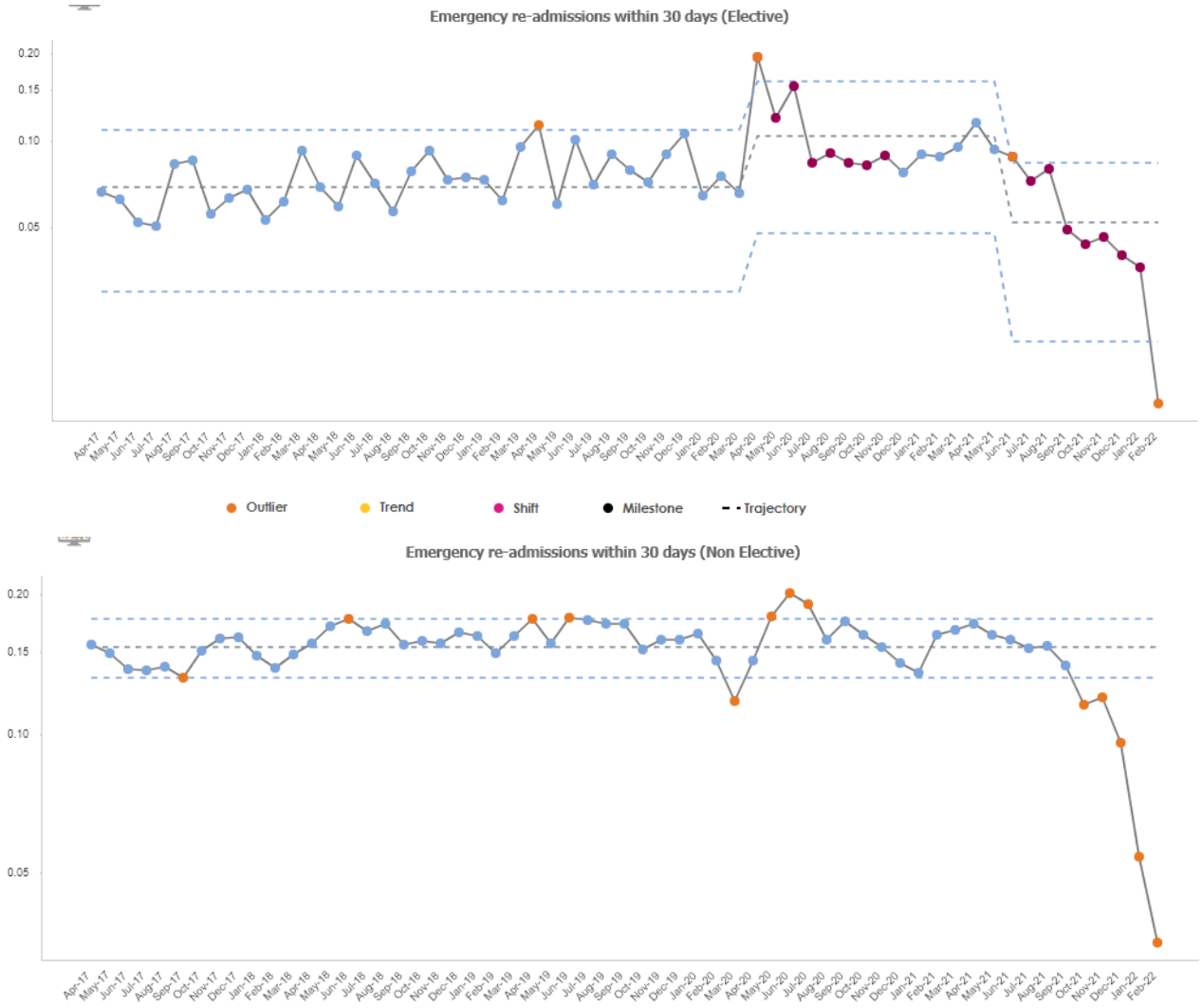
Average length of stay: Elective mean length of stay

The trust average inpatient length of stay for patients admitted as elective to shows that the trust average length of stay in the period April 2020 to March 2021 was 3.9 days.

Emergency re-admissions:

30 day emergency re-admissions following an elective admission

The chart below shows the proportion of patients re-admitted as an emergency following an elective admission in the previous 30 days between April 2017 and Feb 2022. We have seen very lower numbers than usual due to the pause in elective activity during COVID-19.



Source: Royal Free London NHS FT 2017-2022

Benchmark information is not available for this measure

Section 3: Patient experience indicators

National surveys

In 2021/22 the results of four national surveys were published:

- Urgent and emergency care 2020 – September 2021
- In-patient 2020– October 2021
- Children and young people's 2020– December 2021
- Maternity 2021 – February 2022

The results of these national surveys are standardised by the CQC and benchmarked reports are produced. These reports inform trusts, patients and other stakeholders whether each trust is performing 'better than', 'worse than' or 'about the same' as most other trusts. These results can be seen on the CQC website (www.cqc.org.uk).

This year saw the first iteration of the in-patient and the maternity survey using a mixed-mode methodology. This means that patients were offered the opportunity of completing the survey online before receiving a postal questionnaire. This change has seen an increase in the response rates for the trust in these surveys.

Urgent and emergency care survey

This survey consists of two separate questionnaires; one for patients attending a type one service (major A&E departments which are consultant led, have full resuscitation facilities and operate 24 hours a day, seven days a week) and another for those attending a type three service (urgent treatment centres which can be doctor or nurse led, treat at least minor injuries and illnesses and can be routinely accessed without an appointment).

Type one report

Completed surveys were received from 259 patients out of the eligible patient sample of 916 (this excludes those that were undeliverable out of the initial 950). This gives the trust a response rate of 28.3% compared to the national response rate of 30.5%.

The type one survey is split into nine sections all of which were scored 'about the same' as most other trusts. As well as scoring 'about the same' for each section, the trust also scored 'about the same' for each of the 38 scored questions.

Type three report

Completed surveys were received from 126 out of the eligible patient sample of 414, giving a response rate of 30.4% compared to a national response rate of 30.8%. Only patient data from the Urgent Treatment Centre at Chase Farm Hospital was submitted for the type three survey.

The trust scored 'about the same' as most other trusts for all of the nine sections, but 'better than' most other trusts in three out of the 32 scored questions:

T14. Did the health professional listen to what you had to say?

RFL score = 9.7, range of scores across England = 8.5 – 9.7

RFL score = 9.8, range of scores across England = 7.5 – 9.8

RFL score = 9.5, range of scores across England = 6.3 – 9.7

Adult in-patient survey

As well as the move to mix-mode methodology, there were significant changes made to the adult in-patient questionnaire for 2020. These included question wording, response options and the order of questions as well as a reduction in the number of questions. The sampling month also changed from July (as was the case from 2014-19) to November. These changes mean that the results cannot be compared to previous years'.

The banding of results has also changed from three bands to seven to provide more granular analysis.

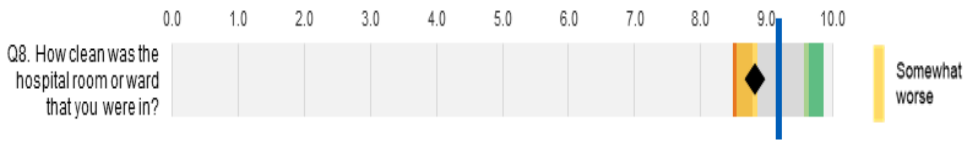
Much worse	Worse	Somewhat worse	About the same	Somewhat better	Better	Much better

516 patients completed the in-patient survey, giving a response rate of 45% (up from 38% in 2019), compared to the national response rate of 46%. This increase is partly due to the mix-mode methodology described above. Nationally, 64% of surveys were completed online.

The trust scored 'about the same' as most other trust for all sections of the survey (now 10 when previously it was 12) – the same as it has for each in-patient survey since 2014.

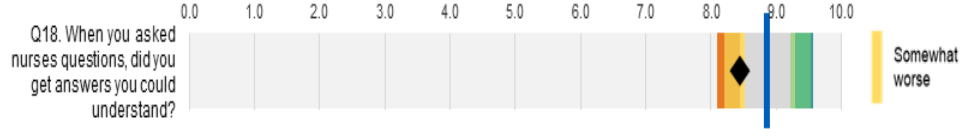
The trust did not score better than most other trusts in any question, but scored 'somewhat worse' than expected compared to other trusts in three.

- How clean was the hospital room or ward that you were in?



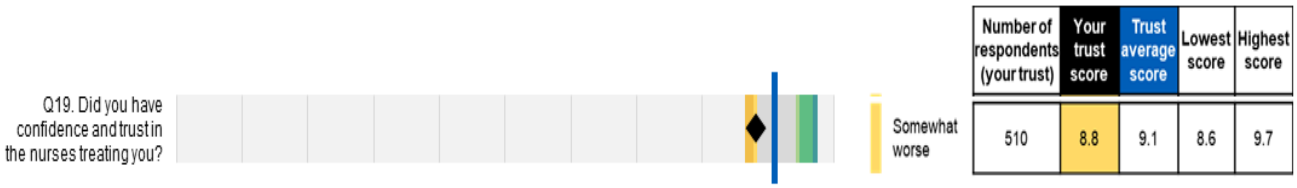
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
499	8.8	9.2	8.5	9.9

- When you asked nurses questions, did you get answers you could understand?



Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
489	8.5	8.9	8.1	9.6

- Did you have confidence and trust in the nurses treating you?



Children and young people's patient experience survey

Three different questionnaires are used in this survey, depending on the age of the patient:

- 0-7 (for parents/carers to complete only)
- 8-11
- 12-15

The 8-11 and 12-15 questionnaires include sections for both the patient and parent or carer to complete.

A total of 29% responded to the survey, compared to the national response rate of 24%.

Unlike the other CQC national surveys no section scores are published.

When compared to other trusts six questions were rated as better than expected, two as somewhat better than expected, three as somewhat worse and one as much worse. The remaining 53 were rated about the same.

Parent/ patient	Question	RFL score	Average score	Range of scores
Better than expected				
8-15 patient	Did you like the hospital food?	7.7	6.8	4.6 – 8.8
12-15 patient	Was the ward suitable for someone of your age?	9.2	8.3	7.3 – 9.7
8-15 patient	When the hospital staff spoke with you, did you understand what they said?	9.0	8.4	7.1 – 9.5
8-15 patient	Did you feel able to ask questions?	9.8	9.5	8.4 – 10.0
12-15 patient	If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?	9.7	9.2	7.9 – 10.0
8-15 patient	Before the operation or procedure, did hospital staff explain to you what would be done?	9.9	9.6	8.6 – 10.0

Somewhat better than expected				
0-15 parents	Before your child had any operations or procedures, did a member of staff explain to you what would be done?	9.8	9.6	9.0 – 10.0
8-15 patient	Do you think the people looking after you were friendly	9.7	9.5	8.8 – 10.0
Somewhat worse than expected				
0-7 parents	Were there enough things for your child to do in hospital?	6.9	7.5	5.2 – 9.7
0-15 parents	Did staff involve you in decisions about your child's care and treatment?	8.2	8.6	7.7 – 9.4
0-15 parents	Did a staff member give you advice about caring for your child after you went home?	8.4	8.8	8.0 – 9.7
Much worse than expected				
0-7 parents	Did a member of staff tell you who to talk to if you were worried about your child when you got home?	7.0	8.6	6.8 – 9.8

The trust scored statistically significantly better in 21 of the 55 scored questions when compared to the 2018 survey and significantly worse in one.

Maternity survey

A total of 54% of women completed the 2021 maternity survey (up from 35%in 2019), compared to an average response rate of 53%. As with the increase in the in-patient survey response rate, this is partly due to the move to the mix-mode methodology.

Of the eight sections in the maternity survey, the trust scored somewhat worse than expected in two (during your pregnancy and care in hospital after the birth) and worse in a further two (feeding and care at home after the birth).

14 questions were scored worse than expected and the results can be seen in the table below.

Question	**RFL score**	**Average score**	**Range of scores**
Somewhat worse than expected			
B16. During your pregnancy did midwives provide relevant information about feeding your baby?	5.7	6.7	4.5 – 8.0
D6. Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?	7.6	8.3	7.1 – 9.2

D7. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?*	1.8	3.5	0.9 – 9.8
E3. Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?*	6.9	7.6	6.3 – 8.5
Worse than expected			
B10. During your antenatal check-ups, did your midwives ask you about your mental health?	6.6	8.0	6.5 – 9.4
B12. Were you given enough support for your mental health during your pregnancy?	7.4	8.4	6.3 – 9.6
D8. Thinking about your stay in hospital, how clean was the hospital room or ward you were in?	8.2	8.9	8.0 – 9.8
E2. Were your decisions about how you wanted to feed your baby respected by midwives?*	8.4	8.9	8.1 – 9.4
F2. When you were at home after the birth of your baby, did you have a phone number for a midwifery or health visiting team that you could contact?	9.0	9.5	8.5 – 10.0
F3. If you contacted a midwifery or health visiting team, were you given the help you needed?	7.7	8.5	7.1 – 9.6
F12. Did a midwife or health visitor ask you about your mental health?*	8.9	9.5	8.4 – 9.9
F16. In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby?*	6.0	7.1	5.1 – 8.3
F18. In the six weeks after the birth of your baby did you receive help and advice from health professionals about your baby's health and progress?*	6.6	7.6	6.1 – 8.7
Much worse than expected			
F17. If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?	3.9	6.0	3.9 – 7.9

Those questions marked with an asterisk also saw a statistically significant decrease in score in 2021.

National cancer patient experience survey

Although not part of the official national survey programme, the results of the 2020 national cancer patient experience survey were published in November 2021. The survey was run on a voluntary basis in 2020 due to the unprecedented pressure that the pandemic put on cancer services.

55 trusts took part in this voluntary survey, compared to 141 trusts that participated in the 2019 survey. The trust response rate was 52% compared to the national response rate of 59%.

The survey again comprised of 52 scored questions and comparability tables highlight five questions where significant year-on-year improvement occurred:

Question	Score 2020	Score 2019
Q.14 Patient felt that treatment options were completely explained	85%	79%
Q.33 Patient had confidence and trust in all ward nurses treating them	82%	63%
Q.34 Patient thought there were always or nearly always enough nurses on duty to care for them	75%	53%
Q. 37 Patient definitely found hospital staff to discuss worries or fears during their inpatient visit	58%	41%
Q.59 Patient felt length of time for attending clinics and appointments for cancer was about right	70%	63%

Friends and Family Test (FFT)

The FFT now asks patients to rate their overall experience from ‘very good’ to ‘very poor’; instead of asking how likely they are to recommend the service. The tables below show the results for the trust for 2021/22.

Patient experience feedback is collected using a combination of feedback kiosks, tablets and QR codes linked to online surveys. In the autumn, it was noted that the number of responses received via the QR code in the emergency departments was very low, so SMS was introduced. This has seen a dramatic increase in the amount of feedback received.

In-patient	% patients reporting a good / very good experience	Number of responses
Apr-21	72%	495
May-21	80%	418
Jun-21	78%	380
Jul-21	84%	364
Aug-21	79%	238
Sep-21	84%	342
Oct-21	79%	254
Nov-21	84%	369
Dec-21	82%	275
Jan-22	82%	277
Feb-22	85%	407
Mar-22	85%	401

Out-patient	% patients reporting a good / very good experience	Number of responses
Apr-21	84%	540
May-21	84%	436
Jun-21	86%	551
Jul-21	84%	574
Aug-21	89%	479
Sep-21	83%	499
Oct-21	86%	425
Nov-21	81%	483
Dec-21	83%	352
Jan-22	84%	416
Feb-22	84%	593
Mar-22	88%	620

Maternity	Q1 - antenatal care		Q2 - labour and birth		Q3 - postnatal care		Q4 - postnatal community	
	% good/very good exp.	Number of responses	% good/very good exp.	Number of responses	% good/very good exp.	Number of responses	% good/very good exp.	Number of responses
Apr-21	47%	17	96%	105	94%	88	63%	8
May-21	50%	14	94%	79	92%	59	100%	1
Jun-21	33%	33	89%	102	93%	76	71%	7
Jul-21	40%	35	92%	111	90%	92	100%	5
Aug-21	57%	14	91%	110	89%	88	67%	6
Sep-21	47%	19	91%	115	89%	87	89%	9
Oct-21	58%	38	94%	155	92%	131	90%	10
Nov-21	70%	20	91%	143	89%	114	100%	3
Dec-21	47%	17	93%	99	89%	85	67%	9
Jan-22	58%	24	87%	100	82%	83	100%	6
Feb-22	56%	18	95%	131	87%	101	100%	5
Mar-22	55%	29	96%	144	96%	112	88%	8

Emergency Department	% patients reporting a good / very good experience	Number of responses
Apr-21	82%	85
May-21	82%	90
Jun-21	71%	113
Jul-21	79%	82
Aug-21	72%	79
Sep-21	78%	86
Oct-21	77%	96
Nov-21	77%	2,184
Dec-21	82%	2,697
Jan-22	81%	2,497
Feb-22	78%	2,791
Mar-22	74%	3,216

Learning Disability Improvement Standards Survey

Every year the trust participates in benchmarking itself against the NHS Improvement standards for people with learning disabilities. This includes 100 surveys for patients/carers of children and adults with a learning disability and or autism to complete, a staff survey and an executive response as to how the trust is meeting the needs of people with a learning disability and or autism.

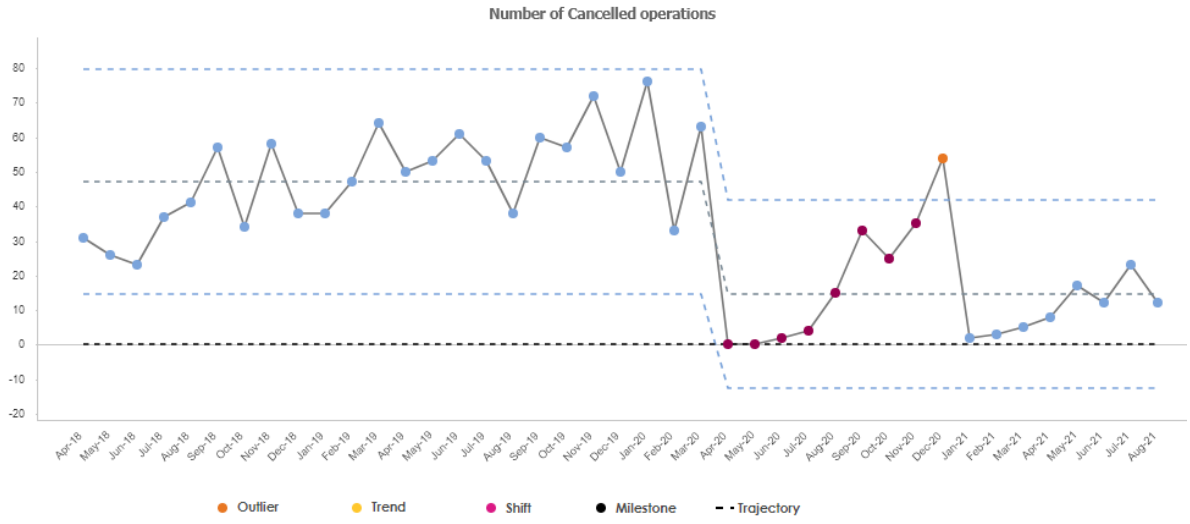
During the covid-19 pandemic the trust ensured that reasonable adjustments were made for people with learning disabilities and or autism by ensuring that those who required visiting of carers/family while in hospital continued to receive this. If required carers and family members are permitted to stay overnight, patients with learning disability and autism are given longer appointment times and/or first or last appointments of the day.

The trust is committed to continually improving and responding to the needs of patients with learning disability and or autism and will therefore focus on improving patient committees in the coming year to ensure these voices are heard.

The trust has developed easy read complaints information to make the process of feeding back any concerns or issues more accessible for people with a learning disability and or autism. The trust has also developed easy read DNACPR information as it is recognised this was an area of concern for people with learning disabilities, especially during the pandemic.

Volume of cancelled operations

This is the volume of last minute (on the day of surgery or following admission) cancellations for non-clinical reasons. Over the course of 2020/21, we have seen fewer cancellations as elective activity has been paused for most of the financial year due to the COVID pandemic. The negative outlier is due to elective activity briefly restarting before having to be paused again due to the second wave.



Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
3	5	8	17	12	23	12

3.2 Performance against key national indicators

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

Operational Performance

Key Indicator	Target	Q1	Q2	Q3	Q4	2021/22
A&E: <4 hour wait from arrival to admission / transfer / discharge	95.00%	84.93%	76.93%	68.27%	68.70%	75.25%
Diagnostics: <6 week wait from request to diagnostic test	99.00%	91.95%	NA	NA	NA	91.95%
Cancer: <2 week wait from referral to date first seen (all)	93.00%	90.50%	81.18%	66.85%	61.70%	77.73%
Cancer: <2 week wait from referral to date first seen for symptomatic breast patients	93.00%	77.14%	87.83%	61.22%	58.62%	73.72%
Cancer: <31 day wait from diagnosis to first treatment	96.00%	97.16%	95.15%	94.97%	91.41%	95.33%
Cancer: <31 day wait from diagnosis to subsequent treatment (surgery)	94.00%	94.19%	89.55%	93.88%	89.47%	92.23%
Cancer: <31 day wait from diagnosis to subsequent treatment (chemotherapy)	98.00%	98.89%	100.00%	100.00%	63.64%	96.03%
Cancer: <31 day wait from diagnosis to subsequent treatment (radiotherapy)	94.00%	93.71%	92.14%	93.68%	39.13%	87.77%
Cancer: <62 day wait from referral to first treatment	85.00%	74.26%	70.02%	63.62%	57.84%	68.15%
Cancer: <62 day wait from referral to first treatment for screening service referrals	90.00%	84.44%	84.29%	74.37%	61.76%	79.11%

Patient Safety

Key Indicator	Target	Q1	Q2	Q3	Q4	2021/22
C. difficile infections	NA	29	21	9	NA	59
C. difficile infections attributable to lapses in care	0	0	0	0	NA	0
MRSA infections	0	0	2	1	NA	3

3.3 Our plans for improvement

This section contains an overview of our plans with regard to the Care Quality Commission and also a selection of plans for improvement from each of our main hospital sites.

A. The Care Quality Commission
B. Quality Improvement plans from each of our main hospital sites

A. The Care Quality Commission

Following the Care Quality Commission's unannounced Royal Free Hospital maternity services inspection in October 2020, the CQC undertook a follow-up, unannounced inspection of the maternity core service at the Royal Free Hospital in late May 2021 and at Barnet Hospital in early June 2021The inspection reports were published on 27 August 2021.

As a result of the improvement actions undertaken, the maternity ratings for safe and well-led on the Royal Free Hospital site improved from 'Inadequate' to 'Requires improvement'. At Barnet Hospital, the maternity ratings remained static for safe, effective, caring, responsive and well-led. Following these inspections, the CQC made further fourteen 'should-do' recommendations. The Trust has developed an action plan for improvement that the Barnet and Group Executive Committees monitor.

As a result, the site and Group ratings remain as:

	Safe	Effective	Caring	Responsive	Well led	Overall
Group	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Barnet Hospital	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Chase Farm Hospital	Requires improvement	Good	Good	Good	Good	Good
Royal Free Hospital	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

All completed actions for improvement are being monitored or embedded as business-as usual. Actions requiring completion are highlighted in blue in the table below. The ‘should-do’ actions taken in response to the May/June 2021 CQC inspections by site are detailed below.

Cross site inspection findings and actions

The CQC said:	Trust update:
1. ‘The trust should consider their population’s profile, health deprivation, disability and the broader needs of their culturally diverse communities when planning the service’	We have: ✓ Established a maternity equality and inclusion working group which includes staff, MVP and women from diverse backgrounds to develop a programme on wider EDI agenda. ✓ Created a population profile sourced from EPR and benchmarked using Health Intent Review of referrals to vulnerable teams. We are: ➢ Working through the equality, diversity and inclusion in maternity working group in partnership with the MVP Conduct engagement activities with targeted groups of women representing different population groups. ➢ Exploring the equity of access for women from the nine protected characteristics.

2. 'The trust should ensure there is an active non-executive board-level maternity safety champion'	We have: ✓ Identified a non-executive board-level maternity safety champion. ✓ A system in place to provide cover NED if any long absences occur.
3. 'The trust should make sure they initiate changes to services based on feedback received from women and implement the changes with the support of the MVP'	We have: ✓ Service developments implemented through coproduction with the MVP and diverse groups and individuals. ✓ Implemented suggestions raised by women as part of FFT, surveys and engagement activities. ✓ Ensured feedback is used to make informed decisions on service improvement or re-design.

Barnet Hospital inspection findings and actions

The CQC said:	Trust update:
4. 'The trust should ensure that managers make sure they monitor cleaning of all areas and the birthing pools all the time and complete weekly audits to ensure that women and babies are protected from infection'	We have: ✓ Developed a standard operating procedure in place setting out the cleaning standards. ✓ Set up weekly audits to demonstrate the birthing pools are cleaned correctly in accordance with the standard operating procedure.
5. 'The trust should ensure that it routinely monitors wait times in the maternity day care unit (MDAU) and reviews the results and adjusts staffing levels to ensure women are seen in a timely way'	We have: ✓ Established a working group to review the MDU pathway, medical staff cover and environment. ✓ Implemented regular waiting time audits. ✓ Reviewed the triage pathway due to interlines between triage and the maternity day unit as identified by the maternity NHSE/I improvement advisor.
6. 'The trust should ensure that delivery suite consultants and midwifery shift co-ordinators should always attend daily cross-site safety huddles'	We are: ➢ Monitoring the attendance at cross site huddles and explore the reasons for consultants and coordinators not attending. ➢ Communicating to MDT members of stakeholder attendance requirements.

Royal Free Hospital inspection findings and actions

The CQC said:	Trust update:
7. 'The service should ensure that midwifery staff have protected time to attend multidisciplinary training'	We have: ✓ Presented the CNST standard to board in July 2021 demonstrates that staff attend multidisciplinary training. ✓ Ensured staff attendance at training is audited quarterly and presented to quarterly cross site maternity risk meeting and LMNS Board.
8. 'The trust should consider strategically embedding staff and women engagement into the service development and improvement plans' 9. 'The service should consider carrying our regular staff satisfaction and wellbeing surveys in order to regular measure changes in engagement and satisfaction levels and be able to address any issues or concerns in a timely manner'	We have: ✓ MVP work plan agreed for 2021/22 which includes staff representation. We are: ➢ Following the external review of cultural issues raised in maternity in May 2021, a maternity transformation group was established, and the following work streams have been agreed: - fair and transparent leadership - continuity of carer model - culture and behaviours - staff wellbeing ➢ Providing protected time for staff to attend CPG meetings. Invitation for women and MVP to attend CPG meetings.
10. 'The trust should develop a standard operating procedure that identifies how women are referred into tertiary level maternal medicine centres. All policies and guidance need to be in line with the national guidance and evidence-based practice.'	We are: ➢ Awaiting LMNS planning and implementation.

11. 'The service should consider improving the maternity dashboard and regularly review it against local and national standard to improve the outcomes' 12. 'The service should carry out a regular and comprehensive audit related to pain relief'	We have: ✓ This has been added to the risk register, including issues relating to inadequate data quality which are on-going, and the risk level is reported as high. ✓ Merged IT domains following RFH adoption of EPR. ✓ Pain relief audit to be added to the bi-monthly comprehensive audit. We are: ➢ Working with Cerner to address missing data quality, continue to generate dashboard manually until this can be achieved. Cerner EPR v2 deployed 29 Sept 2021. Should improve missing data ➢ Developing a business case for dedicated IT midwives to make data quality corrections in Cerner. ➢ Appointing two midwifery information officers to support the adoption and development of the EPR; and on-going training of maternity staff. ➢ Continuing training by IT midwives to reduce manual data corrections. ➢ Meeting with IM&T to resolve Data entry errors or omissions. ➢ MSDS version 2.0 update to be implemented by Jan 2022.
13. 'The service should improve midwifery staff involvement in Quality Improvement projects' 14. 'The service should ensure the ward coordinators are always supernumerary'	We have: ✓ Explored if RFL improvement advisor can offer targeted QI support for midwifery staff. ✓ The antenatal / postnatal ward coordinator to be supernumerary. We are: ➢ Ward staff to be given time to attend QI training and CPG meetings. Example: postnatal pathway and breastfeeding support at night and in the community QI project in collaboration with MVP. ➢ Designed targeted QI support for midwifery staff in consultation with the staff group. This may involve bespoke training and support or signposting to existing resources.

The Trust continues to make progress towards completing these actions for improvement.

The section below outlines the progress made in response to CQC inspections undertaken between December 2018 and March 2021.

Unannounced CQC maternity core-service inspection at Royal Free Hospital (October 2020)

The CQC issued a Section 29a warning notice to the Trust on 13/11/2020. The Trust made the necessary improvements within the section notice timeframes and the CQC lifted the Section 29a warning notice in January 2021. All actions for improvement are complete, with ongoing monitoring in place or embedded into business-as-usual.

Announced trust-wide CQC core-service inspection (December 2018)

In response to the 11 must-do and 81 should-do improvement requirements, the Trust implemented a CQC improvement action plan. The actions were developed, agreed upon, and implemented across each business unit. Each business unit's Local Executive Committee (LEC) and Clinical Performance & Patient Safety Committee (CPPSC) monitors progress.

CQC must-do findings:

The Trust has completed all the must-do improvement actions in July 2021 identified in the inspection report published in April 2019. The completed actions are monitored to ensure ongoing compliance.

CQC should do findings and actions:

- During 2021-22, Barnet Hospital business has two actions remaining open around critical care guidelines and mandatory training compliance. These open actions are expected to be completed by the end of the year.
- The Royal Free Hospital also has two actions that remain open, relating to mandatory training compliance and appraisal rates. These open actions are expected to be completed by the end of the year.
- All should do actions for Chase Farm Hospital have been completed and are being monitored.

B. Quality Improvement Plans from each of our main hospital sites

Across the organisation, at team, service, site and group levels, there is much improvement work underway. In a report of this nature, it isn't possible to cover everything – so we have highlighted three projects, each led by one of our main hospital sites:

a) Barnet Hospital – What Matters to You Day (2021)

International What Matters To You Day (WMTYD) began in Norway in 2014, with the goal of encouraging meaningful conversations between patients, carers, families and their health care providers. The idea behind the question is to switch from asking patients "what's the matter with you?" to "what matters to you?" Asking this simple question helps to establish a relationship between people giving and receiving care, better understanding the person in the context of their own life and the things that are important to them. With this insight staff are in a much better position to work with the patient to find the best way forward for them and act on what is shared.

Barnet celebrated WMTYD with a variety of activities throughout the week. On the day itself, a WMTY stall was held in Barnet hospital where PE and QI teams engaged staff, encouraging them to have WMTY conversations with their patients using the resources on offer. The team also took the opportunity to ask staff what matters to them. Colleagues wrote their answers on a placard and a display was created on the second floor of the hospital.

Key areas of focus in the patient experience and involvement work plan for Barnet informed the site specific activities throughout the week. For example, the head of patient experience and involvement (HoPE) hosted a live demonstration of the ViewPoint survey dashboard to show staff how they can easily access their patient experience survey results.

In addition to the patient conversation tools, a compassionate visiting conversation tool was devised for managers and leaders to open up a conversation with their teams about how they are embedding compassionate visiting guidance in their areas. The director of nursing and other senior nurses visited teams to facilitate these conversations and encourage participation on WMTY day.

The PE team also announced a monthly patient and public involvement webinar series, in response to staff feedback for more support in how they can involve patients and their relatives in their own care and in the business of the trust.

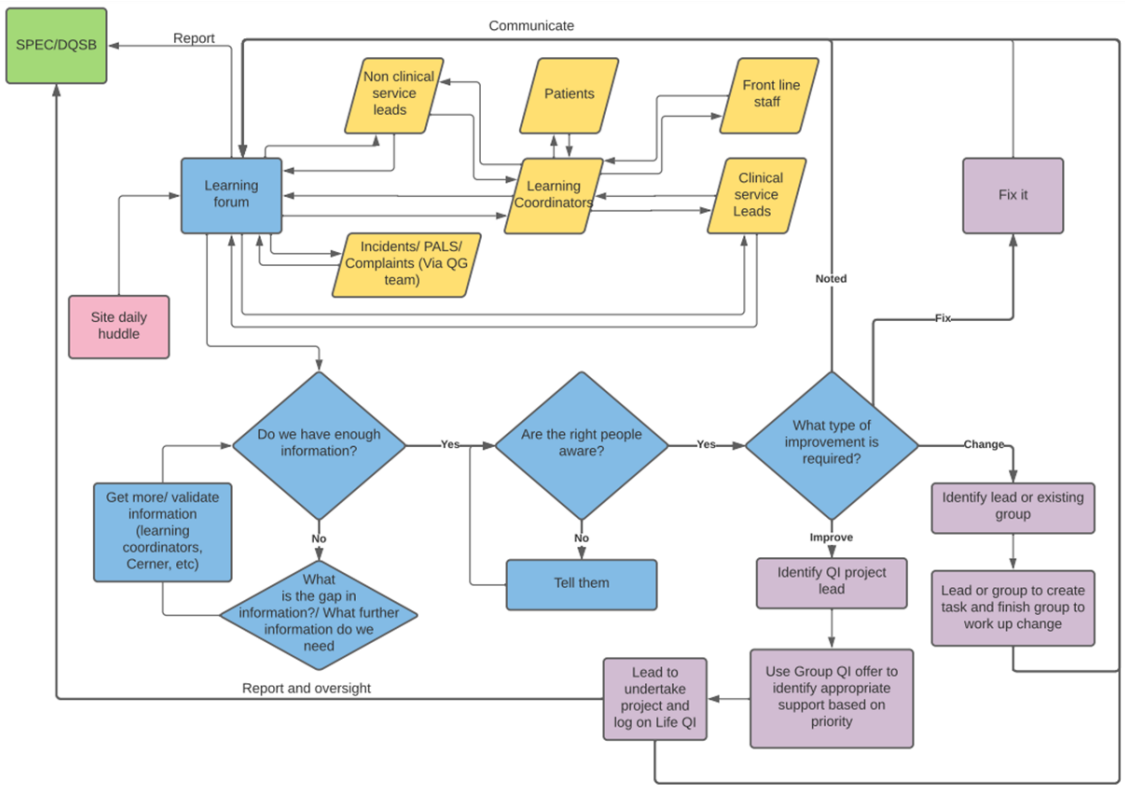
The Barnet patient experience Twitter account (@barnet_ptep) was launched to coincide with WMTY, which has established a new platform for the team to engage with staff and patients and vice versa.

b) Chase Farm Hospital – Learning Health System

We have been piloting a learning health system for 18 months at Chase Farm Hospital. This is a system of embedding continuous improvement across the hospital and putting what matters to our staff and patients at the centre of improvement

We are currently undergoing an evaluation of this, being led by UCLP. We will be using the outputs of this to further develop the system

We plan to make our Learning Coordinators (who are currently employed on the bank) permanent in 2022/2023.



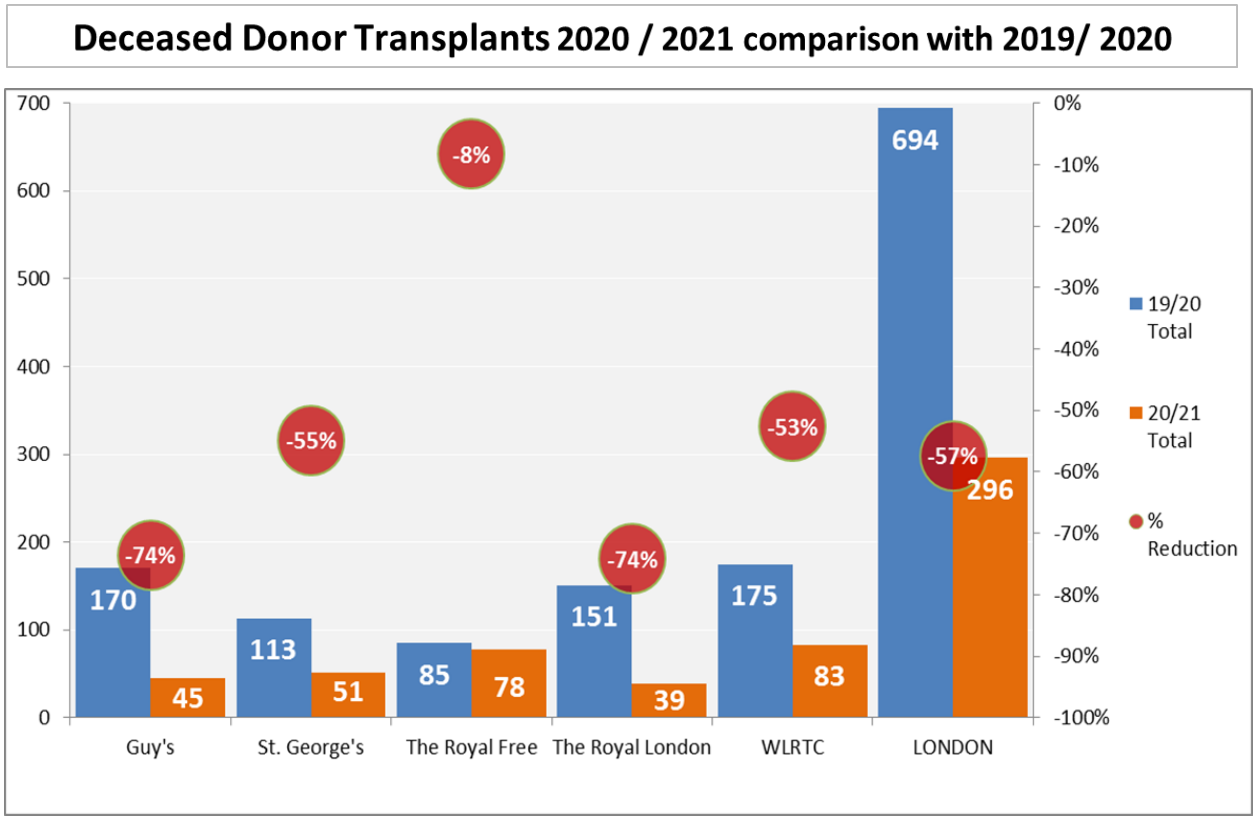
c) Royal Free Hospital – Restarting Kidney Transplantation at the Royal Free

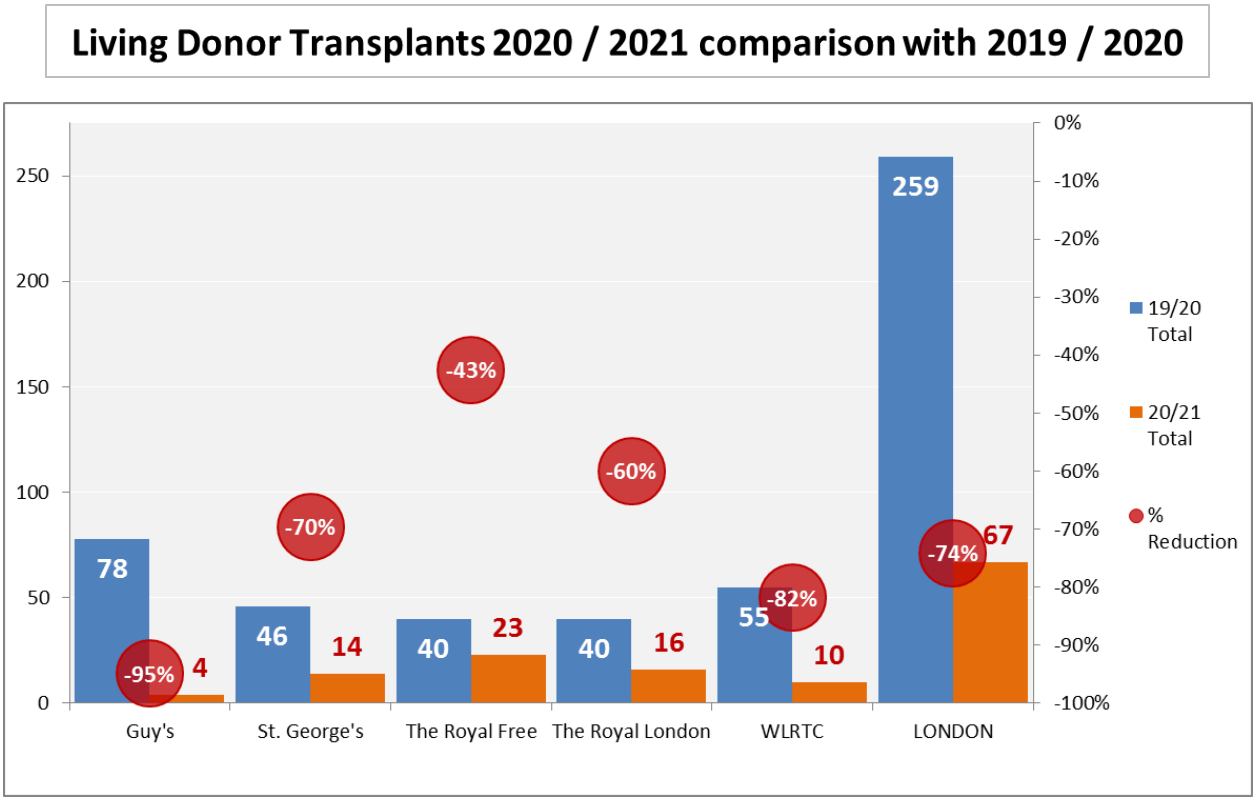
The catchment area for our transplant unit covers much of North Central London and extends up into Hertfordshire. Currently there are around 200 people on the active waiting list for a transplant. Prior to the pandemic, approximately 120 transplants were done each year, with over 1000 patients being cared for with a working kidney transplant.

A kidney transplant is the best treatment for medically suitable patients with end stage kidney disease. This may be a transplant from a live donor who will usually be someone who is close to you or from a deceased donor where they or their family have wanted their organs to be used. During the pandemic, the number of transplants carried out was significantly reduced with London seeing a 57% reduction in the number of adult deceased donor transplants performed and a 74% reduction in the number of adult live donor kidney transplants performed.

In order to safely restart the programme, the renal team carried out an improvement exercise to re-evaluate the transplant programme and map out the pathway and protocols required to make it a more efficient and safe service upon re-start. Actions taken included the introduction of:

- Risk based listing
- COVID-19 secure admission pathway
- Separate transplant inpatients
- Separate staffing
- COVID-19 secure outpatients





Through introduction of these measures the renal transplantation service has been able to increase delivery of kidney transplants and tackle the long waiting lists more effectively during 2021/22 and has helped improve the position across the entire London network.

Annexes

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

Statements from Commissioners:

Statements from Healthwatch organisations:

Statements from Overview and Scrutiny Committees:

Statement from the Council of Governors:

Annex 2: Statement of Directors' responsibilities for the quality report

This section will be completed in full by final submission

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 2021/22 and supporting guidance: detailed requirements for quality reports 2021/22;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2021 to March 2022
  - papers relating to quality reported to the board over the period April 2021 to March 2022
  - feedback from commissioners dated 25 May 2021 and 27 May 2021
  - feedback from governors dated 02 June 2021
  - feedback from local Healthwatch organisations dated 06 May 2021 and 28 May 2021
  - feedback from Overview and Scrutiny Committees dated 27 May 2021
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated July 2020
  - the latest national patient survey dated July 2021
  - the latest national staff survey dated March 2022
  - CQC inspection report dated June 2021
- 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:

Appendices

Appendix A:

Unannounced CQC maternity core-service inspection at Royal Free Hospital (October 2020)
A maternal death and the subsequent coroner's preventing future deaths notification received in August 2020 raised safety concerns and triggered the inspection.

Following the inspection in October 2020, the CQC contacted the Trust on 13/11/2020, expressing concern that they were not assured the Trust's maternity services are learning from incidents and improving practice to keep our patients safe. The CQC issued a Section 29a warning notice to the Trust on 13/11/2020. The Trust made the necessary improvements within the section within the timeframes so that the CQC lifted the Section 29a warning notice in January 2021. All actions for improvement are complete, with ongoing monitoring in place or embedded into business-as-usual.

Royal Free Hospital inspection findings and actions:

The CQC said:	Trust update:
The trust must ensure actions and lessons learned following a safety incident are implemented in a timely and effectively way. (Regulation 12)	We have: ✓ Reviewed and amended the Trust incident policy in accordance with the section 29a warning notice Clinical Governance and Learning action plan. ✓ Reviewed the Trust risk management policy in accordance with the section 29a warning notice. o The review determined that a separate maternity risk management strategy was required, linking with the Trust's response to immediate and essential action 1 of the Ockenden Report. ✓ Strengthened the dissemination of information relating to learning from maternity patient incidents in accordance with the section 29a warning notice Clinical Governance and Learning action plan. ✓ Updated the DATIX incident form in accordance with the section 29a warning notice Clinical Governance and Learning action plan. ✓ Amended the Serious Incident notification mailing list in accordance with the section 29a warning notice Clinical Governance and Learning action plan. ✓ Amended the Trust's Inquest Policy to ensure clear guidance of the PFD notification and reporting processes in accordance with the section 29a warning notice Clinical Governance and Learning action plan.
The trust must ensure effective monitoring of compliance following the implementation of recommendations and lessons learned. (Regulation 17)	We have: ✓ Reviewed all HSIB actions and collated into a themed action plan in accordance with the section 29a warning notice Clinical Governance and Learning action plan. ✓ Undertaken an audit of all HSIB referred cases in January 2021 to ensure compliance with processes and timely implementation of recommendations.

	✓ Reviewed and updated the format and content of the 'SI Action Evidence Monitoring Report' presented quarterly at CPPSC and CSIC to improve the effective monitoring of implementation of lessons learned. ✓ Completed an audit of MEOWS to ascertain if improved compliance has been embedded following a patient safety incident. ✓ Senior midwives have undertaken observational reviews of SBAR handovers and provided immediate feedback on any non-compliance with protocol.
The trust must have patient safety information leaflets available in other languages. (Regulation 12)	We have: ✓ Developed a guide for staff on how to access non-written forms of communication for patients including how to access the language interpretation service (The Big Word). ✓ Worked with neighbouring maternity units to identify any gaps in essential maternity patient information leaflets. ✓ Identified the top 10 languages used by RFL maternity service users and produced translations of all clinical maternity patient leaflets into those languages. ✓ Signposted maternity service users to approved websites that enable a range of personalised choices of how information is received. ✓ Reviewed the Trust's webpage to ensure non-English speaking women, contains clear information and has links to accessing the information in other languages. ✓ Implemented the Trust's equality, diversity and inclusion action plan across maternity services.
The trust must ensure information explaining to patients how to raise concerns or make a complaint is easily available. (Regulation 16(2)	We have: ✓ Developed a poster that outlines how to raise a concern including via the MVP. ✓ Undertaken daily checks that all necessary patient information leaflets, including PALS leaflets, are on display within clinical areas and any omissions documented at handover. ✓ Information on PALS and how to raise a concern is clearly accessible via the Trust website and within maternity hand-held records.
The trust must have an effective mechanism to manage resuscitation trolleys. (Regulation 12)	We have: ✓ Allocated staff to undertake resuscitation trolley checks as a standard agenda item at handover. All checks are documented daily including medications and perimortem caesarean section pack. ✓ Raised awareness to staff to continuously check for expired medicines across all clinical areas and return any out of date medications to pharmacy.
The trust must ensure it complies with the Duty of Candour regulations. (Regulation 20)	We have: ✓ Undertaken a review and amended the Trust's Duty of Candour policy in accordance with the section

	29a warning notice Clinical Governance and Learning action plan. ✓ Reviewed and amended monthly SI Progress Reports SOP to include monthly audit of completed Duty of Candour letters to monitor compliance with the Trust's amended Duty of Candour policy, including escalation and recommendations in the event of non-compliance. ✓ Scoped options for the reinstatement of regular Duty of Candour training.
The trust must ensure their governance arrangements have effective structures, processes and systems of accountability. (Regulation 17)	We have: ✓ Commissioned an independent review of the Trust's quality governance processes in accordance with the section 29a warning notice Clinical Governance and Learning action plan.
The trust must ensure internal audit processes function well, are timely and have a positive impact on quality governance. (Regulation 17)	We have: ✓ Completed a deep dive into maternity services to identify areas of practice where audit will help to improve standards of practice and support evidence of improved learning. ✓ Established a consistent and robust approach for the reporting of clinical effectiveness standards and outcomes and highlighting areas where the Trust is not fully compliant or is identified as an outlier. ✓ Recruited into vacant quality governance posts to enable quality governance processes, including internal audit, to function more effectively.
The service must ensure electronic and paper patient record systems are suitable and reliable. (Regulation 17)	We have: ✓ Ordered and deployed new portable computer hardware. ✓ IT technical support available within clinical areas on weekdays. ✓ Educated staff on basic troubleshooting. ✓ Ordered and installed Cerner connectivity engines and installed trunking to secure cables. ✓ User guides and videos to support workflows. ✓ Reinstated electronic MEOWS. ✓ Purchased new scanners to enable administration of medication (e-prescribing). ✓ Trained super-users and staff. ✓ Midwifery information officers to embed workflows. ✓ Ensured decision making processes are made clear and that the rationale behind such changes are clearly articulated to frontline staff, maternity staff should be informed and able to explain the reasons for changing to paper MEOWs on the Royal Free Hospital site but maintaining use of EPR MEOWS at Barnet Hospital.

Appendix B: Progress against CQC inspection findings

Announced trust-wide CQC core-service inspection (December 2018)

In response to the 11 must-do and 81 should-do improvement requirements, the Trust implemented a CQC improvement action plan. The actions were developed, agreed upon, and implemented across each business unit. Each business unit's local executive committee (LEC), clinical performance & patient safety committee (CPPSC) monitors progress.

CQC must-do findings

The Trust has completed all the must-do improvement actions in July 2021 identified in the inspection report published in April 2019. The completed actions are monitored to ensure ongoing compliance.

All completed actions for improvement are being monitored or embedded as business-as usual. Findings and actions in bold have been completed since the last quality accounts.

CQC should do findings and actions

During 2021-22, Barnet Hospital business has two actions remaining open around critical care guidelines and mandatory training compliance. These open actions are expected to be completed by the end of the year.

At Royal Free Hospital, two actions also remain open, relating to mandatory training compliance and appraisal rates. These open actions are expected to be completed by the end of 2022/23.

All should do actions for Chase Farm Hospital have been completed and are being monitored.

Appendix C: Changes made to the quality report

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Appx 2A Minute Extract – CLCH Quality Account, 2020-21

The Committee put on record its thanks to all CLCH staff who had continued to provide wonderful care throughout the pandemic. The Committee also put on record the following comments on the Draft Quality Account: The Committee would like to congratulate and compliment the Trust on the following:

- an emphasis on a clinically curious culture: 'Making Every Contact Count' which is important for the quality of care and avoidance of harm.
- for being recognised in various national award schemes and obtaining a Burdett Trust Grant to undertake a research project entitled 'Rehabilitation and Recovery following Critical illness related to Covid 19'.
- that CLCH staff had been redeployed to the Nightingale Hospital and to large scale vaccination hubs across North London. The Committee was also impressed that CLCH had set up an academy to provide vaccination training.
- for maintaining a strong performance against its Quality KPIs despite the pandemic, continuing to enhance its quality of care and reducing levels of harm through robust governance structures.
- maintaining its existing 'Good' rating in the CQC Report which was published in June 2020 and achieving an 'Outstanding' in the' Well-Led' domain of Community Health Services for Adults.
- its staff education and training initiatives, such as 'reverse mentoring', and for implementing the Apprentice Nursing Associate role across the Trust.
- that CLCH had submitted records to the Secondary Uses Services for inclusion in the Hospital Episode Statistics. This had included 99.1% of data submitted with the patients' NHS number.
- its emphasis on continuity of child protection and children in need was welcomed as Covid had presented challenges for this and the Trust's work with other Boroughs.
- that Jade Ward and Adams Ward at Edgware Community Hospital had received good feedback in a survey on the quality and variety of their food and on staff helpfulness. However, it was noted that staff needed to remind patients about the variety of snacks and drinks available.
- for recruiting two extra members of staff to support research into Long Covid.
- the 'Freedom to Speak Up' (FTSU) initiative, which included five of the 11 champions being from BAME backgrounds.
- that actions had been taken to improve data quality and that the importance of continuing to work to improve data was recognised by the Trust.
- its KPIs being either improved or remaining the same in the Positive Patient Experience.
- its plans to improve the quality of referrals in planned care in Barnet. Although this had been paused during the pandemic as staff had been redeployed, the Committee was pleased that this will re-start.
- that the 'One Care Home Team' had supported 59 care homes in Barnet during the pandemic.
- that the Trust had managed to double its number of volunteers who had worked in various roles including in PPE, the Academy, befriending and other pivotal support roles during the pandemic.

However, the Committee expressed its concerns regarding the following:

- that in the audit aimed at assessing antibiotic prescribing for dental paediatric patients, prescription errors had occurred regarding prescribing the correct dose.
- that consultations were not offered in some cases to children in need during the pandemic. Over 70 families hadn't been seen in the last two months and a significant number of these also hadn't been seen since 2019, even in a virtual setting.
- that at the Pembridge Day Hospice the 'Do Not Attempt Cardiopulmonary Resuscitation' forms had not all been fully completed and some had not been discussed with the patients.
- that a hydration audit at Athlone Rehabilitation Unit in the North-West area showed that only 28% of fluid charts had been completed accurately and 56% of patients were identified as at risk of dehydration.
- that during an observational audit of protected meal times, one third of audit days at Jade Ward at Edgware Community Hospital had demonstrated that there had been no hand wipes on trays or given to the patients during meal times. There had also been several interruptions to meal times on Jade Ward as well as Marjory Warren Ward at Finchley Memorial Hospital.
- that in a CQC report published in June 2020, the Trust were given a rating of 'Requires Improvement' in the 'Safe' domain in Community Health Services for Children, Young People and Families and four areas were listed as 'of concern'.
- that regarding case record reviews, CLCH need to check record keeping and also improve communication with acute providers among other criticisms.
- that there had been 13 patient safety incidents resulting in severe harm in the past year, compared with 11 the previous year although it was noted that there had been an increase in patient numbers during the past year due to patients who were shielding with no face-to-face GP access.
- that in the bedded units there had been nine falls compared with seven last year, 43 Category 2 pressure ulcers and four category 3 and 4 pressure ulcers compared with one last year. All these categories had a target of zero.
- that staff sickness had slightly increased over the past year, which was disappointing but understandable in the circumstances.
- that the Committee noted that 12% of serious incident actions remain open, compared with a target of 100% completion.

CLCH RESPONSE TO HOSC COMMENTS

The CLCH Audit process is part of the continuous improvement approach outlined in the trust's quality strategy. It ensures continuous checking of the effectiveness of existing clinical processes and provides an opportunity to identify wider organizational learning, through the oversight of our clinical effectiveness group chaired by the Medical Director.

The feedback from the Barnet Health & Overview Scrutiny Committee is welcome and we have outlined our response to the issues they have highlighted:

1. Prescription errors had occurred regarding prescribing the correct dose.

   CLCH Response: The audit findings have been shared with the teams involved; discussions and actions to aid ongoing learning have taken place. The trust medication management committee oversees the embedding of good medication management practice and compliance to agreed policy and professional standards.

2. 70 families hadn't been seen in the last two months and a significant number of these also hadn't been seen since 2019, even in a virtual setting.

   CLCH Response: This audit was carried out across the whole division covering 9 boroughs. The non-compliance specific to Barnet was 25.3%. Each team implemented an action plan following the audit, which have now been completed. To embed learning from these audit findings the leadership team has put a process in place to ensure that staff have allocated time in their diaries for targeted vulnerable family support. This is discussed at 1-1 meetings with Team Leads and during safeguarding supervision. All families not seen virtually during the first lockdown were followed up with virtual and face to face.

3. At the Pembridge Day Hospice the 'Do Not Attempt Cardiopulmonary Resuscitation' forms had not all been fully completed and some had not been discussed with the patients.

   CLCH Response: There is an expectation that all patients attending the Day Hospice are provided with the opportunity to discuss resuscitation and that the DNACPR form is signed by members of the MDT in line with CLCH Trust policy. The audit has identified some gaps that have now rectified and improvement measures have been put in place to strengthen ongoing compliance. We have a scheduled re-audit to assess level of improvement in compliance.

4. Hydration audit at Athlone Rehabilitation Unit showed that only 28% of fluid charts had been completed accurately and 56% of patients were identified as at risk of dehydration.

   CLCH Response: Further to the audit findings CLCH have enhanced the monitoring of compliance with fluid intake monitoring in Athlone and have started auditing bedside folders weekly and checking fluid balance charts at each handover (as per the process for medication charts). Areas of non-compliance are addressed with the staff immediately to identify any areas of support that might be required, this will continue on a weekly basis until there is a sustained improvement. The trust dietician is also delivering continuous refresher MUST training.

5. One third of audit days at Jade Ward at Edgware Community Hospital had demonstrated that there had been no hand wipes on trays or given to the patients during meal times. There had also been several interruptions to meal times on Jade Ward as well as Marjory Warren Ward.

CLCH Response: There is greater oversight by our ward matrons on ensuring that hand wipes are given to all patients during meal times and both wards practice protected meal times to avoid disruption and patient interruption during this time.

6. that in a CQC report published in June 2020, the Trust were given a rating of 'Requires Improvement' in the 'Safe' domain in Community Health Services for Children, Young People and Families and four areas were listed as 'of concern'.

CLCH Response: The CQC set three actions that the Trust must take to improve (governed under requirement notices). The Trust submitted its action plans to support the improvements to the CQC in July 2020. Progress was reported by the relevant services/departments into the CLCH Compliance team who coordinate the Trust's regulatory compliance, and monthly updates were presented to the Trust's Patient Safety and Risk Group (PSRG) for assurance and critique and completed in March 2021. Some residual work continues, and the Trust updates CQC during their monthly engagements meeting

7. Case record reviews, CLCH need to check record keeping and also improve communication with acute providers.

CLCH Response: All trust services are involved in record keeping audits on an ongoing basis to ensure compliance with agreed trust policy and professional standards. In addition, the trust undertakes case reviews and staff discuss these though clinical supervision processes to ensure care is provided at the correct level and where gaps in record keeping or engagement with partners are identified, actions are promptly put in place to remedy these.

8. There had been 13 patient safety incidents resulting in severe harm in the past year, compared with 11 the previous year.

CLCH Response: The patient safety incidents reported that resulted in severe harm consisted of five pressure ulcers, four falls, two treatment problem and two delay/failure to diagnose. As outlined in our Quality Accounts; the trust has instigated numerous actions to learn from all adverse events with particular focus on targeted support for teams in the management of pressure ulcers, lower limb wounds through a focus on podiatry and targeted falls prevention work.

9. The bedded units there had been nine falls compared with seven last year, 43 Category 2 pressure ulcers and four category 3 and 4 pressure ulcers compared with one last year. All these categories had a target of zero.

CLCH Response: The trust has reported 43 category 2 pressure ulcers in our bedded units in 2020/21. This is a continued decrease from the 44 reported in 2019/20 and the 57 reported in

2018/19. The trust continues to review all category 2 pressure ulcers developing in the bedded units each month, to support the embedding of best practice and reduction in the incidents of further deterioration or re-occurrence.
It is also important to recognise that the trust has had an increased the number of hospital beds by 97 beds in the reporting period 2019/20, with the adoption of the West Herts community beds.

10. Staff sickness had slightly increased over the past year, which was disappointing but understandable in the circumstances.

CLCH Response: There has been an increase in sickness levels from the 4.4% to 5.5%. The trust continues to support staff well-being through several initiatives such as our staff well-being group, engagement of our employee health and some targeted work through our staff networks as outlined in our new Promoting Equality & Tackling Inequality Strategy**.**

11. 12% of serious incident actions remain open, compared with a target of 100% completion.

CLCH Response: The process of incident investigation and development of action plans to aid learning is an integral part of the trust's delivery of its preventing harm campaign as outlined in the quality strategy. Through the Patient Safety Risk Group CLCH has implemented a rigorous process of challenge and checking the timely closure of all actions and the sharing of 7 minute learning briefings.

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CLCH QUALITY ACCOUNT 2021 – 22

PART 1: ABOUT OUR QUALITY ACCOUNT

Welcome to the Central London Community Healthcare NHS Trust (CLCH) Quality Account for 2021 – 2022.

What is a Quality Account?

A Quality Account is an annual report that providers of NHS healthcare services must publish to inform the public of the quality of the services they provide. This is so you know more about our commitment to provide you with the best quality healthcare services. It also encourages us to focus on service quality and helps us find ways to continually improve.

Why has CLCH produced a Quality Account?

CLCH is a community healthcare provider, providing healthcare to people in their homes and the local community and therefore we are statutorily required to publish a Quality Account.

What does the CLCH Quality Account include?

In April 2020 we launched our quality strategy: *Improving Quality in Everything We Do Our Quality Strategy* 2020 – 2025.

The quality strategy described our four quality campaigns. These are: a positive patient experience; preventing harm; smart effective care and modelling the way. Within the strategy key outcomes and their associated measures of success were listed for each of these four campaigns.

The quality strategy also made clear how our Quality Account priorities would be aligned with the four quality campaigns. Performance against these campaigns is incorporated into the Quality Account.

How can I get involved now and in future?

At the end of this document you will find details of how to let us know what you think of our Quality Account, what we can improve on and how you can be involved in developing the report for next year. If you would like to receive a printed copy of the CLCH Quality Account, please contact us via e-mail clch.communications@nhs.net.

ABOUT CLCH

We provide community health services to more than two million people across eleven London boroughs and Hertfordshire. Every day, our professionals provide high quality healthcare in people's homes and local clinics, helping them to stay well, manage their own health with the right support and avoid unnecessary trips to, or long stays in hospital. We provide care and support for people at every stage of their lives; providing health visiting for new-born babies through to community nursing, stroke rehabilitation and palliative care for people towards the end of their lives. We provide a wide range of services in the community including:

- Adult community nursing, including 24-hour district nursing, community matrons and case management.
- Specialist nursing including continence; respiratory, heart failure; tissue viability and diabetes.
- Children and family services including health visiting, school nursing, community nursing, speech and language therapy, blood disorders and occupational therapy.
- Rehabilitation and therapies including physiotherapy, occupational therapy, foot care, speech and language therapy.
- End of life care, supporting people to make decisions and to receive care at the end of their life.
- Long-term condition management supporting people with complex and substantial ongoing health needs caused by disability or chronic illness.
- Specialist services including delivering parts of long term condition management for people living with diabetes, heart failure, Parkinson's and lung disease, homeless health services, community dental services, sexual health and contraceptive services and psychological therapies.
- Walk-in and urgent care centres providing care for over 220,000 people with minor illnesses, minor injuries and providing a range of health advice and information.
- A lymphedema service in Hertfordshire providing support and management for cancer related lymphedema and for those with complex oedema at end of life.

Vision mission and values:

Our vision is to *Deliver great care closer to home.*

Our mission is *Working together to give children a better start and adults greater independence.*
Our core values provide a reference point for staff on how we should conduct ourselves when working with patients, colleagues and partners and they are as follows:

- Quality: we put quality at the heart of everything we do
- Relationships: we value our relationships with others
- Delivery: we deliver services we are proud of
- Community: we make a positive difference in our communities

Further Information about these and about our services and where we provide them is provided on our website at the following link: https://clch.nhs.uk/about-us

Safeguarding:
Further information about safeguarding and the annual safeguarding declaration can be found in the CLCH annual safeguarding report https://www.clch.nhs.uk/services/safeguarding

STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

I am pleased to present the CLCH Quality Account for the year ending March 2022. This has been another challenging year due to the ongoing Covid -19 pandemic. I'm however proud to note that our staff and services have successfully responded to ongoing pressures and have continued to deliver safe & effective care to the communities we serve.

During the year we have successfully maintained a strong performance against the quality key performance indicators (KPIs) despite the impact of the pandemic. We have continued to report excellent feedback from our positive patient experience campaign, with nearly 100% of patients reporting through our experience surveys that they were treated with respect and dignity. We have embedded our Equality Strategy and have reported improvements in the recording of ethnicity in our clinical records and hosted a national meeting in November 2021 attended by staff from NHS organisations from across the country, where we shared examples of our good practice.

We are extremely proud that our teams have continued to excel with some being recognised in national award schemes. The Academy was shortlisted for three awards at the Student Nursing Times Awards and the Merton Tissue Viability Team won the Community Nursing Placement of the Year. Five of our staff received The Queen's Nurse award from the Queen's Nursing Institute (QNI). The award is given to community nurses who provide exceptional care to their patients and demonstrate a continuing passion and enthusiasm for nursing. It is a very special acknowledgement of the commitment made and work undertaken to ensure the very best provision of care is achieved for our communities and patients.

In 2021 we also successfully welcomed our new Brent services into the newly formed Outer Northwest Division and worked through the pandemic to ensure systems were in place to enable the delivery of good quality and safe community services to the population of Brent.

Finally, my sincere thanks to all our staff for their continued commitment and compassion in successfully delivering high quality care over this period.

I can confirm that the information contained in this document is, to the best of my knowledge and belief, an accurate reflection of our performance for the period covered by the report.

James Benson – Interim Chief Executive Officer

STATEMENT OF THE CHAIR OF THE QUALITY COMMITTEE

We are in the second year of delivering our refreshed quality strategy '*Improving Quality in Everything We Do'.* The Quality Committee has continued to meet quarterly throughout 2021/2022 and has monitored the delivery of our quality priorities and outcomes. As in previous years the committee has received monthly updates, including a quality dashboard and in-depth reports on progress against our targets. I am pleased to report that once again we have been successful in delivering on our strategy campaigns despite the pandemic.

In particular, the Trust has maintained strong performance against its quality key performance indicators (KPIs). We have achieved excellent levels of engagement and feedback from our patients, with over 96% of patients who completed our experience survey reporting their overall experience as either good or very good. We have also secured marked improvements in our preventing harm indicators, as our safety improvement initiatives continue to have a positive impact on quality whilst we bed in the new NHS Strategy.

There has been unprecedented demand on our staffing resource this year and we are grateful to our volunteers who have stepped forward to help ease the pressure on our clinical teams. We have successfully enhanced our work with volunteers, and they are now supporting us in improving the recruitment processes and implementation of the new Volunteer Communications & Engagement Plan.

To ensure we maintain safe staffing levels, our recruitment work is ongoing. I am pleased to report success in our international recruitment processes, with 100% of our candidates passing their test of competence (OSCEs) to date. We can also report that we have maintained high levels of statutory & mandatory training compliance through our Academy, whilst our Clinical Simulation Team have designed training sessions to support our school engagement programme.

The pandemic has undoubtedly posed a challenge to the delivery of business-as-usual activities across our organisation and the NHS, which has made the existence of robust governance processes essential to maintaining high levels of patient safety. In the last year we have enhanced our quality monitoring and assurance processes through the roll out of our e-core standards self-assessment process. This complements our quality development units (QDU) Accreditation by allowing us to identify and celebrate outstanding care by great teams and enabling the early identification of quality improvement opportunities. Our service improvements initiative, through Quality Councils & Shared Governance, remains in place, with 200 staff involved in over 35 councils across the Trust.

We have also been working to deliver on the goals set out in our Promoting Equality and Tackling Inequality Strategy. In the last year the Quality Committee has received assurance on equality of access to our services, with particular focus on Diabetes Services, together with the lessons we can learn from different communities' groups.

Even with such unprecedented demands on our services as a result of the pandemic, it has been a successful year and this is a testament to the resilience and hard work of all our staff who have supported new ways of working as well as numerous NHS initiatives such as the large scale covid 19 vaccination processes and the roll out of virtual wards.

I would like to take this opportunity to thank our staff as well as all members of the Quality Committee for their commitment, dedication, and support in putting quality at the heart of all that we do.

Dr Carol Cole
Chair of Quality Committee

PART 2 - PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

PRIORITIES FOR IMPROVEMENT 2022 - 2023

Our four quality campaigns for 2022-2023 are the same as laid out in our quality strategy namely:

- a positive patient experience;
- preventing harm;
- smart effective care
- modelling the way.

For each of these campaigns there are key outcomes and associated measures of success. To measure our performance against these outcomes, the trust's quality committee has agreed a dashboard which will measure our progress against them. Progress against the outcomes will be reported to the committee on a quarterly basis as part of our comprehensive quality report. Progress is reported to the board via the quality section of the performance report. The information we collect will be used to review how well we have performed over the year. Good practice will be shared and where areas of weaknesses have been identified we will address these.

Further and more detailed information about the development of, and the rationale behind, our quality priorities can also be found in our quality strategy. The strategy can be found here: https://clch.nhs.uk/about-us/quality

The quality campaigns, their key outcomes and associated measures of success for **2022 – 2023** are as described in the tables below. It should be noted that as the strategy is a five year one, the measures of success have been divided up and split across different financial years.

WHOM DID WE INVOLVE AND ENGAGE WITH TO DETERMINE OUR QUALITY PRIORITIES?

In January 2020 we refreshed and updated our quality strategy and sent it to all our external stakeholders for their comments. During the consultation we confirmed that the quality priorities described in the strategy would be the same as the quality priorities in our *Quality Account.* As part of this original consultation, the Trust facilitated engagement events across each of our divisions, these allowed us to engage with both staff and patients asking them for their views on the updated quality strategy. Additionally we held meetings with staff, patients and other stakeholders, requesting their input into our updated quality strategy and reminding them that the quality priorities in the strategy would be mapped to our *Quality Account.* Following this in February 2022 we wrote to our stakeholders and asked if they had any further comments on our quality priorities. We also took the opportunity to confirm that, as in previous years, the priorities as outlined in our quality strategy would be taken forward as our quality priorities in our *Quality Account.*

CAMPAIGN ONE: A POSITIVE PATIENT EXPERIENCE
Enhancing the experience of our patients, carers and their families.

KEY PRIORITY / OUTCOME	MEASURES OF SUCCESS APRIL 2020- NOV 2021	MEASURES OF SUCCESS DEC 2021- JULY 2023
Services are designed and care delivered in a way that involves patients, carers and families as partners in care	We will maintain the proportion of patients who felt that they were treated with respect and dignity at 95%	We will maintain the proportion of patients who felt that they were treated with respect and dignity at 95%
	We will maintain the proportion of patients reporting their overall experience as very good or good at 95%	We will maintain the proportion of patients reporting their overall experience as very good or good at 95%
	The proportion of patients who felt staff took time to find out about them will be 95%	The proportion of patients who felt staff took time to find out about them will be maintained at 95%
	We will develop a policy and process to ensure patient/ user/ carer are involved in every service change.	We will ensure that 80% of patient/ user/ carer feel involved in each service change
Staff* work in services that they believe are delivering the best positive outcomes for patients, carers and families ***Including volunteers**	Staff, friends and family test - percentage of staff recommending CLCH as a place for Treatment will be 75%	Staff, friends and family test - percentage of staff recommending CLCH as a place for Treatment will be 80%
	We will enhance the number of volunteers for the trust and embed volunteers as part of the service	We will increase volunteer numbers by 50% from 2020/21 baseline in services where volunteer participation improves patient experience
	We will complete an annual volunteer survey to understand their impact on services and their experience	We will develop you said we did stories to share volunteers' experiences To continue to complete an annual volunteer survey to understand their impact on services and their experience

KEY PRIORITY /OUTCOME	MEASURES OF SUCCESS APRIL 2020 – NOV 2021	MEASURES OF SUCCES DEC 2021 – JULY 2023
Feedback from patients, carers and families is taken seriously and influences improvements in care	We will continue to respond to 95% of patients' concerns (PALS) within 5 working days	We will continue to respond to 97% of patients' concerns (PALS) within 5 working days
	We will continue to respond to 100% of complaints within 25 days	We will continue to respond to 100% of complaints within 25 days
	We will continue to respond to 100% of complex complaints within the agreed deadline	We will continue to respond to 100% of complex complaints within the agreed deadline
	We will continue to acknowledge 100% of complaints within 3 working days	We will continue to acknowledge 100% of complaints within 3 working days
The patients and the public's voice is integral in the decision making process when making changes to services or care delivery	We will develop and implement one Always Events in each division	We will transfer the learning from each *always event* across the trust
	We will continue to deliver borough based quarterly co-design initiatives using patient and staff feedback/ stories	We will review the impact and learning from quarterly projects on the overall patient experience
Transforming healthcare for babies, their mothers and families in the UK **(UNICEF Baby Friendly Initiative)**	All health visiting services will have a plan for breastfeeding assessment at level 1 -3 (Where services have already achieved this, they will achieve gold in the 1 year assessment)	50% of health visiting services will have achieved level 2 breast feeding accreditation or greater

CAMPAIGN TWO: PREVENTING HARM

Keeping our patients, their families and our staff safe.

KEY PRIORITY / OUTCOME	MEASURES OF SUCCESS APRIL 2020- NOV 2021	MEASURES OF SUCCESS DEC 2021- JULY 2023
Robust, effective systems and processes in place to deliver harm free care all the time	97% of clinical incidents will not cause harm	Maintain/ or improve on the Proportion of clinical incidents that did not cause harm reported in 2020/21
	100% of patients in bedded units will not have a fall with harm (moderate or above)	100% of patients in bedded units will not have a fall with harm (moderate or above)
	100% of patients in bedded units will not have a NEW (CLCH acquired) category 2-4 pressure ulcer	100% of patients in bedded units will not have a NEW (CLCH acquired) category 2-4 pressure ulcer
	100% of all Serious Incident investigations will be completed on time in accordance with national guidance	100% of all Serious Incident investigations will continue to be completed on time in accordance with national guidance
	100% of all Serious Incident actions will be completed on time in accordance with locally agreed timescales	100% of all Serious Incident actions will continue to be completed on time in accordance with locally agreed timescales

KEY PRIORITY / OUTCOME	MEASURES OF SUCCESS APRIL 2020- NOV 2021	MEASURES OF SUCCESS DEC 2021- JULY 2023
Enhance the embedding of a safety culture in the trust ensuring learning from adverse events and compliance with national best practice	We will undertake a safety culture survey	There will be evidence of an improvement in the safety culture compared to baseline
	Each division will share a single serious incident learning example using the 7-minute learning tool through divisional board and patient safety risk group	Each division will share at least 4 incident learning examples in divisional boards using the 7-minute learning tool through divisional board and patient safety risk group
	80% of teams will have undertaken a core standards annual health check assessment	90% of teams will have undertaken a core standards annual health check assessment and identified action plans that are completed on time
	100% compliance with the timely closure of actions from risks on the register	No outstanding actions from risks on the register

CAMPAIGN THREE: SMART, EFFECTIVE CARE

Ensuring patients and service users receive the best evidence-based care, every time

KEY PRIORITY / OUTCOME	MEASURES OF SUCCESS APRIL 2020- NOV 2021	MEASURES OF SUCCESS DEC 2021- JULY 2023
Making Every Contact Count (MECC) promoting health in the population we serve	95% staff trained at MECC level one 95% clinical staff trained at level two	95% staff trained at MECC level one 95% clinical staff trained at level two
	We will launch MECC link across the Trust"	We will evaluate the use of MECC link with our clinical staff
All staff are supported to drive a clinically curious culture and increase shared learning while improving clinical effectiveness	We will increase the number of research projects involving/led by clinical staff within the Trust by ≥ 10%	We will increase the number of research projects involving/led by clinical staff within the Trust by ≥ 15%
	100% of services/ individuals undertaking a clinical audit/service evaluation/QI project will submit a clinical improvement poster to the clinical effectiveness team	Clinical improvement posters will be displayed on all key Trust sites presented at Trust business meetings, divisional and service/team meetings, other appropriate settings and uploaded to the Hub. Target: ≥ 80%

CAMPAIGN FOUR: MODELLING THE WAY

Providing innovative models of care, education, and professional practice

KEY PRIORITY / OUTCOME	MEASURES OF SUCCESS APRIL 2020 - NOV 2021	MEASURES OF SUCCESS DEC 2021- JULY 2023
Implementing Reverse Mentoring for all staff ensuring career opportunities are accessible to all	Training will be in place for senior clinical staff at band 8b or above to undertake reverse mentor training A support network for reverse mentors will be implemented	60% of clinical staff at band 8b or above will have undertaken training Mentoring opportunities will be publicised for staff Trust wide
All staff have the core identified statutory and mandatory skills for their roles	We will continue to maintain statutory and mandatory training compliance at 95%	We will continue to maintain statutory and mandatory training compliance at 95 %
Staff receive appropriate education and training to ensure they have the right skills to support new models of care	All learning needs will be discussed as part of the annual appraisal process	Each professional group will have development portfolios to support staff having the right skills and knowledge to support new models of care
Safe, sustainable and productive staffing: Right place and time	100% of clinical staffing establishment changes will be discussed through the Clinical staffing panel prior to Quality Impact Assessment	100% of clinical staffing establishment changes will be discussed through the Clinical staffing panel prior to Quality Impact Assessment
Ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times	We will continue to implement and support the Apprentice Nursing Associate (ANA) role across the Trust	All community nursing and bedded services will have 1/2 ANAs in place
	We will develop safe staffing models for the AHP workforce and review opportunities for new AHP roles supporting new models of care	We will evaluate safe staffing models for AHP workforce and any new roles developed
	We will continue to develop professional networks and deliver events for all staffing groups across the Trust	We will continue to develop Professional networks and deliver / events to be delivered for all staffing groups across the Trust and primary care

STATEMENTS OF ASSURANCE FROM THE BOARD

Review of services

During 2021-2022 CLCH provided 111 different services. The Trust has reviewed all the data available to them on the quality of care in 100% of services. The income generated by the NHS services reviewed in 2021-2022 represents 100% of the total income generated from the provision of NHS services by CLCH for 2021-2022

Secondary use services

CLCH submitted records during 2021-2022 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics. The percentage of records in the published data which included patients' valid NHS number was 99.4% and which included patient's valid General Medical Practice Code was 97.3%.

All 100% of this information related to records for patients admitted to our walk-in centres.

Clinical coding error rate

CLCH was not subject to the Payment by Results clinical coding audit during 2021-22.

Data Security and Protection (DSP) Toolkit

The Trust last submitted a '*standards met'* for the 2020-2021 DSP toolkit which stated that CLCH had met all the standards required of the Toolkit. We submitted this assessment following a report from the Trust's auditors which had given CLCH an overall assessment of *substantial assurance* in relation to our assessment of our performance against the toolkit. The next submission is not due until June 2022.

PARTICIPATION IN CLINICAL AUDITS

Clinical outcome reviews.

During 2021-22, there were no clinical outcome reviews (formerly known as national confidential enquires) which covered services provided by CLCH. Therefore, CLCH did not participate in any clinical outcome reviews.

National clinical audits

During this period, CLCH registered in all five eligible national clinical audits, namely, the National Diabetes Audit (NDA), the Sentinel Stroke National Audit Programme (SSNAP), the National Audit of Cardiac Rehabilitation (NACR), the National Asthma and COPD Audit Programme (NACAP) Pulmonary Rehabilitation Audit, and the National Audit of Inpatient Falls (NAIF). However, we only undertook work on the three national clinical audits listed below due to the pandemic.

National clinical audits		
National Clinical Audit	Participation	Outcomes and actions
National Audit of Cardiac Rehabilitation (NACR)	Services taking part: • Harrow COPD Respiratory Service • West Herts Respiratory Service • Merton Cardio-Respiratory Service • Barnet Community Respiratory COPD Service • Cardiac Rehabilitation Service, Hertfordshire Data collection is in progress.	At the peak of the pandemic, redeployment of cardiac rehabilitation (CR) staff to other services (close to 80% at its peak), together with reduced referral from cardiology, reduced uptake to CR. The NACR Steering Group stated the audit should not place an additional burden on clinical teams to check and validate uptake figures; therefore, the report focused on CR service delivery quality and inequalities related to patient participation during the pandemic. Actions: • Develop and implement strategies to halt the widening inequalities gap in CR participation • Ensure that the content and quality of CR delivery align with national standards • Ensure that all CR delivery modes (home-based, group-based and hybrid versions) are offered to all eligible patients and that patient choice is supported
National Asthma and COPD Audit Programme (NACAP) Pulmonary Rehabilitation Audit	Services taking part: • Harrow COPD Respiratory Service • West Herts Respiratory Service • Merton Cardio-Respiratory Service • Barnet Community Respiratory COPD Service • Respiratory Service Hertfordshire. Data collection is in progress.	The NACAP has not yet published the Pulmonary Rehabilitation Audit Report for the 2021 period.

National Audit of Inpatient Falls (NAIF)	A requirement of the audit was that the National Hip Fractures Database (BHFD) would identify any patients who sustain a hip fracture in our patient services. These patients would be included in the audit and subsequent orthopaedic care would be monitored. We however participated in the NAIF Facilities Audit in 2021. Services taking part: • Inpatient Units: Inner (Alexandra Unit) • Inpatient Units: Inner (Athlone House) • Inpatient Units: Barnet (Jade Ward) • Inpatient Units: Barnet (Adams Ward)	Key outcome from the Facilities Audit: - Leadership/resources Senior leaders should include time for participation in NAIF and related QI activities in job specifications and plans for falls leads/practitioners/coordinators. For 2022, we will look to register new inpatient areas across Brent and units in Hertfordshire.

LOCAL AUDITS

The reports of nine local clinical audits that were reviewed by CLCH in 2021-2022 are described in the table below. The actions that the trust intends to take, as a response to the audits, to improve the quality of healthcare provided are also incorporated. Due to COVID-19, pandemic there have been fewer audits than in previous years.

Title	Division	Service	Outcomes and Actions
1. FP10 Handling Audit	Trust-wide	All Services	The FP10 handling audit aimed at ensuring that Non-Medical Prescribers (NMPs) were compliant with Trust and national standards for FP10 storage and record keeping, in line CQC Regulation 17. Key findings included: 95% overall Trust compliance, 83% of NMPs completed the audit, the lowest standard compliance (92%) is 'access to room/area where NMP prescription pad kept is controlled', 97% of NMPs were aware of the reporting process when prescriptions are lost/stolen. Recommended actions included the Medicines Management Team to update its internal NMP database to ensure updated records of active and develop guidance on storage; they will also roll out electronic prescriptions to all community services where clinical systems allow; services/prescribers will work with CBUs and Estates to

			ensure locks are installed in rooms where prescriptions are kept.
2. NEWS2 Audit in Bedded and Rapid Response service	Trust- wide	All Services	This audit aimed at seeking assurance that the NEWS2 scoring tool was in use across the bedded and rapid response services in the Trust and measured practice against the Royal College of General Practitioners guidance (NEWS2, 2017) and the trust Deteriorating Patient policy, and the NICE Sepsis Quality Standard: Assessment and escalation (Sepsis Quality standard QS161, 2017). Key findings included: overall accuracy of calculations and frequency of vital sign monitoring – high compliance in line with Trust policy, there was good compliance with monitoring patients in line with Trust policy because of an escalated NEWS2 score - 99.1%. Recommended actions included: NEWS2 should be included in clinical supervision sessions with clinicians, where appropriate, to reinforce good practice and address any areas for improvement with staff, a campaign to improve awareness of sepsis in bedded and rapid response services, and to reinforce the importance of considering sepsis as a differential when NEWS2 scores are elevated; case-based discussions during group supervision to allow for discussion between team members.
3. Written Consent for Dental Sedation in CLCH Community Dental Service (CDS)	Inner North West	Community Dental Services	The audit aimed to see if CLCH Dental practitioners were complying with GDC guidelines to obtain appropriate written consent prior to carrying out IS or IVS in the CDS. All patients who have conscious sedation should have a pre-operative written consent form which is kept securely as part of the patient's dental record on Carestream R4 (dental electronic patient record system – R4). Findings included: 92 patients received sedation in the period February - April 2021 and out this number - ▪ 100% of adult patients had a consent form in their R4 notes.

			▪ 100% of adult patients who could consent had Consent Form 1 in their R4 notes ▪ 92% of paediatric patients had a consent form in their R4 notes ▪ 2% of paediatric patients had Consent Form 1 in their R4 notes instead of Consent Form 2. Recommended actions included reminding staff that all conscious sedation patients should have written consent prior to dental treatment, all consent forms should be uploaded and stored in R4 contemporaneously, and that all patients should have their consent recorded on an appropriate form depending on age and capacity.
4. Compliance with Reporting of Radiographs in Clinical Records and Quality Assurance Image Audit	Inner North West	Community Dental Services	The re-audit aimed at providing assurance in the service's high-quality record keeping including the justification, grading, and reporting of dental radiographs Findings included: justification was recorded in 92% of records audited (10% increase from 2019 and 27% increase from 2018), grading was recorded in 87% of radiographs taken (13% increase from 2019 and 16% increase from 2018), Reporting was recorded in 98% of radiographs taken (11% increase since 2019 and 2018). Recommended actions included reminding dental clinicians of the need to record appropriately; and increase awareness and encourage use of R4 for data entry and reporting management capabilities.
5. Recording of Recommended Recall Interval for CDS patients	Inner North West	Community Dental Services	The audit aimed at establishing that CLCH Community Dentists were compliant with NICE guidance CG19, with the objective that patients were being offered the appropriate level of care according to their individual needs Key findings included: 98% of patients receiving continuing care with the CDS had a recommended recall interval recorded in the clinical records, 20% of patients were discharged from CDS care at the end of their course of treatment, 45% of the discharged

			patients had a letter sent to their general dental practitioner (GDP) which included a Recommended Recall interval. Recommendation actions included CDS dentists to continue recording recommended recall Interval in clinical notes for all patients receiving continuing care with the CDS. This can be in the Clinical Notes and/or the NICE Oral Health Review tab at the discretion of the dentist; discharged patients should have a recommended recall interval included in the discharge letter to their GDP – to be spot checked; domiciliary patient records should include a risk assessment and specific detail if a recommended recall interval is not made – to be spot checked.
6. Female genital mutilation audit (FGM)	Safeguarding/ Quality Division	Relevant services	The FGM audit aimed at ascertaining that staff were following mandatory reporting procedures and routine screening in line with the 2015 guidance and that the CLCH FGM Recording, and Reporting Policy was being implemented in the Trust. Key findings included information regarding FGM was included on 37% of summaries; 54% of the mother's records were flagged; 6% of the records showed that female children's records had been flagged and alerts added. Recommended actions included the incorporation of the audit findings into the new CLCH FGM policy and update all staff across CLCH with the recording requirements; share the findings through Safeguarding committee, safeguarding bulletin and professional/quality forums; share findings with the designated professionals across all boroughs; review the new FGM processes in January 2023.
7. Documentation audit	Safeguarding/ Quality Division	Brent 0-19 Universal Service	The aim of this audit was to measure Brent 0-19 Universal Service's record keeping practices against NMC and CLCH record keeping standards. Findings included the London Continuum of Need (LCON) was recorded accurately in 63.1% of

			records; allergies and sensitivities were not recorded in 46% of records; safeguarding alerts/flags were not updated in 31% of cases; 73% of cases recorded a care plan. Recommended actions included record keeping aide memoires to be circulated to staff; School nurse staff to design more appropriate school nurse audit tool for auditing purposes; team leads to complete an audit with staff who did not undertake the 2021 audit.
8. The Manual Handling Risk Assessment form and patient white board service evaluation	North Central	Jade Ward	Information on the Moving and Handling Risk Assessment form completed by Physiotherapists was not always the same as the information on whiteboards above patients' beds or was incorrectly updated. This service evaluation aimed to ensure the correct updating of both items to help prevent falls and aid communication with the MDT. The findings indicated a broad variation of input. Recommended actions identified included sharing findings with staff, including those working at weekends, and implementing a trial to set protected time for updating.

Acronyms and explanations of terms

AMaT	The Trust's clinical audit management system (Audit Management and Tracking)
BPE	Basic Periodontal Examination
CBU	Clinical Business Unit
CDS	Community Dental Services
CLCH	Central London Community Healthcare NHS Trust
CR	Cardiac rehabilitation
CQC	Care Quality Commission
FGM	Female Genital Mutilation
FP10	Prescription form
GDC	General Dental Council
GDP	General Dental Practitioner
IS	Inhalation Sedation
IVS	Intravenous Sedation
LCON	London Continuum of Need (a guide used to assess and meet the needs of children and their families)
NEWS2	National Early Warning Score
NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
NMC	Nursing And Midwifery Council
NMPs	Non-Medical Prescribers
PRN	*'pro re nata'* - medicines that are taken "as needed"
QA	Quality Assurance
QS	Quality Standards
R4	Carestream R4 (dental electronic patient record system)

PARTICIPATION IN RESEARCH

Research at CLCH has embarked on a new journey to adapt to the everchanging impacts of the COVID-19 pandemic. The pandemic has demonstrated the importance of research in the NHS with world class innovative vaccines, and treatments to prevent and reduce the health implications of the corona virus. We launched the new CLCH Research Strategy (2021-2024) as part of our commitment to embedding an inclusive research culture and creating equity of opportunity. The strategic vision is underpinned by key priorities:

1. To increase the research culture within CLCH
2. To give all CLCH staff and service users the chance to participate in health care research
3. To expand research opportunities across the Trust
4. To become a leader for healthcare research in community settings

132 CLCH patients and staff were recruited during 2020/21 to participate in research approved by a research ethics committee.

Participant recruitment across studies 2021-2022.		
IRAS Ref	Full Title	Recruitment
277676	AHP perceptions of NHS research capability and culture: A national research capacity in context survey.	57
282858	Psychological impact of COVID- 19- pandemic and experience: An international survey.	24
282232	A randomised, double blind, placebo-controlled study to evaluate clinical performance and safety of the Gedea pessary in adult women with bacterial vaginosis – Nefertiti.	18
235092	A prospective, multicentre, randomised, assessor blinded study comparing the efficacy and patient reported outcomes of two different daily gekotm treatment duration in conjunction with standard care, with each other and to standard care alone, in patients with venous leg ulcers.	5
293143	Electronic Palliative Care Co-ordination Systems (EPaCCS) in end-of-life care: evaluating their implementation and optimising future service provision.	4
291746	BabyBreathe Trial: A randomised controlled trial of a complex intervention to prevent return to smoking postpartum.	3
300361	Neuropsychological Consequences of COVID-19: Long COVID and the role of Virtual Hospitals.	20
290383	Mental health and wellbeing of NW London health and social care staff during COVID-19.	1
Total:		132

For the Geko VLU Efficacy study (235092), the clinical team successfully recruited five patients in year and twelve patients overall against a target of five. This success led to CLCH being in the top three highest recruiting sites out of 21 participating NHS Trusts and was the 2nd highest recruiting site in 2021/22.

The Trust was proud to become a member of the North West London Clinical Research Trials Alliance. The alliance is a collaboration of NHS Trust based clinical research facilities, primary care, and the London Ambulance Service. The alliance will bring together expertise across the region to support staff to develop their skills and advanced clinical practice. It will enable CLCH to enhance its footprint in the clinical research landscape with new opportunities for patients to access cutting-edge therapies.

CLCH and London South Bank University (LSBU) have been collaborating to support clinical academic pathways for staff at CLCH. This will develop their skills and knowledge to become future research leaders and build evidence-based practice. One of our Specialist Speech and Language Therapists was

successful in securing a place on the Integrated Clinical Academic (ICA) Internship pathway. This is organised by Health Education England (HEE) and the National Institute for Health Research (NIHR).

FREEDOM TO SPEAK UP (FTSU)

CLCH is committed to promoting an open and transparent culture across the organisation to ensure that all members of staff experience a compassionate climate where they are confident to speak up and everyone can learn. This includes anyone who undertakes work for the trust.

FTSU is included within the trust's welcome booklet, induction for staff, a handout given to bank workers and volunteers. Core FTSU training has been developed in line with National guidelines on Freedom to Speak Up training in the health sector in England and is included within the statutory and mandatory booklet completed annually by all staff.

There is a FTSU page on the intranet and to track and monitor engagement with FTSU, a service timeline has been added to this. A FTSU module has been developed and included in the Trust's Leadership and People Development Programme, in line with the national guidelines, which covers creating the right environment, supporting speaking up and listening well.

Staff are encouraged to speak up about anything related to the quality of care, patient safety, bullying or harassment or anything else that affects their working lives, so that we have an opportunity to address their issues. Staff can raise concerns through their line manager, more senior managers, clinical leads, the patient safety team, safeguarding team, staff representatives, Human Resources, directors, nominated non-executive, director, trust local counter fraud specialist, or by using formal processes. A new FTSU Guardian has been recruited and we look forward to welcoming them into post in April. Staff are also provided with details as to how they can speak up to an outside body. Our Non-Executive Director Champion for FTSU is Dr Carol Cole, chair of the Quality Committee.

Staff can choose to raise their concern by name, confidentially or anonymously. If confidential, we strive to maintain confidentiality unless we are required to disclose it by law, e.g. by the police. Feedback will be given to staff who raise concerns through progress updates and, wherever possible, by sharing the full investigation report with them whilst respecting the confidentiality of others.

The FTSU guardian 2021/22 reports have been completed and returns submitted for those periods to the NGO.

COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN) AND LOCAL INCENTIVE SCHEME (LIS) PAYMENT FRAMEWORKS

Due to the pandemic, in March 2020 NHS England decided to roll forward all NHS block contracts. These contracts would normally be renegotiated annually. This also applied to CQUINs and LISs – i.e. that 100% delivery should be assumed for 2021/22. This was to allow NHS Trusts to free up as much capacity as possible and prioritise their workloads to focus on managing their response to the pandemic.

Given this, the usual information in respect of planned CQUINS and our achievement in respect of them is not available for inclusion in the 2021-2022 quality account. CQUIN work will restart in 2022/23.

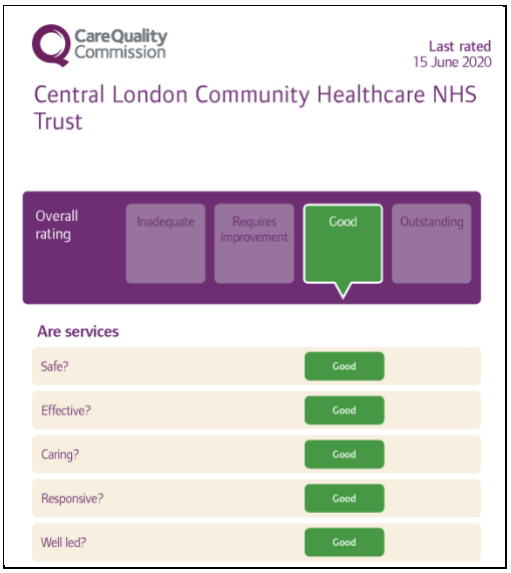
CARE QUALITY COMMISSION (CQC)

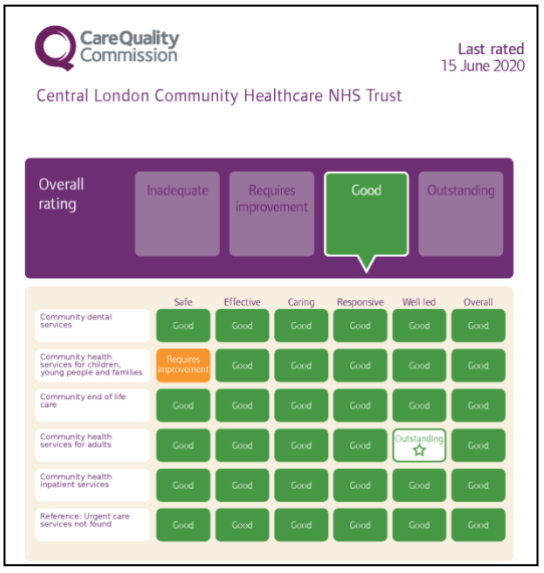
CLCH is registered with the CQC under the provider code RYX without any conditions. The CQC has not taken any enforcement action against CLCH during 2021/22. Furthermore, the Trust has not

participated in any special reviews or investigations by the CQC during the reporting period that ended 31st March 2022.

At our last inspection, in February 2020, the CQC inspected one of the Trust's core services- community health services for children and young people. The well-led assessment element of the inspection, scheduled for March 2020, was postponed due to the COVID-19 outbreak and has not been rescheduled.

In June 2020, CQC published their report which rated the Trust as 'Good' overall, with no changes to the ratings in the core service inspected. The grids below reflect the Trust's current rating.





As can be seen from the grid, the Trust was given a rating of *requires improvement for* the *safe domain* in community health services for children and young people, at the 2020 inspection. This rating was awarded based on the following judgements made by CQC:

- High vacancy rates and large caseload sizes in Brent, which impacted on the delivery of the mandated Healthy Child Programme and the safe management of waiting lists.
- Staff did not always complete, or review, treatment records in a timely manner with important information.
- Lone working practices were not robust and staff understanding varied.
- No robust system was in place to monitor the use of prescription pads in the children's community nursing team.

We were issued with three actions which we were required to take to improve the core service's *safe domain.* Individual plans to address the actions were written and assigned to responsible owners who undertook the necessary work. Progress was monitored through the Trust's monthly Patient Safety and Risk Group.

Our current rating and latest inspection reports can be found on the CQC website at: https://www.cqc.org.uk/provider/RYX.

DATA QUALITY

High quality data is a key component of information governance. It is essential for both the effective delivery of patient care and enabling continuous improvements in care provision. We are fully committed to improving the quality of data across all our services. We recognise the importance of

our duties with personal data - keeping it accurate and up to date, treating it with the strictest confidence, managing it securely, and sharing it only in full compliance with the Caldicott principles. During 2021/22 we have taken the following actions to improve data quality:

- Developed a Data Quality Plan and undertaken a wide range of data improvement tasks set out therein. The plan has sought to improve the accuracy of the Trust's reporting data, make more data available for scrutiny by relevant stakeholders, and place a greater emphasis on reconciliation. The plan has been overseen and delivered by members of the Trust's data forum with clinical and operational input.

- Migrated Trust information reporting to Power BI. This provides activity and performance reporting refreshed daily, including contacts, referrals, ethnicity recording completeness, and outcome timeliness. All current reporting has been migrated from QlikView to Power BI and additional functionality is in the pipeline. Power BI enables more intuitive and detailed analysis of data and allows Trust activity data to be shared with a much wider corporate and clinical audience. This has, for example, allowed greater scrutiny of waiting times by operational teams and more rapid resolution of outliers, thus aiding data quality improvement and patient care.

- In collaboration with wider corporate teams, staff in IM&T have been engaged with data quality initiatives such as clinical template and counting rules standardisation and embracing the migration towards broader use of the Community Services Dataset with continuous improvement and closer monitoring of Trust submissions.

- Continued with an initiative to increase the completeness of patient ethnicity recording, which resulted in an improvement from 84% to 90% over the 2021 calendar year. This has involved creating new reporting, amending systems templates, and mapping, and engaging with front line staff to improve their recording practices.

The Data Forum (DF), led by the Associate Director of Information Management and Business Intelligence, has oversight of this area of work. The group has strong operational input from divisional business managers. This group has the following specific aims to improve data quality in 2022/23:

- To actively support the implementation of the data quality framework by assisting in the operational implementation of the Data Quality Plan.

- To identify, and regularly review, a representative set of data quality metrics which appropriately reflect the level of data quality within the Trust with a view to establishing improvement activity and corrective actions.

- To work collaboratively with all divisions, corporate services, and other stakeholders to consider data and reporting improvement initiatives and uphold a high standard of data integrity throughout.

- To agree and promote a series of data standards within the Trust.

- To act as an advocate and champion for the importance of data quality issues.

We will also be taking the following actions in 2022/23 to improve data quality:

- Continue working on the tasks set out in the Data Quality Plan and setting a new plan for the year ahead, including a systematic approach to standardisation, and adhering to emergent National Data Standards for Community Services.

- Working directly with services to expose data quality problems at source, highlighting their responsibilities and encouraging the improvement of data collection and reporting.

- Using Power BI as the platform for the Trust's Self-Service Business Intelligence portal, expanding its user base to the whole Trust, and adding to its functionality, in particular data quality monitoring tools

- Aligning with current Trust strategies to enhance the value of data and extend its use for service improvement and much wider analysis.

LEARNING FROM DEATHS: 2021 – 2022

From April 2017, all Trusts have been required to collect and publish information on deaths and serious incidents, including evidence of learning and improvements being made because of that information. In October 2018, CLCH published a *Learning from Death* (LfD) Policy based on NHS Improvement's National *Guidance on Learning from Deaths.* It was updated in January 2020 and is now fully embedded for adults across our services. All deaths within the Trust are reported via the incident reporting system - Datix. As part of the LfD process, Service Team Leaders and Directors of Nursing & Therapies triage each case to ascertain whether a case record review should be carried out using a modified PRISM 2 (preventable incidents, survival, and mortality study 2) form. The case record reviews are completed by Clinical Directors / Divisional Medical Directors from the relevant divisions and discussed at the Trust's bi-monthly Resuscitation and Mortality Group.

CLCH is engaged in the multiagency statutory review of deaths of children and young people. In 2020, considering the changes introduced by Working *Together to Safeguard Children 2018* we revised our internal processes to support learning and governance with the child death review process. As part of this process, the Associate Director of Safeguarding and the Trust's children's division present an overview of deaths of children and young people known to our services biannually at the resuscitation and mortality group meeting. This includes findings from the child death overview panels (CDOPs), themes, and lessons learnt.

The internal processes relating to the overview of deaths of people with learning disabilities in the Trust were also revised in 2020/21. All deaths of people with learning disabilities have been reported to the learning disabilities mortality review programme (LeDeR) since 2017. From March 2021, the learning disability teams also started presenting an overview of deaths of people with learning disabilities biannually to the Trust's Resuscitation and Mortality Group. This includes findings from the LeDeR reviews, themes, and lessons learnt. the Learning Disability Strategy was reviewed in December 2020 and emphasis is given to learning from deaths of people with Learning Disabilities e.g., a CLCH *Learning from LeDeR* event and a commitment to train all staff who are band 6 and above to carry out multi-agency reviews.

	Prescribed Information	Form of Statement
1.	The number of in- patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	From Apr 2021 – Mar 2022, 2894, CLCH patients died as follows (includes expected hospice deaths): • 666 in Q1 • 749 in Q3 • 687 in Q2 • 792 in Q4 Of this number, the following number were in-patients: 2 in the first quarter, 3 in the second quarter, 2 in the third quarter and 5 in the fourth quarter.
2.	The number of deaths included in item	From Apr 2021 to Mar 2022, 10 case reviews were completed, 9 were case record, (PRISM)

	1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	reviews and 1 incident review were completed in relation to the 2894 of the deaths included in item 1. In 3 cases, the deaths were subjected to both a case record (PRISM) review and an investigation (Case 6: 2021 – 2022, Case 7: 2021 – 2022, Case 8: 2021 – 2022). The number of cases in each quarter for which a case record review or an investigation was carried out was: • 3 in Q1 • 2 in Q3 • 3 in Q2 • 2 in Q4
3.	An estimate of the number of deaths during the reporting period included in item 2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	1 representing 11% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: • 0 in Q1 • 1 in Q3 • 0 in Q2 • 0 in Q4
4.	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 3.	**Case 19 (2020 – 2021)** a) All Divisions need to regularly ensure that they have sufficient staff members nominated to enter relevant patient deaths onto the CPNS register. b) All divisions need accountable senior clinician who will ensure that all relevant deaths are entered onto the CPNS register within a reasonable time frame. **Case 1 (2021 – 2022)** a) Importance of early discussion of resuscitation with patients to allow advance decision making. b) Importance of staff being familiar with enhanced PPE needed for resuscitation in bedded area (which is likely to be different to their usual PPE). c) Importance of debrief and emotional support for staff after a patient death, particularly if this was unexpected/ involved a resuscitation attempt. **Case 2 (2021 – 2022)** No action points relating to Learning from Death or the clinical management of the patient were noted. **Case 3 (2021 – 2022)** In cases where a ceiling of care is agreed, more careful documentation needed if patient deteriorates to record that consideration has

		been given to escalation in medical management but has been ruled out. **Case 4 (2021 – 2022)** No action points relating to Learning from Death or the clinical management of the patient were noted. **Case 5 (2021 – 2022)** a) All ward staff need to be aware of protocols in relation to treatment of hypoglycaemia. b) All ward staff need to comply with protocols for recording of fluid balance. c) Medication reviews need to be repeated if patients' renal function deteriorates to stop nephrotoxic drugs if indicated. d) Family meetings should be documented in specific section rather than in shared contemporaneous records. e) Although the patient deteriorated throughout the course of the admission, this was not reflected in discussions at MDT or in Family meetings. **Case 6 (2021 – 2022)** a) Patient was not suitable for admission onto a rehabilitation unit and should have been transferred back to the acute hospital for investigation. b) Nursing staff need to be given clearer guidance re: calculating and recording of NEWS scores in patients on supplemental oxygen. c) Medical team failure to recognize deteriorating patient and escalate appropriately, and senior members of medical team failed to review junior doctor decision making, (This case is currently being investigated as an External Serious Incident). **Case 7 (2021 – 2022)** a) Patients' Resuscitation status needs to be discussed during the weekly Consultant ward round and in the weekly MDT meeting. b) The weekly Consultant ward round proforma to have a record of resuscitation status of each patient. c) Learning from the case to be summarized in a "7-minute Learning tool" and discussed within the division and at the Trust's Patient Safety & Quality Group. d) The Standard Operation procedure for the management of the deceased patient needs to be reviewed and updated as the patient died within 28 days of a positive PCR for

		COVID-19 but they were not entered on the CPNS register. **Case 8 (2021 – 2022)** No action points relating to Learning from Death or the clinical management of the patient were noted. **Case 9 (2021 – 2022)** No action points relating to Learning from Death or the clinical management of the patient were noted.
5.	A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 4).	**Case 19 (2020 – 2021)** a) Senior management team from each Division have identified accountable clinician who will be responsible for ensuring relevant deaths are entered onto the CPNS register. Each Division has identified either the Divisional Nursing Director (ONW, SW, Herts) or the Divisional Medical Director (INW and NC) who will be responsible for checks and hold ultimate accountability within the Divisions. **Case 1 (2021 – 2022)** a) Learning described in section 4 disseminated to the service level teams by the Divisional Nursing Directors and Divisional Medical Directors. b) PPE guidance has been reviewed to clarify guidance and emphasis will be given to use of PPE during Resuscitation attempts during Annual Resuscitation training for staff. As clinical staff who would participate in a Resuscitation attempt have now been vaccinated, a review of PPE is taking place. c) Divisional Nursing Directors and Divisional Medical Directors have cascaded this information back to the Service level clinical leads and managers. **Case 2 (2021 – 2022) - N/A** **Case 3 (2021 – 2022)** Divisional Nursing Directors and Divisional Medical Directors have cascaded this information back to the service level clinical leads and managers. **Case 4 (2021 – 2022) - N/A** **Case 5 (2021 – 2022)** a) Trust Mortality Lead will present this case in an upcoming multi-professional ward team

		meeting and will emphasise need to follow Hypoglycaemia protocol. b) Trust Mortality Lead will present this case in an upcoming multi-professional ward team meeting and will emphasise importance of recording fluid balance in fluid balance charts. c) Trust Mortality Lead will present this case in an upcoming multi-professional ward team meeting and will emphasise importance of regular medication reviews and ad hoc medication reviews if a patient's condition changes in order to check whether medication is contraindicated. d) Ward manager will feedback to ward staff re: the importance of documenting medical and nursing records in the specified sections of the records rather than recording them as one narrative in the shared contemporaneous records. e) Trust Mortality Lead will present this case in an upcoming multi-professional ward team meeting and will emphasise need for reviewing management plans if a patient's condition changes and for documenting that the management plan has been reviewed in the clinical records. f) The Clinical Directors and Nursing Directors are meeting to discuss whether the clinical environment in our community rehabilitation wards, current staffing levels and staff training is currently suitable to care for patients with the higher clinical acuity we have been admitting from our acute hospital partners since the pandemic began. This discussion will include an assessment of changes to training and the environment which need to be made to care for these higher acuity patients safely. **Case 6 (2021 – 2022)** This case is being investigated as an External Serious Incident. **Case 7 (2021 – 2022)** a) This has been fed back to the Consultant and the Divisional Board will monitor this in the Divisional Quality forum by auditing the Consultant ward round proforma documentation on resuscitation status. b) Learning from the case to be summarized in a "7-minute Learning tool" and discussed within the division and at the Trust's Patient Safety & Quality Group. c) The Head of Nursing will review Standard Operation procedure for the management of the deceased patient.

		Case 8 (2021 – 2022) - N/A **Case 9 (2021 – 2022) - N/A**
6.	An assessment of the impact of the actions described in item 5 which were taken by the provider during the reporting period.	**Case 19 (2020 – 2021)** No impact as yet. **Case 1 (2021 – 2022)** No impact as yet. **Case 3 (2021 – 2022)** No impact as yet. **Case 5 (2021 – 2022)** No impact as yet. **Case 6 (2021 – 2022)** No impact as yet. **Case 7 (2021 – 2022)** No impact as yet.
7.	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 2 in the relevant document for that previous reporting period.	1 case record reviews and 0 investigations completed after 2020 -2021 which related to deaths which took place before the start of the reporting period **(Case 19 (2020 – 2021 – please see sections 4, 5 & 6 of this document).**
8.	An estimate of the number of deaths included in item 7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.	0 representing 0% of patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.
9.	A revised estimate of the number of deaths during the previous reporting period stated in item 3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 8.	0 representing 0% of the patient deaths during 2020 – 2021 are judged to be more likely than not to have been due to problems in the care provided to patients.

INCIDENT REPORTING

The following two questions have been asked of all Trusts.

The data made available to the National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre with regard to the percentage of patients aged (i) 0 to 15; and (ii) 16 or over:

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.

This metric is normally only applied to acute units where the measure is an indication of inappropriate early discharge. As such, it is not reported by community Trusts and so has not been responded to.

The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

For the year 2021/22, 15,040 patient safety incidents were reported within CLCH. Of these incidents, nine (0.06%) resulted in severe harm. This is a reduction in the number of incidents that caused harm from the previous year (2020/21) when we reported that thirteen incidents from 10,723 resulted in severe harm (0.12%).

There is no information available for this reporting period from the National Reporting and Learning System (NRLS) about the rate of patient safety incidents, so this information is not available. The most recent report from NRLS covers the period April 2020 to March 2021.

There were no incidents that resulted in a death. The patient safety incidents reported that resulted in severe harm consisted of four category 4 pressure ulcers, two falls, one unexplained injury, one unwell illness/sepsis, one treatment problem.

CLCH considers that this data is as described for the following reasons:

- The Patient Safety Team work closely with clinical colleagues across all divisions to raise awareness of timely incident reporting, and the prompt review and approval of reported incidents by managers. This ensures improved classification of incidents and logging of the level of harm.

- We have enhanced our quality assurance monitoring and reporting arrangements with the appointment of a data analyst who checks and verifies the quality of our reported data

- Regular feedback to teams is provided through communication channels such as the Hub (Trust intranet), divisional quality forums, the Spotlight on Quality e-newsletter, as well as direct feedback to relevant staff about reported incidents.

- Using early warning triggers to identify when levels of reporting drop below what is expected based on historical data, size and activity of any given team.

- Supporting a fair safety culture that is improvement focused and does not seek to apportion blame.

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

- The continued review all the incidents, with a particular focus on inpatient falls, and pressure ulcers. This enables the early identification of emerging issues that may require urgent follow up.

- The continued monitoring of reported incidents to ensure the early identification of serious incidents that require a 48-hour review and explore the need for further in-depth investigation.

- Meeting weekly with a group of senior clinicians to review all community acquired pressure ulcers, and monthly to review of all category two inpatient pressure ulcers.

- Reviewing all reported podiatry incidents monthly. This has continued to strengthen collaborative working in the multi-disciplinary teams. This approach has been shared to help improve communication between teams across the trust.

- The continued use of root cause analysis (RCA) methodologies to investigate and share learning across the Trust.

- Implementing action plans following the completion of investigations to prevent reoccurrence.

- Ensuring Ward Matrons/Manager Network Meetings take place each month. They meet virtually to share learning, best practice, review their bedded scorecard, and identify targeted areas for improvement.

- Providing additional Datix training sessions for staff who have recently joined CLCH particularly members of our new Outer North West London Division.

- Ensuring our Patient Safety Risk Group, and Quality Committee remain focused on providing the correct level of scrutiny to drive safety.

PART 3: OTHER INFORMATION - QUALITY PERFORMANCE AND PROGRESS AGAINST OUR QUALITY PRIORITIES 2020-2021

Trust wide quality scorecard: The following scorecard describes Trust performance against the quality campaign key performance indicators (KPIs). Performance against our quality strategy measures of success is incorporated into the relevant tables below.

TRUST WIDE PERFORMANCE SCORECARD

QUALITY CAMPAIGN	KEY PERFORMANCE INDICATOR	2021/22 TARGET	PERFORMANCE	
			Previous year 2020-2021	2021-2022
A Positive Patient Experience Changing behaviours and care to enhance the experience of our patients and service users	Proportion of patients who felt staff took time to find out about them	95.0 %	97.7 %	97.0%
	Proportion of patients who were treated with respect and dignity	95.0 %	98.8 %	99.3%
	Friends and family test - Percentage of Staff recommending CLCH as a place for Treatment	80.0 %	NA*	
	Patient Friends and family test - Proportion of Patients rating their overall experience as very good or good	92.0 %	96.9 %	96.8%
	Proportion of patients' concerns (PALS) responded to within 5 working days	95.0 %	100.0 %	100.0 %
	Proportion of complaints responded to within 25 days	100.0 %	100%	100.0 %
	Proportion of complaints responded to within agreed deadline	100.0 %	100%	100.0 %
	Proportion of complaints acknowledged within 3 working days	100.0 %	100%	100.0 %

*Due to the pandemic, Trusts were asked to suspend the Staff FFT.

QUALITY CAMPAIGN	KEY PERFORMANCE INDICATOR	TARGET	PREVIOUS YEAR 2020-2021	2021-2022
Preventing Harm Incidents and Risk	Proportion of clinical incidents that did not cause harm (moderate to catastrophic categories)	97.0 %	99.2 %	99.2%
	Zero tolerance to falls in bedded units with harm (moderate or above)	0	9	8
	Zero tolerance of new (CLCH acquired) category 3 and 4 pressure ulcers in bedded units	0	4	3
	Zero tolerance of new (CLCH acquired) category 2 pressure ulcers in bedded units	0	43	24
	Zero tolerance on the number of patients in our bedded areas who have reported a CAUTI	0	New KPI in 2021/22	1
Smart, Effective Care	Percentage of deaths in community hospitals (expected and unexpected) compared to all discharges (excluding palliative and end of life care)	3.8 %	0.25 %	1.4%
	Percentage of Central Alerting System (CAS) alerts including Patient Safety Alerts (PSAs) due, and responded to, within deadline	90.0 %	94.6 %	90.5%
	Percentage of hand hygiene episodes observed across CLCH bedded areas that are compliant with policy	97.0 %	100.0 %	99.8%
	Percentage of staff trained at Making Every Contact Count level one. Non – Clinical	95%	95.7 %	95.9%
	Percentage of staff trained at Making Every Contact Count level two. Clinical	95%	92.9 %	93.1%
Modelling the Way	Statutory and Mandatory training - Non-Clinical*	95 %	96.2 %	96.5%
	Statutory and Mandatory training – Clinical*	95 %	94.1 %	95.8%

QUALITY CAMPAIGN	KEY PERFORMANCE INDICATOR	TARGET	PREVIOUS YEAR	2021-2022
Workforce *	Staff Turnover rate – 12 month rolling (Clinical)		12.9 %	14.1%
	Sickness absence rate - 12 month rolling (Clinical)		5.5 %	5.6%
	Percentage of staff who have an appraisal		78.9 %	77.4%
	Staff Vacancy rate (Clinical)		13.9 %	18.3%

* Workforce is not one of the quality priorities as described in the Trust quality strategy, but information has been included here for completeness

PROGRESS AGAINST OUR QUALITY PRIORITIES

CAMPAIGN ONE: A POSITIVE PATIENT EXPERIENCE

Key Priority / Outcome	Measures of Success Jan 2022-July 2023	Update
Services are designed and care delivered in a way that involves patients, carers, and families as partners in care	We will maintain the proportion of patients who felt that they were treated with respect and dignity at 95%	This KPI has been achieved throughout 2021/22. The year-end position is 99.3%
	We will maintain the proportion of patients reporting their overall experience as very good or good at 95%	This KPI has been achieved throughout 2021/22. The year-end position is 96.8%
	The proportion of patients who felt staff took time to find out about them will be maintained at 95%	This KPI has been achieved throughout 2021/22. The year-end position is 97%
	We will ensure that 80% of patient/user/carer feel involved in each service change	The action plan for patient and carer involvement has now been signed off at PEG, we will be working with the transformation and QI teams to establish SMART milestones in 22/23 to reach our 80% target. The action plan includes the first draft of the Patient Representative Policy, and the milestones which will allow us to advertise for new patient representatives in April 2022. Patients continue to report a high level of involvement in their care through the monthly Patient Experience KPIs. Patient involvement in QI, Shared Governance, and Transformation Projects is improving. We continue to work with our divisions to

Key Priority / Outcome	Measures of Success Jan 2022-July 2023	Update
		ensure that patients are involved when a service is being changed.
Staff* work in services that they believe are delivering the best positive outcomes for patients, carers, and families *Including volunteers	Staff, friends, and family test – percentage of staff recommending CLCH as a place for treatment will be 80%	This target has not been achieved. The Q3 Pulse Survey (National Quarterly Pulse Check) only had a 3.6% (t=165) response rate and 57.1% of staff who responded would be happy to recommend CLCH as a place for treatment. The National Staff Survey (Q3 of 21/22), published in March 22, found that 70.2% of staff would be happy to recommend CLCH as a place for treatment. We are working to improve our score through: • Schwartz Rounds have continued to focus on *Caring through and living with COVID*. • The monthly Spotlight on Quality highlights best practice and exemplar teams. • The Patient Experience Team continue to collect staff and patient stories about caring through COVID.
	We will increase volunteer numbers by 50% from 2020/21 baseline in services where volunteer participation improves patient experience	We will not achieve this target. The main issues are changes to services due to COVID, the confidence of older volunteers to come forward, and low unemployment. We have 38 volunteers with a further 44 applications in progress and we are confident that we can recruit 100 more volunteers by October 2022. Recruitment is now online. This is faster, more user friendly, and enables us to advertise directly on many more platforms. In Q3 & Q4 we developed new working relationships with Brunel University, and Barnet and Southgate College as well as strengthening our existing relationships with Westminster University, and local high schools. Recruitment is easier when we have enough exciting opportunities. Over Q3 & Q4, we've added six new services who work with volunteers, taking us to eighteen with a further 28 in the pipeline. A detailed communications and engagement plan has also been

Key Priority / Outcome	Measures of Success Jan 2022-July 2023	Update
		developed to support recruitment and retention. The Volunteering Services Lead now attends the Divisional Management Boards and Quality meetings (DMBQ), and Quality Forums to identify volunteering opportunities.
	To continue to complete an annual volunteer survey to understand their impact on services and their experience	The final satisfaction survey of our 2020/21 volunteers showed: • 95% would recommend volunteering at CLCH • 85% feel well supported • 75% see the difference they're making • 65% have learned new skills in their role • 84% feel CLCH communicates well There was an improvement to volunteer communication. Areas for improvement in 22/23 are: • demonstrating the impact of the volunteer role • upskilling volunteers
	We will develop 'you said we did' stories to share volunteers experiences	We are collecting volunteer stories. Two have been shared in Spotlight on Quality and on Facebook, Twitter, and Instagram to promote the benefits of volunteering with CLCH. We have been able to demonstrate improvements for volunteers based on their feedback. These includes a monthly newsletter, and an online induction process, which is quicker and facilitates better communication and support for new volunteers.
Feedback from patients, carers and families is taken seriously and influences improvements in care.	We will continue to respond to 97% of patients' concerns (PALS) within 5 working days	100% compliance was maintained throughout 2020/21.
	We will continue to respond to 100% of complaints within 25 days	100% compliance was maintained throughout 2021/22.
	We will continue to respond to 100% of complex complaints within the agreed deadline	100% compliance was maintained throughout 2021/22.
	We will continue to acknowledge 100% of complaints within 3 working days	100% compliance was maintained throughout 2021/22.

Key Priority / Outcome	Measures of Success Jan 2022-July 2023	Update
The patient and the public voice are integral in the decision-making process when making changes to services or care delivery	We will transfer the learning from each Always Event across the Trust	The Always Event projects that were paused during the pandemic, are now under review at Divisional Quality Forums. Each division will start an Always Event in 2022/23. The original District Nursing Always Event is under consideration by a Shared Governance Quality Council. They are reviewing the leaflets that have been used to inform patients about their team, and their visits. Despite the pausing of Always Events, the EOL Always event has continued to develop. A working group has been meeting and is exploring getting feedback from staff, patient representatives as well as the public. The Health Equalities Programme Manager has developed a poster which will be used to start promoting the project. The Outer NW Division (& originally CHD) Always Event produced leaflets that provide general information about the School Nursing Service such as contact details, location, and services available. The leaflets were produced in multiple languages and widely distributed to all special schools. Now that it is complete leaning from this project has been shared.
	We will review the impact and learning from quarterly projects on the overall patient experience	Quarterly projects continue across each clinical division. The impact of the projects and the learning from their success are shared at divisional boards, QSRG meetings with external stakeholders, and monthly at PEG.
Transforming healthcare for babies, their mothers and families in the UK (UNICEF Baby Friendly Initiative, BFI)	50% of health visiting services will have achieved level 2 breast feeding accreditation or greater	The Inner North West services have successfully maintained UNICEF BFI Gold Baby Friendly Accreditation, following submission of their Annual Report and Audit in January 22. UNICEF BFI noted that they were "*delighted to see the quality of work that is being implemented within CLCH and the positive outcomes being achieved as a result*". All other boroughs have successfully reached stage 2 BFI accreditation. Brent: stage 3 BFI accreditation, working towards stage 3 re accreditation in 2022

Key Priority / Outcome	Measures of Success Jan 2022-July 2023	Update
		Ealing: stage 2 BFI accreditation, working towards stage 3 in 2022 Merton: stage 3 BFI accreditation, working towards stage 3 re accreditation in 2022 Wandsworth & Richmond: stage 2 BFI accreditation, working towards stage 3 in 2023

CAMPAIGN TWO: PREVENTING HARM

Key Priority / Outcome	**Measures of Success Jan 2022-July 2023**	**Update**
Robust, effective systems and processes in place to deliver harm free care all the time	Maintain/ or improve on the Proportion of clinical incidents that did not cause harm reported in 2021/22	As reported in section 3.3, the year-end figure for 2021/22 is 99.2%. This is a slight improvement from 99.1% in 2020/21.
	100% of patients in bedded units will not have a fall with harm (moderate or above)	As reported in section 3.5, one fall with harm was reported in Q4 and a total of eight falls with harm were reported during 2021/22.
	100% of patients in bedded units will not have a NEW (CLCH acquired) category 2-4 pressure ulcer	In Q4, one category three and six category two pressure ulcers were reported. In total 24 category 2-3 pressure ulcers were reported during 2021/22. No category four pressure ulcers were reported this year.
	100% of all Serious Incident investigations will be completed on time in accordance with national guidance	In Q4, 66.7% (2 out of 3) of External Serious Incident Root Cause Analysis (RCA) reports were completed on time in Q4. For 2021/22, 89% were submitted on time. Details in Section 3.12.
	100% of all Serious Incident actions will be completed on time in accordance with locally agreed timescales	92 incident actions were due in Q4 (taken from Datix actions module) and 14 remain open. Action plan meetings are arranged to ensure actions are completed so that action plans can be closed. Both PSRG and Patient Safety Managers continue to emphasise the importance of timely closure. During 2021/22, 409 Incident actions were logged and 16 (3.9%) remain open.

Key Priority / Outcome	Measures of Success Jan 2022-July 2023	Update
Enhance the embedding of a safety culture in the trust ensuring learning from adverse events and compliance with national best practice	There will be evidence of an improvement in the safety culture compared to baseline	An assessment of safety culture will be undertaken using results from the 2021 NHS Staff Survey, published in Spring 2022, together with feedback from the Accreditation Audit and E-Core Standards process. Data sources will be reviewed to identify what is working well, and opportunities to enhance our safety culture in line with the NHS National Patient Safety Strategy.
	Each division will share at least 4 incident learning examples in divisional boards using the 7-minute-learning tool through divisional board and patient safety risk group	A total of thirteen 7-minute learning tools were submitted in Q4. In 2021/22, 57 7-minute learning tools were shared at PSRG. Patient Safety Managers continue to work across all services to identify incidents where learning would be beneficial.
	90% of teams will have undertaken a core standards annual health check assessment and identified action plans that are completed on time	100% of teams have now completed the Core Standards self-assessment: • 86% RAG rated green • 11% RAG rated amber • 3% RAG rated red. All red and amber teams will need to repeat the assessment in 6 months' time along with Implementing an action plan to address non-compliant areas.
	No outstanding actions from risks on the register	62 individual risk actions were due in Q4, 9 remain open. A summary and detailed report of overdue Incident and Risk actions is circulated bi-weekly, and members of the safety team work closely with risk owners to review and close actions within the given timeframe.

CAMPAIGN THREE: SMART EFFECTIVE CARE

Key Priority / Outcome	Measures of Success Jan 2022-July 2023	Update
Making Every Contact Count (MECC): promoting health in the population we serve	95% staff trained at MECC level one 95% clinical staff trained at level two	At year-end we achieved our target for training non-clinical staff but not for our clinical teams where we achieved 1.9% below target.
	We will evaluate the use of MECC link with our clinical staff	The MECC link was circulated in 2019 and launched by the Medical Director and Chief Nurse: (https://www.mecclink.co.uk). In Q1 22/23, we will evaluate this with staff when we launch the new population health training.
All staff are supported to drive a clinically curious culture and increase shared learning while improving clinical effectiveness	We will increase the number of research projects involving/led by clinical staff within the Trust by ≥ 15%	The Trust has achieved this with an increase in the number of research projects involving or led by clinical staff. Nine recruiting studies opened in 21/22 compared to seven in 20/21. Commercial study recruitment has also increased from one participant in 19/20 to 23 participants in 21/22.
	Clinical improvement posters will be displayed on all key Trust sites presented at Trust Business Meetings, divisional and service/ team meetings, other appropriate settings and uploaded to the Hub. Target: ≥ 80%	Of the clinical audits, service evaluations, and QI projects registered in Q4 by services, 20% presented clinical improvement posters during service/team meetings. The Clinical Effectiveness Team is working with the Deputy Chief Nurse (Director of Quality & Safety) to improve this performance.

CAMPAIGN FOUR: MODELLING THE WAY

Key Priority / Outcome	Measures of Success Jan 2022-July 2023	Update
Implementing Reverse Mentoring for all staff ensuring career opportunities are accessible to all	60% of clinical staff at band 8b or above will have undertaken training	The Trust began reverse mentorship in 2020 and cohort five starts in May 2022. With a dedicated lead now in place, there is a robust plan to offer cohorts bimonthly.
	Mentoring opportunities will be publicised for staff Trust wide	Details were publicised in the monthly Spotlight on Quality, and the Trust wide communications bulletins.
All staff have the core identified statutory and mandatory skills for	We will continue to maintain Statutory and Mandatory Training compliance at 95%	At year-end the Trust exceeded our 95% target for both clinical and non-clinical staff.
Staff receive appropriate education and training to ensure they have the right skills to support new models of care	Each professional group will have development portfolios to support staff having the right skills and knowledge to support new models of care	The Academy submitted a finalised Continuing Professional Development (CPD) Investment Plan to HEE, which accounted fully for the monies allocated. The Academy has also delivered against the Workforce Funding Plan submitted to the NWL ICS. The annual learning needs process has started with templates sent to all divisions for review and completion as part of business planning for 2022/23. The Academy is looking to develop a multi professional band 7 and 8a clinical leadership programme.
Safe, sustainable, and productive staffing: Right place and time	100% of clinical staffing establishment changes will be discussed through the Clinical staffing panel prior to Quality Impact Assessment	The Clinical Staffing Panel continues to review all proposed establishment changes monthly before QIA. Extra panels have been held to ensure that any QIPP workforce proposals are reviewed prior to QIA.

Key Priority / Outcome	Measures of Success Jan 2022-July 2023	Update
Ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times	All community nursing and bedded services will have 1/2 ANAs in place	The ANA role has been implemented across all community nursing and bedded services except Brent where it is being phased into the establishments as part of their agreed staffing levels. In 2022/21, the Trust met its target for ANA training for both NWL and Hertfordshire. The target for 2022/23 has been set and we plan to exceed it as part of our continued commitment to supporting this role.
	We will evaluate safe staffing models for AHP workforce, and any new roles developed	Work has started on the required AHP safe staffing levels for inpatient areas. Our new AHP Lead is in post, and we are reviewing regional and national work on best practice for AHP staffing levels. This work will be undertaken in Q1 and discussed at the Clinical Staffing Panel. We continue to report AHP Care Hours Per Patient Bed Day for our Inpatient areas monthly.
	We will continue to develop Professional networks and deliver/events to be delivered for all staffing groups across the Trust and primary care	Several conferences have been delivered though 2021/22 – see section 5.3 and the 2022/23 Conference dates have been agreed. Professional Networks are now being reviewed as part of the Clinical Workforce Group with the aim of implementing them across the Trust where there are gaps.

SHARED GOVERNANCE PROJECTS

Division	Quality Campaign	Project	Number of staff involved	Project progress
North Central Division	Positive Patient experience	Improving family involvement in the patients' care	6	This quality council started in Q3 with the aim to improve the updates and information shared with family members of patients across the bedded units. Feedback from PALs data were included in the change ideas. The project was on pause in Q4 due to staff capacity but will be restarted in Q1.
	Modelling the Way	Improving the MDT meeting	6	The quality council was on hold during Q4 due to staff capacity. In Q1 this will be restarted using the data gathered previously regarding the positives, negatives and improvements of the processes involved with the MDT.
	Modelling the Way	Improving staff retention on the bedded units (new)	4	This quality council are presently collecting data regarding staff morale. This will be analysed in Q1, and change ideas tested taken forward.
	Positive Patient Experience	Improve the uptake of 6-8 week maternal mood contacts with the Health Visiting Service in Barnet.	6	The quality council devised an allocation sheet for all due Maternal Mood Assessments of clients who initially had a New Birth Visit carried out by a bank/agency Health Visitor. The sheet was utilised by allocating out the assessments accordingly by the Team Leader to permanent Health Visitors within the Barnet 0-19 Team. This had a huge impact on our KPI's, as clients were not then being missed from receiving a Maternal Mood Assessment, and they were also being completed within the given timeframe. The council have completed and will be showcasing their work on Spotlight on Quality.
Inner North West Division	Positive patient experience	Improve access to mainstream service for LD clients	5	The quality council added a referral prompt to the falls assessment plan. The prompt is to help clinicians identify if the mainstream services would be appropriate to action out the treatment plan. The council will collect feedback regarding the outcomes of this change and will be collecting patient/carers feedback regarding the service.
	Positive patient experience	Raising the voice of the Child with health conditions	5	A quality council is working in collaboration with a Primary school, 3 children with diabetes and their parents. The aim is to improve children's awareness of diabetes from a child perspective. The three children voices have been made into a video regarding how it feels to have diabetes, and what they would like their friends to know about their condition. The council are also putting a comic strip together which will be tested as a training tool.

Division	Quality Campaign	Project	Number of staff involved	Project progress
	Preventing Harm	Improving the communication of safeguarding information between Social Care Services, Health Visitors and School Nurses	4	In Q3 the QC paused whilst waiting for the result of the H&F tender. Feedback from Social Care has indicated the project is integral for communication and information sharing at safeguarding meetings. In Q1 the ideas from this quality council will be shared across other Boroughs and incorporated into the work carried out as part of the "Time to Shine".
	Positive patient experience	To increase the number of women supported to breastfeed in the Inner Boroughs and improve rate of data recording of infant feeding in the Inner Boroughs	4	The last part of the data required is still being analysed, presently it is heading towards 95%, the required level to submit the data to Public Health England. The next steps to ensure the data collected will continue at this level of 95%.
	Modelling the way	To improve staff morale and retention of staff in the Speech and Language therapists ELT and dysphagia. (new)	7	A new quality council who would like to make improvements in their working environment with regards to involvement in decisions and how that effects their morale. They have met three times and have themes linking to change ideas which they will start in April.
Outer North West Division	Modelling the way	Improve continence guidelines and training to complete bladder and bowel assessments in Brent.	4	In Q3 the training slides and information were prepared by the Clinical Lead Specialist. The training has started to be shared with patient facing staff in NWLH and the outcome of this will continue to be reviewed through data collection of staff confidence of assessment completion prior to leaving the hospital.
	Modelling the Way	Tackling bullying and harassment in Harrow	6	The QC met at the end of Q3 and are revisiting their change ideas. In Q1 their ideas will be heard and supported to be taken forward by the bullying and harassment task force group.
	Positive patient experience	SG/QI Use data to compare areas of deprivation with breastfeeding rates and see if we give targeted support to improve rates of breast feeding where it is needed (14 days and 8 week)	5	The quality council in Brent have continued to collate the data from PHE (Public Health England) with the Data Analyst. Data is still being analysed and comparing this with the Trusts breast feeding uptake. Gaps have been identified; next steps are to ensure the varied cultural needs of service users in Brent are met.
	Positive Patient Experience	Improve the communication and uptake of e-red book between CLCH and the Families in Ealing.	5	Process maps have been created around the E-Redbook process for both Admin Staff, and the process that a parent needs to complete. Feedback from the parents and admin staff around how they find the process around the activation of the E-Redbook has been analysed. The findings so far are that the process is long, not all services acknowledge the e red book and other areas of the Trust are not involving admin staff in the process. This has been escalated. Next steps ideas to promote e red book and streamline process.

Division	Quality Campaign	Project	Number of staff involved	Project progress
South West Division	Positive Patient Experience	Improving communication through information folders for patients in the Community in Merton.	5	Over 200 folders have been distributed by the Chair and members of her team. The feedback from patients, carers and professionals has continued to be positive. The inserts have been translated into 5 different languages and these will be saved in a shared drive to be used for all staff. Two other divisions are now taking forward ideas from the folders. The learning and outcomes of this council will now be showcased across the Trust.
	Preventing harm	Improving pathways and competencies in pressure ulcer awareness.	6	This is a new Quality Council presently recruiting nurses to the council to work together with AHPs regarding awareness and management of Pressure ulcers. The pathways will be reviewed and ideas to improve collaboration of both AHPs and nursing staff in the prevention of and management of PUs.
	Modelling the way	Creating a CLCH E-Learning module on Tongue Tie Training	5	This quality council is chaired by a School Nurse in Merton. In Q3 a quick survey was sent out across the Trust to HVs identify the gaps in staff knowledge and training regarding babies with tongue tie. Key themes for training were identified. In Q4 this information will be used to help plan the content of the training carried out by a Lactation consultant and Infant Feeding Lead in Merton. The Academy are supporting with the process of the ILearn module being created once the content has been devised. Indira is still currently putting the content together. QC Liaising with the academy around this.
	Modelling the Way	Improving staff morale in the Brocklebank, Bridge Lane and Roehampton Team in Wandsworth	6	The council have tested their first change idea of informal coffee and chats within their teams to get to know each other and feel part of the team. The feedback from this was analysed and changes made in 2 areas around the name of the get together and the time. Christmas get togethers also trialled within each area and this was reviewed in Q4. Meeting with CBU Managers arranged for the middle of March to share progress and barriers facing in hope of gaining their support with pushing the project forward.
	Positive patient experience	Improving the environment of the clinical room for Children and young people.	5	In Q3 this quality council of paediatric physiotherapists have collected staff and service user feedback to improve the clinical room they use for consultations. The feedback has identified ideas for decoration which have been shared with estates who have offered support to commence with the design ideas. The work is due to start at the end of December. In Q4 due to Omicron the project had to be paused. The QC are now

Division	Quality Campaign	Project	Number of staff involved	Project progress
				awaiting a new date for work to commence in Q1.
Herts	Positive patient experience	Reducing PALs complaints in Planned Care in Herts regarding deferred/missed appointments.	7	The quality council used staff and patient feedback to change the process regarding deferred/missed appointments. The messaging service and waiting list reminders tested resulted in reduction of complaints regarding deferred and missed appointments. This streamlined process which will now be shared across other areas of the Trust.
	Positive patient experience	Increase the number of virtual consultations in Hertfordshire Planned Community Therapy Teams.	6	In Q4 the council continued to test their triage flow chart and support service users using virtual consultations. In Q1 the learning from this project will be shared and the triage template continue to be used.
	Smart Effective care	Improving the process of inputting S1 using handheld devices.	6	A new quality council, the staff have collected feedback regarding the positives and negatives of a handheld device. Research into devices used across other Trusts will be carried out and clinical systems will be integral as a stakeholder in the council. The plan is to pilot the use of handheld devices in one service in Herts and review the feedback.
	Modelling the way.	Increasing the support of research in the Long Covid service.	6	This is a new council, who have been part of the Joy in Work collaboration to improve patient satisfaction in the long covid service. In Q4 they have been incorporating support of research into their service to develop their rehab pathways and improving the MDT meeting. The QC are currently devising a resource book for patients to aid self-management. Redesigning and launching their referral forms once agreed with CCG and looking into the inequality of access to the Long Covid Service.
	Modelling the Way	To improve staff wellbeing and connectedness in Dacorum and Watford Planned Therapy Care Teams.	6	The council have identified the effect on staff due to lone working and no social contact due to covid. The council have been collecting more information through a quick survey through MS teams and the results showed 50% feel less connected. Virtual coffee mornings started as change idea and a review questionnaire of this idea showed an increase in peoples wellbeing by 0.5 in score. In Q1 coffee mornings will continue but with a focus and will be reviewed.
	Smart Effective care	To improve processes between the Herts SPA and Specialist Services (New)	8	A new quality council who are brainstorming the improvements required around workload, understanding of new services and communication between SPA and Specialist services. They will start their change ideas in Q1.

Division	Quality Campaign	Project	Number of staff involved	Project progress
Trust wide	Modelling the Way	Improving development opportunities and raise morale in the finance department.	8	The council reviewed their survey in Q3 in line with the new way of working. The work was paused due to capacity but will be restarted in Q1 alongside staff morale project for the senior members of this team.
	Positive patient experience	Improving the continence service across the Trust	7	In Q3 and Q4 evidence had started to be collected regarding what is going well and where the gaps and improvements can be made across the Trust. This highlighted that there are differences in suppliers and processes across the Trust. Due to this moving forward in Q1 it will be divided back into divisions to map the processes being carried out, recruit patient representatives and start testing change ideas.
	Smart effective care	Improving the duty HV process	12	This was a Trust wide QI/SG from the HV reimagining. The processes of all the tasks coming into 'duty' were mapped. Issues were highlighted from this regarding admin vs clinical task and staff capacity to carry out duty due to the decreased number of HVs. Ealing is now piloting change ideas regarding the role of the CNN and Community staff nurse in the Duty rota and reduction of admin tasks to clinical staff through the duty line.
	Modelling the way	Supporting research across the Trust	6	The shared governance team has highlighted research support across the QCs which has been supported by the research team. In Q1 staff will be meeting to share their ideas regarding the access to and time to utilise research support.
	Modelling the Way	Tackling bullying and harassment in the workplace by staff	10	In Q4 the QC was on hold due to staff capacity but their ideas continued to be fed into the Bullying and Harassment Steering group by the SG Lead and the animation highlighted in the anti-bullying week. In Q1 there will be a recruitment drive to gain more members to restart the council.
	Positive patient experience.	Charity donations through the shared governance model	5	The shared governance model was used regarding the practical use of Charity money donated to Athlone ward was carried out using staff and service user feedback through the shared governance model. Phase 1: Ideas shared include the garden area to be redesigned for staff and the possibility of large, mounted TVs for patients and relatives. This work is due to start in April 22. Phase 2 will take forward further ideas including Team development – away days, radios, and a coffee machine.
	Modelling the Way	Improving opportunities for career development of Administrators and making staff feel valued	10	The quality council have continued to work on their first admin newsletter with a survey regarding value and career opportunities in non-clinical staff.

Division	Quality Campaign	Project	Number of staff involved	Project progress
				Members of the QC presented at the non-clinical conference and in Q1 further staff will be recruited to push forward with the admin forum for 2022.
	Modelling the Way	Raising the profile of Allied Health Professionals	7	This quality council are looking at staff development. The last meeting highlighted that staff are not aware of the resources available to them such as career development clinics, mentorship programmes, and secondment opportunities. In Q1 next steps will be decided how to improve staff awareness of these opportunities.
	Modelling the Way	Improving communication across AHPs	7	This Quality Council have highlighted the issues regarding communication across the Trust and would like to pilot the change idea of Communication Champions within the Trust. This was discussed with Comms team who were receptive to this, and next steps are to decide how to take this idea forward.
	Preventing harm	SG/QI Improve accessibility of safeguarding resources for HV staff and evaluate the content and change as needed	7	The team have been testing the change ideas of review links, one policy per page, QR codes, leaflets and posters for safeguarding resources. There is now a policy on a page completed and the feedback regarding this was very positive during safeguarding week.
	Positive patient experience	Improving the understanding of the views of BAME communities for end of life and palliative care. (new)	6	This a new quality council who are presently recruiting staff and have designed a poster with a QR code to collect information regarding the views of BAME communities for end of life and palliative care. These findings will be taken forward to decide change ideas and to shape trainings for staff to give best patient and family care.
	Smart effective care	Improving completion of the S1 new birth templates	4	Previously started pre covid this quality council are regrouping to continue their collection of data around the barriers and learning needs of staff completing the S1 template.

TRUST QUALITY PROJECTS AND INITIATIVES

The Trust was involved in several other quality projects and initiatives. These included the following:

Volunteers and Patient Representatives: Our **volunteers** are a vital and welcome resource who proved invaluable during the pandemic. Volunteer recruitment is now online. This is faster, more user friendly, and enables us to advertise directly on many more platforms. Over Q3 & Q4, we've added six new services who work with volunteers, taking us to eighteen with a further 28 in the pipeline. Induction has also moved online to make starting at the Trust more efficient and welcoming too. Our volunteer survey this year showed that 95% would recommend volunteering at CLCH, 85% feel well supported and 84% feel CLCH communicates well.

To better hear from our patients and involve them in our services we have reviewed our **Patient Representative** Policy, and job description. We began advertising for the new role in April 2022.

Always Events: The Outer NW Division (& originally Child Health Division) **Always Event** produced leaflets that provide general information about the School Nursing Service such as contact details, location, and services available. The leaflets were produced in multiple languages and widely distributed to all special schools. Now that it is complete, leaning from this project has been shared.

Breastfeeding BFI Accreditation: The Inner North West services have successfully maintained UNICEF BFI Gold Baby Friendly Accreditation, following submission of their Annual Report and Audit in January 22. UNICEF BFI noted that they were "*delighted to see the quality of work that is being implemented within CLCH and the positive outcomes being achieved as a result*." All other boroughs have successfully reached stage 2 BFI accreditation:

- Brent: stage 3 BFI accreditation, working towards stage 3 re accreditation in 22
- Ealing: stage 2 BFI accreditation, working towards stage 3 in 22
- Merton: stage 3 BFI accreditation, working towards stage 3 re accreditation in 22
- Wandsworth & Richmond: stage 2 BFI accreditation, working towards stage 3 in 23

The Health Equalities team initiatives: Leading campaign One (Access to Services) of our **Equalities Strategy**, the Health Equalities Team has driven projects and investigated ways to achieve equity of access to CLCH services with respect to protected characteristics of our patient population that the Trust routinely collects (i.e., age, sex, and ethnicity). Achievements to date include:

- **Improving access to our Diabetes Service** through a co-production project between CLCH staff, and people with lived experience of diabetes, to design a survey, asking critical questions about access to healthcare and diabetes services.
- **Redesign of the Equality and Health Inequalities Impact Assessment (EHIA)** to ensure consideration is given to the impacts of service changes on people with protected characteristics, and low socioeconomic status.
- **Digital Inclusion:** We supported the Homeless Health Service to acquire ten mobile devices with three months connectivity. These enabled users to reconnect with friends, family, and support services.
- **Health Equalities Dashboard**: The Health Equalities Dashboard, an interface enabling staff to view CLCH activity, waiting times and DNA rates with respect to age, sex, ethnicity, and deprivation, is in the closed testing stage. The Dashboard has been developed to operate on Power BI and will enable staff to view health inequalities within specific service reporting lines.
- **Ethnicity Recording:** The Health Equalities Team has achieved improvements in the ethnicity recording completion rates. In February 2021, the ethnicity completion rate was 83% and it has reached and stayed consistently at approximately 90% over the past nine months. This has been achieved through the publishing of materials to empower staff to ask about ethnicity and to educate both staff and service users about the importance and use of this information.
- **Website Accessibility:** The Trust's external website is now more accessible by integrating *Recite Me*. Beyond simple text translation, the software offers language, sight, and hearing adjustments by reading text aloud, amending fonts, and altering the colour scheme amongst further features.

7-minute learning: A total of 57 **7-minute learning tools** were shared across the Trust in 2021/22. This quick easy way to share learning from incidents and best practice will continue to expand in 2022/23.

E-Core Standards self-assessment: Every team in the Trust has now completed the **E-Core Standards self-assessment**. 86% were RAG rated green. This forms the basis for more teams starting the journey to become **Quality Development Units** (QDU). Five services have achieved QDU status. The Herts Podiatry Service is the latest team to do so, despite the challenges of redeployment during the pandemic.

Tackling unacceptable behaviour campaign: In 2021/22 the following actions were taken to manage and minimise violence and aggression towards staff as part of our **Tackling unacceptable behaviour campaign:**

- Completion of a pilot project to provide assurance on the robust implementation of staff and patient emergency alarm systems at Trust sites. Following the pilot, a Standard Operating Procedure was approved for rollout in Q1 22/23.
- Reports were circulated to all divisions on the use of Skyguard personal safety devices.
- The second *'Tackling Unacceptable Behaviour Week'* took place in April 2021, to shine a spotlight on this important issue and how we can all work together to manage and minimise incidents of violence and aggression.
- Production of four training videos to help staff address and challenge unacceptable behaviour.
- *'Violence and Aggression at Work'* and *'Lone Worker'* policies updated.
- Introduction of a standard operating procedure and visual flowchart to support incident handlers in addressing unacceptable behaviour against staff with the perpetrators.
- Publishing of case studies covering examples of the application of sanctions to tackle unacceptable behaviour against staff.
- Distribution of new materials for the public-facing *"I'm not a target"* campaign featuring staff from across the Trust.
- Introduction of newsletter aimed at helping lone workers to stay safe and to manage and minimise the risk of violence and aggression while undertaking their duties.
- Collaborative learning sessions with partner organisations to ensure best practice.
- Continuation of security site visits in response to security concerns and reported incidents, with identified actions monitored at divisional estates groups.
- Targeted conflict resolution training provided to inpatient units and walk-in centres

The CLCH Academy: The Academy has continued to deliver essential clinical skills training across the Trust. Key highlights of 2021/22 include:

- The Tissue Viability Team in Merton won the Student Nursing Times Award for Community Placement of the Year
- Introduction of the Professional Nurse Advocate (PNA) Role across the Trust
- Appointment of Dr Chris Flood as Professor of Healthcare Practice in conjunction with London Southbank University
- Launch of the Long COVID Introductory Module on E-Learning for Health (ELfH)
- Continued provision of training for the Northwest mass vaccination centres
- The Research and Development Department was integrated into the Academy, and launched the CLCH Research Strategy 2021
- Introduction of the 0 – 19 Practice Development Nurse (PDN) role across the Trust
- Leadership and People Development (LPD) programme

The Academy has risen to the challenges presented by limited face to face contact to support the delivery of an exciting range of virtual conferences this year:

- International Nurses Day (May 2021)
- Promoting Equality and Tackling Inequality (May 2021)
- Learning Disability (June 2021)
- Disability and Wellbeing (Sept 2021)
- Safeguarding (Sept 2021)
- Race and Equality (Oct 2021)
- Allied Health Professionals Day (Oct 2021)
- Non-clinical (Nov 2021)
- Health Visiting (Nov 2021)

NHSEI commissioned the CLCH Academy to develop two Long Covid training packages. The first, a basic awareness of Long Covid was successfully launched in 2021. This has now been updated to ensure it is more interactive and new sessions on Living with Long COVID and Managing Symptoms of Long COVID have been launched on 1 April. Each of the e-learning sessions takes approximately 30 minutes to complete and a certificate is available to download on completing each session.

Research: To support our vision to become leaders in community-based research, in July 2021, the Trust launched its new Research Strategy 2021-2024. Delivery of the strategy is being managed through agreed annual implementation plans (AIPs) that monitor the progress and effectiveness of strategic actions and deliverables are overseen by the Trust Research Governance Committee, Modelling the Way Group and Quality Committee. The Trust has achieved its quality measures under the 'Smart effective Care' pathway by increasing the number of research projects involving, or led by clinical staff, by 20% against an initial target of 10%, with 9 recruiting studies opened in year 2021-2022 compared to 7 studies in 2020-2021. Commercial study recruitment has also increased from 1 participant in 2019-2020 to 23 participants in 2021-2022.

The Trust was proud to become a member of the North West London Clinical Research Trials Alliance. As the only community provider partner this creates a valuable opportunity to showcase our expertise, capabilities, and services.

School Engagement: A dedicated **School Engagement** Steering Group is now managing and monitoring our school engagement workstream. It has created a series of videos which schools and students can access to explore the different professions available at CLCH. Students even have the chance to undertake **virtual work experience** placements on our website.

Overseas recruitment: Our overseas recruitment campaign continues with new staff recruited and on-boarded every month. In the last 12 months, we have completed 226 interviews, offered 128 positions, and onboarded 105 international recruits. We continue to support our new recruits with the OSCE Preparation Programme and 100% of our staff have passed. We also continue to offer the OSCE Preparation Programme to other Trusts. We have shared some of our recruitment successes at the **Queen's Nursing Institute** and across London.

Funding from NHS England has allowed us to recruit three OSCE Preparation Practice Development Staff for a fixed period. They were all themselves international recruits from earlier years able to draw on their own lived experience to provide invaluable training and pastoral support to our new recruits. Over the last year, they developed two guides - one for our international recruits to support their induction into the Trust and their migration to the UK, and one for managers and teams welcoming an international recruit into their service.

In Q4, we have joined the new Capital AHP International Recruitment Programme as an early adopter. This programme will mirror the Capital Nurse International Recruitment programme ensuring best practice and consistent recruitment is undertaken across London. We have increased our AHP international recruitment plans for all AHPs, and our agency has launched a Speech and Language Therapists Campaign in Australia, New Zealand and South Africa.

Quality Improvement: 121 active and 63 completed **Quality Improvement** projects were registered at the end of 2021/22, including **The Joy in Work Improvement Collaborative**. Twenty-one teams (eighty-five members of staff) from clinical and corporate divisions joined the Improvement Collaborative and set up improvement projects with the common purpose of improving their joy in work. Through six learning sets, participants learned quality improvement tools and methods, and shared their progress and learning. In between learning sets each team was supported by an improvement coach.

ANNEX1: STATEMENTS FROM COMMISSIONERS, LOCAL HEALTHWATCH ORGANISATIONS AND OVERVIEW AND SCRUTINY COMMITTEES

This will be completed after receipt of stakeholder comments

We would like to thank those who reviewed and provided comments on our 2021-2022 Quality Account. We have considered the comments received and where appropriate the comments were responded to.

ANNEX 2: STATEMENT OF DIRECTORS' RESPONSIBILITIES FOR THE QUALITY REPORT

This will be completed after it is signed off, and receipt of stakeholder comments

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 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
- board minutes and papers for the period April 2021 to March 2022
    - papers relating to quality reported to the board over the period April 2021 to March 2022
    - feedback from commissioners dated xxxx
    - feedback from local Healthwatch organisations
    - feedback from Barnet overview and scrutiny committees dated xxxx
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009. (NB: The complaints report will be attached as an appendix the Quality Account)
- the latest national staff survey
- CQC inspection reports

The quality report presents a balanced picture of the NHS Trust'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, is subject to appropriate scrutiny and review the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting 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:

Angela Greatley OBE

Chair

James Benson

Interim Chief Executive

FEEDBACK AND FURTHER INFORMATION

Now that you have read our Quality Account, we would really like to know what you think, how we can improve and how you would like to be involved in developing our quality accounts in future.

If you would like to comment on the account, please e mail
billy.hatifani@nhs.net

Alternatively you can send a letter to:
Billy Hatifani
Deputy Chief Nurse (Director of Quality and Safety)
2nd Floor, Parsons Green Health Centre
5-7 Parsons Green
London SW6 4UL

Further advice and information
If you would like to talk to someone about your experiences of CLCH services or if you would like to discuss a service, please contact our patient advice and liaison service (PALS) in confidence via email clchpals@nhs.net or on 0800 368 0412 or writing to the PALS team at the above address.

USEFUL CONTACTS AND LINKS

CLCH - Patient Advice and Liaison Service (PALS)
Email pals@clch.nhs.uk
Tel 0800 368 0412
Switchboard for service contacts
Tel 020 7798 1300

HEALTHCARE ORGANISATIONS

Care Quality Commission
Tel 03000 61 61 61 www.cqc.org.uk

NHS Choices
www.nhs.uk

LOCAL HEALTHWATCHES

Barnet Healthwatch
c/o Community Barnet
Barnet House, 1255 High Road
London, N20 OEJ
Tel 020 8364 8400 x218 or 219
www.healthwatchbarnet.co.uk

Brent Healthwatch
SEIDs Hub, Empire Way
Wembley HA9 0RJ
Tel: 0208 102 9174
www.healthwatchbrent.co.uk/

Central West London Healthwatch
For Hammersmith and Fulham, Kensington and Chelsea and Westminster
5.22 Grand Union Studios, 332 Ladbroke Grove,
London, W10 5AD

Tel: 020 8968 7049
info@healthwatchcentralwestlondon.org
www.healthwatchcwl.co.uk

Ealing Healthwatch
46 St. Mary's Road
Ealing
W5 5RG
Tel: 0203 8860830
www.healthwatchealing.org.uk/

Hertfordshire Healthwatch
1 Silver Court
Welwyn Garden City
Hertfordshire
AL7 1LT
www.healthwatchhertfordshire.co.uk/

Hounslow Healthwatch
45 St Mary's Road
Ealing
W5 5RG
Tel: 0203 603 2438
https://www.healthwatchhounslow.co.uk/

Merton Healthwatch
Vestry Hall, London Road
CR4 3UD
Tel: 0208 685 2282
www.healthwatchmerton.co.uk

Richmond Healthwatch
www.healthwatchrichmond.co.uk
Tel: 020 8099 5335
https://www.healthwatchrichmond.co.uk/

Wandsworth Healthwatch
3rd Floor Trident Business Centre
89 Bickersteth Road
Tooting
SW17 9SH
Tel: 0208 8516 7767
https://www.healthwatchwandsworth.co.uk

LOCAL CLINICAL COMMISSIONING GROUPS

Barnet CCG
Tel 020 8952 2381 www.barnetccg.nhs.uk

Central London CCG
Tel 020 3350 4321 www.centrallondonccg.nhs.uk

Hammersmith and Fulham CCG
Tel 020 7150 8000
www.hammersmithfulhamccg.nhs.uk

Ealing CCG
www.ealingccg.nhs.uk

East and North Hertfordshire CCG
Tel 01707 685 000
www.enhertsccg.nhs.uk/contact-us

Harrow CCG
Tel 020 8422 6644
www.harrowccg.nhs.uk

Hertfordshire Valleys CCG
Tel 01442 898 888
www.hertsvalleysccg.nhs.uk

Merton CCG
Tel 020 3668 1221
www.mertonccg.nhs.uk

Wandsworth CCG
Tel 0208 812 6600
http://www.wandsworthccg.nhs.uk

West London CCG
Tel 020 7150 8000
www.westlondonccg.nhs.uk

LOCAL AUTHORITIES

Barnet
Tel: 020 8359 2000
www.barnet.gov.uk

Brent
Tel: 020 8937 1234
www.brent.gov.uk

Ealing
Tel: 020 8825 5000
www.ealing.gov.uk

Harrow
Tel: 020 8863 5611
www.harrow.gov.uk

Hammersmith and Fulham
Tel 020 8748 3020
www.lbhf.gov.uk

Hertfordshire County Council
Tel 0300 123 4040
www.hertfordshire.gov.uk

Hounslow
Tel: 0208 583 2000
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Richmond
020 8891 1411
www.richmond.gov.uk

Royal Borough of Kensington and Chelsea
Tel: 020 7361 3000
www.rbkc.gov.uk

Merton
Tel: 020 8274 4901
www.merton.gov.uk

Wandsworth
Tel: 020 8871 6000
www.wandsworth.gov.uk

Westminster
Tel 020 7641 6000
www.westminster.gov.uk

GLOSSARY

15 Steps Challenge: This is a tool to help staff, service users and others to work together to identify improvements that can be made to enhance the service user experience. The idea is to see the ward through a service user's eyes. Members of the 15 step challenge team walk onto a ward or residential unit and take note of their first impressions.

Allied Health Professionals (AHP): Allied health professionals (AHPs) provide treatment and help rehabilitate adults and children who are ill, have disabilities or special needs, to live life as fully as possible. They work across a wide range of different settings including the community, people's homes and schools, as well as hospitals.

Always Event: These are those aspects of the care experience that should *always occur* when patients, their family members or other care partners, and service users interact with health care professionals and the health care delivery system. An Always Event must meet the following four criteria: Important, Evidence – based, Measurable and Affordable and Sustainable.

Baseline data: This is the initial collection of data which serves as a basis for comparison with the subsequently acquired data.

Being Open: Being Open is a set of principles that healthcare staff should use when communicating with patients, their families and carers following a patient safety incident.

Care Quality Commission (CQC): The CQC is the independent regulator of health and adult social care services in England. It ensures that the care provided by hospitals, dentists, ambulances, care homes and home-care agencies meets government standards of quality and safety.

Catheter: A catheter is a thin flexible tube which is inserted into the body, usually along the tube through which urine passes (the urethra) or through a hole in the abdomen. The catheter is then guided into the bladder, allowing urine to flow through it and into a drainage bag.

CBU: Clinical business unit.

Central alerting system (CAS) alerts: This is cascading system for issuing patient safety alerts,

important public health messages and other safety critical information and guidance to the NHS and others.

Clinical Commissioning Groups (**CCGs)**: CCGs are independent statutory bodies, governed by members who are the GP practices in their area. A CCG has control of a local health care budget and commissions healthcare services on behalf of the local population.

Compassion in practice: Compassion in practice is a three year vision and strategy for nursing, midwifery and care staff, drawn up by the Chief Nursing Officer for England and launched in December 2012.

Commissioning: This is the planning and purchasing of NHS services to meet the health needs of a local population. It involves deciding what services are needed and ensuring that they are provided.

Commissioning for quality and innovation payment framework (CQUIN): The CQUIN payment framework enables commissioners to reward excellence. It links a proportion of a healthcare provider's income to the achievement of local quality improvement goals.

Cold Chain: This is the process used to maintain optimal cold temperature conditions during the transport, storage, and handling of certain pharmaceuticals, starting at the manufacturer and ending with the administration of the vaccine to the patient.

DATIX: A web based risk management system, via which the Trust manages its complaints, incidents and risks.

Exemplar ward: These are wards where consistently high quality care and innovation in clinical practice has been demonstrated

FFT: Family and friends test

Incident: An event or circumstance that could have resulted, or did result, in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors or members of the public.

Key performance indicators (KPIs): Key performance indicators help define and measure progress towards organisational goals. As the primary means of communicating performance across the organisation, KPIs focus on a range of areas. Once an organisation has analysed its mission, identified all its stakeholders and defined its goals, KPIs offer a way of measuring progress toward these goals

National Institute for Health and Care Excellence (NICE): Nice provides independent, authoritative and evidence-based guidance on the most effective ways to prevent, diagnose and treat disease and ill health, reducing inequalities and variation.

National Health Service Litigation Authority (NHSLA): The NHSLA manages negligence and other claims against the NHS in England on behalf of its member organisations.

Never Event: These are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place. A list of incidents described as Never Events is published by the Department of Health.

National Reporting and Learning System (NRLS): The NRLS receives confidential reports of patient safety incidents from healthcare staff across England and Wales. Clinicians and safety experts analyse these reports to identify common risks to patients and opportunities to improve patient safety.

Nursing and Midwifery Council (NMC): The NMC is the nursing and midwifery regulator.

Palliative care: This is an approach that improves the quality of life of patients and their families facing

the problems associated with terminal illness. This is through the prevention and relief of suffering by means of early identification and excellent assessment and treatment of pain and other problems that could be physical or spiritual in nature.

PALS: Patient Advice and Liaison Service (PALS) provide a point of contact for patients, their families and their carers, and offer confidential advice, support and information about the services at CLCH.

Patient led inspection of the care environment (PLACE): PLACE is the system for assessing the quality of the patient environment. PLACE assessments will see local people go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness and general building maintenance.

PSAs: These alerts rapidly warn the healthcare system of risks. They provide guidance on preventing potential incidents that may lead to harm or death

Patient pathways: The patient pathway gives an outline of what is likely to happen on the patient's journey and can be used both for patient information and for planning services as a template pathway can be created for common services and operations. You can think of it as a timeline, on which every event relating to treatment can be entered.

Patient safety thermometer or NHS safety thermometer: The NHS Safety Thermometer provides a 'temperature check' on harm. The tool measures four high-volume patient safety issues (pressure ulcers, falls, urinary tract infection - in patients with a catheter - and venous thromboembolism). The data is used at national, regional and local level (organisational as well as at ward and team level) to support quality improvements through ensuring harm free care.

Patient reported experience measures (PREMS): These are more commonly known as patient surveys and can include paper based surveys; the use of electronic kiosks; hand held devices; and telephone surveys

Patient reported outcomes measures (PROMs): Patient Reported Outcome Measures (PROMs) are a means of collecting information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves.

PPE: Personal protective equipment.

Pressure ulcers: A pressure ulcer is localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers. Pressure ulcers are graded according to severity, with grade one being the least severe and grade four the most severe.

Prevent: Prevent is one of the strands of the Government's counter-terrorism strategy

Repository: the lessons identified from pressure ulcer learning are placed in a `repository'. This allows staff to reflect on their practice and modify future actions as appropriate.

Root cause analysis (RCA): A systematic investigation technique that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened.

Serious incident: In summary these are incidents that occurred in NHS funded services and resulted in one or more of the following: unexpected or avoidable death; serious harm; allegations of abuse; a prevention of continuation of the provision of healthcare services; or a *never event*.

Schwartz rounds: The Schwartz rounds are an opportunity for staff to acknowledge and reflect upon the emotional impact of our daily working lives openly and honestly

Tissue viability: The literal meaning of tissue viability refers to the preservation of tissue. The tissue viability service is a nurse-led specialist service whose aim is to promote the healing of compromised tissue.

Venous thromboembolism (VTE): Venous thromboembolism is a condition in which a blood clot (thrombus) forms in a vein. It most commonly occurs in the deep veins of the legs; this is called deep vein thrombosis. The thrombus may dislodge from its site of origin to travel in the blood – a phenomenon called embolism.

ANNUAL COMPLAINTS REPORT

The annual complaints report will be attached here when published

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Appx 3A, Minute Extract, North London Hospice Quality Account 2020-21

The Committee put on record its thanks to all NLH staff who had continued to provide wonderful care throughout the pandemic. The Committee also put on record the following comments on the Draft Quality Account: The Committee congratulated and complimented NLH on the following:

- for including the interesting and positive patient story at the start of the Quality Account.
- for coping so well in extreme circumstances during the pandemic and also making good progress on its priorities for 2021 particularly further developing their database, Egton Medical Information Services (EMIS), which improved efficiencies across services.
- that the training for non-medical prescribers was impressive.
- that support for patients had been offered virtually during the pandemic, with virtual assessments and consultations.
- for exceeding most of its objectives in providing virtual support for the Health and Wellbeing Service, particularly as this was helpful for patients who were to ill or fatigues to travel.
- its aim to work with the Health Information Exchange (HIE) which enabled the Hospice to access Primary Care patients' records and for continuing to work towards implementing technology to enable it to share its records with other Trusts.
- achieving their ambition of becoming a research centre.
- that some visitors for patients at the very end of life had been allowed access throughout the year.
- Gaining funding from Health Education England which enabled palliative and endof-life training to be delivered to 36 London Ambulance Service paramedics and technicians and that ten had successfully completed the Level 5 accredited course.

However, the Committee expressed its concerns regarding the following:

- that there were some areas of non-compliance in the Infection, Prevention and Control Audits including the need for improved stock rotation of clinical equipment, improved labelling of sharps bins, ensuring carpets are in a good state of repair and ensuring that urine jugs are only being allocated to a single service user.
- that the Hand Hygiene Audit which took place in IPU only had an 84% compliance level.
- that the Audit of Preferred Place of Death seemed haphazard.
- that the Audit of Community Non-Medical Prescribing identified that communication with GPs could be improved and that FP10 handwritten prescriptions are not always accepted by pharmacists.
- that there had been some transdermal patch incidents, with the wrong dose being given in some cases and omissions of doses in other cases.
- that the number of volunteers was down to 620 from 830 the previous year (2019-20) and from 950 two years ago (2018-19).
- that there had been 141 closed bed days during the year compared with 160 in 2019-20, which was largely due to fire and safety work in the bedrooms, and only 12 in 2018-19. However, it was noted that this had not prevented any admissions.
- that the highest category of medication incidents are administration errors followed by dose omissions, although action is being taken and there is a quality improvement project on medication safety being developed.

- that the number of patient falls had increased over the last quarter of 2020/21 though these had not resulted in serious harm.
- that the number of staff being recruited to the Hospice had gone down from 71 the previous year to 39 this year.
- that there were some areas needing improvement in the Staff Satisfaction Survey, specifically in relation to processes and procedures to support effective working, communication, leadership and engagement, career development and the environment. However, the Committee noted that the Hospice had appointed an Interim Head of Communications, Marketing and Digital who will help in reviewing the Trust's internal and external communications

North London Hospice Update 2020/21 Quality Account

The actions taken on the committee's comments are highlighted in bold below:

1. That there were some areas of non-compliance in the infection prevention and control audits including the need for improved stock rotation for clinical equipment, improved labelling of sharps bins, ensuring carpets are in a good state of repair and ensuring that urine jugs are only being allocated to a single service user.
   That the hand hygiene audit that took place in IPU only had an 84% compliance level.
   There are improved levels of compliance for a recent infection control audit in community services and in IPU. This included hand hygiene and a sharps bin audit. There is on-going work to ensure our communal carpeted areas are in a good state of repair which has included replacement of flooring. There are no carpeted areas in clinical areas.

2. That the audit of preferred place of death seemed haphazard.
   There has been improved reporting on EMIS over the past six months. During July to Sept out of 443 deaths across community teams, 87% (384) had Preferred place of death (PPD) recorded, 13% (59) had no PPD recorded. This represents an improvement from the initial audit where it was recorded in 60% of cases.

   A full re-audit will be undertaken in April 2022.

3. That the Audit of Community Non-medical prescribing identified that communication with GPs could be improved and that handwritten prescriptions are not always accepted by pharmacists.
   Communication with our local GPs has improved since the last audit. The handwritten prescription issue has now been resolved with the local pharmacist. The non-medical prescribing policy has been reviewed.

4. That there had been some transdermal patch incidents with the wrong dose being given in some cases and omissions of doses in other cases.
   We continue to monitor these medication incidents; in the first six months of this year, we have had 5 incidents which is a lower trend to last year. We were unable to find any themes in these incidents and there were no adverse reactions reported.

5. That the number of volunteers was down to 620 from 830 the previous year (2019-20) and from 950 two years ago (2018-19).
   The pandemic has impacted greatly on our volunteer numbers within the organisation. Not only have we changed the delivery of some of our services for example virtual groups in our Health and Well-being service, but there also continues to be other significant factors including the demographics of the volunteers and volunteer choice. We are keeping in contact with volunteers who are not actively volunteering for us at present. We have been successful in recruiting some new volunteers across retail and the inpatient unit where volunteers are now supporting these areas.

6. That there had been 141 closed bed days during the year compared with 160 in 2019-20, which was largely due to fire and safety work in the bedrooms, and only 12 in 2018-19. However, it was noted that this had not prevented any admissions.
   We continue to monitor our closed bed days. Our bed occupancy levels have greatly increased this year from 65.6% in Q1 to 73.2% in Q2, this is now higher than the national average for medium sized hospices. Our Q1 closed bed days were 156 (one room was being refurbished and one room had a long-term shower issue). In Q2 our closed bed days were 6, the fuel crisis affected our services during this time.

7. That the highest category of medication incidents are administration errors followed by dose omissions, although action is being taken and there is a quality improvement project on medication safety being developed.
   Our medication incidents remain high compared to the national average over the last two quarters. We have implemented a dose omission point prevalence audit which demonstrates that true dose omissions have reduced in Q1 and Q2. We have re-designed the hospice drug chart in a way that reduces the risk of making errors when prescribing, drug administration and drug documentation errors. This is due to be trialled alongside the regular charts, but we believe that this will go a long way in reducing our medication incidents. Additionally, we continue to provide educational support to our staff and provide real time feedback with a focus on supporting staff in achieving their competencies.

8. That the number of patient falls had increased over the last quarter of 2020/21, though these had not resulted in serious harm.
   Our patient falls have reduced over the last two quarters and have not resulted in any harm. We have participated in the Hospice UK falls audit programme for Q1 which aims to explore the reasons

and learning from patient falls. Our falls reporting is significantly lower than the national average.

9. That the number of staff being recruited to the Hospice had gone from 71 the previous year to 39 this year.
   We have experienced some recruitment challenges during the Covid-19 pandemic. However, we have had some significant successes, for example our community services now have a full complement of staff, additionally our medical staffing has greatly improved.

10. That there were some areas needing improvement in the staff satisfaction survey specifically in relation to processes and procedures to support effective working, communication, leadership and engagement, career development and the environment. However, the Committee noted that the hospice had appointed an interim Head of Communications, Marketing and Digital who will help in reviewing the Trust's internal and external communications.
    We have successfully implemented our leadership walkround framework which has been an excellent mechanism to improve how the leadership team and Trustees engage with local services on matters that are important to them in improving patient and staff safety and to deliver news on service developments. We have a very active staff forum and have recently engaged with staff on the development of our new vision and values. Our staff newsletter has also been updated so that it is more engaging to all audiences. We have also developed new local operational policies to support the effective working of teams.

    Our 2021-22 staff/volunteer survey is currently open. In the last six months we have developed a new Organisational Strategy, Equality, Diversity and Inclusion Strategy, Clinical Strategy, and a People Organisational Development Strategy.

    Fran Deane, Director of Clinical Services
    Nada Schiavone, Assistant Director Quality
    25.11.2021

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NORTH·LONDON
HOSPICE
Registered Charity No. 285300

QUALITY ACCOUNT 2021 – 2022

DRAFT V0.7

Our Vision, Our Purpose, Our Values, Our Strategic ambitions

OUR VISION

The best of life, at the end of life, for everyone.

OUR PURPOSE

North London Hospice - working together to provide palliative care and support, when and where you need us most.

OUR VALUES

C

Collaborative and learning

Share learning, educate and work supportively together.

O

Open and honest

Be clear and transparent in the way we work and respond to others.

R

Respectful and empowering

Be kind, enable and value everyone's contribution.

E

Equal and Inclusive

Treat people fairly, be welcoming and involve them.

CORPORATE
strategic ambitions

Compliments from Our Community

FIRST CONTACT, Palliative Care Support Service & BARNET COMMUNITY TEAMS - "I am writing to say a very big thank you to all of the members of the hospice who helped care for my mum xxx and who also offered kindness and help to me and my aunt, you were all angels - you really were. So, kind and I really don't know how we would have been able to care for mum in her own home as she wished in her final weeks without you all. From my first phone call with xxx and xxx who helped with advice, also with xxx and the wonderful nurses who came at night to be with mum. Thank you all."

ENFIELD COMMUITY & BEREAVEMENT TEAMS - "We are writing to send you our heartfelt thanks for everything you did for our mum in the last weeks of her life, Mum became quite worried about going into hospital, and it was with your help and care that we were able to keep her at home as she wished. Every single person that we spoke with or met - from the person who answered the phone to the nurses that visited - and all those we spoke with in between, were kind, compassionate and caring as well as practical and helpful. The phone calls we received from you during mum's last weeks to check how things were going as well as the visits were really reassuring. Both we and mum's carers felt we were safe knowing you were there, and we could talk with you whenever we needed. The Bereavement service has also been so very welcoming indeed. We cannot thank you enough for everything you did and for taking so much anxiety from our shoulders in those last weeks and days."

Thank you for the breathlessness group. I have been really good over the last month, my breathing feels a bit better. I have followed your advice about exercise and am really proud of myself – I have been increasing my exercise and am now able to go up and down the stairs without really thinking about it. I am noticing that my legs feel stronger and am now trying to do small amounts of walking without my walking stick.

CONTENTS

EXECUTIVE SUMMARY

North London Hospice (NLH) reports in this 2021-22 Quality Account on the quality of its clinical services.

The three Priority for Improvement projects completed this year are outlined in the account and have resulted in:

- Digitalisation of patient information so patients can have instant access to digital information if they require
- Development of a 'just and learning culture' framework and learning tools to support some of the improvement work the hospice has undertaken
- A review of how virtual assessments are undertaken in these services to ensure delivery is more effective.

The three projects for the coming year are outlined in the account. They are:

- A review of Health and Wellbeing Service Intervention Pathways
- Nutrition management in our Inpatient Unit
- Managing Medication Authorisation and Administration Charts (MAAR) in the Community

Key service developments and partnership working are reported on, and the key clinical services' annual data is presented. The results from the user survey showed that patient and carers were highly satisfied with their experience of NLH services. Our incidents are reported, with consideration given to falls, medicine and pressure ulcer incidents.

Comments on the Quality Account from external local organisations are included.

PATIENT STORY- The Journey of a patient's wife

My thoughts as a wife on how you have helped me craft a good death

The Community Nurse Specialist, xx helping me plan where M would die.

The team helping me plan for toileting requirements when M got progressively weaker. We were always prepared for the next stage with urine bottle, commode and for the last 12 hours nappies

The team avoiding an acute admission- the clinical nurse specialist's home visit with London Ambulance Service when M dropped his systolic blood pressure to 60, xx and the GP doing a joint home visit when he developed heart failure.

xx putting in an urgent request for carers, they started 24 hrs before he fell which was exactly why I requested carers to ensure he was never alone when I was doing the school run. They also bathed him properly when he got too weak to shower, and after 5 months of me being his sole carer, it gave me some respite so I could enjoy being a wife to my husband in the last four weeks. They helped with creams and positioning, so M never developed pressure sores. They afforded him dignity and autonomy as he was not dependent on me alone.

xx helping escalate our application for Attendance allowance and disability badges. She also managed a difficult zoom consultation between M and myself when I knew he was dying and needed him to be intentional about how he spent his time and expressed his appreciation for me!

Everyone prescribing syringe driver drugs in advance so when M wanted to start the drugs, it happened within 4 hours of his request, and he was pain free and comfortable for the last 4 days.

The whole team allowing me to be the wife, not the doctor and supporting me emotionally

PART 1: CHIEF EXECUTIVE'S STATEMENT: STATEMENT OF QUALITY

It is with great pleasure that I introduce you to North London Hospice's (NLH) 2021-2022 Quality Account which has been developed in consultation with NLH clinical service staff and managers, the executive team and the board of trustees. As we look at the publication of the 2021/22 report, we are in a period of recovery from being significantly challenged by the Covid-19 pandemic which has affected every aspect of the hospice operations. With our priority in keeping our patients and staff safe from infection to our income-generating capability, every single aspect of how the hospice is run and operated continued to be reviewed. As a small organisation with extremely dedicated, creative, innovative and responsive staff, we are proud that we have found ways around the different challenges created through the pandemic. We believe North London Hospice has more than survived throughout the Covid-19 pandemic and has in fact become stronger in many ways now that we are in recovery.

Despite the operational pressures to our services during the year, we have remained focused on continuing to deliver quality improvements at the hospice and held a very successful staff conference celebrating our achievements. We saw over 3,600 people use our services through our Health & Wellbeing Centre, our community services or on our In-Patient Unit. The Health and Wellbeing service has been the hardest impacted service during the Covid-19 pandemic due to it being primarily an outpatient service and so much of the activities were based on the provision of groups and opportunities for socialisation and peer support.

The last year saw us launch our new Strategic Plan (2021-25), where our new vision – ***The best of life, at the end of life, for everyone***, was designed through staff and volunteer engagement. The launch of our strategy together with our new CORE values and purpose at our all-staff conference was an opportunity for us to share our ambitions for the future. We must now look ahead and focus our efforts on implementing our new Strategic Plan, with our priorities being a continued focus on the quality of care we provide and our staff and volunteer experiences of working at North London Hospice. These two areas are critical to our future success.

Over the past 12 months, our Clinical, People, Finance, Communications and Marketing and Equality, Diversity and Inclusion Strategies have all been supported and approved by the board. The executive team have worked hard to ensure each strategy aligns with our approach to innovation and ambition and we want all our staff and volunteers to come with us on our strategic journey.

These strategies will give us all a framework from which to work and help us all to achieve more together than ever before.

With innovation and ambition, comes an opportunity to gain experience and change as an organisation and we have looked at many emergent ideas for improvement. One of our Priorities for Improvement this year was to implement a Patient Safety Culture to further develop our leadership walkrounds and develop a culture guide for staff.

Two further projects this year have also seen us firstly develop the effectiveness of our virtual assessments and reviews to support patients at home in the community and secondly the digital transformation of patient information. I am pleased to see the progress that has been made with our 'priorities for improvements' this year despite our operational pressures due to Covid-19. It demonstrates our commitment to the ongoing development and delivery of quality services.

Next year's 'priorities for improvements' will see some dedicated development work on nutrition management in our Inpatient Unit, Health and Wellbeing Service Intervention Pathways and Managing Medication Authorisation and Administration Charts (MAAR) in the Community.

I continue to remain proud how teams and volunteers work flexibly and innovatively to provide care that is required to our communities in the boroughs of Barnet, Enfield & Haringey. We would like to thank all our staff, trustees, donors, volunteers, and supporters for everything they do to continue to help us achieve our aims, despite continued significant pressures, they have risen to the many varied challenges we have experienced.

We are absolutely committed to delivering the highest standards of quality and safety and we continue to be forward looking and open to opportunities which will enhance the quality of palliative and end-of-life care locally including those which involve partnership working and collaboration. This year's Quality Account details some of this work and we are pleased to share this with you as we continue our journey of improvement in a post COVID-19 world.

I can confirm the accuracy of this Quality Account and will ensure the quality of the care we provide is regularly reviewed and improvements are made as needed.

Declan Carroll

Chief Executive

INTRODUCTION

Quality Accounts provide an overview of our services, information about the quality of the hospice's clinical care and improvements to the public, local authority scrutiny boards and commissioners. This is our opportunity to share with you information about how well we have delivered services in the past year which are safe, effective and offer our patients and their support network a good experience. We also highlight our priorities for the coming year which is based on our strategic plan. Some sections and statements are mandatory for inclusion. These are italicised to help identify them.

Our care is centred on the patient. We respect individuality and each person's dignity and right to privacy. We care for the whole person – their physical, emotional, spiritual, social needs and goals. The care includes support to those important to them, their families and carers through an individual's illness and into bereavement. We care for people during the advanced stages of all life-limiting conditions, including cancer, heart failure, lung, kidney and neurological diseases.

North London Hospice (NLH) started to produce and share its Quality Accounts from June 2012. The full year's Quality Account (QA) will be found on the internet (NHS website and NLH website) and copies will be readily available to read in the reception areas at the Finchley and Winchmore Hill sites.

OUR CLINICAL SERVICES

The hospice's services are provided by specially trained multi-professional teams, which include doctors, nurses, physiotherapists, occupational therapists, a paramedic, social workers, counsellors, clinical psychologists, spiritual care and chaplaincy as well as a range of volunteer roles. NLH offers the following clinical services:

- Community Specialist Palliative Care Team (CSPCT)
- Overnight Clinical Nurse Specialist Service/Out of Hours Telephone Advice Service
- Health & Wellbeing (H&W)
- In-Patient Unit (IPU)
- Palliative Care Support Service (PCSS) - NLH's Hospice at Home service
- Bereavement Service
- First Contact Centre

For a full description of our services please see Appendix One.

PART 2: PRIORITIES FOR IMPROVEMENT 2021-22

The following priorities for improvement for 2021-2022 were identified by the clinical teams and were endorsed by the clinical governance and assurance committee, board of trustees, local commissioners and health and overview scrutiny committees.

The priorities for improvement are under the three required domains of patient experience, patient safety and clinical effectiveness.

Priority One: Patient Safety - Developing a just and learning culture framework

What we planned to do:

- To further develop our leadership walkrounds through our clinical services
- Developing a just culture guide with quality improvement methodology tools
- Review our system for reporting incidents and make improvements.

Progress against the plan:

Leadership Walkrounds

It has been a challenging year operationally, but we completed our intended programme of leadership walkrounds completing the cycle with all services. This was an opportunity for members of the Executive Team and Trustees to engage with staff in all clinical services on matters relating to patient and staff safety in an open and sensitive way. The outcomes of these walkabouts is feedback to the board and a plan is formulated to address any concerns or innovations going forward.

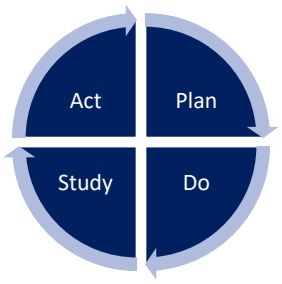
Just culture guide -development framework

We developed a just culture guide accessible to all staff to further communicate our approach to a just and learning culture. This includes a learning tools section which contains standardised quality improvement tools available to all staff. This also supports and benefits existing governance, policy and validation mechanisms to improve the safety and experience of the people we serve and our colleagues.

To support the delivery of our new clinical strategy we have further developed our approach to quality improvement to help teams solve problems at their own level and to ensure a culture of quality, safety and learning. Our experience is

that we will best achieve this by using a simple yet effective improvement model to bring about positive change which is embedded in our improvement tools:

Plan, Do, Study, Act (PDSA)



Incident reporting system

We reviewed our existing system for reporting incidents (sentinel) and following system upgrades this has improved our dashboard reporting and we are able to capture actions and learning more readily and more importantly to encourage our staff to report incidents and to learn from them. Throughout the year we have further developed how our Quality reports are developed. There was not an appetite to use the 'excellence reporting' module on sentinel in the organisation to capture examples of excellent practice. A proposal on an award recognition scheme was put forward to the Executive Team to show the considerations and benefits of developing a recognition scheme to support embedding the new values.

Challenges to date:
Due to the impact of Covid-19 on service operations we have not always been able to get the right level of engagement to progress project timelines timely and with support.

Going forward:
Our leadership walkrounds have proved to be very beneficial to staff who have welcomed this type of engagement and so we want to extend these in the coming year to retail, volunteering and other non-clinical services. We will continue to promote our approach to quality improvement by providing staff training and coaching on improvement methodologies and development an intranet page on Quality for staff to access tools.

Priority Two: Clinical Effectiveness - Virtual consultations (Video Consultations)

What we planned to do:

- To explore virtual assessments - the scope, processes required to ensure consistent, safe, equitable, high-quality delivery and appropriate user selection to develop working practices for the future and develop staff knowledge, skills, confidence and competence. To look at mechanisms for reporting on excellence.

Progress against the plan:

- We identified staff's views and training needs
- Trainers were identified to train and support staff in each NLH location/ office
- Reviewed the decision-making flow chart that identifies when it is appropriate to carry out a video consultation
- Developed a policy for undertaking virtual video consultations (in Draft)
- We are currently offering patients the option of a video consultation

Challenges to Date:

Due to the third wave of the Covid-19 pandemic and the impact on staff it was not possible to review all real-time user and staff survey for all virtual consultations.

Going forward:

Partnership meeting scheduled with North Central London Palliative care services – Camden and Islington to share practice plan for the future to develop a North Central London policy. The review of real time user and staff surveys will be undertaken this year.

Priority Three*:* Patient Experience - Digital Transformation of Patient Information

What we planned to do:

- Digitalise user information leaflets so that service users can have instant access to digital information as a primary option, in line with our strategic plan, driving the "digital first" approach with printed information sent / given where needed
- Link service user information to scannable QR codes (barcode) with codes to be added to all leaflets published by NLH and linked to the NLH website,

reducing printing costs to reduce the environmental impact, resources and driving service users to the NLH website for further information on the services and care we provide
- Develop online user survey links to replicate the paper surveys and link to the current data input system so that results are uploaded in real-time
- Work with the marketing and communications team to ensure consistency of look, feel and messaging across all NLH service user publications and identify opportunities to drive the advancement of equality, diversity and inclusion (ED&I) through service user information
- Seek user feedback on our publications, including meeting the needs of minority groups in our community.

Progress against the plan:

All leaflets have been updated and are available in a digital format on the NLH website and in a paper version, we have an on-going rolling programme for leaflet updates.

QR codes have been created for all leaflets and there is a standalone leaflet detailing all the codes. This can be used by all staff when meeting patients, relatives, and carers.

There is an on-going system in place for reviewing the clinical content of all leaflets by named individuals, the process is supported by the User Involvement Lead.

Relationships are progressively being formed with both patients and relatives who are asked to review service user information to ensure the content is appropriate, easy to read and understand, this work is on-going, and we are actively seeking out opportunities where service users can be involved in driving improvements in the service and care we provide.

A small number of resources are available in both standard and large print, the use of infographics is increasing, and we are progressively ensuring the content is accessible to all users.

We have worked with the commissioner and other specialist palliative care providers in North Central London to review patient and users surveys, agreeing a core set of questions to be used by all providers in 2022-23. Work will now progress on digitalising the new surveys.

As part of our Communications and Marketing strategy we have started a rebranding exercise, and this will inform further improvements in this area through 2022 – including the use of information and surveys in different formats and language in line with our ED&I Strategy.

Challenges to Date:

Paper leaflets have been used by services to provide user information over several years and whilst we are making progress, it has proved a challenge to drive the "digital first" approach. It should also be noted that a significant number of our patients and relatives fall within an age group who often prefer to have resources in a non-digital format.

The pandemic and some vacant staff posts have made it a challenge to produce all resources in a format which is accessible to a wider group of users (i.e., standard, and large print) but there is a resource review programme in place and the organisation has recently recruited a Digital Design and Content Co-ordinator to support this area of work.

Going forward:

The digital transformation of patient information is on-going and has been embedded in both our communications and organisational strategic plan.

We will manage our resources to ensure we achieve the greatest impact amongst the communities we serve, we will broaden our reach and continue to seek out opportunities to involve our service users, listening to their feedback and adopting a culture of continuous improvement.

Our resources and methods of seeking feedback will continue to be more inclusive, driving the advancement of ED&I (Equality, Diversity and Inclusion), widening our reach, and continuously striving to meet the needs of minority groups in our diverse community. We are currently looking to develop a Patient Experience and Engagement Strategy.

LOOKING FORWARD: PRIORITIES FOR IMPROVEMENT 2022-23

The following priority for improvement projects for 2022-23 have been identified by the clinical teams and approved by the clinical governance and assurance committee and the Board of Trustees.

The priorities for improvement projects are detailed under the three required domains of Patient Safety, Clinical Effectiveness and Patient Experience:

Priority One 1: Patient Safety - Managing Medication Authorisation and Administration Charts (MAAR) in the Community

How we identified this project:

Currently Clinical Nurse Specialists (CNSs) in the community palliative care teams recommend medications for subcutaneous use to be administered to patients to manage their symptoms (pain, nausea and vomiting, noisy secretions, breathlessness and anxiety and distress). This is usually when patients are unable to take their medication orally, usually for end-of-life care. As part of our current process the nurses complete the MAAR chart with the medications and doses and send it to GPs to check, agree, and authorise (sign) the MAAR chart so the medication can be administered.

Best practice is that the MAAR chart should be written and signed by the prescribing professional either the GP, Hospital or Hospice Doctor or Non-Medical Prescriber and not prepopulated. The Palliative care team continue to offer specialist advice regarding symptom management and guidance on how to complete MAAR charts but will no longer prepopulate a MAAR chart. This is the recommendation of the Pan London MAAR Chart Group.

What we plan to do:

To ensure safe practice in line with national recommendations, the project will involve working with NLH staff to introduce a change in practice and to work with external colleagues mainly GPs and District Nurses to provide education and to support the change in the wider community.

What the outcomes will be:

- Provide information and education for NLH staff on changes to practice
- Develop internal processes for advising on MAAR Charts including template letters and safety checks
- Review the community operational policy and introduce a revised policy as appropriate
- Provide information and education to GPs with the support of the end of life care leads and NLH community teams.

Priority Two: Clinical Effectiveness - Health and Wellbeing Service Intervention Pathways

How we identified this project:

The Health and Wellbeing service has had a significant review of its provision post-pandemic alongside the launch of the new Strategic Plan 2021-2025 and Clinical Strategy. To support the objectives within our strategy, the Health & Wellbeing service model is changing to that of an 'Outpatients model, with a goal

centred, intervention pathway approach aimed at those with a palliative diagnosis.

What we plan to do:

Using a co-productive model, we will develop pathways of interventions based on common symptoms and diagnosis. We will engage with patients and colleagues to identify the common themes of symptoms to help develop a menu of treatment interventions alongside identifying trigger factors for referral into palliative care.

We will pilot the use of Goal Attainment Scale (GAS-Light)– a framework to support goal setting, monitoring and reviewing outcomes, using the Outcome Assessment and Complexity Collaborative (OACC) suite of outcome measures to identify the point where GAS-light will be able to be used.

What the outcomes will be:

1. To establish intervention pathways for:

- Heart Failure
- Respiratory Disease
- Rare neurological conditions
- Peripheral neuropathy (as an additional issue)

2. To establish trigger factors for when those with Heart Failure, respiratory disease, rare neurological disease should be referred to palliative care

3. Pilot and evaluate the use of GAS- light in an outpatient setting

4. To increase reach

5. To provide self-management skills

Priority Three: Patient Experience - Nutrition development in the Inpatient Unit

How we identified this project:

Existing patient feedback on nutritional care and catering on the inpatient unit indicates there is an opportunity for improvement. Additionally, staff feedback suggests the current nutritional assessment policy is not adequately meeting the needs of our patients.

What we plan to do:

1. Development of a working group to include key internal stakeholders.

2. Collect baseline data on current nutritional assessment and care by auditing against existing policy.

3. Review of existing patient feedback and identification of themes prior to seeking further, more detailed feedback as required.

3. If required, identification and implementation of an improved nursing assessment of patients' nutritional needs which focuses on the individual patient's goals and preferences e.g., the PLANC tool devised by Dorothy House Hospice.

4. Revision of Nutrition Policy to include high quality, individualised nutritional advice.

5. Development of the catering menu and provision outside usual mealtimes.

What the outcomes will be:

Implement assessment tool & advice.

Changes to menu based on patient / family information.

Improved awareness of patients of the access to food / drink out of hours.

How progress to achieve these priorities will be monitored

The progress against the outcomes outlined against our quality priorities above will be reported and monitored by quarterly progress reports to the Quality and Risk Group and quarterly progress reports to the Clinical Governance and Assurance Committee, a sub-committee of the Board.

STATEMENTS OF ASSURANCE FROM THE BOARD

The following are a series of statements (italicised) that all providers must include in their Quality Account. Many of these statements are not directly applicable to specialist palliative care providers such as NLH.

Review of services

During 2021-22, NLH provided and/or sub-contracted two services where the direct care was NHS-funded and three services that were part NHS-funded through a grant.

NLH has reviewed all the data available to them on the quality of care in these NHS services.

The NHS grant income received for these services reviewed in 2021-22 represents 33% per cent of the total operational income generated by NLH for the reporting period.

Participation in clinical audits

During 2021-22, there were 0 national clinical audits and 0 national confidential enquiries covering NHS services that NLH provides. During that period NLH did not participate in any national clinical audits or 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 NLH was eligible to participate in during 2021-22 are as follows (nil).

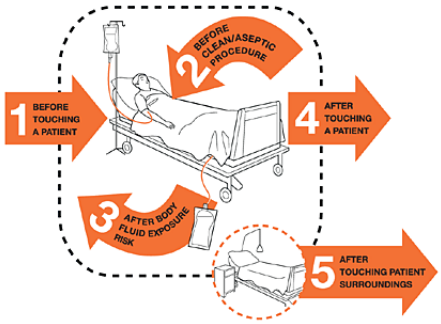
The national clinical audits and national confidential enquiries that NLH participated in, and for which data collection was completed for 2021-22, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (nil).

The reports of 0 national clinical audits are reviewed by the provider in 2021-22 and NLH intends to take the following actions to improve the quality of healthcare provided (nil).

North London Hospice recognises that audit has two main drivers-Quality Improvement and Quality Assurance. It provides the opportunity to both change practice and improve practice. The hospice produces an Annual Audit Programme of Planned Audit Activity and reports on each audit. Audit underpins several quality improvement areas for North London Hospice including:

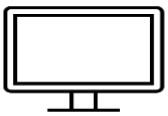
- Clinical Governance
- Risk Management
- Quality improvement
- Benchmarking.

In 2021-22 the following clinical audits were carried out by NLH and the organisation undertook the following actions to improve the quality of healthcare provided. This year we have focused on documenting our improvements.

Infection Prevention and Control Audits

Background Audits have been completed at all three of our sites against national standards for infection prevention and control.
What we did well Our annual infection control audits demonstrated 98% compliance in IPU, 96% compliance in Health and Well-being (HWB) service and 100% compliance in community teams. We commenced a programme of monthly hygiene audits in IPU.
Where can improvements be made In IPU - catheter care plans were not always updated to demonstrate reassessment of care provided. Ensure that no inappropriate items are stored in the dirty utilities.
Use of Integrated Palliative Care Outcome Scale (IPOS) in Outpatients Audit

Background This audit looked at the use of the IPOS for health and wellbeing patients and if practice reflects the services operational policy. IPOS is a tool for measurement of palliative care concerns covering multiple domains of physical and psychological symptoms, social and spiritual issues, communication, information needs and practical concerns. IPOS form(s) are to be completed initially at the first assessment and repeated if the patients phase of illness changes.

What we did well Our audit demonstrated 100% compliance with completion of the tool.
Where can improvements be made *There were no improvements identified.*
Five Priorities of Care Audit across all our services

Background The Five Priorities of Care provide the basis for caring for someone at the end of their life and recognises that in many cases, enabling the individual to plan for death should start well before a person reaches the end of their life. The five priorities focus on: recognising that someone is dying; communicating sensitively with them and their family; involving them in decisions; supporting them and their family; involving them in decisions; supporting them and their family; and creating an individual plan of care that includes adequate nutrition and hydration. It involves developing and delivering an individualised plan of care to achieve the essentials of good care. The aim of this audit is to ensure that the electronic documentation at the end of life is clear and complete.
What we did well Our audit showed 100% of patients had 5P's paperwork that was clearly completed.
Where can improvements be made There were no improvements identified from the audit.
Content of IPU discharge summaries audit

Background In this audit, we included standards including content of summary of admission, discharging drug list, ACP (Advance Care Planning) discussions including DNAR (Do not attempt resuscitation) discussions, and copy sent to GP within 2 working days.
What we did well 100% of patients had a discharge summary 100% of patients had a clear summary explaining the patient issues, including appropriate actions for the GP 100% of patients had a drug list in their discharge summary
Where can improvements be made? *Content of discharge letters* - 7% of letters did not have the patients admission and discharge date, 27% of letters did not have the Do Not Attempt Resuscitation

status of the patient and 13% of letters did not include the patients treatment escalation plan recorded.
DoLS (Deprivation of Liberty Safeguards Audit)

Background An audit was undertaken to determine the level of compliance with completing and submitting the DoLS forms to the CQC (Care Quality Commission). The audit supports preparations in 2022-23 for the introduction of the new Liberty Protection Safeguards.
What we did well The audit demonstrated that 100% of DoLS forms are completed accurately, and always submitted to CQC and since August 2021 they are recorded on EMIS via DoLS template as per policy.
Where can improvements be made Our next audit will look at the quality of the DoLS procedure undertaken.
Medication Management Audits

Background Controlled Drugs management (92%), Accountable Officer (94.5%) and Medicines Management (94.5%) audits have been undertaken. All three audits have been devised by Hospice UK to demonstrate the organisations compliance with current law and regulation and in accordance with best practice.
What we did well A quality improvement project on the development of a new drug chart has been implemented which will support increased compliance.
Where can improvements be made- review of the Controlled Drug register to make improvements ahead of a re-print.
Prescribing at the End of Life (EOL) on the Inpatient Unit

Background This audit reviewed eight randomly selected deaths looking at prescribing, discussions with patients and their nominated person(s) regarding recognition of dying.
What we did well Our results demonstrated that it had been recognised that patients were dying and discussions about death and dying were taking place. Every patient had been prescribed anticipatory medication for pain.
Where can improvements be made Continuing to ensure the use of the Five Priorities of Care template in the clinical database as identified in the related audit which meets the documentation standards discussed in the audit.

Dose omissions audits

Background We continued monthly point prevalence dose omissions as part of our medication safety quality improvement project; we measured the frequency at which medications prescribed were omitted.
What we did well We continued to do these monthly. The results of the audit are shared with nursing staff monthly to highlight how many doses did not have omission codes and signatures. There has been a reduction in these unsigned omissions following the audit and there are now usually 2-3 omissions found each time the audit is carried out. Each of these is investigated and summarised in the result write up. Our earlier dose omission audits were 7-9 omitted doses. We used our findings to inform the development of the new drug chart.
Where can improvements be made In the last audit in March 2022, it was found that dose omissions were occurring because patients were unable to take their medications at prescribed times as they were either asleep or have personal care and the nurse planned to give them medicines once they were able to take them. We have reiterated that dose omission codes should be documented during drug rounds and the medication can be signed for later rather than leaving charts blank. This will aim to get our dose admission to zero.
Medical gases audit

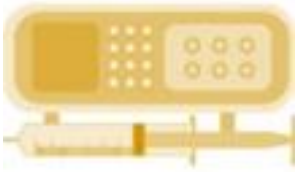
Background The North London Hospice, stores oxygen (gas cylinders), for medical use by patients within the in-patient unit and outpatient unit (H&W) as required and appropriate. Medical gases, such as oxygen are regulated and certain standards must be adhered too. This audit will determine compliance of current processes with the required medical gases standards.
What we did well Overall, we had 100% compliance in 7 out of the 8 audited domains.
Where can improvements be made Maintenance to the cage for cylinder storage to ensure safe. Review of the oxygen standard operating procedure system and training requirements for staff.

Clinical record keeping audits IPU

Background This audit was carried out to give evidence-based assurance that clinical record keeping standards and best practice is being carried out within the service which complies with NLH Records Management Policy.
What we did well Where it was identified in the clinical record that there was a record of problems that had arisen, actions taken to recitify them was documented in 100% of cases. There were no abbreviations used that were not on the agreed abbreviations list. No records contained any personal judgements.
Where can improvements be made 57% records did not include the name, designation, and signature of the staff member. This has been shared with staff and we will re-audit in 2022-23.
Clinical record keeping audits H&W

Background The clinical record keeping audit checklist for clinical notes was adapted slightly to include further information – who was the patient known to within the team, the last date of contact and is there a date for a discussion at a future Multidisciplinary (MDT) meeting.
What we did well The H&W team maintain accurate and timely records with very clear treatment plans related to the patients issues and clear evidence of the patient involvement in the decisions making process. No records contained any personal judgements.
Where can improvements be made Do not attempt resuscitation is not always appropriate to discuss with the H&W cohort of patients, however when it was discussed it was not always documented accurately and therefore did not appear on the summary page on the electronic records. Common abbreviations for therapy staff are in the notes, however, they are not within the agreed list for the hospice. The abbreviation list is being updated accordingly

Clinical record keeping audits Community Services

Background- as above audits
What we did well The Community teams maintain accurate and timely records with very clear treatment plans 100%. Good compliance with patient involvement in decisions about their care 95%. Notable practice with identification of carers and the identification of problems and team actions.100%
Where can improvements be made Recording of ethnicity, keeping DNAR status up to date and the recording of consent.
Safe Management of Equipment Audit

Background This audit determined compliance of current processes with the required medical devices standards.
What we did well Equipment on the IPU in good working order. Staff aware of responsibilities for decontamination of equipment. 'I am clean' stickers were present on all equipment in H&W. Significant work is underway to develop comprehensive asset registers and organisation of servicing contracts. We developed an organisational risk assessment in response to the audit findings.
Where can improvements be made Improving equipment storage facilities in IPU, improving the completion of checklists for cleaning where these are used. In March we were able to see an improvement in completion of these. We have introduced a new electronic assest register.
Verification of Expected Death Audit
Background- To audit current practice on IPU against 4th edition of Care After Death: Registered Nurse Verification of Expected Adult Death (RNVoEAD) guidance (Jan 2022, Hospice UK) prior to identifying and implementing opportunities for improvement.
What we did well All patients were verified within the 4 hour timeframe within the policy with 80% of patients verified in less than 1 hour after death.

Where can improvements be made Results indicate good level of timely verification within 1 hour but we need to explore strategies to improve documentation as some data missing from initial review of EMIS records.We will update our policy to reflect the timings and also amend induction information for junior doctors.
Internal CQC Audits

Background We completed a programme of CQC style very detailed audits across all our services aimed at CQC preparedness against the 5 CQC Domains.
What we did well The audits showed that NLH fulfilled all the CQC requirements for SAFE, EFFECTIVE, CARING, RESPONSIVE and WELL-LED domains to a high standard across IPU, H&W and our community services. We triangulated our information by talking to a cohort of patients and different staff groups and observed episodes of care where possible.
Some examples are listed below: *SAFE:* Implementation of a new drug chart to facilitate improvements in medication safety. Implementation of safety huddles in community services to improve communication in teams and management of cases. *EFFECTIVENESS*: Some virtual groups have been working very well, for example acupressure online. The breathlessness and fatigue group has been very beneficial to our patients. *CARING:* Compassionate Neighbours continued to support our patients during the year, with a move to more telephone or virtual support. The hospice receives many compliments. *RESPONSIVE:* Implementation of a duty desk to streamline patient contact to ensure the right care at the right time. *WELL-LED:* In the last year there have been efforts to deliver elements of a people strategy for example the establishment of an equality, diversity and inclusion group, on-going promotion of freedom to speak up guardians, increasing compliance with mandatory training, regular staff forums, a collaborative review of the hospice's vision, purpose and values.
Where can improvements be made We recognised the need to formalise our clinical record keeping audits across services, improve the closure rates of all incidents, increase our hand hygiene audits, improve practice with the decontamination of medical devices and revisit the membership of our Audit Steering group to improve mechanisms for feedback and learning. These have been achieved.

Research

Over the last year we have achieved our ambition of becoming research active hospice. We are developing a Research Strategy focusing on external partnerships and collaborations and encouraging research engagement and participation. The hospice has been involved in several ethically approved research studies:

1. Investigating Methods to Capture User Experience of Video Consultations in Palliative Care project with our Medical Director and a Medical Student had two notable outcomes with reference to disseminating findings:

Won first place prize for best oral presentation at Royal Society of Medicine 16th December our Medical Director presented a Poster Abstract at the 17th World Congress of the European Association for Palliative Care online, 6th-8th October 2021. "Investigating Methods to Capture User Experience of Video Consultations in Palliative Care " poster number L-66. This original research aimed to identify how palliative care teams can best capture patient and family feedback following video consultations with some useful observations.

2. The PallUP study looking at improving home-based palliative care for older people. Our deputy Medical Director is a member of the research steering group supporting the research team reframe the research programme due to the impact of covid. As an organisation we have also participated in the 2 surveys they have circulated on identifying the palliative care needs of older people living with frailty in the community.

3. Participated in a survey exploring the Roles, Benefits and Drawbacks of Paramedics in Hospice Palliative Care.

4. Participated in the National survey on the provision of physical activity in hospice care across the UK.

5. Participated in a survey exploring Emergency department (ED) attendance by people with dementia towards the end of life.

6. Participated in an Optimal Care study. (Optimising Palliative Care through electronic coordination): Survey of team members working with patients in palliative or end of life care. Participants contributed to a detailed survey examining the value and impact of Electronic Palliative Care Co-ordination Systems (EPaCCS) on advance care planning in the management of patients receiving Palliative Care.

7. Participated in a study on the use of subcutaneous anxiolytics in palliative medicine which are largely based on clinical expertise. To summarize practices and experiences in the use of subcutaneous midazolam in palliative medicine researchers conducted a survey in Norway, Denmark, and the UK. Survey developed at The Palliative Care Unit, St. Olavs hospital, Trondheim University Hospital in cooperation with the Palliative Care Research Centre, NTNU and external co-developers.

Quality improvement and innovation goals agreed with our commissioners

NLH income in 2021-22 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.

What others say about us

The Care Quality Commission (CQC) monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety. They consider five domains of service provision:

- Is the service safe?
- Is the service effective?
- Is the service caring?
- Is the service responsive?
- Is the service well led?

They publish their inspection performance ratings and reports to help the public.

NLH is required to register with the Care Quality Commission and its current registration status is unconditional. NLH has the following conditions on its registration (none). The Care Quality Commission has not taken any enforcement action against North London Hospice during 2021-22 as of 31 March 2022.

NLH has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

NLH's three sites were separately inspected in 2016. NLH was found to be compliant in all the areas assessed and each site was rated "Good" in all domains. Our Director of Clinical Services maintains regular contact with our CQC inspector.

DATA QUALITY

NLH did not submit records during 2021-22 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data as it is not applicable to independent hospices.

Information Governance (IG) refers to the way in which organisations process and handle information, ensuring this is in a secure and confidential manner. The Data Security and Protection Toolkit is an online self-assessment tool that must be completed annually by all organisations that have access to NHS patient data and systems. It enables these organisations to measure their performance against the National Data Guardian's 10 data security standards and to provide assurance that they are practicing good information governance ensuring data security and personal information is handled correctly.

The hospice completed its 2020/21 toolkit submission in April 2021. The 2021-22 submission will be completed by June 2022.

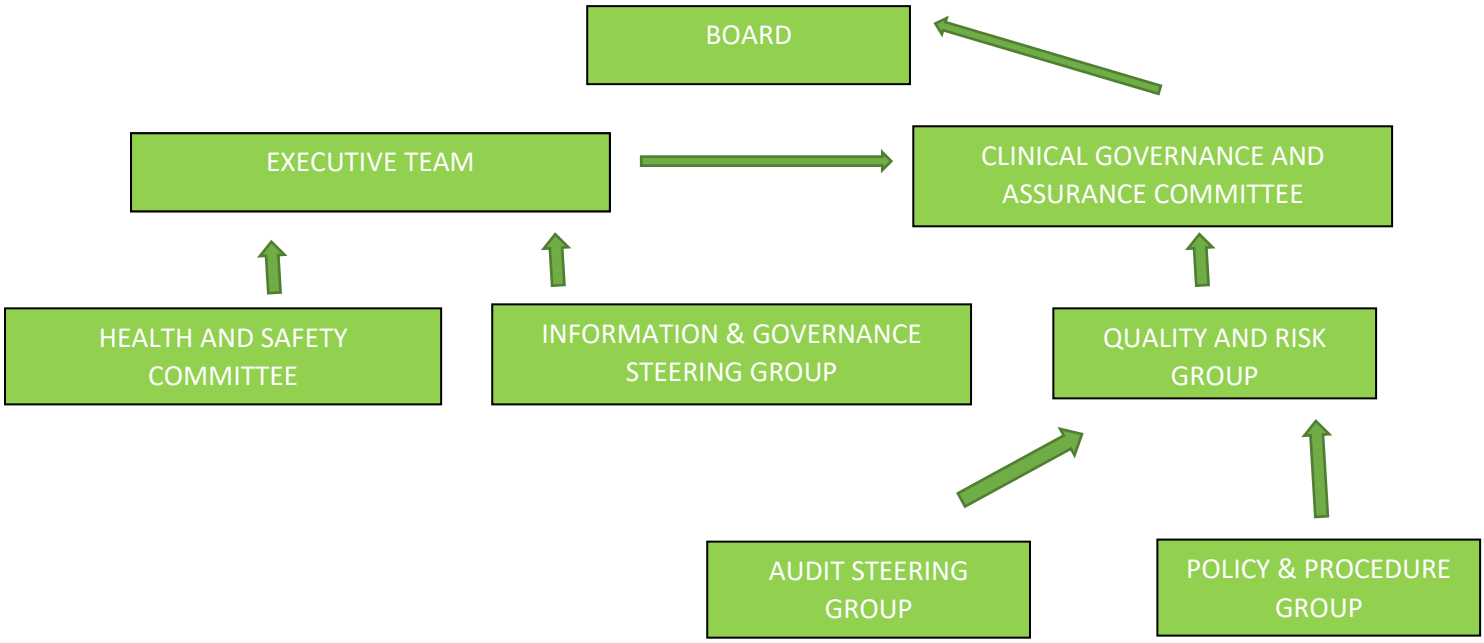
NLH was not subject to the payments by results clinical coding audit during 2021-22 by the *Audit Commission*. This is not applicable to independent hospices.

For details regarding Information Governance please see Appendix Two.

PART 3: QUALITY OVERVIEW-

QUALITY SYSTEMS

NLH has quality at the heart of everything it does as depicted in the diagram of reporting and quality assurance arrangements below:



For a full description of our groups that oversee, and review quality please see Appendix Three. NLH strives to see quality improvement across its services, and this Quality Account represents a small reflection on some of the initiatives we undertake.

KEY SERVICE DEVELOPMENTS OF 2021-22:

Clinical Strategy

The clinical leadership group produced its first clinical strategy for 2021-25. The clinical strategy is aligned and supports the delivery of the overall organisational 4 year strategic plan. It also aligns and supports with other key strategy documents including people, fundraising, equality, diversity and inclusion, communications and Marketing and Retail. The strategy has six overarching clinical objectives:

- We will work towards understanding the needs of our population to ensure we provide our services to more people. We will ensure our services are responsive to the identified need and promote equity of access.
- We will work together with our patients, service users, their support networks, our communities and partners to ensure the provision of

integrated and individualised palliative care and support. We will continually monitor our performance and measure the impact of our services.
- We will use learning to influence and develop our services.
- We will embrace a culture of innovation and creativity to ensure we continually meet the needs of our service users.
- We will develop our workforce (staff and volunteers) to ensure we have the right people, with the right skills to meet the needs of our service users.
- We deliver high quality safe care, ensuring a culture of learning development and improvement.

Non-Medical Prescribing

Expanding the number of non-medical prescribers within the organisations has continued this year. Three staff successfully completed their qualifications. A further three staff commenced their courses and will graduate in 2022-23.

Bereavement

The challenges the pandemic created are unprecedented and stretched most of us to the limit, particularly those who were bereaved.

Walk&Talk group – going the extra mile

Volunteers leading the group kept up to date and responded to changing guidelines, meeting as often as possible. Those unable to attend were still supported by the group and nobody coped alone when times felt tough. Many of the group members also choose to connect outside the walk and talk session and have been a great support to each other. This is such an amazing achievement and correlates with the core values of the service, recognising that authentic human understanding has a worth beyond measure, and is not exclusively achieved within the confines of counselling or one to one contact. Having access to others who have had a similar shared experience, want to listen, and try to understand, without judgement, is a great gift to offer someone.

48 sessions took place in 2021, sometimes with over 20 people attending each session.

Feedback from attendees:

"I have found the walks very helpful and I'm extremely grateful to you for putting me in touch with the group. I received a warm welcome and the volunteers were very kind."

"I have found and made so many friends through this group it breaks down the isolation often felt when losing a loved one."

Over the last 6 months we have recruited and trained an additional 17 bereavement support volunteers, bringing our total to 33. The training received excellent feedback and all volunteers are contributing to the service and have been allocated reflective practice groups.

Volunteering

We currently have 592 active volunteers. 351 volunteers work in retail and 242 are patient facing. Responding to our volunteer survey we have focussed on maintaining connection with volunteers who were unable to volunteer during the Covid-19 restrictions as well as welcoming volunteers back with refresher training and ongoing support. As a result, those volunteers who have returned report feeling well prepared and well supported. In a survey comparing results with other hospices across the UK, North London Hospice scored 5% higher than others for volunteer satisfaction in terms of development (83%) and support (94%). We have also streamlined our recruitment process and are able to offer online presentations for training ensuring that volunteers can start swiftly and easily.

Health and Wellbeing Service

During a second year of restricted activity due to the pandemic the team now operates a fully hybrid service where the patient has choice whether to engage face to face, virtually or by phone. There has been an increase in attendance at the centre since January 2022 however, many users of the service prefer the virtual interventions, particularly for the group-based activities. The referrals have remained lower than pre pandemic and those that have been referred have been more symptomatic.

The general wellbeing and social activities are now delivered by the Compassionate Neighbour programme. With the changes in referrals and some current staffing vacancies we have taken the opportunity to review the Health and Wellbeing Service during the last quarter of the year. Although this is not complete, there are work streams considering:

- nursing and medical roles within the Health and Wellbeing team
- our approach to Outreach and wider engagement within the community
- Multi-disciplinary meetings

The review has also led to a Priority for Improvement for next year working on pathway interventions.

Community Development

Community Development supports the North London Hospice ambition to reach further into our communities. It connects the hospice with community in a variety of ways such as through bespoke talks, forum membership and

involvement and stakeholder events. Fostering this connectedness raises awareness of our services, builds trust and partnership opportunities.

This year we have identified a need to formalise our strategy for community engagement and user involvement in 2022-23. This will help increase our knowledge of the palliative care needs of the communities in our area and adapt care, support, services, and information to support them. There has also been close collaboration with the Equalities, Diversity, and Inclusion project through which we have started to reach out to a range of communities.

Ways Community Development engages:

Compassionate Neighbours

This year we have reviewed and developed the Compassionate Neighbours model. The referral criteria for external organisations were refined from 'chronic' to 'life limiting' to align with those of the Hospice and this has improved the appropriateness of the referrals received.

In addition to the one-to-one matches – which have risen by nearly 50% in the last 12 months and are predominantly face to face again – the model has grown to include three new components:

- Face to face and virtual groups
- a respite service
- transition service where time-limited support is available for those being discharged from NLH services.

The group activities were designed to support patients, community members, carers and people who were wanting to engage within community members experiencing similar issues of ill health and/or bereavement. The groups are

volunteer led and each has a specific area of interest (for example silk painting, film club, gentle exercise, and knitting/crochet) with a social element to encourage new friendships. In February 2022, the scheme also took on an allotment close to the Health and Wellbeing building for use by anyone connected with the Hospice.

Training for new Compassionate Neighbours is now offered quarterly and is facilitated by a small team of Compassionate Neighbours. The network of actively involved Compassionate Neighbours is now over 100 and they speak at least 24 languages between them.

The connections with local partnerships continue, particularly in Haringey where we have good links with social prescribers and the Haringey Memory Service.

Compassionate Neighbours in numbers 2021/2022

	2020/2021	**2021/2022**
Compassionate Neighbours trained	91	39 (total:271)
Referrals received	84	165
Referral source ratio (internal: external)	58:42	72:28
Introductions/matches	67	100
Number of new group activity launched	N/A	7

IPU

Over the past year we have freshened up our patient bedrooms by replacing curtains and bedding, the rooms now look more inviting and welcoming. We replaced our existing riser recliner chairs with chairs with an enhanced level of pressure relief and have replaced several patient fridges.

Our Clinical Team work closely with our catering provider Valeside to provide personalised menus for our patients. This ensures patients are able to enjoy meals which meet their needs.

We have created a Staff Rest room on our In-Patient Unit which provides staff with an area to relax and recharge during their break times.

We have seen some challenges of facilitating timely admissions to the IPU due to issues with ambulance transport from both acute hospitals and in the community. This has meant on occasion admissions have had to be cancelled as the patient would not arrive whilst a doctor was available on the unit. In order to try and limit these occasions we changed the doctors hours in order to have a doctor working till 7pm a number of days a week. We have also facilitated

doctors seeing patients in the community on the day of their planned admission to complete the clerking of the patient whilst awaiting transport.

Quality Improvement projects (QIP) informing service developments in IPU

1. **Responding to Urgency of Need in Palliative Care (RUN-PC) triage score used by First Contact to prioritise admissions to IPU**

We developed a quality improvement project to improve the prioritisation of referrals response times and inter-rater reliability. The RUN–PC Triage Tool is a novel evidence-based and validated specialist palliative care triage decision-making tool to facilitate equitable, efficient, and transparent allocation of specialist palliative care services by urgency of need. The prioritisation of referrals to IPU occurs during the daily bed meeting. To prioritise a referral the RUN-PC score is utilised. Data collected on the distribution of RUN-PC scores of referrals to IPU show the compliance with recommended response times and inter-rater reliability is not always being met. The aim of this project is to improve the referral response time and inter-rater by changing the scoring methodology.

The QIP has led to several improvements:

- Using the recommended response times as described by the RUN-PC manual.

- Developing more detailed scoring guidance to ensure scoring is more objective and reproducible.

- Discussion at bed meeting restricted to fully assessed and scored referrals unless clearly very urgent.

- Addition of target admission date to referrals list on the clinical database.

PARTNERSHIP WORKING

North Central London Clinical Commissioning Group (CCG)

NLH has worked with our North Central London(NCL) commissioner to support the development of a service specification that has been approved by the CCG to establish a Single Point of Access (SPA) for palliative care services across NCL. A steering group has been established and terms of referenced established.

The SPA for Palliative Care, will provide a 24/7 single point of access for patients, their carers, and professionals to enable them to access support, help, advice, and onward referrals to other appropriate services if required. It aims to support patients in their preferred place of care (PPC) wherever possible and will

be staffed by Clinical Nurse Specialists. The SPA will have access (with patient consent) to the full electronic patient record to inform and enhance care and the advice provided. NLH and Marie Curie are working in partnership with NCL CCG to be lead providers for the service once operational in Quarter 3 of 2022/23.

We have supported the commissioner with completion of the Ambitions for Palliative & End of Life Care self assessment tool for the three boroughs that we serve.

Ongoing partnership working

We have continued to work in partnership with Noah's Ark, the Enfield Community Heart Failure team and Enfield Pulmonary rehabilitation service. We are also working with the North Central London Cancer Alliance on the Personal Cancer Care Programme.

Partnership working continues with the Barnet Patient Engagement Group and colleagues in Jewish Care, Healthwatch Barnet, Barnet Carers, Age UK, Dementia services, Multifaith forum and GP Patient Engagement to encourage a local conversation about preparing for end-of-life decisions and care. This year, once again, NLH worked closely to produce a public engagement campaign for Dying Matters Week.

Partnership working with Marie Curie Hospice Hampstead

We have continued to meet regularly with the senior management team at Marie Curie in Hampstead to share experiences and consider opportunities for collaborative working.

Enfield Respiratory Team

We continue to provide input into their 'Pulmonary Rehabilitation' courses exploring advanced care planning and the role and services of North London Hospice.

Partnerships Community Borough teams

Our community teams have regular meetings with Partnerships Community Borough Teams. These include:

- Regular meetings with district nursing to discuss care plans for people under joint care
- GP meetings
- Neurological meetings
- Heart failure meetings
- Enhanced health for care homes meetings
- Multi Agency Care and Coordination (MACCT) case by case as needed

Overnight Service

The Betty Messenger Foundation funded the establishment of our Overnight Service in 2019. This three year funding came to an end in December 2021. Whilst the NCL single point of access model is agreed, NLH board have agreed to continue to fund the service.

LEARNING AND DEVELOPMENT

The continued altering covid restrictions impacted the work of the learning and development team. However, adaptability and teamwork ensured another successful year for education in the hospice.

A wealth of internal courses were offered in addition to mandatory training including coaching, mentoring, IT skills and handling difficult conversations and bespoke training days covering the care certificate. The virtual clinical training went from strength-to-strength and a poster detailing its success was presented at the Hospice UK conference in Liverpool. Additional posters were presented outlining the overnight service and our online mindfulness and meditation psychological support group.

Direct mentoring, support and reflection opportunities were also regularly offered by the team. A new e-learning and booking training system 'Relias' was also introduced. The system provides a more engaging, informative, and accurate learning experience and has been received positively by staff.

Despite the restrictions imposed by covid, several external courses were safely delivered including our accredited level 5 palliative care course, Namaste, Summer School and DNACPR training. We received positive feedback from Barnet and Southgate College over the quality of the Level 5 course; "Overall, excellent work and clear feedback, so well done."

We also commenced the running of the European certificate in essential palliative Care (ECEPC) in partnership with 13 other hospices. Bespoke training packages were also delivered to care home staff on individualised care planning and dementia. 8 courses were also provided in partnership with an international school to provide an insight into a career in healthcare. These were very well attended, received excellent feedback, and resulted in additional fundraising for the Hospice. Comments included:

"The whole day was an incredibly valuable experience"

"Really enjoyed it, such an informative and interesting day"

Information events to raise awareness of careers in healthcare was also held for students within our boroughs. This was attended by over 70 young people.

As many care homes remained 'closed' to non-essential visitors we continued to support Enfield care homes through virtual means. Recorded teaching presentations were available for access via a Moodle and 'live' virtual end of life training sessions were also offered to all the homes.

The team continued to support seven apprentices: six completing Nursing Associate Training (TNA) and one a management degree. We are very proud that four of the TNAs successfully completed their course at the end of March and are being interviewed for roles within the hospice. The team also supported a 'Kickstarter' for a six-month placement in gaining valuable work experience to support them in a future career.

The wonderful work of the hospice was also celebrated with a staff conference held at Stone X stadium. Despite the challenges of Covid, 119 staff safely attended and the overall feedback was positive with the day receiving a rating of 4.3/5.

Learning & Development - A year in figures

End-of-year figures show that mandatory training compliance levels stand at 91%.

1741 learners attended courses or training

443 hours of support given through mentoring

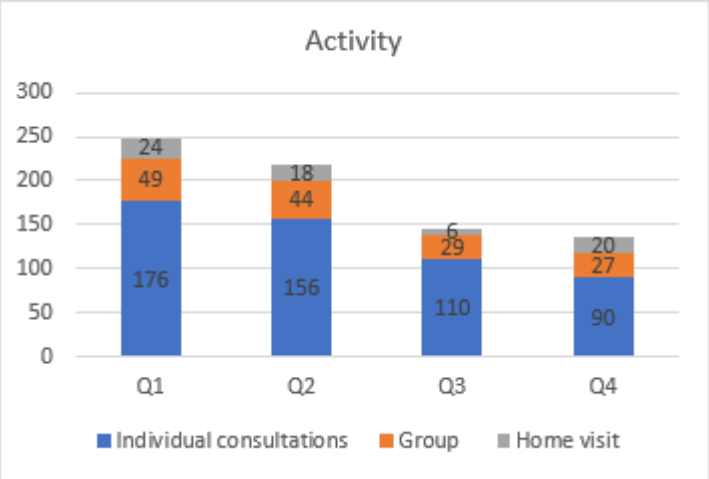
SERVICE ACTIVITY DATA

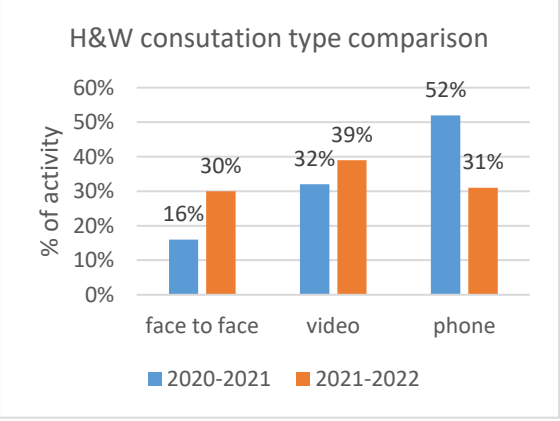
NLH monitors the performance of different aspects of its services quarterly against some annual targets. Highlights of this year are included here.

Inpatient Unit (IPU)

	2020-21	2021-22
Admissions	341	346
Patient died on IPU	71%	77%
Patients discharged home	29%	23%
Length of stay	13.1 days	
Closed bed days	141	156

Health & Wellbeing Service





Community Teams

Place of death	2020-21	2021-22
Usual place of residence	72%	75%
Hospice	17%	14%
Hospital	11%	11%
Other	0%	0%
Percentage of patients achieving their preferred place of death	87%	89%

Palliative Care Support Service (PCSS)

	2020-21	2021-22
Number of patients support	374	442
Average hours of direct care provided per patient supported	27 (equates to 3 nights)	28 (equates to 3.1 nights)

Community Overnight Service

	2020-21	2021-22
Total number of calls received (5pm-8am)	7059	6724
Total number of visits (8pm-8am)	428	316

SERVICE USER EXPERIENCE

NLH values all feedback from people who have used our services and experienced our care. The hospice has a range of feedback resources which are used to capture experience: comment cards, verbal or written suggestions, compliments and thank you cards, patient/family stories, routine surveys (both internal operational surveys and NCL aligned surveys), concerns and complaints.

Feedback is shared and reviewed by services with team members and through NLH governance groups.

Patients and families can provide feedback on the service and care they receive, and the User Involvement Lead is available to support where needed.

All feedback is collated and analysed for themes and used to identify improvements and implement changes. We adopt a user centred approach and endeavour to drive a culture of continuous improvement through understanding the needs and preferences of our patients and their families.

2021 User Surveys

In 2021 the annual service-specific surveys have been undertaken by both paper and real-time surveys using a tablet device.

Paper surveys were sent from May 2021-October 2021

- Community patients and relatives
- Palliative Care Support Service relatives (PCSS)
- Inpatient unit patient and relatives (IPU)
- Health and Wellbeing patients (H&W)

A total of 2,357 surveys were sent out (28% increase on 2020), 462 surveys were returned representing a 19.6% response rate.

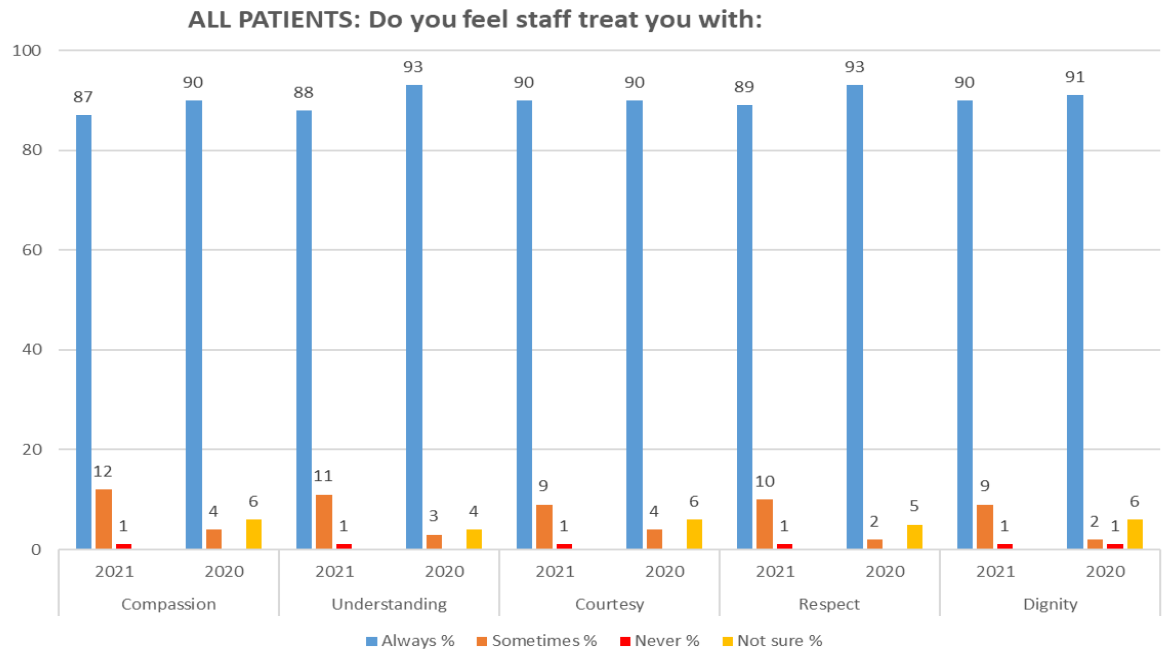
In 2021, 36 In-Patient Unit and 29 Health & Wellbeing surveys were completed the aim of the tablet surveys is to be able to provide real-time feedback which allows us to be immediately responsive to issues raised.

When analysing our comparative results from 2020 we noted an error in the data presented in the 2020 quality account. The 2020 data has been corrected in the graphs that follow and the results are comparable with the 2021 results.

Results: Key Performance Indicators

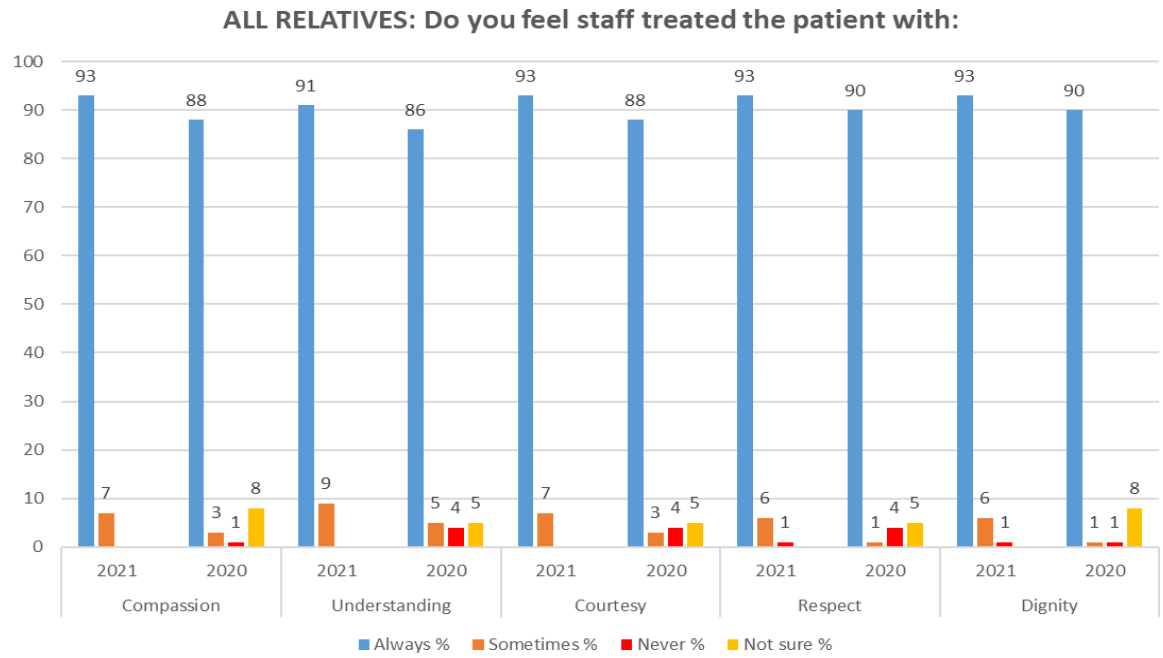
Key Performance Indicator 1: Are you/was the patient treated with compassion, understanding, courtesy, respect, and dignity?

Patient results:



Overall results show, above 85% "Always" scores were reported across all patient services. The option of not sure was removed in the 2021 surveys

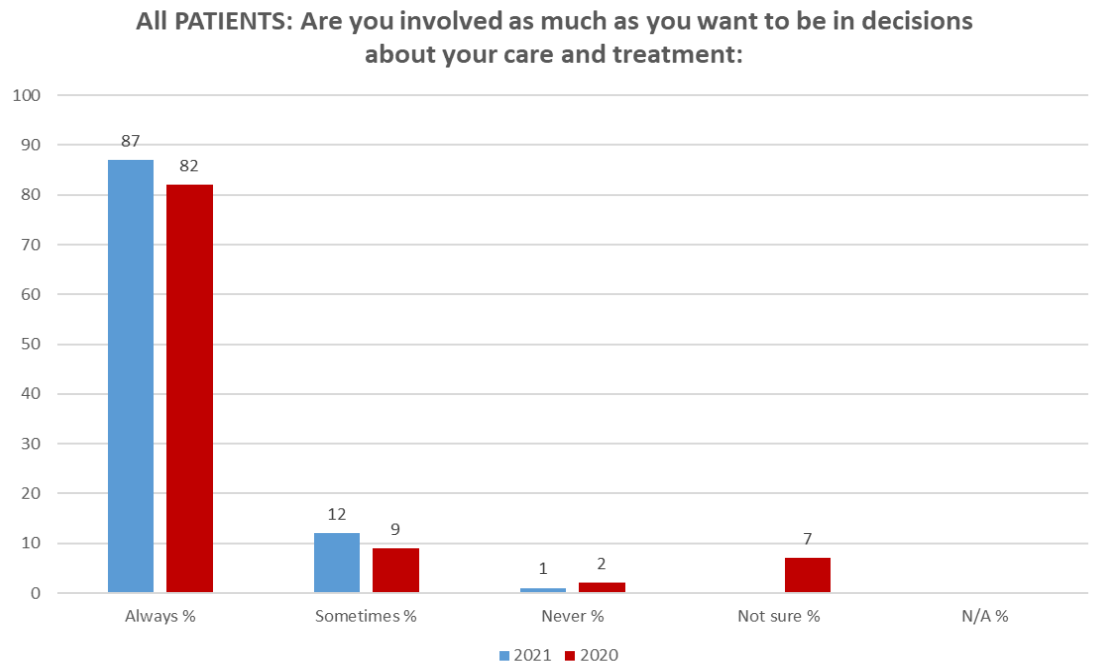
Relative results:



Overall results show, above 90% "Always" scores were reported across all relative services.

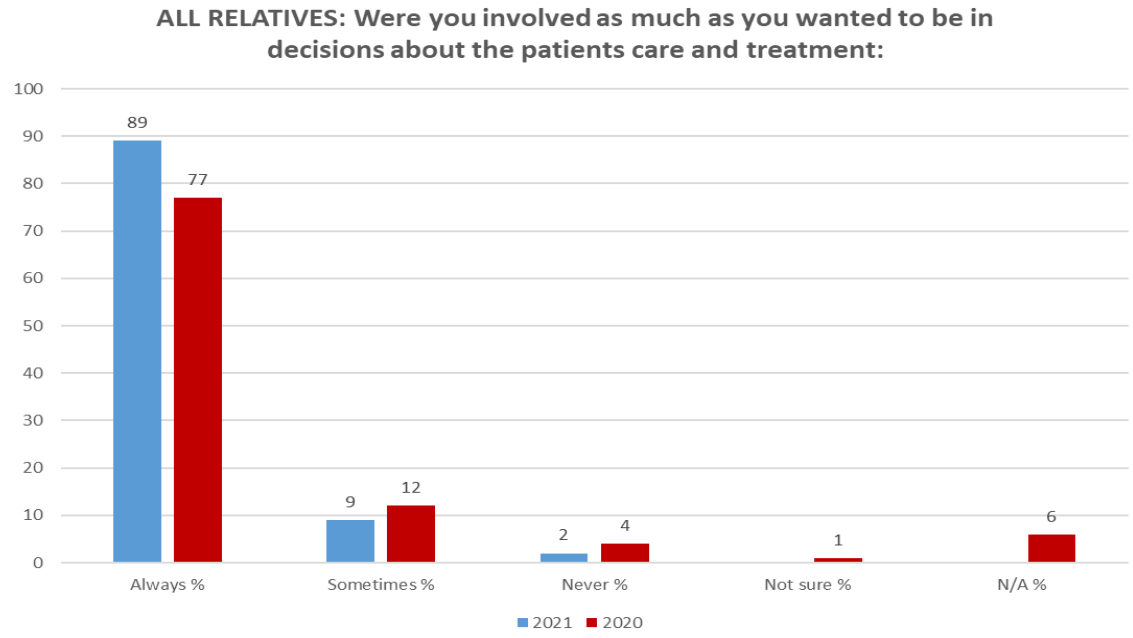
Key Performance Indicator 2: Are you involved as much as you want to be in decisions about your care and treatment?

Patients results:



Overall results show, 87% "Always" scores were reported across patient services with 1% of patients reporting a score of "Never" (2 CT Barnet / 1 IPU patient)

Relative results:



Overall results show 89% "Always" scores were reported across relative services with 2% of relatives recording a "Never" score (2 CT Haringey, 2 CT Barnet, 1 IPU patient)

Key Performance Indicator 3: Would you recommend the service to friends and family?

Our responses are in line with those used in the NHS Family and Friends test:

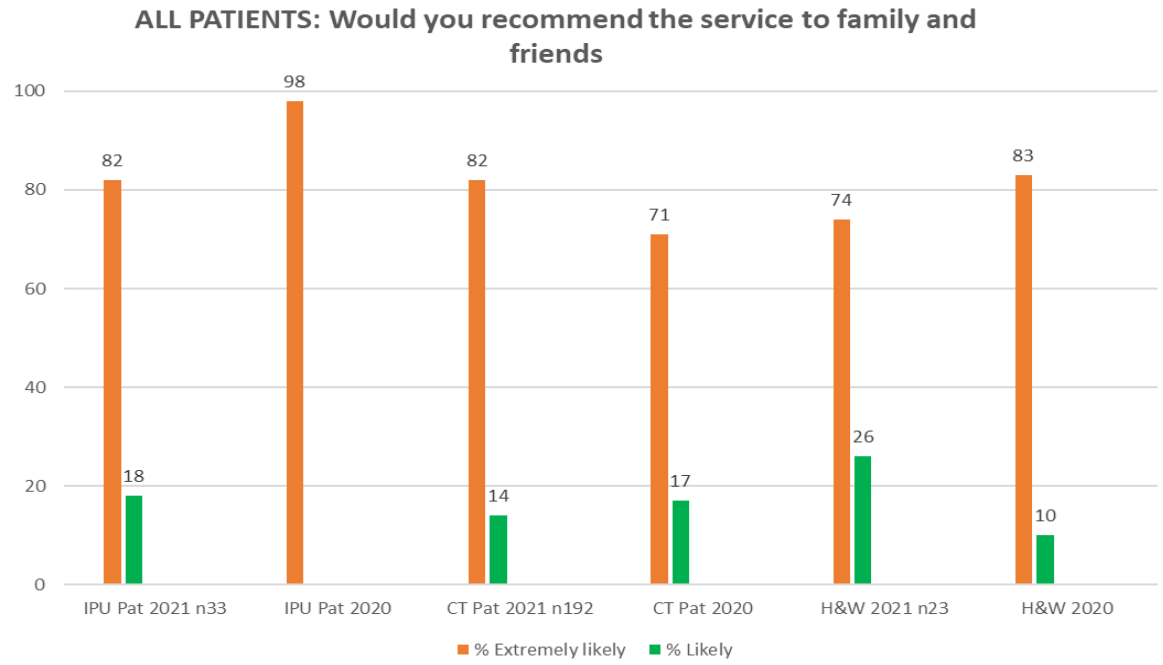
Extremely likely

Likely

Neither likely or unlikely

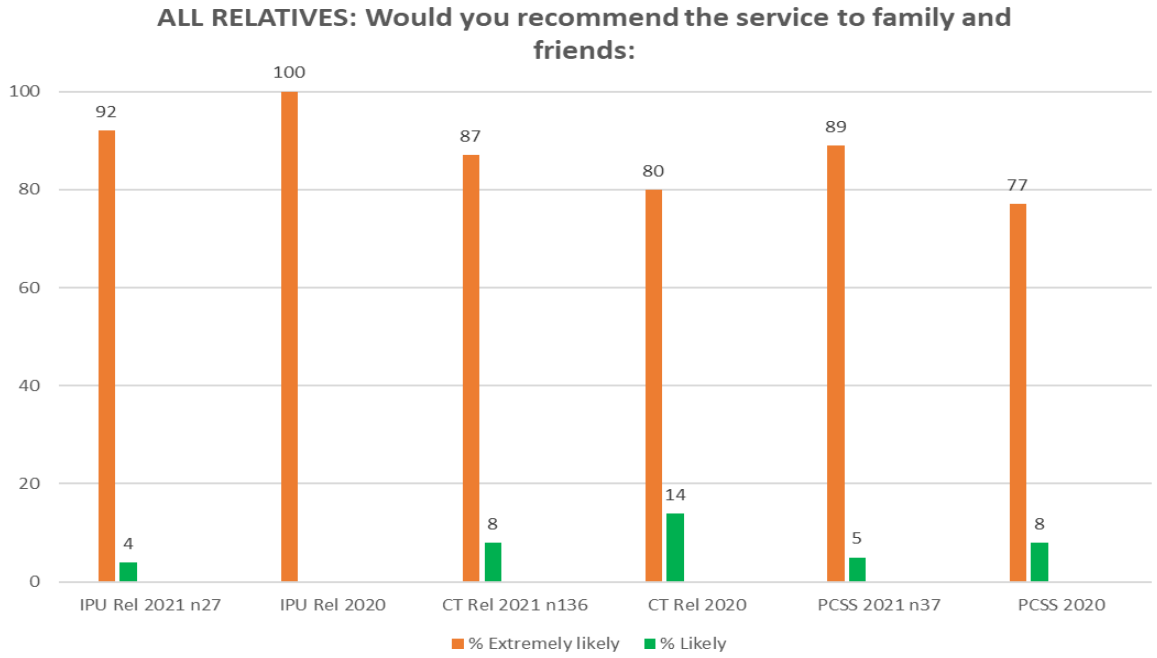
Unlikely

Patient results:



Above 80% "Extremely likely" scores were reported across IPU and Community patients. H&W reported a score of 74% in Extremely Likely. It should be noted that in 2021 there has been a reduced Health & Wellbeing service

Relatives' results:



Above 85% "Extremely likely" scores were reported across all relative service areas

Complaints

Quality Performance Indicator	2020-2021	2021-2022
Number of Complaints (NLH target fewer than 30)	18	15

Quality Performance Indicator	2020-2021	2021-2022
Investigations completed,	16	13

complaint upheld/partially		
Investigations completed; complaint not upheld	2	2
Investigations unable to proceed as complainant not able to give full information	0	0
In progress	0	0

NLH receives complaints about clinical and non-clinical (charity shops) aspects of its business. This year we received a total of 15 complaints:

- 10 were clinical (patient service) 4 were retail, 1 related to facilities

The 10 clinical complaints involved the community services. Less than 0.3% of patients and families supported by NLH this year made a complaint.

The themes of clinical complaints raised this year were predominantly communication of staff to service users and care of patient.

All clinical complaints upheld, partially upheld or not upheld have been completed and actions and learnings have been taken forward including:

- Booking and out of hours processes have been examined to ensure the PCSS service are fully aware when staff are booked to attend patient homes
- Teams are regularly reminded of transparency when communicating corporate caseloads and outstanding tasks are routinely distributed at morning team meetings
- Clear and comprehensive information is provided in respect to end-of-life "anticipatory" medication to both relatives and patients
- Teams are given the autonomy to consider purchasing medications over the counter when appropriate or necessary
- Service user surveys will be undertaken across 12 months of the year, providing a more equitable and inclusive service to all users, promoting

good practice, and supporting our advancement of equality, diversity and inclusion
- Community clinical teams have undertaken an education session on nerve block

As well as complaints we record and monitor concerns and compliments. Concerns are an issue raised by a user that requires consideration and investigation.

Concerns:

In 2021 we received 4 concerns all relating to clinical care. The most re-occurring theme was communication of staff to service user and care of patient. The following are examples of concerns raised this year and actions taken in response.

Patients' family requested PCSS/HCA visit by overnight service – visit did not take place and family feel they did not have the support they needed	The PCSS booking process has been reviewed and HCA's now telephone PCSS staff to ensure they are aware they are booked and required to attend a patients home
Delay of sample being requested by doctor and being sent to laboratory, delay of medication being prescribed and administered to patient	Significant improvement and clarity of written communication on the nursing handover sheets
Family concerned that they wanted to be with the patient when they passed away. There was no discussion with them about patient prognosis on admission	Doctors / nurses speak with relatives together Joint handover sheets to improve communication Review of patient "Things to know about me document"

Compliments:

This year we recorded 207 written compliments. Themes were care for patients, relatives, carers, above and beyond, kindness of staff, overwhelming support during difficult times. Below are examples of compliments received from our patients, families and carers.

To the many nurses, doctors, assistants, cleaners, and volunteers who cared for our father. We are more grateful than we can ever express for the skill and tenderness you showed him and for the two days he was with you. Thank you, we plan to fundraise for you in a number of ways.

In-Patient Unit compliment

To everyone at North London Hospice, thank you so much for making it possible for my partner to pass away peacefully at home. With your wonderful support I was able to fulfil her wishes. You are a fantastic organisation, and I will try to repay a small part of what you gave us by giving you my support.

Community team compliment

I would just like to say an enormous thank you to the staff, at the North London Hospice. At 8:45 on a Saturday evening you helped me with medication for my mum
Your kindness to us was so very much appreciated and you looked after Mum with kid gloves over her final week.
Please accept the enclosed donation on behalf of our wonderful Mum With appreciation and very best wishes,
PCSS compliment

PATIENT SAFETY-

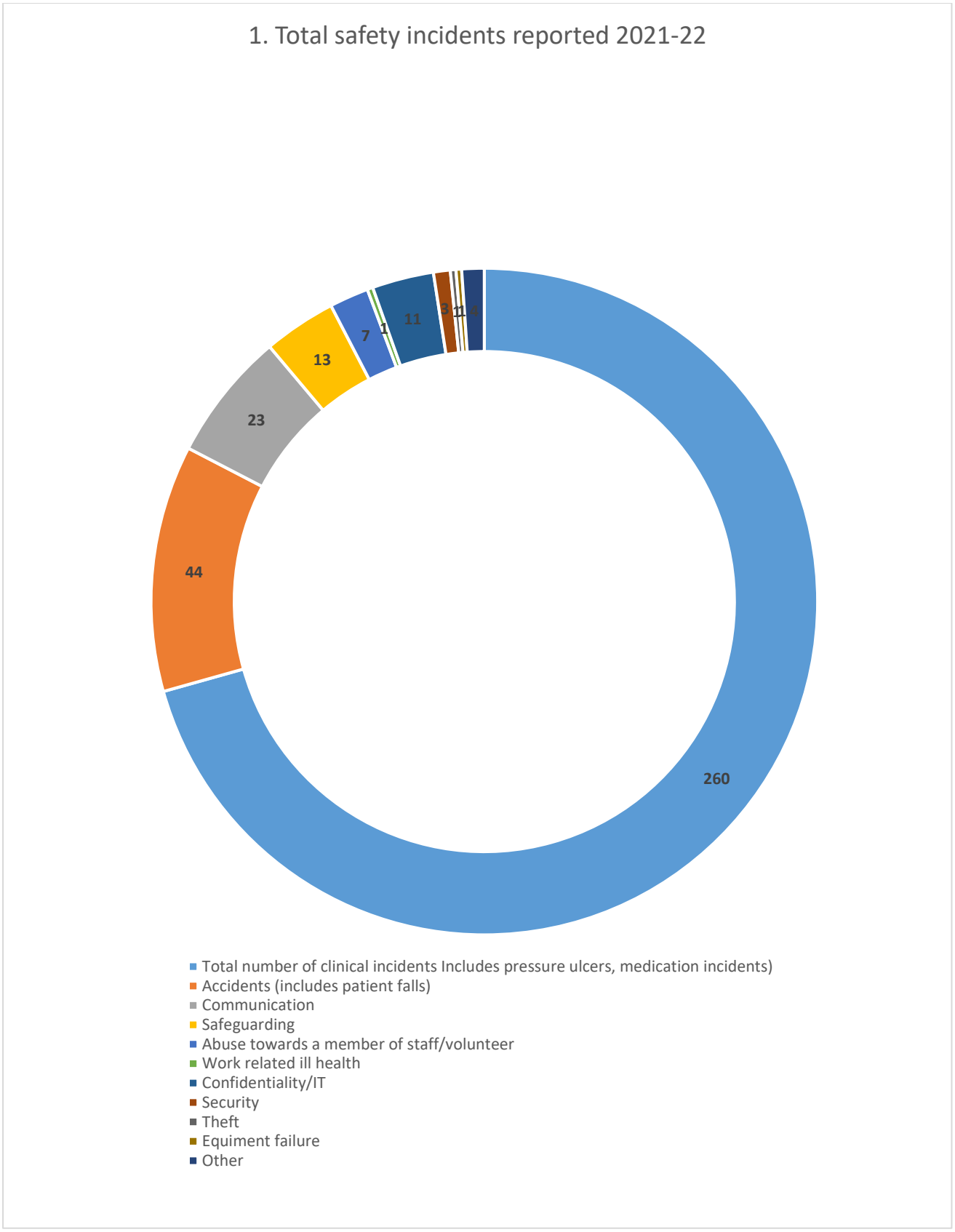
North London Hospice continues to report clinical, non-clinical incidents and near misses and reports on organisational learning and encourages an open approach. The quality and risk group review the themes, trends and improvements relating to incidents.

Table 1 below shows the number of incidents and near misses reported over the last three years.

Table 1 Total number of incidents reported on sentinel 2019-22

	2019-20	2020-21	2021-22
Total number of incidents	489	417	368

Chart 1 below shows the categories of incidents reported during 2021-22.


1. Total safety incidents reported 2021-22
260
44
23
13
7
1
11
3
1
1
4
Total number of clinical incidents Includes pressure ulcers, medication incidents)
Accidents (includes patient falls)
Communication
Safeguarding
Abuse towards a member of staff/volunteer
Work related ill health
Confidentiality/IT
Security
Theft
Equiment failure
Other

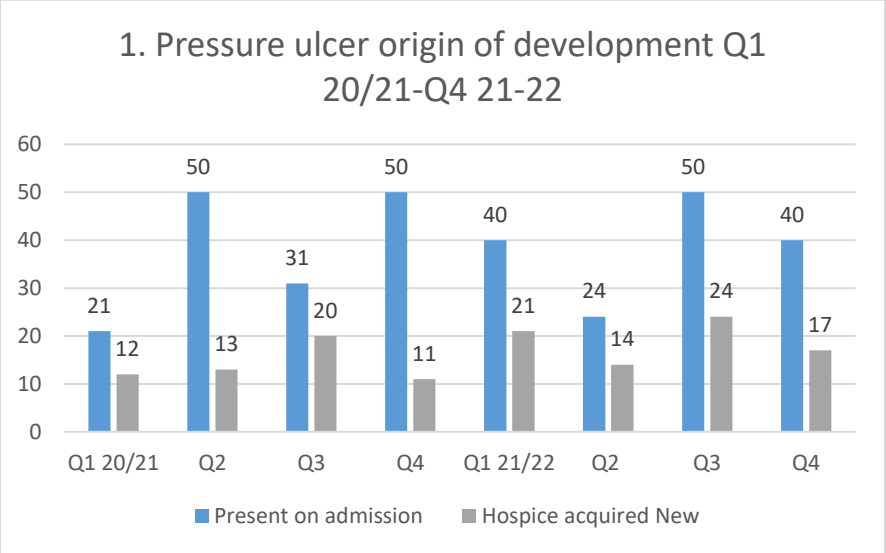
Analysis of incidents 2021-22

A decrease in the number of incidents were reported this year from the previous year.

Pressure Ulcers 2021/22

Our highest reported category of type of clinical incident is pressure ulcers. We report on newly acquired pressure ulcers and those that are present on admission and not attributed to the hospice hence our greater numbers of incidents reported.

Graph 1 below shows the number of pressure ulcers present on admission compared with those pressure ulcers newly acquired in the hospice over the past two years. The majority of pressure ulcers reported were already present on admission to the hospice (in comparison with other hospices the pressure ulcers already present on admission at NLH are above average).



New pressure ulcers

This year saw an increase in new pressure ulcers being reported, from 56 reported last year to 76 this year. There were similar trends in those pressure ulcers present on admission to last year. IPU has had higher numbers of hospice acquired pressure ulcers when compared with other hospices (Hospice UK Benchmarking reports). Whilst we continue to strive to reduce the number of hospice acquired pressure ulcers, it is of note that the numbers of patients admitted with pressure ulcers is also higher than national average (patients admitted from home, care homes and hospital). This has led staff to reason that it is something about our cohort of patients – elderly and frailty in the main, that leads to high numbers of ulcers.

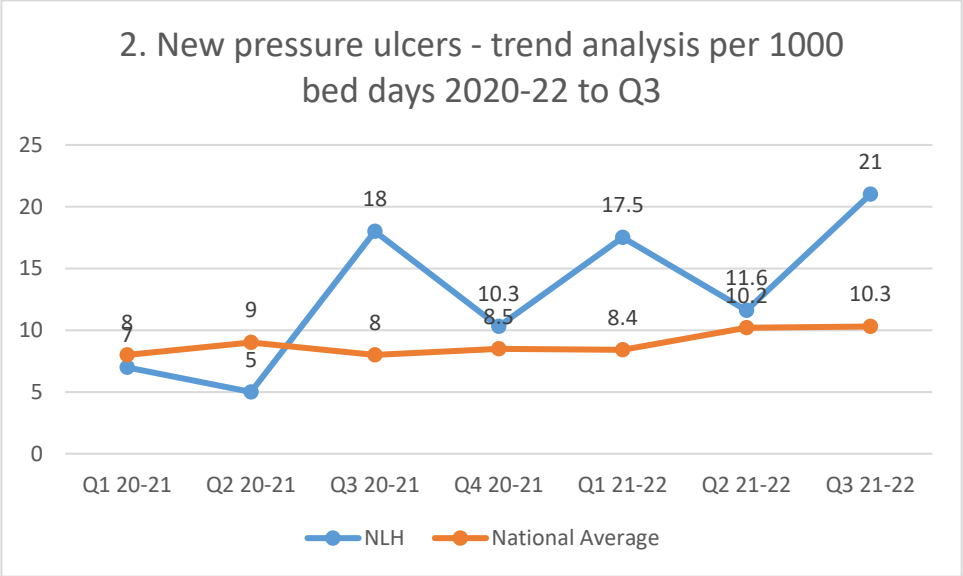
What has been done?

SSKIN (Skin, surface, keep moving, incontinence, nutrition and hydration) charts have been reviewed and amended to support care.

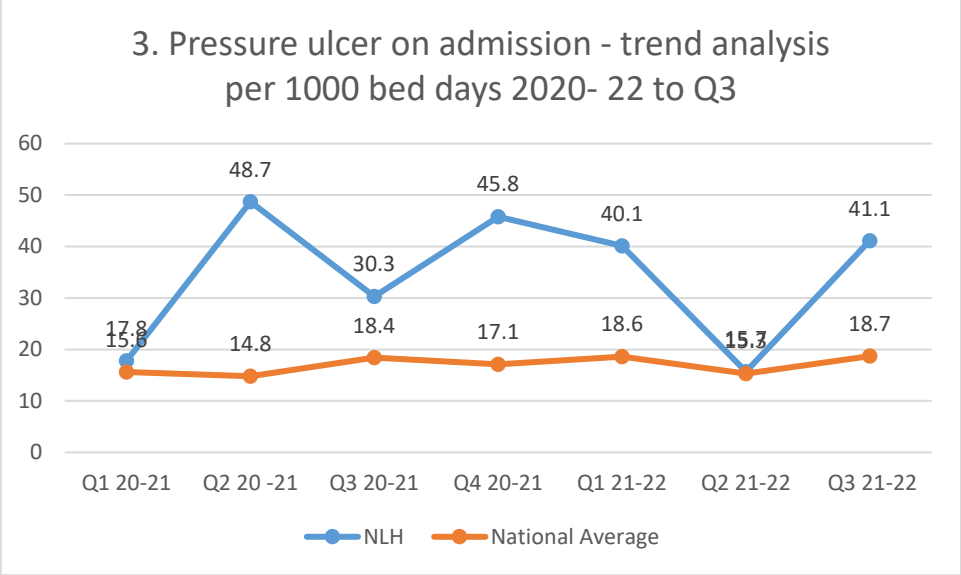
RCAs (Root Cause Analysis) are undertaken for hospice acquired Stage 3, 4, ungradable and deep tissue injury pressure ulcers. They demonstrate care undertaken with thought given to maintaining patient comfort, and in accordance with their wishes.

Our areas of focus have been on RCAs – this has mainly been for DTIs (Deep Tissue Injuries), and mainly developed during the last week of life, and therefore their development has been consistent with organ failure at end of life. However, going forwards we want to conduct a quality improvement project to look in more detail at the other hospice acquired pressure ulcers and not just high grade to see if there is anything different that should be done in practice.

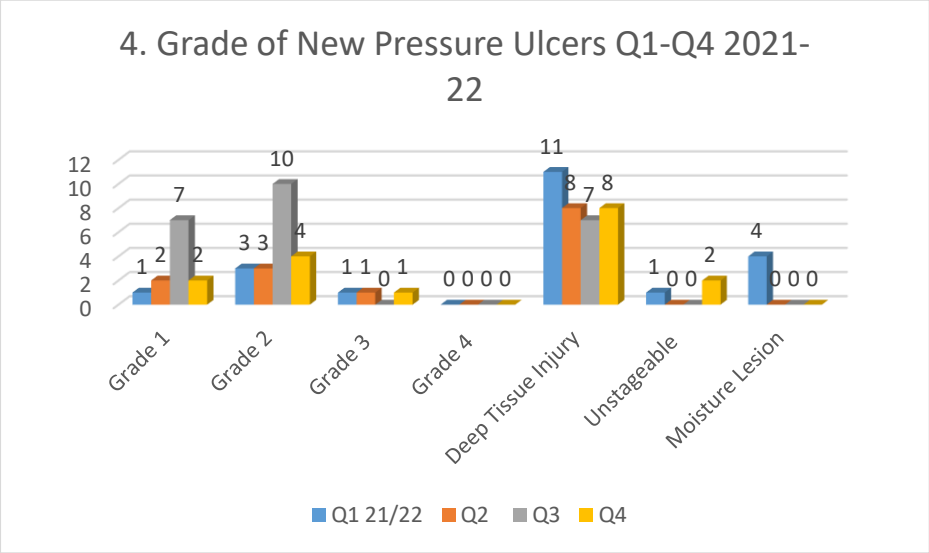
Graph 2 below shows trends in new pressure ulcers reported over the last 2 years per 1,000 bed days compared to the national average. It demonstrates a decreasing trend of new pressure ulcers over the last two years.



Graph 3 below shows trends in pressure ulcers present on admission reported over the last 2 years per 1,000 bed days compared to the national average. It demonstrates similar trends to last year possibly due to the impact of the Covid-19 pandemic on frailer patients staying at home for longer.



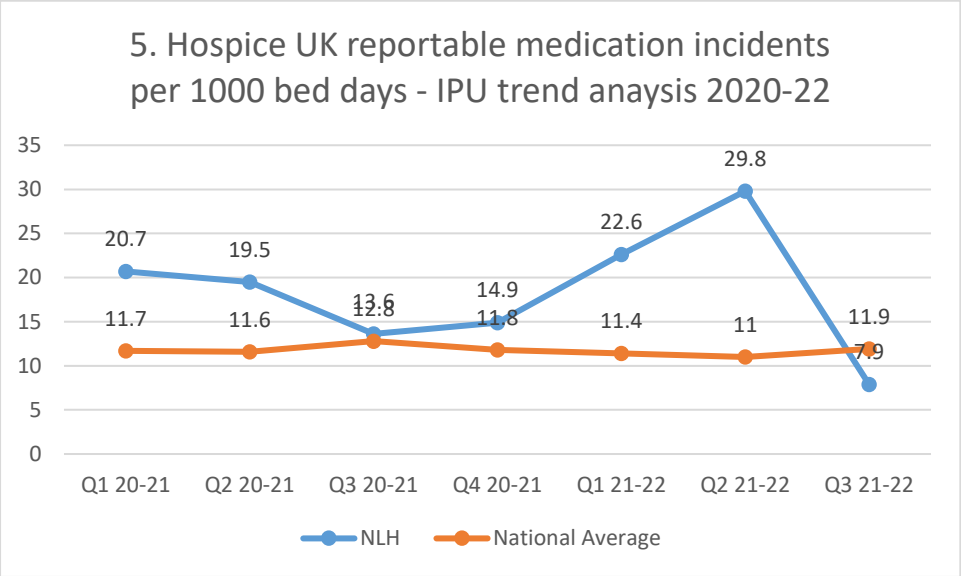
Graph 4 below shows the grading of all new pressure ulcers over the year. Moisture lesions, grade 1, grade 2, grade 3, grade 4 and unstageable pressure ulcers remain at low levels. Deep Tissue injuries were found in patients who were mostly in the dying phases (last week of life).



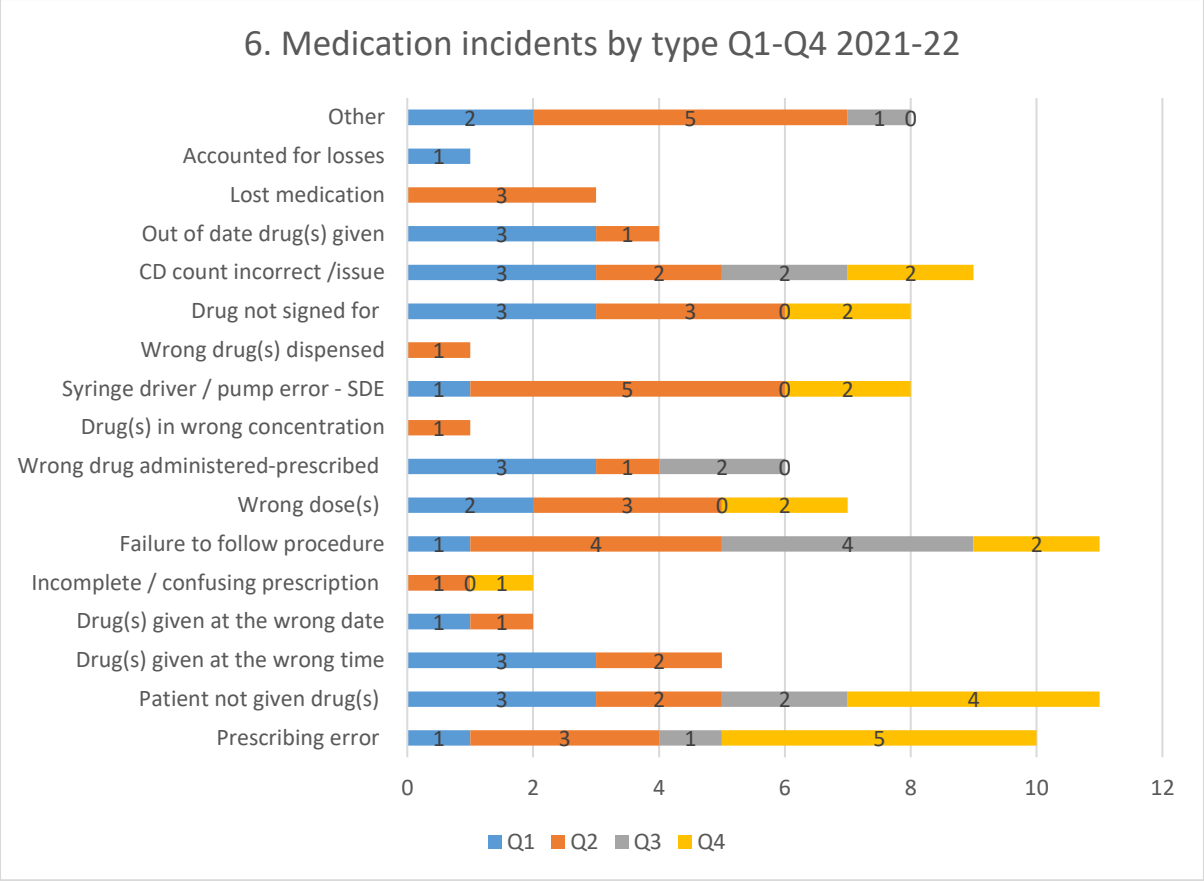
Medication incidents

Last year we reported 67 medication incidents in IPU compared to 94 this year. In the Hospice UK clinical benchmarking graph 5 you can see that our medication incidents in Q1 were 22.6 per 1000 bed days compared to a national average of 11.4. However, in Q3 these had reduced significantly to 11.9 per 1000 bed days and overall, for the year a lower trend has been seen in Q3-Q4.

This year we completed our Quality Improvement Project on the development of a new drug chart and have implemented new patient identification wrist bands on IPU to improve safer working practices.



We separate medication incidents from those that were not patient-related (pharmacy dispensing issue etc.) and those that directly affected a patient. Graph 6 below shows a comparison of the types of incidents over the year. No patient harm occurred as a result of medication incidents. We have improved the way in which we categorise our medication incidents in the last two quarters. Some of our incidents are not attributable to NLH and involve external health care professionals, there were 5 of these reported by our community services.



Patient Falls

There was a significant decrease in trends in the number of patient falls overall this year. Last year 37 falls were reported on IPU compared to 24 this year. Of the 24 patient falls, 70% resulted in no harm, 30% resulted in low harm. All falls are reviewed and monitored for trends and themes via a falls dashboard developed by Hospice UK.

National benchmarking with other hospices (this covers In-Patient Unit incidents only)

Patient safety is a key domain of quality in hospice care. Quality indicators are useful to demonstrate safe and harm-free care. The Hospice UK Clinical Benchmarking toolkit focuses on three core patient safety metrics relating to patient activity:

- Falls
- Pressure ulcers
- Medication incidents

Newly acquired Pressure ulcers IPU Only

	2020-21	2021-22
Number of pressure ulcers	56	75
Pressure ulcers per 1,000 occupied bed days	10.6	
Hospice UK Benchmarking Pressure Ulcers per 1,000 occupied bed days (for hospices of the size of NLH)	8.7	

Falls IPU Only

	2020-21	2021-22
Number of patient related slips, trips and falls	37	24
Falls per 1,000 occupied bed days	9.6	
Hospice UK Benchmarking Falls per 1000 occupied bed days (for Hospices of the size of NLH)	11.7	

Medicine Incidents IPU Only

	2020-21	2021-22
Number of medicine incidents	67	83
Medicine incidents per 1000 occupied bed days	17.3	
Hospice UK Benchmarking Medicine incidents per 1,000 occupied bed days	11.9	

Duty of candour

NHS England requires providers to indicate how they are implementing duty of candour. The duty relates to the culture as well as the practice of being open and transparent with service users and relevant stakeholders, regarding care and treatment. In the case of any serious clinical incidents reported then it will

be subject to duty of candour. There were no duty of candour incidents reported during 2021-22.

Infection Prevention and Control

QUALITY AND PERFORMANCE INDICATOR(S)	NUMBER 2020-21	NUMBER 2021-22
Patients who contracted Clostridium Difficile, Pseudomonas, Salmonella, ESBL or Klebsiella pneumonia whilst on the IPU (NLH target 0)	0	0

There were no hospice attributable MRSA, C-difficile, or Norovirus cases in 2021-22. To ensure compliance and regular review, internal audits are undertaken for infection control compliance.

Covid-19 pandemic

In response to the Covid-19 pandemic the organisation has implemented all guidance related to the care and management of suspected and confirmed cases of Covid-19.

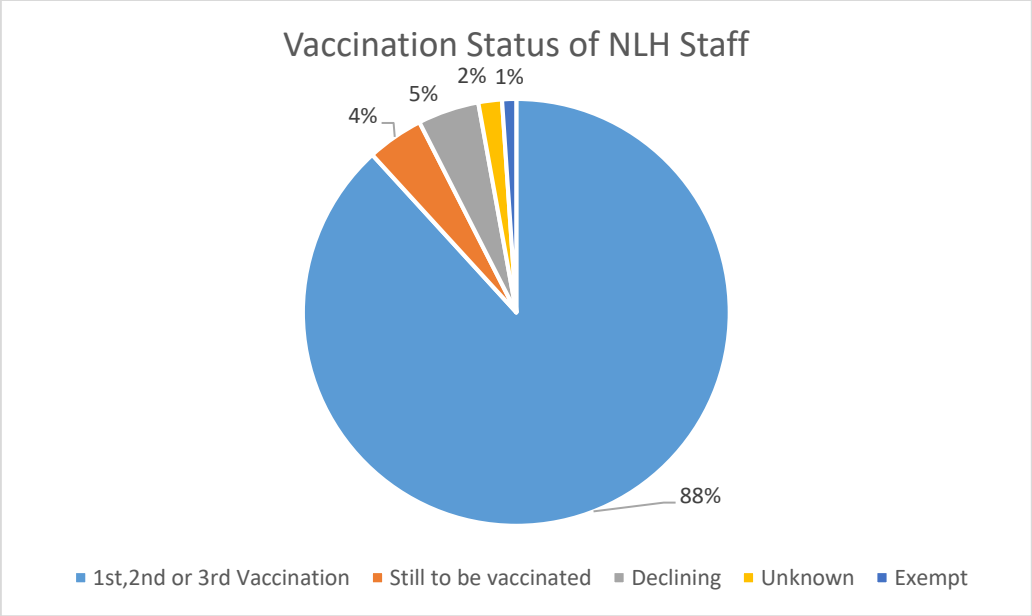
NLH PEOPLE

NLH PEOPLE

NLH employs a total of 215 (173.99 WTE) permanent staff and 43 bank staff. It benefits from the efforts 592 volunteers who are used as required in clinical and non-clinical roles. The hospice has many staff working part-time or flexible hours. In addition, we have a further 13 medical staff that make up our workforce and are employed by our local NHS employers.

	2020 -21	2021 -22
Staff joined	39	41
Staff left	62	52

All hospice staff have been offered a vaccination. Medicus Health Partners provided vaccinations to the majority of the hospice's patient-facing staff ahead of the hospice being able to access the North Central London vaccination programme. Volunteers working on our In-Patient Unit have also been offered a vaccination.



Staff Survey

NLH use the Hospice UK-sponsored staff survey where some questions relate to the indicators above. Below are a few of the questions asked and responses:

The following is a summary of feedback received from the staff and volunteer engagement survey in November 2021. Overall, there was a very positive response to the survey with a staff response rate of 71% with overwhelmingly high scores across a number of questions as follows including:

- Enjoying the work they do and the people they work with
- Being proud to work for the organisation
- If a friend or relative needed treatment they would be happy with the standard of care provided.
- Believing in the aims of the charity

There are some clear areas of improvement from the previous year as follows:

- Feeling supported in developing their careers
- The charity making the best use of their abilities
- The charities processes and procedures helping them to do their job more effectively
- Being happy with the personal development at the Hospice

However, there are some areas where there is room for improvement, specifically and we have agreed a number of actions to take these forward and these are:

- Diving deeper through follow up surveys around communication and wellbeing
    - Further promotion of our wellbeing resources and the EAP service
    - Communication strategy roll out
    - Spotlight on the environment and green issues
    - Career development for staff overall and time given to undertake mandatory training

Bullying at Work

There was a more positive response to the question in the last year I have not experienced bullying at work with 83% stating they agree or strongly agree and 79% of staff in the Hospice benchmark.

Overall, NLH figures are in line with the hospice sector.

In the last year we have developed a new people strategy in line with our new strategic plan and have continued to deliver elements of our people strategy, this has included:

- Developing Values and the behaviours that underpin these with staff and volunteers. Integrating these values into our people practices through one-to-one meetings and appraisal
- Recruitment to an Equality, Diversity, and Inclusion Project lead to take forward our EDI strategy initially concentrating on ensuring we have data on our staff, volunteers and patients but also developing engagement across the Hospice on EDI
- Ongoing promotion of our 'Freedom to Speak Up' Guardians.
- The second cohort of managers have successfully completed the management development programme
- Delivery of HR management training
- Introducing a new e- learning system for both mandatory training as well as more general courses
- Integrating wellbeing into our appraisal process and promoting our team of 'mental health supporters', Employee assistance programme and clinical supervisor
- Regular staff forum meetings and the establishment of a new Volunteer forum.

NLH BOARD OF TRUSTEES QUALITY ACCOUNT COMMENT

NLH board of trustees Quality Account comments

I am proud to be part of a diverse and skilled board which are focused on providing outstanding governance to North London hospice particularly during a period of recovery and resilience building from the Covid-19 pandemic. As trustees, it is our role to ensure robust performance monitoring and to champion on behalf of all patients and families who use the service. We advise and support across all sectors of the organisation, including clinical and fundraising.

The introduction of a five year clinical strategy in 2021 has demonstrated to me the clear vision of the Chief Executive and clinical leadership ream and, in addition, the commitment of the hospice staff and board of trustees to develop and improve the services and reach of the hospice.

This year's quality account provides an insight into some of the areas where service improvements have been achieved, improving patient safety, clinical effectiveness, and the patient experience. Our organisation seeks to be transparent in its work and I have seen evidence of this in the last year in its management incidents and complaints and more improved reporting and feedback to the Clinical Governance and Assurance Committee. By learning from all we do, we aim to provide a clear vision for excellent care for our communities.

I am delighted that NLH has striven in the past year to develop its research capabilities and has been involved in both national projects and local studies the results of which have been presented at national and international conferences.

It has been a privilege to support the truly dedicated Chief Executive and his leadership team to meet the challenges of this past year and to see the resilience and innovation employed during the Covid-19 pandemic.

The response from North London Hospice post Covid-19 pandemic continues to be determined and proportionate and follows these principles:

- Patients, their families, our staff, and volunteer safety is paramount.
- Maintain services where we can –change the models if necessary.
- Look at novel approaches to support the community.
- Maintain our reputation in the community.
- Be here after the outbreak and to be financially robust.

North London Hospice is ever-evolving, as is best shown by our commitment for continuous improvement and the Priorities for Improvement identified for 2022/23.

Cate Woodwark

Chair- Clinical Governance and Assurance Committee

North London Hospice trustee

PART 4: STATEMENTS FROM COMMISSIONERS, HEALTHWATCH, HEALTH OVERVIEW AND SCRUTINY COMMITTEES

APPENDIX ONE: NLH CLINICAL SERVICES

Community Specialist Palliative Care Teams (CSPCT)

They are a team of Clinical Nurse Specialists (CNSs), Associate CNSs (ACNS), Health Care Assistants (HCA), Doctors, Paramedic, Physiotherapists, Occupational Therapists and Social Workers who work in the community to provide expert specialist advice and support to patients (including friends and family network) and health care professionals. They cover the boroughs of Barnet, Enfield and Haringey. They work closely with, and complement, the local Statutory Health and Social Care services such as General Practitioners (GPs), District Nurses (DN), Social Services, hospital teams and other health and social care professionals. The service operates Monday – Friday 08.00 – 17.00.

The service emphasis is based on: -

- Care closer to home - promoting and supporting people in their preferred place of care and preferred place of death
- Facilitation of timely high-quality palliative/ end-of-life care. This is achieved by:

* Carrying out a holistic needs assessment and developing individualised care plans
* Specialist advice to patients and health care professionals on symptom management
* Specialist advice and support on the physical, psychological, emotional and financial needs of the patients and their carers
* Communication and coordination of services including completion of urgent care records for patients which is a shared electronic patient care plan that can be accessed by other professionals such as London Ambulance Service (LAS), GPs and DNs. The care plan includes the patient's wishes and preferences and their resuscitation status supporting them in their preferred place of care.

The service operates between 08.00 – 17.00 on Saturdays and Sundays with a reduced team of CNSs, ACNS and HCA.

Overnight CNS Service / Out-of-hours telephone advice service

Community patients are given the out-of-hours number for telephone advice out of office hours. Local professionals can also access this service out of hours for palliative care advice as needed. Calls are dealt with by a clinical nurse specialist 7 days a week between 17.00 – 08.00. If indicated, the CNS and HCA can visit patients (currently visiting is not available between 17.00-20.00).

Health & Wellbeing Service

The Health & Wellbeing Service comprises a multi-professional team whose underlying aims are to provide early interventions for those with a palliative diagnosis that may be treatable but not curable. To enable individuals to manage their symptoms and be in control of their condition, to gain information to help make the decisions they need to make, to function independently and to live as well as is possible, working towards achieving what matters most to them.

The service offers a range of interventions on an individual and group basis as well as opportunities for social interaction and peer support to both the patient and the carer. However, most of these activities have moved to online due to the impact of the Covid-19 pandemic. The services are available from the time of diagnosis, and we work closely with the other teams in the hospice.

The multi-professional team includes a Palliative Care Consultant, specialist nurses, physiotherapy, occupational therapy, complementary therapy, psychological therapies, spiritual care and social work.

In-Patient Unit (IPU)

NLH In-Patient Unit has 18 single en-suite rooms offering specialist 24-hour care. Patients can be admitted for various reasons such as for symptom control and those experiencing complex psycho-social issues or for end-of-life care. As the unit is a specialist palliative care facility, it is unable to provide long-term care.

Bereavement Service

The bereavement service provides telephone, individual and group support, including regular walk and talk groups in local open space with the support of paid staff and trained bereavement volunteers.

First Contact Service

First contact comprises a team of specialist nurses and administrators and is the first point of access for all referrals to NLH and for all telephone enquiries from patients, families and healthcare professionals.

First contact works in partnership with other hospice services, other primary and secondary care teams and other health and social care providers.

The team provides specialist palliative care advice to referrers and patients. It acts as a signposting service for patients in the last year of life.

APPENDIX TWO: GROUPS THAT OVERSEE AND REVIEW QUALITY WITHIN NLH

Board of Trustees

The board is accountable and responsible for ensuring NLH has an effective programme for managing risks of all types and ensuring quality. To verify that risks are being managed appropriately and that the organisation can deliver its objectives, the board will receive assurance from the clinical governance and assurance committed for clinical and non-clinical risks. It reviews NLH's board risk assurance report.

Executive team (ET)

ET reviews and monitors the minutes of all quality meetings, risk assurance frameworks and clinical and non-clinical risk. Provides comprehensive reports on the organisations key performance indicators for the board and is responsible for the implementation and delivery of the organisations strategy.

Clinical Governance and Assurance Committee (CGA)

Clinical Governance and Assurance Committee (CGA) is a subcommittee of the board and provides assurance that an effective system of control for all risks and monitoring of quality is maintained.

It reviews NLH's clinical key performance indicators and ensures action plans are delivered as indicated. The committee also reviews the results of audit work completed on the hospice's audit steering group and the policy review and development work completed in the policy and procedure group.

Quality and risk group (Q&R)

Q&R reports to the CGA with overarching responsibility for ensuring that risk is identified and properly managed. It will advise on controls for high level risks and to develop the concept of residual risk and ensure that all services take an active role in risk management, including the active development of risk registers.

Q&R is also responsible together with CGA to ensure that the treatment and care provided by the hospice's clinical services is subject to systematic, comprehensive and regular quality monitoring.

Audit steering group (ASG)

ASG is responsible for providing assurance of all audit activity/ quality improvement work through reports to Q&R and CGA. ASG presents its audit plan and audit reports and recommendations to Q&R for approval and monitoring. The audit plan is ratified by CGA on an annual basis. ASG will also ensure that any risks identified during an audit process will be added to the appropriate service risk register.

Policy and procedure group (PPG)

The PPG group ensures the review of all NLH policies and procedures. It reports to the Q&R and CGA.

Health and safety group

The health and safety group ensures the review and monitor of all aspects of health and safety that affect the organisation. It reports to the Executive Team and CGA.

Information Governance Steering Group

The information governance steering group supports and drives the broader information governance agenda and provides the board and executive team with the assurance that information governance best practice mechanisms are in place within the hospice.

APPENDIX THREE: MANDATORY STATEMENTS

The North London Hospice Quality Account is required to include the following mandatory statements despite not being applicable to the work we do.

Participation in clinical audits and research

During 202-22, there were 0 national clinical audits and 0 national confidential enquiries covering NHS services that NLH provides. During that period NLH did not participate in any national clinical audits or 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 NLH was eligible to participate in during 2021-22 are as follows (nil). The national clinical audits and national confidential enquiries that NLH participated in, and for which data collection was completed for 2021-22, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (nil). The reports of 0 national clinical audits are reviewed by the provider in 2021-22 and NLH intends to take the following actions to improve the quality of healthcare provided (nil).

The number of patients receiving NHS services, provided or sub-contracted by NLH in 2021-22, that were recruited during that period to participate in research approved by a research ethics committee was nil.

There were no appropriate, national, ethically approved research studies in palliative care in which NLH was contracted to participate.

Quality improvement and innovation goals agreed with our commissioners

NLH income in 2021-22 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.

Care Quality Commission

NLH is required to register with the Care Quality Commission and its current registration status is unconditional. NLH has the following conditions on its

registration (none). The Care Quality Commission has not taken any enforcement action against North London Hospice during 2021-22 as of 31 March 2022.

NLH has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

DATA QUALITY

NLH did not submit records during 2021-22 to the secondary uses service for inclusion in the hospice episode statistics which are included in the latest published data as it is not applicable to independent hospices.

ACCESSING FURTHER COPIES

Copies of this Quality Account may be downloaded from www.northlondonhospice.org

HOW TO PROVIDE FEEDBACK ON THE ACCOUNT

North London Hospice welcomes feedback, good or bad, on this Quality Account. If you have comments, contact:

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