Improving quality

Improving care

Improving outcomes

Royal Free London NHS Foundation Trust

Quality report 2019/20

Quality report 2019/20

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Part One: Statement on quality from the chief executive

We are delighted to publish our quality account for 2020-2021. The Royal Free London seeks continuously to improve the care we offer patients and results for patients, while also using the resources we receive from the taxpayer and our charitable supporters ever-better.

Our trust staff have responded amazingly to the growing pressures of recent everts around the COVID 19 pandemic. Everyone has kept calm and carried on and I've heard about many lovely acts of kindness towards colleagues and strangers.

For most of us, this is the single largest event that we will face in our lifetimes. It's the biggest challenge that the NHS has ever faced. Our job is to keep the show on the road, and to think both about today, next week and next month. We've got to start imagining what the hospitals and health system will look like as patient numbers increase and we've got to imagine radically different and unfamiliar models of treatment.

There is no escaping that fact, but if we do things together now, things will be better and I am encourage all teams to think about the future as well as the present, and also to remember that this will pass and that we will return to a more stable time, when some of the changes we make now might actually give us a better service.

The three priority areas around which our account is structured span patient safety, effectiveness and patient experience. In the quality account which follows, we present our progress against the quality priorities for 2019-2020 agreed last year in consultation with patients, staff and external stakeholders as well as our priorities for the coming year 2020-21.

The purpose of the quality account is to assure the population we serve, our patients, families, and carers, commissioners and other stakeholders that we provide high quality services. While we strive continuously to improve in all areas, we recognise there are areas and times we don't get things right, and we put particular emphasis on improvement where we fall short. The five overarching quality themes into which these three areas dovetail, which cut across all our specialties and services at the Royal Fee are to:

- *Improve patient experience and to streamline pathways by co-designing and co-producing care with patients and families*: Our work in this theme has been far reaching and wide-ranging. Taking dementia care as a priority example: We have refurbished several wards to be "dementia friendly" and introduced the NHS's first performance theatre space in a hospital. Last year saw a range of creative arts therapies for patients and families, including drawing and music, plus a new "Sundowner" hour on hospital radio, playing classic tunes at dusk when patients living with dementia often become more agitated. Other initiatives, improving both patient experience, flow and efficiency have included strong participation in the "Keep me Mobile" and #EndPJparalysis campaigns. We are adopting co-production and co-design more broadly as an approach and are working on this with the Point of Care Foundation, a charity which exists to help organisations listen and be responsive to patients' perspectives. During the past year we have trained over 40 staff as peer-trainers in co-production techniques across all our divisions and major hospital sites. Finally, we have adopted the simple and beautifully effective technique of asking ("What Matters to You", not only on the international

day promoting and celebrating this, but year-round with the aim of personalising patient care, and attending to their concerns

- *Using information and digitisation to drive improvements in care and reduce unwarranted variation in the care patients receive*: Over the past year we have digitised 13 pathways and, linked to care redesign and application of quality improvement methods through our Clinical Practice Groups (CPG) work, driven substantial improvements in access, safety and effectiveness, often also reducing admissions and length of stay in the process

- *Improve patients' access to our services*: Using the techniques of redesign, improvement and digitisation, with co-design/co-production, we have made substantial improvements in access in numerous areas of care, for example in several cancers and in urgent and emergency care. But too many of our patients still wait too long to be seen, especially in the Emergency Department, and we continue to focus squarely on this

- *Invest in our people* so that our 10,500 staff are all able to bring the best of themselves to work every day. The last year has seen redoubled activity across multiple staff networks including our BME and LGBT+ networks, and new occupational health and education initiatives, for example the launch of a trust-wide collaboration across 15 teams using quality improvement methodology to improve staff Joy in Work. This is grounded in the "What Matters" methodology: starting by supporting staff to ask and answer this as a team. This collaboration is ongoing and is already showing significant improvements not just in staff experience, but also in reduced sickness and staff turnover as well as direct benefit to patients, such as improved access. We are continuing to skill-up our people in our method of quality improvement and to support them to apply these skills to our biggest priorities. Working in partnership with the Institute for Healthcare Improvement (IHI) we have trained over 1,100 of our staff in our method of QI, were delighted that IHI's CEO, Derek Feeley delivered the trust and Royal Free Association's annual Marsden Lecture in October 2019, on the topic of innovating for better care

- *Improving safety – reducing harm to zero*: We remain one of the hospitals with the lowest mortality in the NHS and the only safety goal we believe we can set is zero avoidable harm. While we are not yet at our goal, we have made significant progress across several dimensions of patient safety, including a reduction to 4 "never events" in the year past versus 13 in the previous year. We are also using safety tools and methods to focus on and spread excellent practice, example using Datix reporting to highlight and celebrate excellent practice: "Greatix".

The progress recorded in this quality account is often particularly striking when these five overarching themes have come together in specific patient pathways to drive step-changes in results – one example being in dermatology where a new approach involving initial assessment of a potential skin cancer using a high-quality photograph (rather than all patients going to a traditional outpatients). It is through improvements like these – led by our staff in partnership with our patients that we aim to play our part in achieving the ambitions of the NHS Long-Term Plan, which sets the goal of reducing outpatient appointments by a third over coming years.

The past year has been particularly notable in digital. Our upgraded electronic patient record went live at four hospital sites, and its successful deployment represented extraordinary efforts from staff to transition (essentially overnight) from paper-based to electronic ways of working. The new system ends mountains of patient notes (and hunting for notes), documents clinical details including patients' vital signs into the care record, and ensures scans and other test results are readily and reliably available when needed. Chase Farm Hospital was officially opened in May 2019 nearly paperless, and quickly obtained HIMSS Level 6 certification, the highest level of digital maturity of any NHS hospital. This accreditation reflects our clear goals and processes on patient safety, reducing errors and patient workflow. The digital nurse call system developed at Chase Farm and patient 'wayfinding' systems were both nominated for national awards. And the "Streams" app, now supporting care is

now live on our clinicians' phones. Streams detects Acute Kidney Injury, a common and potentially fatal condition, in seconds by comparing sequential blood tests and flagging the alert in real time to the right clinician. Too often going undetected or untreated in health systems around the world, AKI accounts for over £1b of NHS cost and contributes to around 100,000 deaths in UK per year. Streams helps our clinical teams detect and intervene at the earliest opportunity, saving lives, saving time in hospital and saving the NHS money. I was delighted to see this work acknowledged with the team being deserving winners of the annual Health Service Journal Patient Safety award. Beyond our hospitals we continue to work on sharing information to support better care and on population health across North Central London.

The Quality Account also presents the priorities we have agreed in consultation for the coming year, 2020-2021. We have made multi-year commitments in digital, CPGs and QI, reflecting the complexity and importance these have to results for our patients, population and staff. To reach our aspirations will take several years. Reflecting this, our goals and priorities for the coming year are mostly further and ambitious steps on the same themes as last year. Some goals however are newly-framed to long-standing priority areas: for example, our goals in patient safety reflect a new national patient safety strategy focusing on learning and human factors, which we are pleased to support.

In May 2019 we received the result of our CQC inspection. We were rated Requires Improvement overall. While it is disappointing to move from Good to Requires Improvement, we were pleased that the inspectors highlighted how proud staff were to work for the Royal Free, their dedication to patients, their teamwork, kindness and commitment to improvement. We have focused squarely on addressing the specific issues (mainly in the areas of safe and responsive) which the CQC highlighted. We see these efforts, linked to the themes above, as providing a springboard to an Outstanding CQC rating for the Royal Free London. We are looking forward to welcoming the CQC team back to the trust in August 2020.

Our quality account tells the story of our journey of improvement in results for the population and patients we serve, and for our staff whose unstinting efforts achieve those results.

The evidence provided here demonstrates our focus and progress on the enduring themes which matter most to our patients, population and staff, and how we how we are applying the Royal Free London's world class expertise to meet the needs of those we serve. I believe our 2020-21 priorities reflect a clear focus on what will make the most difference in year ahead, and look forward to reporting progress against our goals.

I confirm to the best of my knowledge the information provided in this document is accurate.

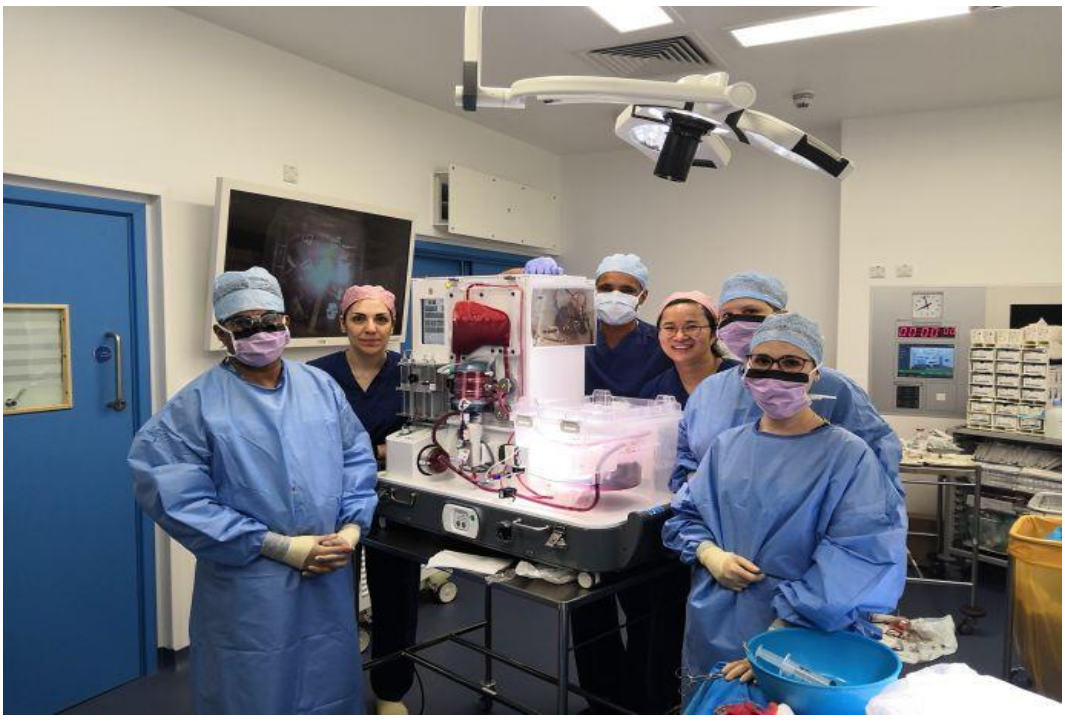
1.2 Highlights of key achievements

A double liver transplant was a success at the Royal Free Hospital thanks to quick-thinking transplant team, new technology and collaboration with a Birmingham NHS trust.

Two successful liver transplants took place at the Royal Free Hospital following a life-saving device and liver being ‘blue-lighted’ by ambulance in a 90-minute rush from Birmingham to London.

The OrganOx machine has been used regularly for facilitating liver transplants at the Royal Free Hospital since April 2019. Simulating the conditions of the body, it keeps the liver alive and active; allowing doctors to more effectively assess whether the transplantation is suitable. OrganOx allows the liver to be kept for an additional 24 hours outside the human body but only one liver can be attached to it at any one time.

The Royal Free Hospital was the first trust in London to use the device and allows doctors to assess how well the donated liver functions and therefore whether it is safe for transplantation.



Professor Joerg-Matthias Pollock, Royal Free Hospital clinical lead for the liver transplant service and consultant liver transplant surgeon, established an ingenious solution. He spoke to Mr Thamara Perera, a surgeon based at the University Hospitals Birmingham NHS Foundation trust, who agreed to loan their OrganOx machine to the Royal Free Hospital. Both liver and machine arrived safely via ambulance within 90 minutes.

As well as being able to test the liver after it had been put on the machine by consultant surgeon Mr Satheesh Iype, the use of the second device also meant that Professor Pollok was also able to rest for a few hours before conducting the second surgery with a fresh anaesthetic team.

Professor Pollok, who assisted his consultant surgeon colleague Mr David Nasralla in the first transplant and carried out the second transplant, said: “I’d like to thank our multi-disciplinary team that worked so hard to enable these two transplants to take place and for the support of our NHS colleagues in Birmingham.

“These transplants really show the power of partnerships and the collaborative spirit of the NHS. If we hadn’t been able to borrow the OrganOx we would have been unable to accept the second liver which would have meant our patient missing out.

Ground-breaking app developed in collaboration with Royal Free London clinicians, providing rapid alert when patients are at risk of acute kidney injury (AKI) goes live at Barnet Hospital.

The Streams app, a secure alerting tool has cut the diagnosis of acute kidney injury at the Royal Free London from hours to minutes. The app was developed by technology experts at Google Health in collaboration with clinicians at the Royal Free London. Streams uses a range of patient data to detect which patients are at risk of AKI and it sends an alert to a clinician, who can then provide appropriate care

Up to 60 doctors and nurses at Barnet Hospital can no receive alerts on their mobile devices when patients are at risk, resulting in treatment being delivered rapidly, improving outcomes for patients and potentially saving lives.

The patient and risk and resuscitation team (PARRT) won a national patient safety award for developing the pioneering kidney care app.

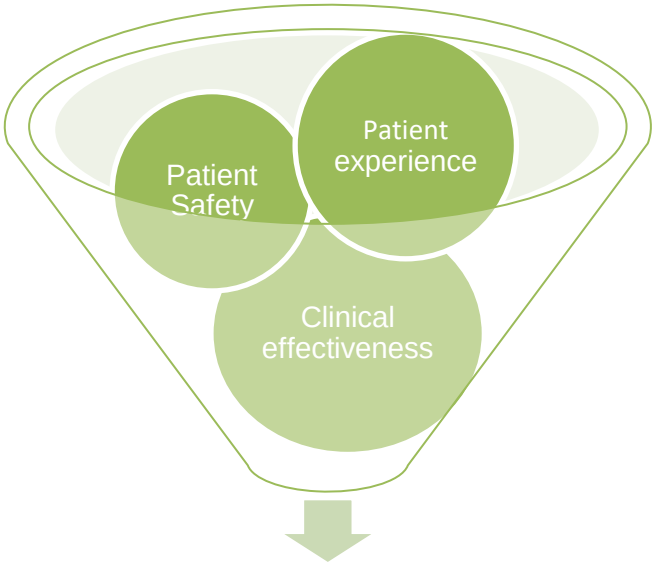
Dr Jenny Cross, consultant nephrologist and the clinical lead for the project, said she was absolutely delighted that the team had won. She said: *"I'm so proud of this clinical team - this award is a testament to their hard work and innovation. We have worked alongside DeepMind Health to develop this app, which allows both doctors and nurses to do our jobs faster and more effectively for the benefit of patients."*

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

Every year all NHS hospitals are required to write a quality report for our stakeholders about the quality of their services. The quality report allows us to be more accountable and helps us to drive improvement in the quality of our services.

Within the quality report we review our performance over the previous year, identify areas for improvement and publish that information. Areas include: patient experience, patient safety and clinical effectiveness

- **Patient safety** – how have we been keeping our patients safe from harm?
- **Clinical effectiveness** – what were the outcomes? how successful is the care provided?
- **Patient experience** - how was the experience for our patients using our services?



This section describes the following:

- Priorities for improvement: progress made against our priorities during 2019/20
- Outline on our quality priorities for improvement chosen for 2020/21
- Feedback on key quality measures as identified within the mandatory statements of assurance from the board.

2.1 Priorities for improvement

What were our quality priorities for 2019/20?

Improving Patient Experience: **delivering excellent experiences**	To further enhance and support dementia care
	To improve our involvement with our patients and carers
Improving Clinical Effectiveness: **delivering excellent outcomes**	To build capability in the workforce
	To develop a superior change-management capability; putting clinicians in charge of their clinical pathway
Improving Patient Safety: **delivering safe care**	To improve safer surgery
	To improve our learning from deaths
	To improve infection prevention and control

Improving Patient Experience: delivering excellent experiences

Priority 1: To further enhance and support dementia care

Hospital can be the worst place for a patient with dementia to be. We know this from the poor clinical outcomes they experience. On average, people with dementia stay in hospital longer, are more likely to die in hospital and are more likely to be discharged to residential or nursing care. In addition, they experience higher levels of confusion, distress, anxiety and are much more likely to lose mobility and functional ability during their stay in hospital.

Refurbishment work has established two dementia-friendly wards at the Royal Free Hospital, including two day rooms in which there is a programme of activities and arts events.

We have also focused on providing specialist training courses for colleagues aimed at understanding the communication, behaviour and needs of people with dementia. These range from a leadership course on the care certificate, to an interactive workshop with Chickenshed theatre.

Although there are areas of excellent practice, we acknowledge that the quality of care people with dementia receive varies between wards. Unnecessary clinical variation needs to be addressed and reduced in order to ensure that all patients have access to the same high quality level of care regardless of which ward they end up in.

We have convened a Dementia and Delirium Clinical Pathway Group, which has established 5 work streams which will address these challenges.

The five work streams are:

- Admission,
- Ward based care,
- Delirium,
- Distressed behaviour
- Risk-positive discharge

Improving Patient Experience: delivering excellent experiences

Priority 2: To improve our involvement with our patients and carers

What does involvement mean? The trust worked with a not-for-profit organisation called Point of Care Foundation to help staff to align with involvement as it means different things to different groups of staff, community organisations, carers and patients, particularly those with long term conditions and those that present with an acute care episode.

The trust held a training day for 29 members of staff across sites and professional disciplines, which included testimonies from patients. This helped to create a shared understanding of involvement, be clear about the goals of engagement and involvement in healthcare, and enabled staff to consider the evidence to inform policy and practice, share knowledge and experience about engagement, and reflect on the opportunities for collaborative learning with patients and carer.

Patients are now part of the Experience Committee on every site, and have an active involvement in the Clinical Pathway Groups. There is a real desire from staff and patients to work more collaboratively and the trust believe that rather than get everything right before starting, it is better to start the journey and revise or change things as we learn together.

Chase Farm Hospital has established a Patient's Council and based on work to date and best practice we will roll out Patient Councils across each site, pilot further patient involvement in interviews. A key piece of work is an approach for remuneration to patients for their collaboration and invaluable involvement.

Improving Clinical Effectiveness: delivering excellent outcomes

Priority 3: To build capability in the workforce

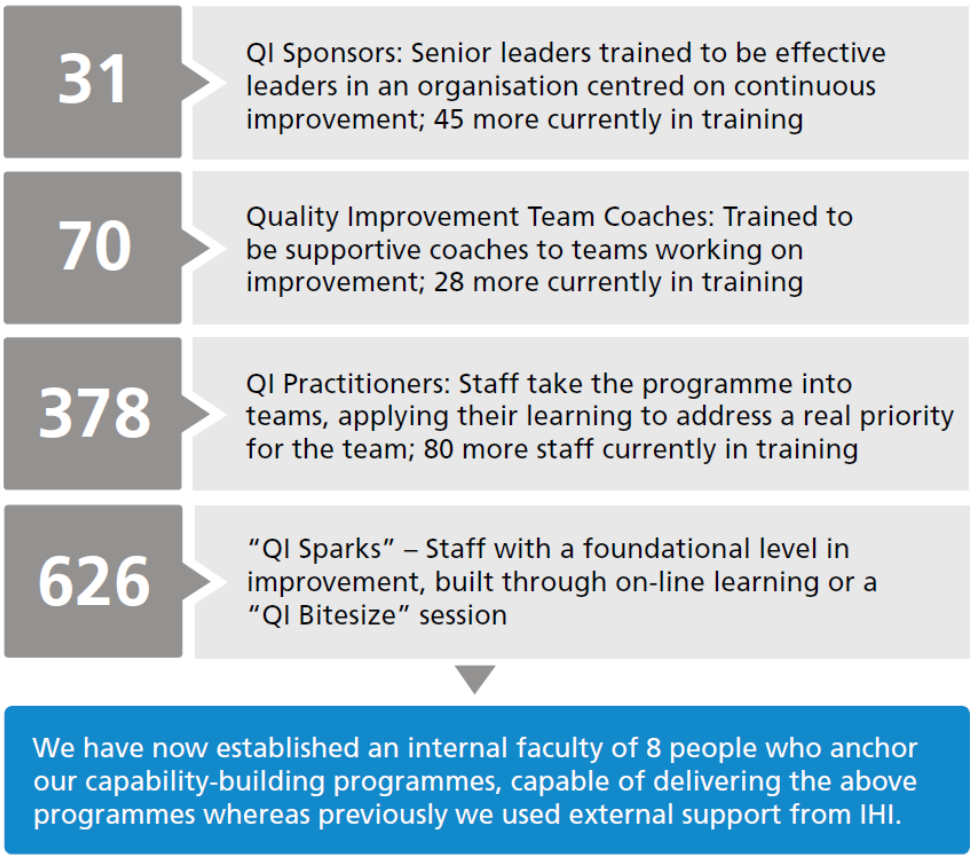
There were three key measures for success for building capacity in the workforce:

- Increase Joy in Work for teams participating in the collaborative by 50% above baseline measures by 31 May 2020

  Staff satisfaction and experience is tightly linked to staff retention, sickness/absence and patient experience & outcomes. The “Joy in Work” collaborative was launched in June 2019 and applies quality improvement (QI) learning and methods to help teams raise their own joy. 4 of the 15 teams are showing results of a 50% increase above baseline in the “good day” measure and early results also indicate positive impact on other metrics, including staff absence/sickness and improvements to patient experience, flow and efficiency. Over 95% of participants said the Joy in Work events represent a good day at work, and that learning from other teams is key to their success.

- Be sustainable in delivering core QI training programmes toward our goal that 20% of staff (2,000 staff) have received formal training in QI by end of 2020

  The trust is committed to applying continuous quality improvement to tackle our most pressing opportunities and challenges, and central to this is the up-skilling of staff in improvement methods and supporting them to use these skills in their daily work. We have trained over 10% of our staff in QI, as follows:



- Further incorporate QI into routine operations and processes across the trust, and further establish opportunities to share learning within and across our sites

  QI continues to be embedded into standard processes across RFL. Local quality committees and some Divisional Boards now include QI as regular item; monthly CEO briefings at our hospital sites include QI project examples as regular items, and QI projects are standing items at several Board and sector committees, including the trust Board, the Clinical Standards and Innovation Committee and the Clinical Quality Review Group).

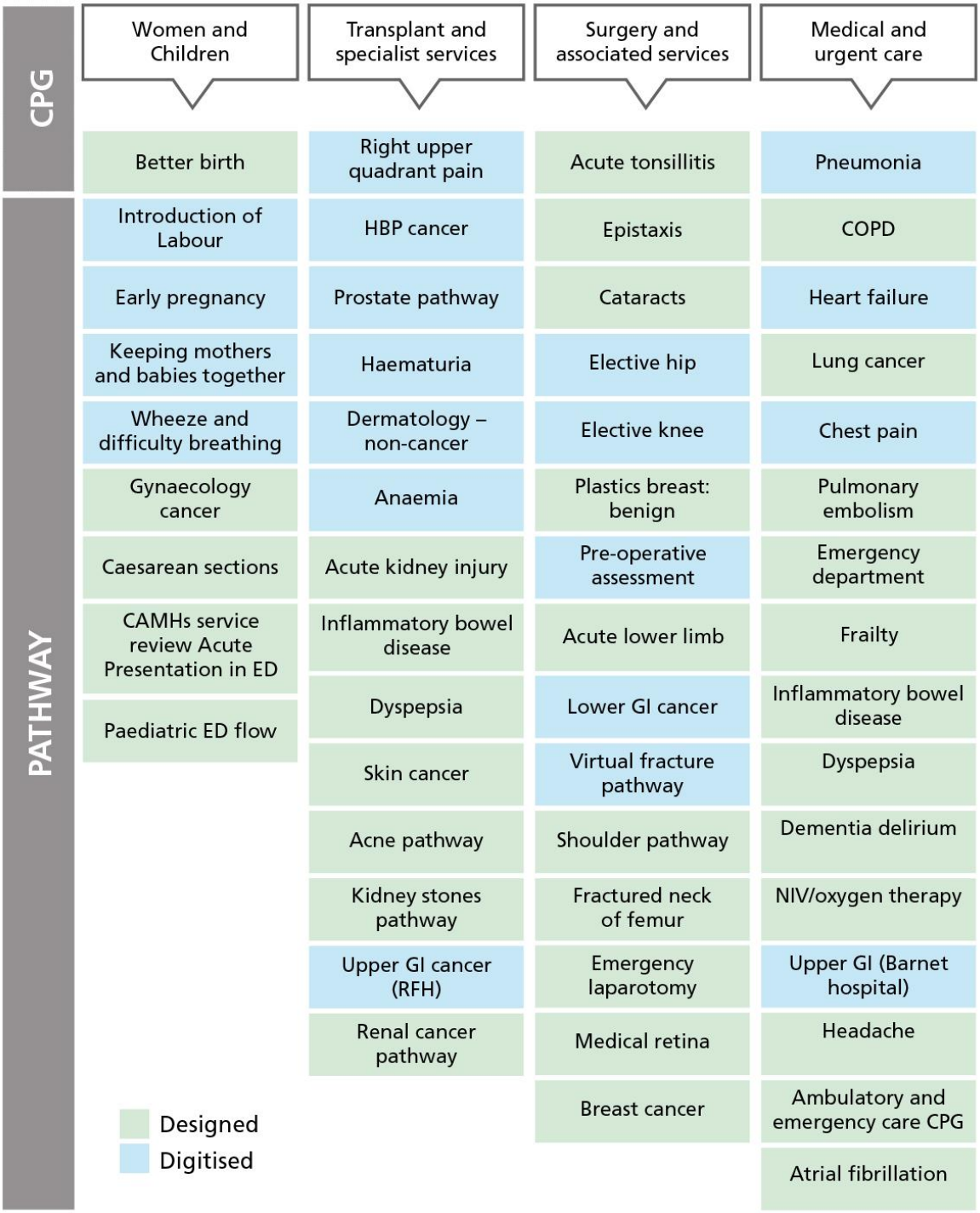
  In November 2019 we held hospital-based improvement celebration events, and we are planning an organisation-wide event for autumn 2020.

Priority 4: To develop a superior change-management capability; putting clinicians in charge of their clinical pathway

Our quality goal for this priority was to have 20 clinical pathways digitised across Clinical Pathway Groups, since variation in clinical practice and process are known to result in worse patient outcomes at higher system costs.

The trust worked with pathway teams to implement evidence based standardised clinical practice and processes as core operating standard across all sites to understand the degree of unwarranted variation in care pathways. We involved patients to help us understand how we can improve pathways for them and used a systematic methodology to improve the patient and administrative process.

This resulted in 20 fully digitised clinical pathways, and we have developed our electronic patient record system to embed local and national guidance to support clinical care.



Looking at data helps understand how well we are doing and what patients think about the care we provide. We found that involving patients to be one of the most important aspects in this process, as it is the simple things that make a big difference. We will continue to work with staff and patients to develop and improve clinical pathways across the trust.

Improving Patient Safety: delivering safe care

Priority 5: To improve safer surgery

The key measure for success for this patient safety priority was to achieve zero never events by the end of March 2020 and to increase by 75% the number of Local Safety Standards for Invasive Procedures (LocSSIPs) in place by the end of March 2020.

We have implemented and embedded a number of LocSSIPs into practice in 2019/20 and the monitoring of these important quality standards is now established within the trust's governance processes.

Unfortunately, there were 5 never events during 2019/20. These have been investigated as serious incidents to enable learning and we will continue with the annual monitoring of the Never Event patient safety alert risk assessments as part of our Safety Strategy for 2020 to 2025.

Improving Patient Safety: delivering safe care
Priority 6: To improve our Learning from Deaths

Our quality measure for 2019/20 was to increase the percentage of reviews of patient deaths recorded centrally by 10%, and to improve the sharing of the learning from serious incidents and patient deaths considered likely to be avoidable (as measured by staff survey) by 5%.

Initially we increased the number of cases included in the Learning from Deaths (LfD) review. However, this became unsustainable and did not provide us with any additional learning, although we continued to share learning via training, newsletters, events and blogs.

As part of our Safety Strategy for 2020 to 2025, Advance Care Planning was identified as an area for improvement across the trust. Therefore, we have re-focused the patient safety Clinical Pathway Group to support the ACP implementation and we will continue with the patient safety Clinical Pathway Group for Advance Care Planning.

We will be implementing the Medical Examiner process from April 2020 which will support the Learning from Deaths (LfD) process.

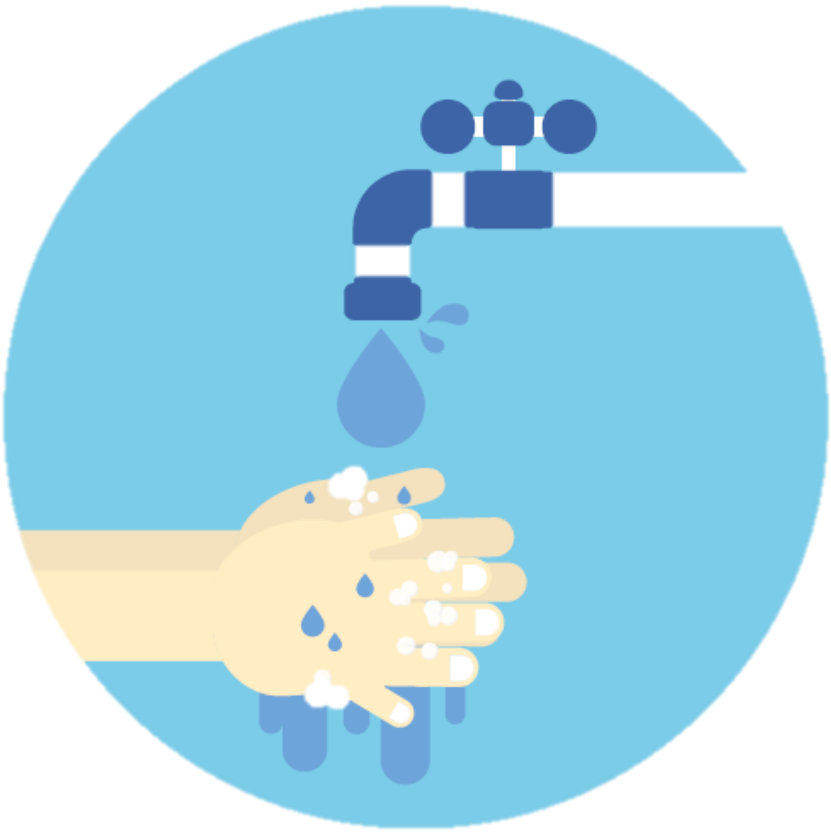
Improving Patient Safety: delivering safe care
Priority 7: To improve Infection Prevention and Control

The main quality challenge for Infection Prevention and Control (IPC) in 2019/20 was to achieve zero MRSA bacteraemia and zero lapse in care for Clostridium difficile (C.diff) patients.

A post infection review and a root cause analysis was undertaken for each case of MRSA bloodstream infection and C. diff infection case respectively and learning from these was fed back to Monthly Divisional Leads, the IPC meeting, Divisional Boards and the Group trust Board. There was implementation of supportive measures when two or more cases were identified on the ward at the same within a same period, and a series of enhanced IPC measures were put in place to support staff and to share learning and improvement.

Due to turnover of staff, on-going IPC education and training is known to be vital to ensure staff are receiving support in this area. The Deep Cleaning Programme and Antibiotic Stewardship (to ensure appropriate prescribing and use of antibiotics in line with trust policy) are both high profile priorities across the trust with full senior management engagement.

We aim to continue to carry out post infection reviews and root cause analyses and share learning and improvements with the rest of the IPC team, and to feedback on progress with our quality priorities to divisional, site and Group level committees.



Our Priorities for improvement (2020/21)

Looking forward to what our quality account priorities will be for the year ahead

The priorities chosen for 2020/21 remain within the quality domain and were drawn from our local intelligence, engagement with the Commissioning for Quality and Innovation (CQUIN), our performance and feedback following consultation with key stakeholders.

Progress in achieving the priorities will be monitored at our strategic committees and reported to the trust board as illustrated in Figure 1.

Additionally, reports will be sent to trust level infection prevention and control committee (Chaired by Director for Infection Prevention and Control (DIPC) and the site level clinical performance and patient safety committees which are chaired by the medical directors

Progress reports will be sent to the Dementia Implementation Group and updates to our commissioners via the Clinical Quality Review Group

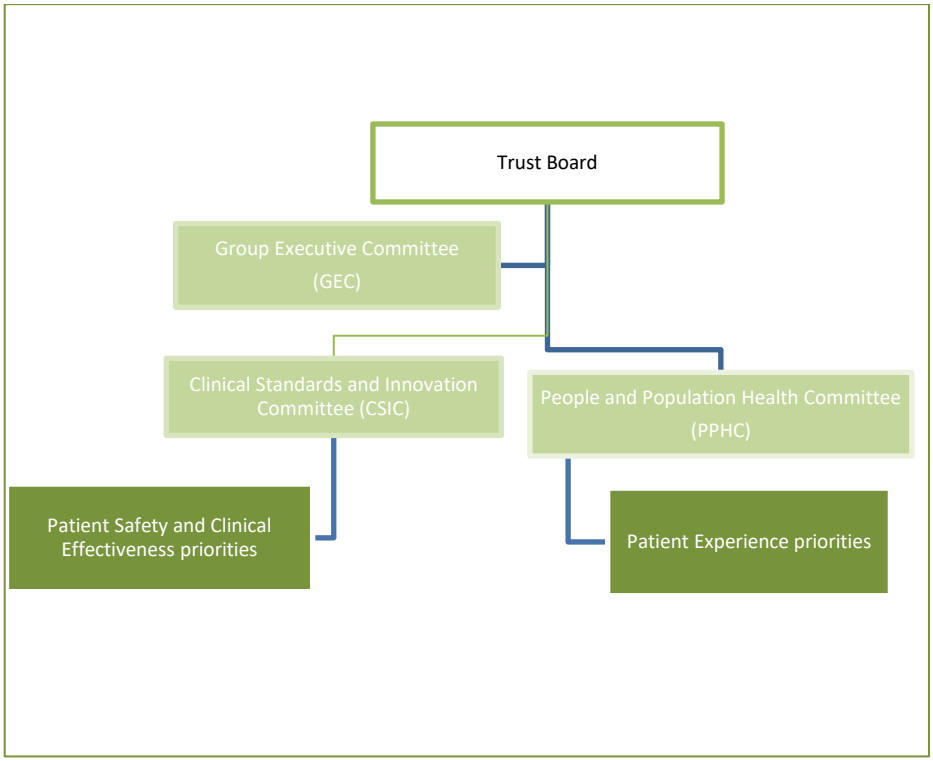


Figure 1: Strategic committees reporting to the trust board

Patient Experience	
1	Establish a Dementia CPG across the organisation, and deliver this in partnership with Barnet Intermediate Care Pathway to further enhance and support dementia care.
2	Provide specialist training and support to staff, in order to recognise and treat symptoms of distress and anxiety before these factors escalate into aggression or restriction.
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.
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.
5	Define and implement our patient involvement framework with its co-design principles, by developing a suite of tools, strategies, and cultural elements into an easy-to-follow framework to support delivery of our patient experience ambitions.
Clinical Effectiveness	
6	Continue to deploy the Quality Improvement (QI) methodology against the trust priority of Joy in Work (JiW) for teams participating in wave 2 of a collaborative by 50% above baseline measures by May 2021, and train at least 70 further staff to apply the JiW framework within their teams.
7	QI projects will be standing items at Divisional and Hospital boards and at trust induction. All QI projects to be registered on the Life QI reporting system with a relevant maturity rating score, so that Divisions have oversight of QI projects taking place, and the Divisional triumvirate can manage these locally, supported by improvement experts.
8	Undertake celebration events to share improvement work regularly at each hospital, with an annual organisation-wide celebration to showcase work and share learning across the trust to encourage and support continuation in our improvement journey.
9	Digitise 11 clinical pathways across our clinical practice group programme, with prioritisation of pathways based on the organisation priorities of Cancer and Ambulatory and Emergency care.
Patient Safety	
10	As part of our Safety Strategy 2020-2025, have zero never events, decrease our Avoidable Harm Score (AHS) from 82 to 66 by 2020/21, and become a zero harm organisation by 2025.
11	Decrease the number of falls incidents with moderate or more harm reported by 5% by March 2021.
12	Decrease medication incidents with moderate or more harm reported by 5% by March 2021.
13	Increase the number of staff trained in mental health first aid to 100 by March 2021.
14	Achieve zero trust attributed meticillin-resistant Staphylococcus aureus bacteraemias (MRSA) cases.
15	Remain below the mandated threshold for trust-attributed zero Clostridium difficile (C.diff) (100 cases 2019/20) and have zero infections due to lapses in care.
16	Reduce Gram negative bacteraemias in line with mandated threshold (- 25% reduction by 2021-2022, with the full 50% by 2023-2024)

2.2 Statements of assurance from the board

Review of services

During 2019/20 the Royal Free London NHS Foundation Trust provided and/or subcontracted TBC relevant health services.

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

The income generated by the relevant health services reviewed in 2019/20 represents TBC% of the total income generated from the provision of relevant health services by the Royal Free London NHS Foundation Trust for 2019/20.

Participating in clinical audits and national confidential enquiries

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

During 2019/20 61 national clinical audits and 10 national confidential enquires covered relevant health services that Royal Free London NHS Foundation Trust provides.

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

The national clinical audits and national confidential enquiries that the Royal Free London NHS Foundation Trust was eligible to participate in, during 2019/20 are detailed in the table below.

The national clinical audits and national confidential enquiries that the Royal Free London NHS Foundation Trust participated in during 2019/20 are detailed in the table 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 2019/20, 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.

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 2019/20 data is not yet published the previous reported participation and ascertainment rates are recorded as an indicator.

Key:

- * = Timeframe for data collection
- RFH = Royal Free Hospital
- BH = Barnet Hospital
- CFH = Chase Farm Hospital

Table: Name of audit, eligibility and participation

Name of Audit	Data collection completed in 2019/20	Trust Eligibility to participate	Participation 2019/20	Case ascertainment
British Association of Urological Surgeons (BAUS): Female stress urinary incontinence audit	Yes	Yes	RFH BH and CFH service not available	N=4 *2016/17 BAUS advised: HES reported no procedures carried out by Urologists from the Royal Free in 2018.
BAUS: Nephrectomy audit	Yes	Yes	RFH BH and CFH service not available	RFH 116 % *2016/18
BAUS: Percutaneous nephrolithotomy (PCNL)	Yes	Yes	RFH BH and CFH service not available	N= 80 *2016/17 and 18 combined BAUS advise : They do not publish case ascertainment because HES data is not very reliable as procedures are coded differently in different hospitals
Cancer: National bowel cancer audit (NBOCA)	Yes	Yes	Reported at trust level, data collected at RFH and BH	N=244/287 (85%) *2017/18
Cancer: National lung cancer audit (NLCA)	Yes	Yes	Reported at trust level, data collected at RFH and BH CFH service not available	N =364 *2017
Cancer: National oesophago-gastric cancer audit (NOGCA)	Yes	Yes	Reported at trust level, data collected at RFH and BH CFH service not available	75-84% *2016/18
Cancer: National prostate cancer audit	Yes	Yes	RFH, BH and CFH	N=428 *2017/18
Chronic obstructive pulmonary disease (COPD) audit programme: Secondary care	Yes	Yes	RFH and BH CFH service not available	RFH: N=242 *2017/18 – Site specific percentage not reported on
COPD audit programme Secondary Care – Adult Asthma	Yes	Yes	RFH and BH CFH service not available	RFH: N=56 *2018/19 – Site specific percentage not reported on

Name of Audit	Data collection completed in 2019/20	Trust Eligibility to participate	Participation 2019/20	Case ascertainment
COPD-Paediatric asthma				TBC from BH
Diabetes: National foot care in diabetes audit	Yes	Yes	RFH BH and CFH service not available	RFH: 1.6% *2017/18 – To be confirmed with Therapies
Diabetes: National diabetes in-patient audit (NaDIA)	Yes	Yes	RFH and BH CFH service not available	NaDia inpatient published in May 2019 reported on hospital characteristics only. Data collected in Sept 19, to be published in March 2020
Diabetes: NaDIA -Harm				RFH: N=9 *2019/20 (up to 3/3/20) BH: N=5 *2019/20 (up to 3/3/20) NaDia Harms report published in May 2019 shows level of participation and number of submissions of each harm at National level only.
Diabetes: National pregnancy in diabetes (NPID) audit	Yes	Yes	RFH and BH CFH service not available	Audit data collection in progress
Diabetes: National diabetes audit (NDA)	Yes	Yes	RFH BH and CFH	N = 1460 Type 1 *2018/19 N = 1310 Type 2 * 2018/19
Diabetes: National diabetes transition audit	Yes	Yes	RFH and BH CFH service not available	Audit extracts data from NDA and NPDA submission. Data reported at national level only.
Diabetes: National paediatric diabetes audit (NPDA)	Yes	Yes	RFH BH and CFH	BH = 107 *2017/18 CFH = 59 *2017/18 RFH= 60 *2017/18
Elective surgery (National PROMs programme)	Yes	Yes	RFH BH and CFH	Pre-operative questionnaires N= 734 (80%)*2017/2018 Post-operative questionnaires N=399 (59%) *2017/2018
Endocrine and thyroid national audit	Yes	Yes	RFH BH and CFH	No report published in 2018/2019
Falls and fragility fractures audit programme (FFFAP): Fracture liaison service database	Yes	Yes	BH RFH and CFH service not available	N=431 *2017
FFFAP: Inpatient falls	Yes	Yes	RFH and BH CFH service not available	RFH = 34 *2017 BH – no data submitted
FFFAP: National hip fracture database	Yes	Yes	RFH and BH CFH service not available	BH =394 *2018 RFH= 185 *2018
Heart: Cardiac rhythm management(CRM)	Yes	Yes	RFH and BH CFH service not available	RFH: N = 139*2016/17 (most procedures undertaken at BH) BH: N = 621*2016/17

Name of Audit	Data collection completed in 2019/20	Trust Eligibility to participate	Participation 2019/20	Case ascertainment
Heart: Myocardial infarction national audit project (MINAP)	Yes	Yes	RFH and BH CFH service not available	RFH and BH: N=1012 103.5%*2017/18
National audit of cardiac rehabilitation ((NACR)	Yes	Yes	RFH and BH CFH service not available	RFH 2/7 KPI's submitted *2019 BH 4/7 KPI's submitted *2019
Heart: National audit of percutaneous coronary interventionsneiaa	Yes	Yes	RFH BH and CFH service not available	N=1087*2017/18
Heart: National heart failure audit	Yes	Yes	RFH and BH CFH service not available	RFH: N=315 *2017/18 BH: N=418 *2017/18
Intensive Care National Audit and Research Centre (ICNARC): Case mix programme: Adult critical care	Yes	Yes	RFH and BH CFH service not available	RFH: N=1725 *2017/18 100% data completeness
ICNARC: National cardiac arrest audit (NCAA)	Yes	Yes	RFH and BH CFH service not available	RFH: N=320 222 calls solely for cardiac arrest N = 177 cardiac arrests attended by the team that met the scope of NCAA *2018/19
Inflammatory bowel disease (IBD) registry: Biological therapies audit (Adult)	Yes	Yes	RFH CFH service not available	RFH: N=23
IBD registry: Biological therapies audit (Paediatric)	Yes	Yes	RFH and BH BH and CFH service not available	Partial submission
National audit of breast cancer in older people	Yes	Yes	Reported at Trust level, data collected at RFH and BH	50-69 yrs N=237 70+ yrs N=157 *2017
National audit of dementia	Yes	Yes	RFH and BH CFH service not available	RFH: N=56 Casenote 100% *2018/19
National audit of pulmonary hypertension audit (NAPH)	Yes	Yes	RFH BH and CFH service not available	N=791*2018/19
National audit of seizures and epilepsies in children and young people (Epilepsy 12)	Yes	Yes	RFH and BH CFH service not available	Submission of data for 2018-2020 in progress
National Audit of Seizure Management in Hospitals (NASH)			RFH and BH CFH service not available	RFH participated to this audit, awaiting publication of report.
National clinical audit of care at the end of life (NACEL)	Yes	Yes	RFH and BH CFH service not available	RFH and BH participated in the Organisation audit and Quality Survey of bereaved relatives
National early inflammatory arthritis audit (NEIAA	Yes	Yes	Reported at trust level, data collected at RFH, BH and CFH	RFL: N=26 15% (National annual median per unit is 17)

Name of Audit	Data collection completed in 2019/20	Trust Eligibility to participate	Participation 2019/20	Case ascertainment
National emergency laparotomy audit (NELA)	Yes	Yes	RFH and BH CFH service not available	RFH: N=83 (71%)*2017/18
National joint registry (NJR)	Yes	Yes	RFH BH and CFH	BH completed ops = 55 (NJR consent rate = 69%)*2018 CFH completed ops = 666 (NJR consent rate = 69%)*2018 Completed op RFH = TBC
National maternity and perinatal audit (NMPA)	Yes	Yes	RFH and BH CFH service not available	BH = 100% *2016/17 RFH=100% *2016/17
National neonatal audit programme (NNAP)	Yes	Yes	RFH and BH CFH service not available	BH = 100%*2017 RFH=100%*2017
National ophthalmology audit (NOD): Adult cataract surgery	Yes	Yes	Reported at trust level, data collected at RFH, BH and CFH	RFL: 47.6% *2017/18
National vascular registry	Yes	Yes	RFH BH and CFH service not available	RFH: 66% *2017
Royal College of Emergency Medicine (RCEM) Fractured neck of femur	Yes	Yes	RFH and BH CFH service not available	To be undertaken in 2020/21 – registration in Spring
RCEM: Pain in children	Yes	Yes	RFH and BH CFH service not available	To be undertaken in 2020/21 – registration in Spring
RCEM Mental Health-Care in Emergency Departments	Yes	Yes	RFH and BH CFH service not available	RFH: N=177
RCEM Assessing Cognitive Impairment in Older People /care in Emergency Departments	Yes	Yes	RFH and BH CFH service not available	RFH: N=155
RCEM Care of Children in Emergency Departments	Yes	Yes	RFH and BH CFH service not available	RFH: N=244
Sentinel stroke national audit programme (SSNAP)	Yes	Yes	RFH and BH CFH service not available	RFH= Clinical audit: 99.1% (Level A) *2018/19
Trauma audit research network (TARN) –Major trauma audit	Yes	Yes	RFH and BH CFH service not available	RFH = 74% *Jan18 - Jul19
UK Parkinson's audit	Yes	Yes	RFH BH and CFH	RFH Neurology: Case note: 27 patients PROMS: 17 patients *2019 RFH Elderly Care: Case note: 21 patients

Name of Audit	Data collection completed in 2019/20	Trust Eligibility to participate	Participation 2019/20	Case ascertainment
				PROMS: 0 patients *2019
BTS - National Adult Community Acquired Pneumonia audit	Yes	Yes	RFH and BH CFH service not available	RFH: N=71
BTS - National Adult NIV Audit	Yes	Yes	RFH and BH CFH service not available	RFH: N=13
Surgical site infection surveillance	Yes	Yes	RFH BH and CFH	All applicable cases were submitted
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Yes	Yes	RFH BH and CFH	All applicable cases were submitted
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Yes	Yes	RFH BH and CFH	All applicable cases were submitted
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	Yes	RFH BH and CFH	All applicable cases were submitted
BTS- National Smoking Cessation Audit 2019	Yes	Yes	RFH and BH CFH service not available	Not applicable as Smoking Cessation service provided by Camden.
Perioperative Quality Improvement Programme (PQIP)	Yes	Yes	RFH and BH CFH service not available	RFH: N= 348 patients*March 17/Aug 19
Society for Acute Medicine Benchmarking Audit (SAMBA) study	Yes	Yes	RFH and BH CFH service not available	RFH: N= 13 patients*2018

During 2019/20, the trust did not participate in the below national audits as the service is not provided by the organisation.

National audit title
National adult cardiac surgery
BAUS: Radical prostatectomy audit
BAUS: Cystectomy
Head and Neck Cancer Audit
National audit of anxiety and depression
National bariatric surgery registry (NBSR)
COPD audit programme: Primary care
COPD audit programme: Pulmonary rehabilitation
National clinical audit of psychosis
National congenital heart disease (CHD)
National neurosurgical audit programme - Consultant-level data
Paediatric intensive care audit network (PICANet)
Prescribing observatory for mental health
UK cystic fibrosis registry

The Royal Free London NHS Foundation Trust also participated in the following national audits by submitting data during 2019/20:

During 2019/20, the trust participated in several other national audits which were not in the HQIP 'Quality accounts' list, published in January 2020. These included the following:

National audit title
NHSBT: Renal transplantation
NHSBT: liver transplantation
Potential donor
Renal registry
National Comparative Audit of Blood Transfusion programme: 2019 Re-audit of the Medical Use of Blood
Molecular Spotlight Audit NLCA
7 Day Services Audit

The reports of 25 national clinical audits were reviewed by the provider in 2019/20 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 governance and clinical risk committee).
- We will use outcomes from national clinical audits to help us prioritise pathway work in our Clinical Practice Groups across our new group of hospitals.
- We will continue to make improvements to our clinical processes where national clinical audits suggest care could be improved.

(Specific actions to improve quality are presented in table below)

Specific actions undertaken to improve quality

National clinical audit	Actions to improve quality
National lung cancer audit (NLCA)	The trust is among the best 1 year survival rates in the country at 48% (43.7% when adjusted for PS/age/stage etc) compared to the national average of 36.7%. We have a surgical resection rate of 30%, during a national campaign by UKLCC to increase this to 25% by 2025 Actions: Data is inaccurate for recording of PS, Stage and involvement of CNS – this is due to

	how data is transferred out of infoflex and is a known issue for 3 years which we have struggled to solve despite involvement of the clinical, IT, admin and NLCA data teams. Further meetings planned to ensure accurate data is exported and reported upon
National Oesophago-gastric cancer audit (NOGCA)	RFH and BH: 82.1% of trust patients with OES cancer & had curative treatment had PET-CT, above the 78.7% National average 94% of patients had complete clinical stage data, above the 90% target 64% of RFL patients fully completed their therapy, higher than the National average of 53.5% 100% of RFL patients fully completed their therapy, again higher than the National average of 96.5% 44.8% of patients with clinical stage 0-3 had curative treatment plans, lower than the 60% England and Wales result Time to referral to start of curative treatment: Median time for RFL was 69 days, slightly longer than National average of 62 days. Actions: The oncology service will carry out a retrospective audit of clinical stage 0-3 patients to determine why curative plans were not proposed and send out lessons learnt to Upper GI MDT A BC has been proposed for a clinical oncology consultant whose responsibilities will include leading on this audit with clear escalation pathways.
Chronic obstructive pulmonary disease (COPD) audit programme: Secondary care	RFH: We are taking part in NACAP (not all units do), and our Case Ascertainment is better than average. NACAP provides nationally benchmarked data. Our mortality is lower, but our length of stay and re-admissions are higher than national figures (no statistics provided). Like other units, we have a challenge to access diagnostic spirometry from primary care. We are not consistently achieving Best Practice Tariff, with financial penalty to the trust. Patients are not consistently getting the high-value Discharge Bundle intervention or 24 hours specialist review. The reasons for this are complex but include lack of available staff, time and support. Our level of respiratory CNS support is lower than comparable units (median 3 in acute trusts of similar size in 2013 in British Thoracic Society data) Actions: We are engaged with a new UCLP Network designed to assist in QI around use of discharge bundles in COPD (Dr Swapna Mandal working as network lead for discharge bundles across UCLP) and working on developing COPD care within the COPD CPG. New respiratory CNS post at Barnet site will assist delivery of services. Additional CNS support at Royal Free site would allow more consistent delivery of care
COPD audit programme Secondary Care – Adult Asthma	RFH: We have a strong asthma service, which on 2018-19 audit data delivers better than national performance for most clinical indicators e.g. early recording of peak flows, core elements of asthma care We have strengthened our severe asthma service, with formalised links into regional Severe Asthma network led from Barts as “prescribing spoke” – only hospital in immediate area to provide full severe asthma service including delivery of biologic therapies for asthma Although performance in audit was better than national benchmarks, would not meet proposed national Best Practice Tariff for asthma Lower than national performance for addressing smoking cessation Only one respiratory clinical nurse specialist at each site is insufficient to support adequate standard and consistency of service, especially in view of the growing demands from the severe asthma service. Actions: Additional CNS support at Barnet site is required. This is also required at Royal Free site. On-going work to reconfigure and strengthen the severe asthma service – dedicated clinic and enhanced role for multi-professional team members. Dr Anant Patel leads the trust Smoke Free action group.
Heart: Cardiac rhythm management(CRM)	RFH and BH: Considerable increase in pacing work between years and above the levels required for training at Barnet; immediate complication rates are low. Good data completeness but some NHS numbers missing. Increasingly more pacemaker patients are being done at the Barnet lab as Royal Free takes on more PCI work. Improve data completeness such as NYHA class. To note data completeness more recently has increased and was previously hampered by ECGs not going from one hospital to another

	with the patient, but this will be resolved fully once Royal Free has electronic ECG capture via EPR Review role of low volume operators <10 devices for permanent devices Actions: Consolidate permanent device work to higher volume Barnet site to reduce variance and operator experience. We are now funded to deploy a dedicated CRM and device management software by IT. This has been tendered for and chosen and once this is also installed – data completeness and clarity will be even more optimal. Review business case for CRM workforce expansion Pacenet software almost (1 more IT step) from deployment for pacing implants and checks etc linked with EPRs. Genesis - our stock taking barcode scanning technology for scanning device equipment, patient and doctor codes is also about to be deployed CLUG monthly meetings have been instituted and CRM LocSIPP signed off and developmental work under way around QI standards at Barnet cath lab also
Myocardial infarction national audit project (MINAP)	Door-to-balloon' time to deliver primary angioplasty (pPCI) for STEMI 95% achieved target of <90mins (Eng mean 88%) Same as 16/17 'Call-to-balloon' time to deliver pPCI for STEMI 87% achieved target <150 mins (Eng mean 70.5%) up from 16/17 Pts diagnosed with STEMI receiving echo pre-discharge 97.73 % (Eng, Wal, NI mean 73%) up from 16/17 Secondary prevention medication for STEMI and nSTEMI prescribed at discharge RFH 98.97% and BH 99.4% (Eng mean 90.4%) better than National standard Proportion nSTEMI pts admitted to cardiac ward 87.25% (RFH); 88.39% (Barnet) (Eng mean 61%) up from 16/17 Proportion pts with STEMI diagnosis who died within 30 days of arrival at hospital (unadjusted) 7.65% (Eng, mean 9.07%) up from 16/17 however better than England result PCI Centre caseload exceeds National minimum requirements. Preferred access route as stated by NICOR/BCIS is radial arterial - Rate of radial artery access for PCI at 85.41% at RFH NICOR/BCIS also indicate drug eluting stents (DES) should be used– Rate of DES use in patients treated by Primary PCI with Stent is 98.74% RFH Rate of referral to cardiac rehabilitation programme following discharge RFH 70.56% and BH 71.20% (Eng mean 81.0%) Below National standard Proportion of nSTEMI pts who had angiography during admission 83.45% (RFH); 94.65% (Barnet) (Eng mean 85%) RFH below England result Actions: Generally the RFH Heart Attack service works very well and our data show a performance above the national average in key areas. Work has been completed on the new CPG Chest Pain pathways which is a key component in further improvement work, however, unfortunately implementation is currently on hold until EPR is introduced at the RFH. The rate of referral to cardiac rehabilitation programme will be reviewed to ensure data quality on this metric is being maintained.
National audit of cardiac rehabilitation (NACR)	RFH: Well established multi-disciplinary team with CNS, physiotherapy/exercise instructor and psychologist input in a tailored programme Clearly identified patients eligible for rehabilitation – pts having suffered MI / MI with PCI and post CABG. Also include out-of-scope patients including patients undergoing valve surgery Currently not delivering to national standards on the following: Duration of rehab programme – 35 days vs national recommendation of 56 days Patient assessment pre- and post CR – 2% and 1% respectively compared to national findings of 89% and 69% MI / MI + PCI waiting times currently 98 and 107 days compared to national recommendations of 24 and 53 days Current service not funded with no dedicated tariff agreed with CCGs Service provision and delivery requires overhaul with clear leadership and adherence to nationally agreed metrics Actions taken: Appointment of B8a senior nurse to review CNS roles and focus on rehab service Assess current administrative processes and explore additional support and use of electronic solutions to avoid duplication Review current access to Royal Free gym which is currently shared with physio team Look at cross-site options with services running at BGH, Chase Farm and Edgware – consider consolidating services Set post CR assessment metrics to allow completion of audit data set

	Review current data entry – all patients are pre-assessed suggesting incorrect / incomplete data entry BH: The BCF service achieved 4 from the 7 KPIs stipulated in the audit Service delivery by a multidisciplinary team Provision of service to MI, MI+PCI and post CABG patients. Patients undergoing other cardiac surgery (valve, aortic and cardiac transplant patients) were also seen, as well as patients with heart failure. Percentage of patients assessed before start and after end of rehab at Chase Farm/Barnet was 97% and 73% respectively, higher than England outcomes of 89% and 69% 35% of patients undergoing a 150 minute exercise programme post cardiac rehab demonstrated improvement compared to a national recommendation of 27% Patients undergoing CR had a reduction in anxiety and depression scores with an increase in those describing themselves as "normal" by 5 and 10% respectively. This is better than national findings of 3.3% and 2.7% The following metrics were not achieved: Duration of rehabilitation : 49 days compared to a national result of 76days Wait for rehabilitation for MI/PCI and CABG being longer than the national average (63 vs 33 days for MI/PCI and 68 vs 46 days for CABG) Actions: Similar to RFH, there is to be review of the service with a view to improving metrics. The data entered into the audit will also need review the duration stated in the audit may not have included additional services including relaxation, health education and a final shuttle walk assessment. This would likely better represent the duration of CR. Actions include: Review of the referral process to ensure timely access Review of admin and workforce numbers Review of the sites of services – currently run over multiple sites Review of the admin processes and data entry to improve support to clinical team
National heart failure audit	RFH: Rates of ACE/ARB prescription and beta-blocker prescription high (86% and 94% respectively compared to 83.8 and 89.3% nationally and an improvement on 2016/17 data) High rates of receiving echocardiography during IP stay (93% compared to 88% nationally and an improvement compared to the 2016-17 data) Higher rates of admission to cardiology ward compared nationally (50.2% vs 46%) and improvements compared to 2016-17 data (50.2% vs 41.9%) An increase in the number of referrals to cardiac rehabilitation (15% compared to 5% in 2016-17) in line with national figures (15%) but still overall low volumes We are currently performing below the national average (England & Wales) in the following areas: **2017-18 England and Wales** — No of admissions: —; Input from Specialist Team: **82%**; Commenced on MRA: **54.70%**; Received Discharge Planning: **91.90%**; Referral to HF CNS for FU: **57.90%**; Referral to HF CNS for FU only: **72.90%**; Referral to cardiac rehabilitation: **15.20%** **RFH**: 305; 68.10%; 47.90%; 48.60%; 52.10%; 59.60%; 15.50% **2016-17 RFH**: 329; 47.1; 50%; 82.40%; 23.50%; 39.10%; 5.10% Rates however have improved compared to last year's audit data in all but one area Actions: This audit data is taken from 2017-18. We continue to perform well in certain national audit targets such as drug prescribing and access to acute diagnostic provision. In the areas where we have not reached the average there is a significant improvement compared to the previous year's audit findings in the vast majority of cases. The aims set out in last year's review have been largely realised. The heart failure CPG continues to be a key enabler in order to for us to improve our performance. The following service improvements have been introduced this year: An increase in the workforce establishment with 3 wte CNSs in post and the introduction of a dedicated Heart Failure SCF. This has increased the number of patients receiving a specialist review and increased capacity for early follow up in the OP clinic A significant increase in data reporting so that real time assessment of performance can take place The introduction of the diuretic lounge to allow early discharge of patients or admission avoidance under specialist review 3 specialist Heart Failure consultants providing input on the IP management of patients reviewed by the CNS/SCF team Ongoing plans for the CPG include: Rapid testing with NT-pro-BNP Increased consultant workforce with the potential to deliver specialist ward rounds Testing and digitisation of the pathway BH:

	Rates of transfer of IP care to the cardiology ward remain high at 68.1% compared to 46% nationally reflecting the ward-based system at BGH Discharge planning is excellent at 100% compared to 91% nationally We are currently performing below the national average in the following areas: **2017-18 England and Wales**: No of admissions —; Input from Specialist Team 82%; Commenced on ACE/ARB 84%; Commenced on B blocker 89%; Commenced on MRA 54.70%; Received echocardiogram 87.70% 2017-18 BGH: 416; 73.80%; 68.50%; 87.50%; 52.90%; 82.70% 2016-17 BGH: 429; 77.90%; 86.30%; 90.40%; 57%; 95.20% **2017-18 England and Wales**: Cardiology FU 56.70%; Referral to HF CNS for FU 57.90%; Referral to HF CNS for FU only 72.90%; Referral to cardiac rehabilitation 15.20% 2017-18 BGH: 42%; 47.00%; 62.10%; 0.60% 2016-17 BGH: 68.80%; 57.30%; 68.80%; 4% Actions: This audit data is taken from 2017-18. There still remains high levels of compliance with specialist care delivery on the cardiology ward and discharge planning. There does appear to be a reduction in compliance with medication prescribing, access to echocardiography and OP follow up compared to the previous year's audit. The following actions a planned: Review of the audit data as it appears conflicting as more patients were managed on a specialist ward There has been an increase in the heart failure workforce with 3.2 wte HF CNSs, a new heart failure consultant appointment and recruitment of a new heart failure SCF Planned opening of a diuretic lounge for admission avoidance and to facilitate early discharge Continued work on implementation of the cross-site Heart Failure CPG as detailed previously
Intensive Care National Audit and Research Centre (ICNARC): Case mix programme: Adult critical care	RFH: Trust performance has been highlighted as better than national average: Discharge to ward - Bed days of care post 8 hour and 24 hour delay's Discharges direct to home. Non-clinical transfers to another unit. Risk adjusted acute hospital mortality. The trust has been highlighted as an outlier in the following areas: High risk admissions from the Ward – large change from 2016/17 and continued in 2018/19. Cause is unclear. New definition from ICNARC to align with SEPSIS – 3 criteria. More complex urology, surgical, liver, and renal failure patients on site. No significant changes from current report and previous year on how ICU operates. Audit performed in September / October 2018 did not reveal any delays to admission (Within GPICS standard of 4 hours from acceptance). ICNARC now do not include renal failure, if on dialysis normally, or liver failure if previous history of liver disease as an organ failure. Likely due to the complexity of patients. Actions: Work with PARRT to re-audit ICU admission process since NEWs now fully embedded.
ICNARC: National cardiac arrest audit (NCAA)	RFH: Data quality is excellent Rates of survival to discharge from hospital are good There is evidence that some of the patients we attempt resuscitation on are not appropriate for CPR There is evidence that clinicians are unclear about families' role in DNAR decisions and need support Actions: MDT working and QI work: 10W, renal wards, ICU Increased use of Co-ordinate My Care plans Aim reading material on DNAR decisions for patients and families
National audit of breast cancer in older people (NABCOP)	RFH and BH: We are positive outliers for patients who are receiving chemotherapy and surgery. We have very poor data recording and hence we are looking as outliers in all the criteria We are trying to change templates in order to provide 90% one stop services for all patients. Actions: Implementing single MDT for all three sites so uniform management is provided across all three sites and data recording is more robust CPG pathway group meetings are in progress in order to address all the above issues.
National audit of dementia	RFH: These results are huge improvement from our previous audit results (NAD R3) in which the overall trust performance was lower than average in most domains. Improvement works were implemented by the Dementia Implementation Group in response to that audit we see those efforts reflected in these more recent results. We are now amongst the top 10 performing trusts in the UK in 4 out of 7 domains (1st in 2 of those). Of the remaining 3 domains, we were placed 16th in one, 26th in another and 136th in our lowest performing domain, "Discharge"

	Our lowest score related to “Discharge” where the auditors were looking for evidence that early conversations relating to discharge were being had amongst colleagues and with families and carers. The poor performance here could in part be due to the fact that these conversations take place in board meetings and MDT meetings which are usually not documented in medical notes and therefore were not picked up in the casenote audit. That being said, we do feel a need to closely examine and improve the way that discharges are handled for this vulnerable group and will focus our attention on this area Actions: Dementia CPG has been convened and one of the major workstreams is “Discharge” – a cross-site MDT will be working in this area using a QI approach which we hope will make lasting improvements and reduce unwarranted variation
National audit of pulmonary hypertension audit (NAPH)	RFH: The RFH team has managed to continue to meet all but one target despite staff changes and database issues. For the past year we complete same-day referral to Papworth on line after the diagnostic cardiac catheter is performed, so delay to surgery is largely down to issues beyond our control. Patients managed at a couple of our outreach services may still be contributing to delays. Actions: We are installing a new web based database, this should improve our ability to track compliance in outreach sites.
National clinical audit of care at the end of life (NACEL)	RFH and BH: Royal Free hospital scored higher than National outcomes for 5 out of the 6 applicable themes. Barnet hospital scored higher than National outcomes for 6 out of the 9 applicable themes. Excellent governance and quality outcomes through robust end of life care policies and guidelines; a 7 day / week Specialist Palliative Care team and accounting for audit and outcomes through the trust’s End of Life Care Steering group. When providing a holistic assessment of care to our dying patients, the RFL do particularly well at managing the physical symptoms at the end of life, which include: pain, nausea & vomiting, secretions, agitation. Outcomes for the communication with families and others at the Royal Free were lower than nationally recorded. Lower than National scores were recorded at Barnet hospital for needs of families and others, Individual plan of care and families’ and others’ experience of care themes. Delayed identification of dying (< 1.5 days before death). Gap in development/documentation of an individualised end of life care plan for the dying. Actions: Merge the Mortality Surveillance Group and End of Life Care Steering group, and establish four working groups (advance care planning, care of the dying, care of the deceased and continue with Learning from Deaths group) Advance Care Planning CPG has been established End of Life Care Plan for the Dying in development and will be built into Cerner & the RFH will have an interim paper document, all supported with a robust education plan Perfect Ward results Mapping of ward resources to support families. Took part in NACEL 2019 audit
National early inflammatory arthritis audit (NEIAA)	RFH: Accepting that we contributed few patients to the audit, our performance metric for recognition and commencement of patients with early inflammatory arthritis on DMARD within the recommended time frame was close to the national mean. It is notable that we underperformed across all the metrics and we have highlighted the understaffing in particular nursing and administrative personnel in improving patient recruitment for the audit to facilitate accurate data entry to reflect our trust activity given that we had approximately 7000 annual patient visits. This result is particularly germane to metric 2 which reported that our trust is underperforming on our capacity to review patients with early inflammatory arthritis as timely manner ie within three weeks of referral. We would anticipate that with adequate staffing and accurate staffing, this should be closer to the national mean. Actions: These issues have been discussed with our departmental manager and audit and compliance leads and I expect to be updated on the urgent steps taken to rectify this as this audit will be ongoing.

National emergency laparotomy audit (NELA)	RFH: Overall good performance with excellent surgical presence in theatre when risk of death > 5% and postoperative critical care admission for high risk cases for predicted risk of death >10% Improved Pre-operative input by a consultant anaesthetist when risk of death was >5% Surgical and Anaesthetic Consultant led service throughout the perioperative period Provision of elderly medicine specialist review for suitable patients (reflective of situation within AHSN and nationally) Timeliness of cases undergoing surgery (NCEPOD theatre) Drop in case ascertainment compared with 2018 Reduction in risk documented pre-operatively, although remains higher than the national average Actions: Plan to roll out MDT emergency laparotomy pathway cross-site (CPG) Ongoing Quality Improvement projects to improve case ascertainment and risk documentation Royal Free remains a UCL Partners Emergency Laparotomy Collaborative to share learning and improvement experiences with more regular feedback of local and AHSN data
National ophthalmology audit (NOD): Adult cataract surgery	RFH, BH and CFH: Rate of adjusted posterior capsular rupture (PCR) in the trust (0.8%) lower than National Average (1.1%). Fully compliant with management of cataracts in adults Better capture of data as 48% of cataract cases audit data collected. Case ascertainment was below the 85% threshold Ensure case complexity is matched by the performing surgeon's grade and experience Actions: Ensure that all staff are trained to input data on Medisite thus allowing for a better capture rate of data Possibly audit data halfway through the year to ensure that compliance is being met
National vascular registry (NVR)	RFH: Clinical outcomes which are at or above national average in all disease groups except carotid disease. Carotid outcomes likely biased by sampling error, as the volume detailed seems smaller than our stated volume of procedures. In all disease areas, the waiting time or delay for intervention is worse than the national average. This puts our patients at risk, and has been flagged as a serious patient safety issue. This is due, largely, to a lack of theatre capacity for vascular procedures, and a failure to recognize the importance of vascular cases in the context of the trusts' burden of cancer-related waiting times. Actions: Have escalated this issue, since the GIRFT report in June 2019, to the trust executive including Susanne Althauser and John Connolly, who have committed to a cardiovascular strategy which prioritizes the needs of vascular patients. Actions for improvement have yet to be fully executed.
RCEM VTE Risk in Lower Limb Immobilisation	RFH: 14% of patients had VTE assessment performed (national average 30%) For patients assessed, treatment was started appropriately for them in ED VTE assessment guidance for lower limb immobilisation had recently changed - also included boots, which was not widely known Large proportion of patients are managed by ENPs No patients received an information leaflet Actions: Education around VTE assessment for lower limb immobilisation has promoted its use Patients are now referred to a doctor for thromboprophylaxis consideration once identified Sticker for clinical reference is now available Leaflet is available
RCEM Vital Signs in Adults	RFH: Standard 1: 70% of patients have observations documented within 15 minutes of arrival – national 50% Standard 2: Patients with abnormal signs have repeat set within 60 minutes 23% - national 23% Standard 3: Recognition of abnormal signs 80% - national 71% Standard 4: Action taken on abnormal observations 75% - national 71% Standard 1: Audit shows 14% only, due to missing GCS. This is a major problem that the nurses do not record GCS, when it is normal. GCS is only recorded when it is abnormal

	Actions: It should be mandatory on Cerner to complete vital signs including GCS on all patients We are likely to maintain these results with RAT
RCEM Feverish Child	RFH: Standard 1: 75% children have their initial assessment within 15 minutes (national average 50%) Standard 2: Use of sepsis stratification tool was 57% (national average 38%) Standard 5: 66% received discharge information – documented. (national average 67%) Standard 6: Various learning arenas were used for teaching Standard 3: Documented evidence of use of the NICE traffic light system was poor and sporadic Standard 4: 31% received a senior review (national average 38%) Blood pressure was poorly recorded in the majority of patients (9%). This data is likely inaccurate because cap refill time was likely being recorded instead. Actions: Increase in senior cover in PED since then mainly staffed with consultant and MG's and plan is to staff with MG overnight when fully recruited at MG level Regular dedicated SIM sessions and e learning platform established and appointment of teaching clinical fellow to improve education and awareness Discharge information (leaflet) Appropriate measurement of blood pressure – capillary refill is the alternative and has been incorporated into PEWS. Results next time will be better.
Sentinel stroke national audit programme (SSNAP)	RFH: The Royal Frees' overall audit compliance score is 99.1%, which is an improvement of 10% from the previous report. This score is also 6% above the National compliance score. In accordance with the NICE guidance for Quality Standard for Stroke, the Royal Free is found to be "Fully Compliant." Throughout the 2018/2019 period, our overall SSNAP scores have consistently been As for each quarterly audit. In relation to Domain 10- Percentage of applicable patients in AF on discharge who are discharged on anticoagulants; the Royal Free Team Centred score is slightly below (0.4%) the national average score, and there is a 2.6% drop in our score from the previous report. This may well be accredited to data entry discrepancies which can be addressed directly with SSNAP themselves, in order to clarify the exact meaning of the criteria. Actions: Regular communications with our partner units throughout the NCL Stroke sector need to be maintained in order to ensure that the necessary flow of data along the stroke pathways is kept to an optimal level so that our overall SSNAP scoring is kept at A. Timescale of action: Ongoing, to be reviewed annually.
Trauma audit research network (TARN) –Major trauma audit	RFH: The trust is one of the best performing in London. Data accreditation and data ascertainment. TARN data is now > 90 % accurate for 5 years and has made meaningful conclusions to evaluate trauma care at the trust. The data for 2016- 2018 shows 100% compliance with data ascertainment and over 90% with accreditation. This is far in excess of what other trusts in the area are achieving. The figures for 2019 are expected to similarly lie between 100-92% again. Improved note keeping across the board is required to improve the trusts ability to perform higher at data accreditation. From recording observations, to documenting grade of medical personnel attending and time of clinical evaluation, grade of surgeon attending. All trauma received in the trust is managed or overseen by an ST4 level doctor or higher. This is not reflected in the clinical documentation and hence this opportunity is lost. Hospital discharge summaries fail to capture particular diagnoses combined with delays to clinical coding, mean the trust is not able to accurately report TARN data within 40 days of discharge and often crucial diagnoses which could be coded for are under-represented. CT transfer times are far below what is nationally expected – ie transfer to CT within 60 minutes. This is not achieved. Actions: A separate CT in Trauma audit is managed by the ED as part of the CPG work in improving access to the CT scanner; by improving patient flow, prioritisation for portering and CT urgency for trauma patients over inpatient scans and constant staff training including improving awareness.

	TILS courses provided by the ED are specific to improving trauma prioritisation and triage of trauma patients. Since the last Trauma Peer Review (2019) the trust has now agreed to provide rehabilitation prescriptions which will be recorded for patients managed in the trust. This is will highlight the trusts absolute compliance with standards in rehabilitation prescriptions against national benchmarks. Enforced use of trauma booklets will capture level and grade of doctor providing trauma care and this is embedded as part of the TILS training.
BTS - National Adult Community Acquired Pneumonia audit	RFH: RFH achieved: rapid admission to CXR (90 vs 173 mins) first abx (161 vs 230 mins) CXR taken and CAP confirmed within 4 hours of admission (Yes in 91.5% Vs 77%) Was CURB65 severity score recorded for this patient? (Yes 47.9 Vs 37.9%) Senior review how many hours from admission (<4 hrs - 52 Vs 39%) Antibiotics were only given in line with local policy in 39% of patients Actions: Reviewing antibiotic policies are part of the CAP CPG
BTS - National Adult NIV Audit	RFH: Low mortality rate compared to national average A follow up plan/decision re long term NIV was made for all patients An escalation plane was made for 77% of patients (a significant improvement) 85% of cases were “successful” i.e. improved Only 40% of patients had an ABG taken within an hour of starting NIV 54% of patients were seen by a specialist 4 hours after starting NIV Actions: We have made significant improvements since the last audit in line with NCEPOD recommendations, however there are areas that could be improved including specialist review, ABGs and nursing ratios. There is an acute NIV CPG which may address some of these issues
Perioperative Quality Improvement Programme (PQIP)	RFH: Good case ascertainment of major hepatobiliary surgical patients Establishment of enhanced recovery (ERAS) programme for both liver and pancreatic resections – successful implementation will be assessed from ongoing PQIP data Presentation of local PQIP projects at national conference to include assessment of risk scoring systems for liver resections, impact of post-operative complications on length of stay & pilot ERAS study project. Need to identify areas of improvement within post- operative morbidity data. Plans to investigate wound infection data within the ERAS cohort Improvement for “DREAM”ing is limited within this patient cohort but ERAS programme aimed to improve these outcome measures Actions: Ongoing implementation of ERAS programmes for both liver and pancreatic resection with PQIP data used to assess key outcome metrics Ongoing work to assess existing or develop new risk scoring systems to better predict post-operative morbidity in liver resection patients Local QI project to investigate wound infections as source of post-operative morbidity

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

The reports of TBC local clinical audits* were reviewed by the provider in 2019/20 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:

- To ensure that all local audits/ quality improvement projects are monitored effectively throughout our clinical divisions, with an increased focus on identifying the outcomes and embedding recommendations

* the local audits undertaken relate to the quality improvement projects previously described

National confidential enquiries: participation and case ascertainment

Table: National confidential enquires and outcome review programmes: participation and case ascertainment

Name	Data collection completed in 2019/20	Trust Eligibility to participate	Participation 2019/20	Case ascertainment
National Confidential Enquiry into Patient Outcome and Death (NCEPOD)- Medical and surgical clinical outcomes review programme				
Dysphagia in Parkinson's Disease	Yes	Yes	RFH and BH CFH service not available	Organisational Questionnaire: 2 Case notes: 6/10 Clinical Questionnaire: 7/10
Acute Bowel Obstruction	Yes	Yes	RFH and BH	Organisational Questionnaire: 2 Clinical Questionnaire: 8/12
In-hospital management of out-of-hospital cardiac arrest	Yes	Yes	RFH and BH CFH service not available	Organisational Questionnaire: 2 Case notes: 10/10 Clinical Questionnaire: 7/7
Physical health in mental health hospitals	N/A	NO	N/A	N/A
National Confidential Enquiry into Patient Outcome and Death (NCEPOD)- Child health clinical outcomes review programme				
Long-term ventilation in children, young people and young adults	N/A	No	N/A	N/A
Learning disability mortality review programme				

LeDer: Learning disability review programme	Yes	Yes	RFH BH and CFH	Cases allocated via Local area Contact in relevant boroughs. 3 cases have been allocated in 2019/2020
MBRRACE-UK (Mothers and Babies – Reducing Risk through Audits and Confidential Enquiries across the UK) - National Maternal, Newborn and Infant Clinical Outcomes Review Programme				
Perinatal Mortality Surveillance	Yes	Yes	RFH and BH CFH service not available	100%
Perinatal morbidity and mortality confidential enquiries	Yes	Yes	RFH and BH CFH service not available	100%
Maternal Mortality surveillance and mortality confidential enquiries	Yes	Yes	RFH and BH CFH service not available	100%
Maternal morbidity confidential enquiries	Yes	Yes	RFH and BH CFH service not available	100%

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 site and corporate levels.

Table: Details of specific actions undertaken from a national confidential enquiry and outcome reviews 2019/20

National confidential enquiry	Actions to improve quality
Delay in transit Acute bowel obstruction	RFH – to be reviewed at March 20 General Surgery directorate meeting
Know the score ***Pulmonary Embolism***	RFH – Compliant to 10/13 recommendations. Partially compliant: Recommendation 7: Calculate the clinical probability of pulmonary embolism in all patient presenting to hospital with a suspected new diagnosis of pulmonary embolism using a validated score, such as the 'Wells' Score'. Record the score in the clinical notes. RFH comment: Adherence to be improved. Requirement to complete Wells Score is included in the pathway. All suspected PE ambulatory patients have Wells Score calculated via sticker. Action: CPG work on pathway continues. This pathway is being digitised at Barnet currently (Feb 2020) however which may bring some improvements however this cannot be fully implemented at the Royal Free until EPR is place. Planned to be compliant: Recommendation 9: Ensure there is a robust system in place to alert the clinician who requested a CTPA or V/Q scan or V/Q SPECT scan of any amendments or updates to the report. This is in line with the Royal College of Radiologist's communication standards for radiology reports 2016. Radiology comment from CFH: Amendments to V/Q reports are visible of Cerner and as per usual practice significant findings are alerted to clinicians via phone or email. No specific protocol for nuclear medicine but this can be done.

Participating in clinical research

The number of patients receiving NHS services provided or sub-contracted by Royal Free London NHS Foundation Trust in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 11828.

The above figure includes 4244 patients recruited into studies on the NIHR portfolio and 7584 patients recruited into studies that are not on the NIHR portfolio. This figure is higher than that reported last year.

The trust is supporting a large research portfolio of over 800 studies, including both commercial and academic research. 133 new studies were approved in 2019/20. The breadth of research taking place within the trust is far reaching and includes clinical and medical device trials, research involving human tissue and quantitative and qualitative research, as well as observational research.

CQUIN Payment framework

A proportion of the Royal Free London NHS Foundation Trust income in 2019/20 was conditional upon achieving quality improvement and innovation goals agreed between the Royal Free London NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.
Further details of the agreed goals for 2019/20 and for the following 12-month period are available electronically at: (https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/)

Table 8: CQUIN scheme priorities 2019/2020

CQUIN scheme priorities 2019/2020	Objective rationale
Antimicrobial Resistance – Lower Urinary Tract Infections in Older People	In support of a major Long Term Plan priority of antimicrobial resistance and stewardship, four steps outlined for UTI will bring reduced inappropriate antibiotic prescribing, improved diagnosis (reducing the use of urine dip stick tests) and improved treatment and management of patients with UTI.
Antimicrobial Resistance – Antibiotic Prophylaxis in Colorectal Surgery	Implementing NICE guidance for Surgical Prophylaxis will reduce the number of doses used for colorectal surgery and improve compliance with antibiotic guidelines. Improvement is expected to deliver safer patient care, increase effective antibiotic use, which is expected to improve both patient mortality and length of stay.
Staff Flu Vaccinations	Staff flu vaccinations are a crucial lever for reducing the spread of flu during winter months, where it can have a significant impact on the health of patients, staff, their families and the overall safe running of NHS services.
Screening and brief advice for tobacco and alcohol use in an inpatient setting	To support people to change their behaviour to reduce the risk to their health from alcohol and tobacco Screening and brief advice is expected to result in 170,000 tobacco users and 60,000 at risk alcohol users receiving brief advice, a key component of their path to cessation.
Hospital Falls	Taking these three key actions as part of a comprehensive multidisciplinary falls intervention will result in fewer falls, bringing length of stay improvements and reduced treatment costs. • Lying and standing blood pressure to be recorded • No hypnotics or anxiolytics to be given during stay OR rationale documented • Mobility assessment and walking aid to be provided if required.

	For a typical medium sized acute provider this would equate to around 250 fewer falls, including four fewer hip fractures and brain injuries.
Eligible patients to be managed in a same day setting (SDEC) • Pulmonary Embolus • Tachycardia with Atrial Fibrillation • Community Acquired Pneumonia	These three conditions are all from the top 10 conditions with which patients present in a SDEC setting. Each have been selected due to focus on a limited set of clear actions to be taken by providers. Improved same day treatment will reduce pressure on hospital beds, improving length of stay and patient experience. The rollout of Same Day Emergency Care is one of the commitments from the Long Term Plan.
Towards Hepatitis C (HCV) Elimination	The trust is a lead provider in reducing harm from Hepatitis C. This is a continuing CQUIN that forms part of a long term project with the end goal being the elimination of Hepatitis C as a major health concern by 2030.
Medicines optimisation	Optimising the use and management of medicines is a significant and realisable opportunity for the NHS. This CQUIN indicator aims to support trusts and Specialised Commissioners to realise the benefits of this opportunity through a series of procedural and cultural changes.
Screening	Improving the uptake of breast cancer screening through the implementation of text reminders using mobile phone numbers from GP clinical systems Faster diagnosis standard, cancer waiting times data, completion and exception reporting.

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.
In 2018/19 a total of 2.5% of the trust's income was conditional upon achieving quality improvement and innovation goals. Our CQUIN payment framework was agreed with NHS North East London Commissioning Support Unit and NHS England. The monetary total for 2018/19 was £11,625,000

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 the Royal Free London NHS Foundation Trust during 2019/20.

The Royal Free London NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during 2019/20.

Information on the quality of data

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

The Patient's NHS number

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

The Royal Free London NHS Foundation Trust submitted records during 2019/20 to the Secondary Uses service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patients' valid NHS numbers were as follows::

% of records	2017/18	2018/19	2019/20
For admitted patient care	98.8%	99.2%	99.2%
For out-patient care	99.2%	99.3%	99.5%
For accident & emergency care	95.7%	97%	97.1%

General Medical Practice Code

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

	2017/18	2018/19	2019/20
For admitted patient care	99.8%	99.8%	99.8%
For outpatient care	99.9%	100%	99.9%
For accident & emergency care	100%	100%	100%

Information Governance (IG)

The Royal Free London NHS Foundation Trust achieved 'standards not fully met (Plan Agreed)' for the Data Security and Protection Toolkit submission 2019/20. The trust completed all but one of the mandatory assertions and has agreed an action plan with NHS Digital to improve annual Information Governance and Data Security training compliance –

During 2018/19 the toolkit assessment has changed and there is no longer an overall score and colour grading.

Payment by Results

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

	2016/17	2017/18	2018/19	2019/20
Information governance assessment score	66%	68%	Not scored	
Overall grading	green	green	Not graded	

Data quality

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

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

- 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.
- • A new Data Improvement Group has been set up to discuss, prioritise and oversee the work required to support data quality improvement across the Trust.
- • 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 Workflow Group continues to create workflows for areas where there is incorrect data recording taking place. They will create workflows to ensure staffs are recording all the necessary information which in turn will help solve data quality issues.

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 (approximately 1.02% of all admissions). While most deaths are unavoidable and would be considered to be “expected”, there will be cases where sub-optimal care in hospital may have contributed to the death. The trust is keen to take every opportunity to learn lessons to improve the quality of care for other patients and families.

During 2019/20, 2025 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:
463 in the first quarter; 487 in the second quarter; TBC in the third quarter; TBC in the fourth quarter.

Due to differences in the reporting periods for Learning from deaths (LfD) reviews and the Quality Accounts, for completeness data are included here for 2018/19 quarters 3 and 4, as these were not included in last year’s Quality Accounts. Likewise review data for 2019/20 quarters 3 and 4 are not available for inclusion in this year’s Quality Accounts.

Table 9: Summary of Learning from deaths (LfD) reviews (meeting criteria 27 in the Quality Accounts prescribed information)

Reporting period		**Number of deaths (27.1)**	**Number of reviews completed (27.2)**	**Number of serious incident investigations**	**Number** of the patient deaths considered likely to be avoidable (ie are judged to be more likely than not to have been due to problems in the care provided to the patient.) **(27.3)**	**Percentage** of the patient deaths considered likely to be avoidable (ie are judged to be more likely than not to have been due to problems in the care provided to the patient.) **(27.3)**
Third quarter	October 2018 to December 2018	576	25	4	3	0.52%
Fourth quarter	January 2019 to March 2019	506	21	5	2	0.40%
Total		**1082**	**46**	**9**	**5**	**0.46%**
First quarter	April 2019 to June 2019	463	12	1	0	0%
Second quarter	July 2019 to September 2019	487	13	5	2	0.41%
Total		**950**	**25**	**6**	**2**	**0.21%**
Third quarter	October 2019 to December 2019		Not yet completed	Not yet completed	Not yet completed	Not yet completed
Fourth quarter	January 2020 to March 2020		Not yet completed	Not yet completed	Not yet completed	Not yet completed
Total						

Reporting Period 2019/20 (Q1 and Q2)

By 31/03/20, from Q1 and Q2 of 2019/20, 25 case record reviews and 6 serious incident investigations have been carried out in relation to 950 of the deaths included in the information presented in Table 9.

In 5 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 and an investigation was carried out was: 52 in Q1, 19 in Q2, as shown in the table. Data for Q3 and Q4 are not yet available.

5 representing 0.41% of patient deaths during the reporting period 2018/19 Q1 and Q2, 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: 3 representing 0.40% for the first quarter; 2 representing 0.42% for the second quarter as shown in the table. Data for Q3 and Q4 are not yet available.

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 (ie 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)

Previous reporting period 2018/19 (Q3 and Q4)

By 31/03/20, from Quarters 3 and 4 of 2018/19, 46 case record reviews and 9 serious incident investigations have been carried out in relation to 1130 of the deaths included in the information presented in the Table. In 9 cases a death was subjected to both a case record review and a serious incident investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 25 in Q3, 21 in Q4, as shown in the table.

There were 5 patient deaths, representing 0.46 % of the patient deaths during the reporting period 2018/19 Q3 and Q4,that were considered likely to be avoidable. These were patient deaths were also identified as incidents prior to the Learning from deaths (LfD) process, and reported as serious incidents.

In relation to each quarter, this consisted of: 3 deaths representing 0.52% for the Q3; 2 deaths representing 0.40% for Q4 as shown in the table. Data for Q1 and Q2 were presented in last year's Quality Accounts.

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 (ie 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)

Previous reporting period 2018/19 (Q1 and Q2) – from 2019 Quality Accounts

Table 10: Summary of Learning from deaths (LfD) reviews (meeting criteria 27 in the Quality Accounts prescribed information)

Reporting period		**Number of deaths (27.7)**	**Number of reviews completed (27.8)**	**Number of serious incident investigations**	**Number** of the patient deaths considered likely to be avoidable (ie are judged to be more likely than not to have been due to problems in the care provided to the patient.) **(27.9)**	**Percentage** of the patient deaths considered likely to be avoidable (ie are judged to be more likely than not to have been due to problems in the care provided to the patient.) **(27.9)**
First quarter	April 2018 to June 2018	498	55	3	1	0.20%
Second quarter	July 2018 to September 2018	477	31	2	2	0.42%
Total		975	86	5	3	0.30%

After 01/04/18, from 2018/19 Q1 and Q2, 86 case record reviews and 5 serious incident investigations have been carried out in relation to 975 of the deaths included in the information presented in the Table. In 5 cases a death was subjected to both a case record review and a serious incident investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 55 in Q1, 31 in Q2, as shown in the table.

There were 3 patient deaths, representing 0.30 % of the patient deaths during the reporting period 2018/19 Q1 and Q2,that were considered likely to be avoidable. These were patient deaths were also identified as incidents prior to the Learning from deaths (LfD) process, and reported as serious incidents.

In relation to each quarter, this consisted of: 1 death representing 0.20% for the Q1; 2 deaths representing 0.42% for Q2 as shown in the table.

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 (ie 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 (27.4)
The 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; it should be noted that these do show differences in care for our patients and we continue to work to ensure that patient care is consistent and of high quality. During 2019/20, we updated our Incident Management Policy to include our Learning lessons from near misses, serious incidents and deaths communications plan. Some of our approaches include:

- Newsletters: Patient safety weekly and monthly bulletins, Divisional newsletters, safety alerts, quarterly Complaints, Litigation, Incidents, PALS and Safety report
- Meetings: Clinical innovations and standards committee, Mortality surveillance group, Hospital Mortality review groups, Hospital Clinical performance & patient safety committees, Safety incident review panel (SIRP), Divisional Quality Safety Boards
- Events: Learning from incidents and near misses event, Audit and quality days, trainee doctors, nursing, AHP induction.

Description of actions taken during 2018/19 (Q3 and Q4) (27.5)
The actions summarised below relate to those patient deaths which were considered likely to be avoidable. From October 2018 to March 2019, we identified 5 patient deaths that were considered likely to be avoidable, all of which were identified and reported as serious incidents:

Incident	FinYear	Quarter	Likert Avoidability
2018/26567	2018/19	Q3	2. Strong evidence of avoidability
2019/5050	2018/19	Q4	2. Strong evidence of avoidability
2019/7157	2018/19	Q4	2. Strong evidence of avoidability
2018/29170	2018/19	Q3	3. Probably avoidable, more than 50/50
2019/6445	2018/19	Q3	3. Probably avoidable, more than 50/50
2019/3740	2018/19	Q4	4. Possibly avoidable but not very likely, less than 50/50
2018/26552	2018/19	Q3	6. Definitely not avoidable ie unavoidable
2019/3744	2018/19	Q4	6. Definitely not avoidable ie unavoidable
2019/7704	2018/19	Q4	6. Definitely not avoidable ie unavoidable

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. We have reworded some of the actions, so that our patients and their families are not identifiable.

Actions

- TBC

Description of actions taken during 2019/20 (Q1 and Q2)
The actions summarised below relate to those patient deaths which were considered likely to be avoidable. From April 2019 to September 2019, we identified 2 patient deaths that were considered likely to be avoidable, all of which were identified and reported as serious incidents:

ID	FinYear	Quarter	Likert Avoidability
2019/9142	2019/20	Q1	TBC
2019/16779	2019/20	Q2	TBC
2019/21001	2019/20	Q2	3 Probably avoidable, more than 50/50
2019/16403	2019/20	Q2	4 Possibly avoidable but not very likely, less than 50/50
2019/16414	2019/20	Q2	4 Possibly avoidable but not very likely, less than 50/50
2019/25322	2019/20	Q2	2 Strong evidence of avoidability

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. We have reworded some of the actions, so that our patients and their families are not identifiable.

Actions
- TBC

Description of proposed actions to take during 2019/20 (27.5)
Actions from quarter 3 and 4 reviews when they are completed will be taken forward during 2019/20 and reported on in next year's Quality Accounts.

Assessment of the impact of the actions taken (27.6)
For each patient death that was considered likely to be avoidable, an investigation was undertaken and the actions to prevent recurrence of the incident were recorded (these actions have been detailed above). These actions are logged in our Risk Management system Datix, and are monitored by the hospital Clinical performance & patient safety committee 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.

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. Friends and Family test (Staff)
6. Venous thromboembolism (VTE)
7. C difficile
8. Patient safety incidents

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

Summary hospital-level mortality (SHMI)

Indicator:

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

Royal Free Performance Oct 15 - Sep 16	Royal Free Performance Oct 16 - Sep 17	Royal Free Performance Oct 17 - Sep 18	Royal Free Performance Oct 18 – Sep - 19	National Average Performance Sep 18 – Aug - 19	Highest Performing NHS Trust Performance Sep 18 – Aug - 19	Lowest Performing NHS Trust Performance Sep 18 – Aug - 19

0.9086 (as expected)	0.8679 (lower than expected)	0.8270 (lower than expected)	0.8207 (lower than expected)	1.0 (as expected)	0.6979 (lower than expected)	1.1877 (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. In addition to data for 2018-19, the chart above also includes data for 2015-16, 2016-17 and 2017-18.

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 for the following reasons; the data has been sourced from NHS Digital.

The latest data available covers the 12 months October 2018 to September 2019. During this period the Royal Free had a mortality risk score of 0.8207, 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 8th out of 129 non-specialist acute trusts.

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

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

https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi

Patient deaths with palliative care code

Indicator:

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

Royal Free Performance Oct 15 – Sep 16	Royal Free Performance Oct 16 – Sep 17	Royal Free Performance Oct 17 – Sep 18	Royal Free Performance Oct 18 – Sep 19	National Average Performance Oct 18 – Sep 19	Highest Performing NHS Trust Performance Oct 18 – Sep 19	Lowest Performing NHS Trust Performance Oct 18 – Sep 19
27.3%	35.5%	40.8%	**35%**	37%	59%	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.

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

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

- The palliative care team have implemented a process whereby they review all discharges each month and identify patients they have given care to in order to capture all patients. Internal audit showed this was correct to 95%. This work now needs to be undertaken at our other sites, including new report development.

The Royal Free London NHS Foundation Trust ranked 80th out of 137 non-specialist acute trusts.

https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi

Patient reported outcome measures scores (PROMS)

Indicator:

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. 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 before and after surgery.

This provides an indication of the outcomes or quality of care delivered to NHS patients and has been collected by all providers of NHS-funded care since April 2009. The table below shows the scores for the adjusted average health gain, which is the casemix-adjusted average gain in health from pre- to post-operative.

Royal Free Performance 2016/17	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
Indicator: Groin hernia surgery						
Low Number rule Applies	0.05	No longer being reported				
Indicator: Varicose vein surgery						
0.12	0.11	No longer being reported				
Indicator: Total hip replacement - primary (EQ-5D Index)						
0.43	0.42	0.41	Low Number rule Applies	0.47	0.55	0.39
Indicator: Knee replacement surgery (EQ-5D index)						
0.31	0.32	0.299	Low Number rule Applies	0.35	0.44	0.26

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reason; nationally the PROMS provider has changed and the trust has a process in place to ensure that the quality of our patients health are captured

During 2019/20, there were not enough RFL patients who completed the questionnaire to calculate the casemix adjusted average gain. The questionnaire is entirely voluntary, and a minimum of 30 patients must complete this in order to get an unbiased score.

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

- obtaining data of actual number of procedures undertaken to compare with figures
- reviewing where pre-operative questionnaires are completed

https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms/for-hip-and-knee-replacement-procedures-april-2019-to-september-2019

Emergency readmissions within 28 days

Indicator:

The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period. Internally the trust review it's 30-day emergency readmission rates for elective patients as part of its board key performance indicators.

Royal Free Performance 2015/2016	Royal Free Performance 2016/2017	Royal Free Performance 2017/2018	Royal Free Performance 2018/2019	National Average Performance 2018/2019	Highest Performing NHS Trust Performance 2018/2019	Lowest Performing NHS Trust Performance 2018/2019
Patients aged 0 to 15 years old						
10.1%	5.2%	10.5%	**9.4%**	12.5%	1.8%	69.2%
Patients aged 16 years old or over						
8.5%	8.3%	12%	**13.2%**	14.6%	2.1%	57.5%

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 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 compares favourably with the rate amongst the 167 non-specialist providers in England; with a lower than average readmission rate observed at Royal Free London Foundation NHS Trust in both paediatric and adult cohorts.

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

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

https://digital.nhs.uk/data-and-information/publications/clinical-indicators/compendium-of-population-health-indicators/compendium-hospital-care/current/emergency-readmissions-to-hospital-within-30-days-of-discharge/emergency-readmissions-to-hospital-within-30-days-of-discharge Ⓐ

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.

Please note that this indicator is currently suspended by NHS Digital with the intention that they will produce it again from summer 2018 onwards. As a result the trust has provided the latest available data to 2016/17. Internally the trust review it's 30-day emergency readmission rates for elective patients as part of its board key performance indicators.

Royal Free Performance 2014/2015	Royal Free Performance 2015/2016	Royal Free Performance 2016/2017	Royal Free Performance 2017/2018	National Average Performance 2017/2018	Highest Performing NHS Trust Performance 2017/2018	Lowest Performing NHS Trust Performance 2017/2018
Patients aged 0 to 15 years old						
9.93%	10.1%	5.2%	**10.5%**	11.7%	1.3%	32.9%
Patients aged 16 years old or over						
9.5%	8.5%	8.3%	**12%**	12.9%	1.8%	46.4%

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 compares favourably with the rate amongst the 136 non-specialist providers in England; with a lower than average readmission rate observed at Royal Free London Foundation NHS Trust in both paediatric and adult cohorts.The relative risk of emergency readmission within 28 days of previous discharge provides further evidence that the Royal Free London Foundation NHS Trust performs better than expected given its casemix and patient profile; the relative risk is 9.8% below (better than) expected. Standardised for both casemix and patient demographics this is the 8th lowest relative risk of any non-specialist English provider.

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

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

https://digital.nhs.uk/data-and-information/publications/clinical-indicators/compendium-of-population-health-indicators/compendium-hospital-care/current/emergency-readmissions-to-hospital-within-30-days-of-discharge/emergency-readmissions-to-hospital-within-30-days-of-discharge Ⓐ

Responsiveness to the personal needs of our patients

Indicator:

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

Royal Free Performance 2015/2016	Royal Free Performance 2016/2017	Royal Free Performance 2017/18	Royal Free Performance 2018/19	National Average Performance 2018/19	Highest Performing NHS Trust Performance 2018/19	Lowest Performing NHS Trust Performance 2018/19
69.9	68.3	67.1	**64**	67.2	85.0	58.9

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.

The NHS has prioritised, through its commissioning strategy, an improvement in hospitals responsiveness to the personal needs of its patients. Information is gathered through patient surveys. A higher score suggests better performance. Trust performance is just below the national average and 2018/19 performance.

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

- Developing site-based experience strategies that identify local issues for patients

- Continuing to deliver and monitor the patient experience strategy goals of cancer and dementia:
    - Cancer experience
        - Commenced the cancer clinical practice group across all tumour types where cancer patient experience will be a key focus
        - Established a cancer CNS community of practice for all cancer nurses
        - Piloting a new app which will gather real-time patient experience metrics split by tumour site
    - Dementia experience
        - 2 elderly care wards (8 West and 10 North) have undergone dementia friendly refurbishment
        - Publication of RFL Dementia Handbook for carers
        - 100 members of staff joined Chickenshed theatre company to complete an innovative study day in advanced comms for dementia
        - Over 600 members of staff have completed specialist CAPER Anchor training

https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current/domain-4-ensuring-that-people-have-a-positive-experience-of-care-nof/4-2-responsiveness-to-inpatients-personal-needs Ⓐ

Friends and Family test (Staff)

Indicator:

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

Royal Free Performance 2016	Royal Free Performance 2017	Royal Free Performance 2018	Royal Free Performance 2019	National Average Performance 2019	Highest Performing NHS Trust Performance 2019	Lowest Performing NHS Trust Performance 2019
75%	74%	73%	**71%**	70%	88%	41%

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the official NHS Staff Survey. Each year the NHS surveys its staff and one of the questions looks at whether or not staff would recommend their hospital as a care provider to family or friends.Trust performance is similar to the national average for acute trust providers on this measure. The Royal Free London NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

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

http://www.nhsstaffsurveyresults.com/Ⓐ

Venous thromboembolism (VTE)

Indicator:

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

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

Royal Free Performance Oct 16 - Dec 16	Royal Free Performance Oct 17 - Dec 17	Royal Free Performance Oct 18 - Dec 18	Royal Free Performance Oct 19 – Dec 19	National Average Performance Oct 19 – Dec 19	Highest Performing NHS Trust Performance Oct 19 – Dec 19	Lowest Performing NHS Trust Performance Oct 19 – Dec 19
95.9%	95.9%	96.5%	**96.9%**	95.0%	100.0%	71.6%

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 Improvement data collection.

The Venous Thromboembolism (VTE) data presented in this report is for the period October 2019 to December 2019.

Venous Thromboembolism (VTE) results in many hospital deaths which are potentially preventable. The government has therefore set hospitals a target requiring 90% of patients to be assessed for risk of VTE.

The Royal Free performed better than the 95% national target, achieving 96.9%, a marginal improvement on Q3 in 2018/19.

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

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

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

https://improvement.nhs.uk/resources/venous-thromboembolism-vte-risk-assessment-201920/Ⓐ

C difficile

Indicator:

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

Royal Free Performance 2015/2016	Royal Free Performance 2016/2017	Royal Free Performance 2017/2018	Royal Free Performance 2018/2019	National Average Performance 2018/2019	Highest Performing NHS Trust Performance 2018/2019	Lowest Performing NHS Trust Performance 2018/2019
17.8	21.0	21.3	**16**	12	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 the Public Health England and compared to internal trust data. .

Clostridium difficile 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 Clostridium difficile infections is a key government target.

Royal Free London NHS Foundation Trust performance was worse than the national average during 2018/19. However, very few of these infections have been attributed to lapses in care by the trust.

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

- The trust is ensuring that all staff adhere to the trust's infection control policies, including hand hygiene and dress code. Delivery of educational programmes, comprehensive antibiotic policies, good bed management with early isolation of symptomatic patients and enhanced environmental cleaning.

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

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

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

https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data

Patient safety incidents

Indicator:

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

	Royal Free Performance Oct 16 - Mar 17	Royal Free Performance Oct 17 - Mar 18	Royal Free Performance Oct 18 - Mar 19	Royal Free Performance Oct 18 - Mar 19	National Average Performance Oct 18 - Mar 19	Highest Performing NHS Trust Performance Oct 18 - Mar 19	Lowest Performing NHS Trust Performance Oct 18 - Mar 19
(a)	5,915 (36.5)	6,549 (39.1)	6,527 (38.8)	**6,693 (37.7)**	5,841 (46.1)	1,278 (27.7)	22,048 (48.4)
(b)	26 (0.44)	33 (0.20)	**24 (0.14)**	**19 (0.1)**	19 (0.19)	1 (0.01)	72 (0.16)

Every six 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 the NRLS, in terms of patient safety incident reporting and the characteristics of their incidents. The information in these reports should be used alongside other local patient safety intelligence and expertise, and supports the NHS to deliver improvements in patient safety.

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

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 lower volume of incidents per 1,000 bed days between Oct 2018 and Mar 2019 (37.7) compared to the national average (46.1).

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

1) Launching our Patient safety Clinical Practice Group (CPG) , which is initially focussed on embedding Local Safety Standards for Invasive Procedures (LocSSIPs). The LocSSIPs are safety checklists for procedures that are undertaken outside theatres eg biopsies and some injections.

2) Developing its patient safety culture, supporting the Trust goals of: zero never events, reducing avoidable deaths and zero avoidable hospital-acquired infections. We have focussed on improving our risk assessment processes for those most serious incidents and continue encouraging staff to report incidents. We have developed our safety learning and communications plan, that supports us providing timely feedback to staff on the outcomes and learning resulting from incident investigations. This is underpinned by safety events, newsletters, blogs and visits to ward areas.

We have robust processes in place to capture incidents, and increase our reporting by an average of 9% 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.

All incidents resulting in severe harm or death undergo additional scrutiny at our weekly, site-based Serious incident review panels (SIRP). 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.

https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current/domain-5-treating-and-caring-for-people-in-a-safe-environment-and-protecting-them-from-avoidable-harm-nof/5-6-patient-safety-incidents-reported-formerly-indicators-5a-5b-and-5-4 Ⓐ

Part three: review of quality performance

3.1 Overview of the quality of care in 2019/20

This section of the quality report presents an overview of the quality of care offered by the trust based on performance in 2019/20 against indicators and national priorities selected by the board in consultation with our stakeholders.

The charts and commentary contained in this report represents 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	• Summary hospital mortality indicator (SHMI) • 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	• Friends and family test • Volume of delayed transfers of care (DTOCs) • Cancelled operations not readmitted within 28 days

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. The calculation for cancer 62 day performance has changed since April 2019 and the definition has been updated below. There has been no change in the basis for calculation for any other measures since 2015/16.

Indicator / Metric	Description / Methodology	Source
Summary Hospital Mortality Indicator (SHMI)	These measures use routinely collected data to calculate an overall "expected" number of deaths if the trust matched the national average performance. The result is a ratio (calculated by dividing the observed number of deaths by the expected deaths).	NHS Digital
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
Friends and Family IP, A&E and maternity scores	The number of responses that scored likely and extremely likely as a percentage of the total number of responses to the IP, A&E and maternity friends and family tests. (Neither Likely or not likely excluded from responses)	Cerner system
Volume of delayed transfer of care (DTOCs)	This is the number of bed days lost in a month to patients who are awaiting a transfer of care to social or NHS community care.	Cerner system
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

This year the presentation of the data has altered since the previous Quality Account. The first chart type (control charts) are consistent with previous years. Benchmarking charts are now shown as lollipop charts.

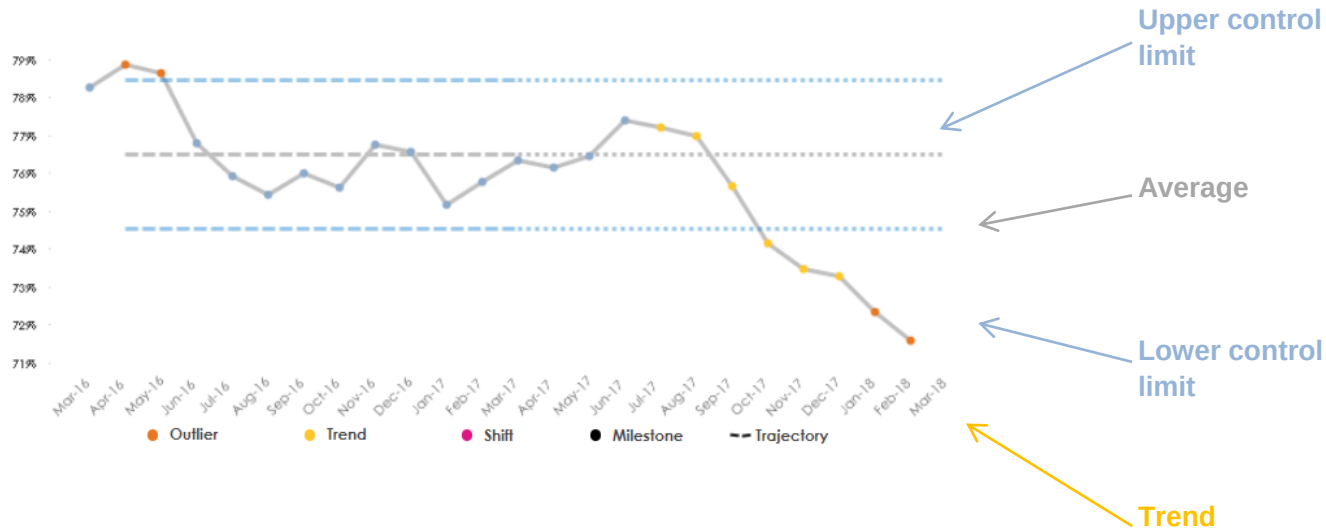
Control charts

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



Lollipop charts

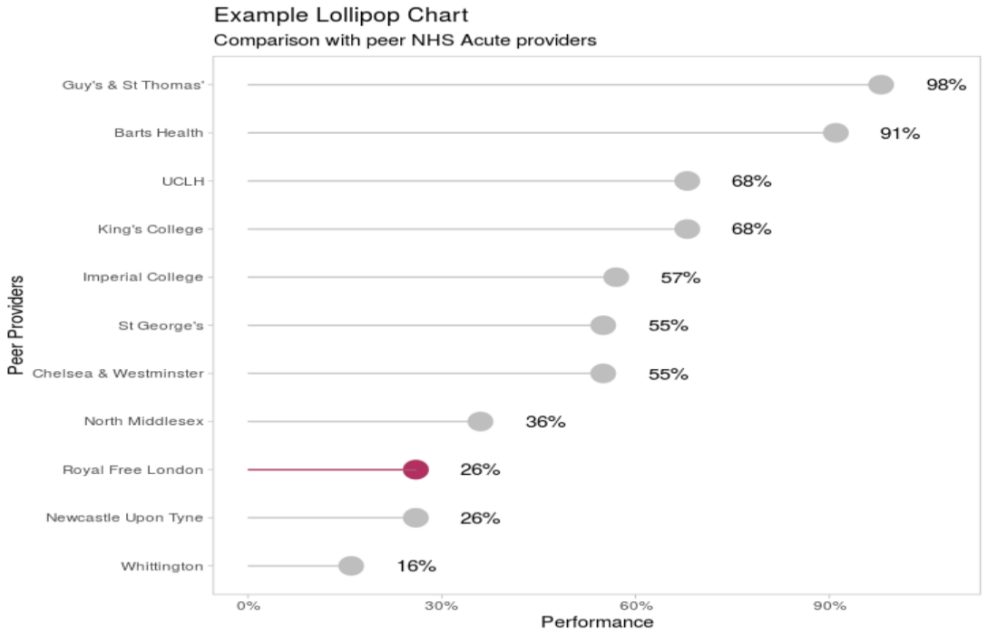
Lollipop charts are a way of displaying aggregate performance data, benchmarked against our peer providers. The chosen peer providers are those identified by the NHS Model Hospital[2] as being those which best match the characteristics and patient population of the Royal Free London.

All charts are aggregate 2019/20 performance, ordered to show the best performing trust at the top, and the worst performing trust at the bottom.

Lollipop charts are essentially bar charts which have been turned on the side, and plot performance from 0 to the overall performance figure for the year. This is calculated as either average performance (e.g. A&E, Cancer) or total volume (e.g. MRSA, c.diff infections). The Royal Free London are highlighted in maroon for easy comparison.

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

Example lollipop chart



Performance against key national indicators

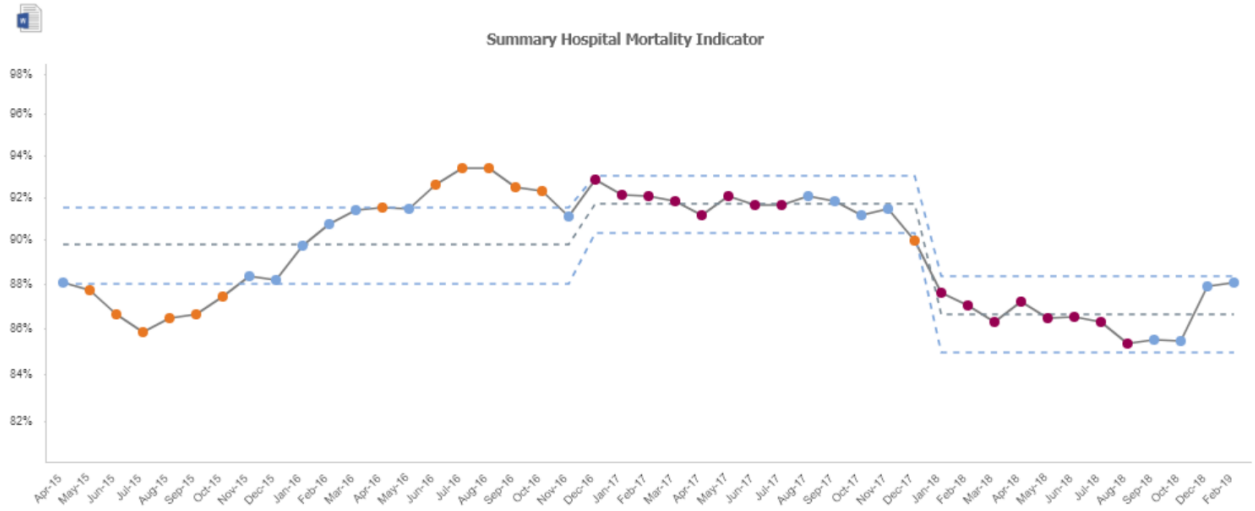
Section 1: Patient Safety

Summary Hospital Mortality Indicator (SHMI)

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

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

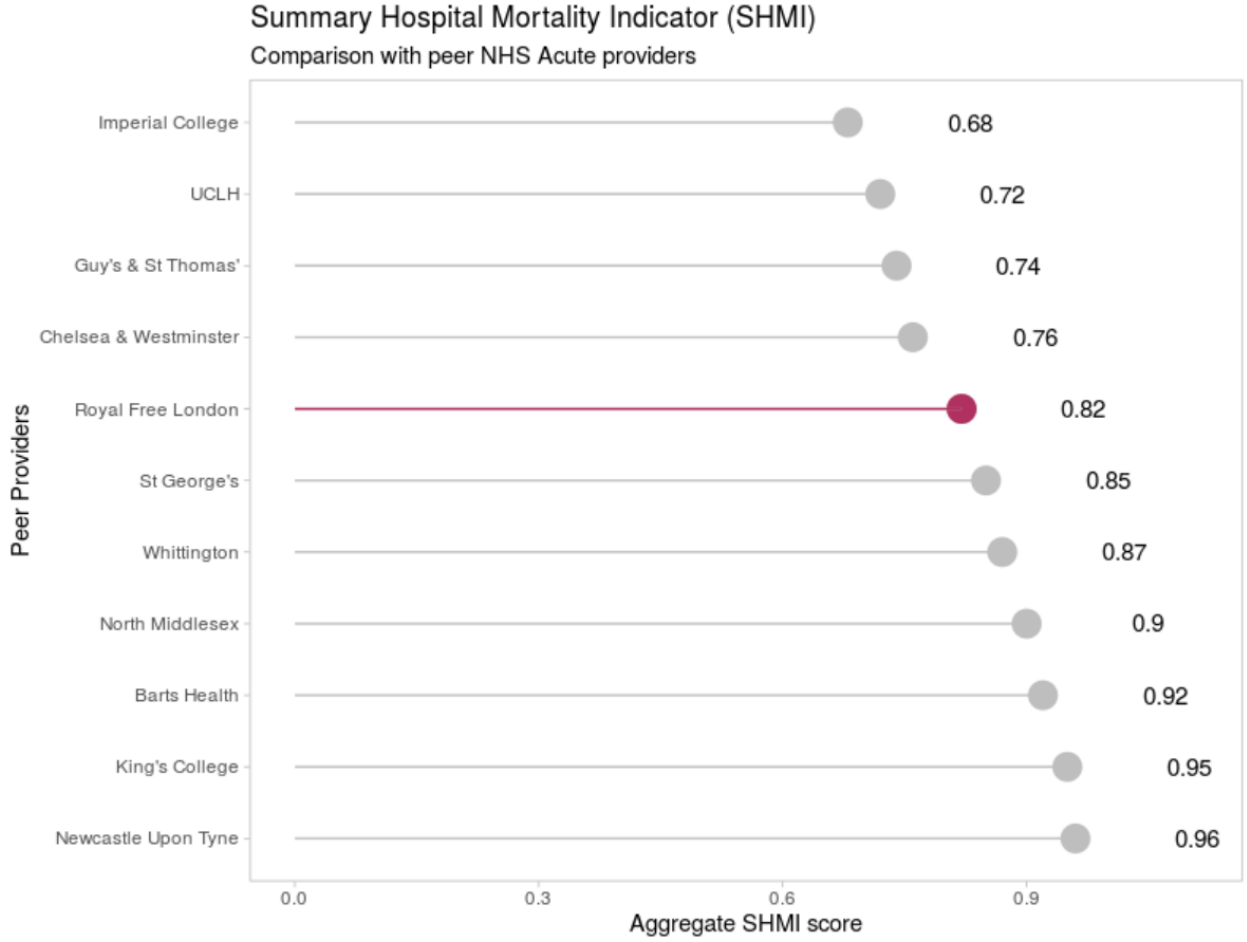
SHMI data is presented below for April 2015 to February 2020. This shows a recent improvement in the trust's score, with a positive shift in performance in January 2018.



Source: Royal Free London NHS Foundation Trust 2015-2019

The chart below shows the Royal Free London SHMI performance benchmarked against peer providers between October 2019 – September 2019 (the latest for which information is currently available). The Royal Free SHMI was 5th lowest (best) out of 10 benchmark peer providers and was statistically 18% lower than expected.

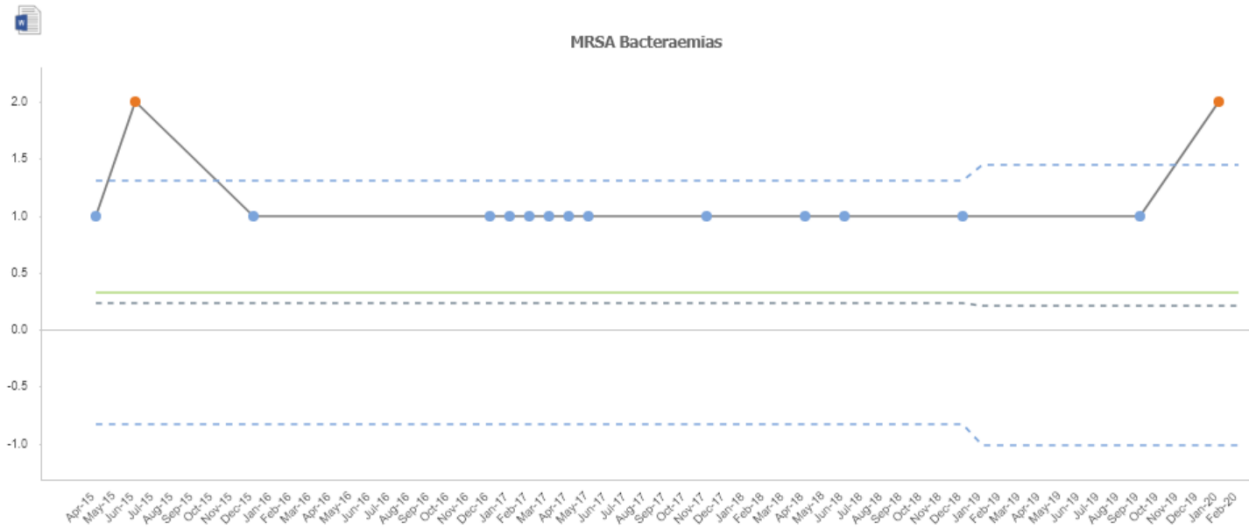
Chart: Summary Hospital-level Mortality Indicator by NHS acute trust



Source: NHS Digital, 2020

Methicillin-resistant staphylococcus aureus (MRSA)

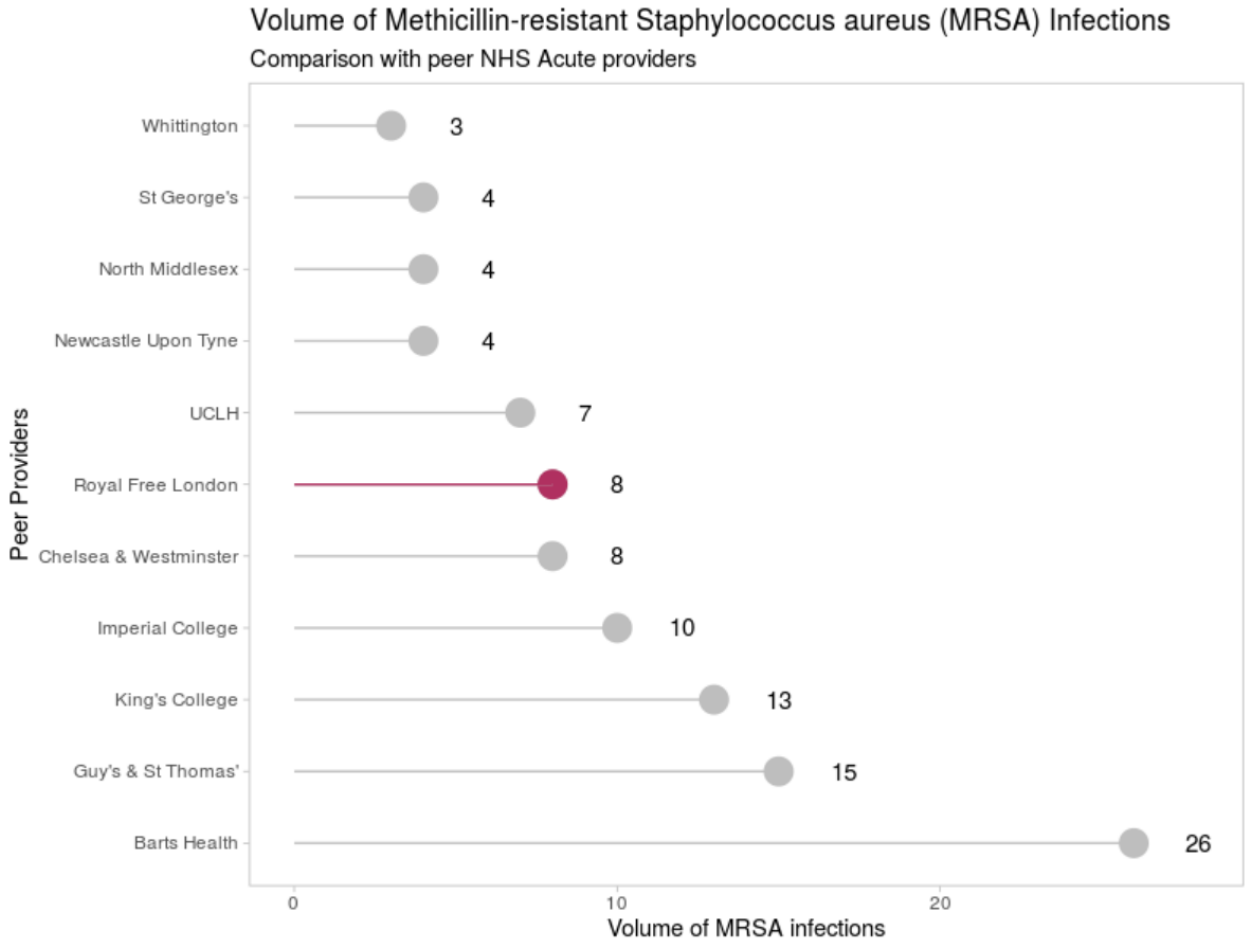
MRSA is an antibiotic resistant infection associated with admission to hospital. The infection can cause an acute illness, particularly when a patient's immune system may be compromised due to an underlying illness. Reducing the rate of MRSA infections is vital to ensure patient safety and is indicative 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 2015-2020

In the twelve months to the end of February 2020 the Royal Free reported 3 MRSA bacteraemias attributable to the Royal Free London. The chart below shows the number of MRSAs by the location at which they were detected. There were 6 cases detected at the Royal Free London, however only two were attributable to the trust.

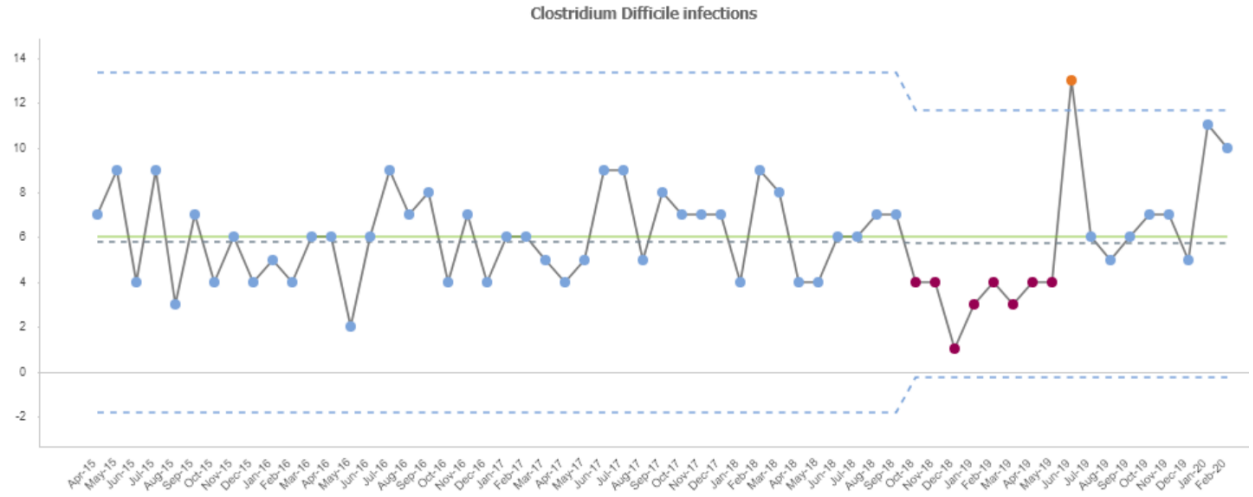
Chart: Total volume of MRSA bacteraemias, February 2019 – February 2020



Source: gov.uk, 2020

C. difficile

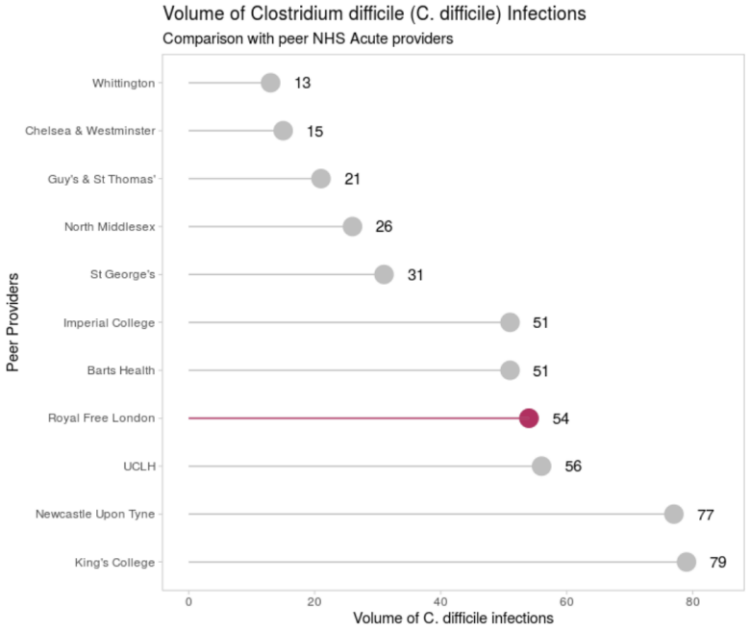
In relation to C. difficile the trust saw a positive shift in performance ending in April 2019, however since then numbers have been variable, with one negative outlier in June 2019.



Source: Royal Free London NHS FT 2015-2020

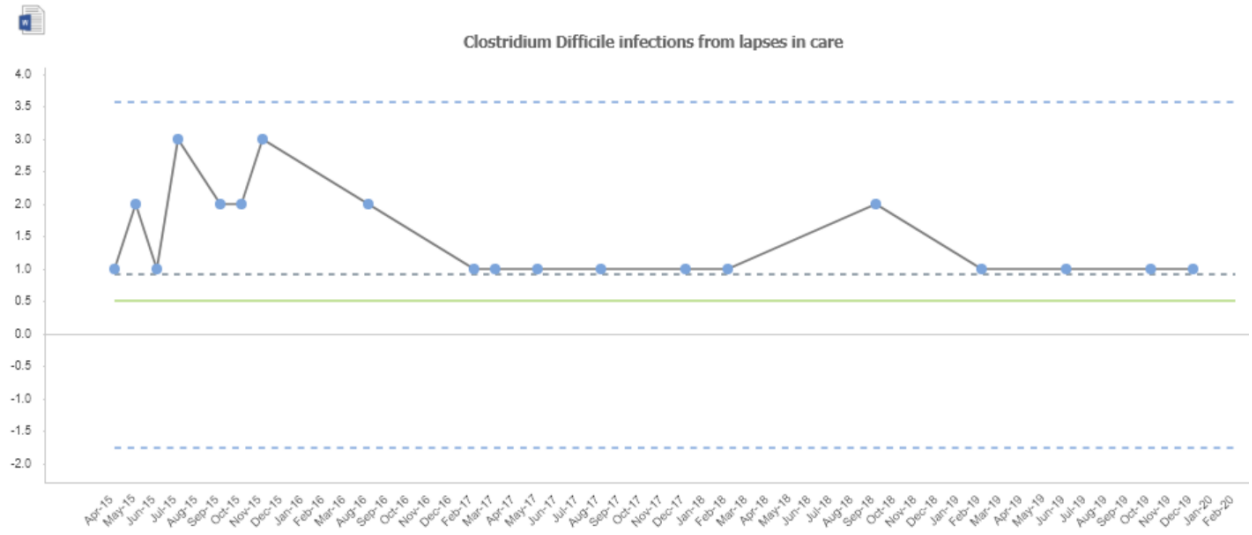
Benchmarking data is available only up to March 2019. Over this time period, the Royal Free London reported 54 infections, the 4th highest compared to the 10 benchmark providers.

Chart: Total volume of c. difficile infections, April 2018 – March 2019



Source: gov.uk, 2020

However, of the c.difficile 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 February 2020.



Source: Royal Free London NHS FT 2015-2020

Section 2: Clinical Effectiveness

Referral to treatment (RTT)

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

From September 2015, NHS England has used as the single measure of compliance with the NHS Constitution, the proportion of pathways where the patient has yet to receive treatment and is actively waiting. For these pathways the national standard requires 92% should be waiting 18 weeks or less to start treatment. This is the 'incompletes' standard.

During 2018/19, the trust worked on improving the way that it tracks patient pathways using a Patient Tracking List (PTL). This was intended to better link patient encounters together to identify whole pathways. However, as part of this work, the trust sought external advice to assure itself of the way that its PTL was constructed. This identified more significant issues than anticipated which meant that the trust needed to re-build the PTL in its entirety. The re-build work identified a large volume of historic patient pathways that needed to be validated to confirm whether patients are still waiting and ensure the trust is reporting correctly. As a result the trust board took the decision in March 2019 to pause national reporting while this work took place.

The trust is currently in the process of carrying out the actions required to support the development of a more accurate incomplete PTL and a return to national reporting by the end of 2020. These include:

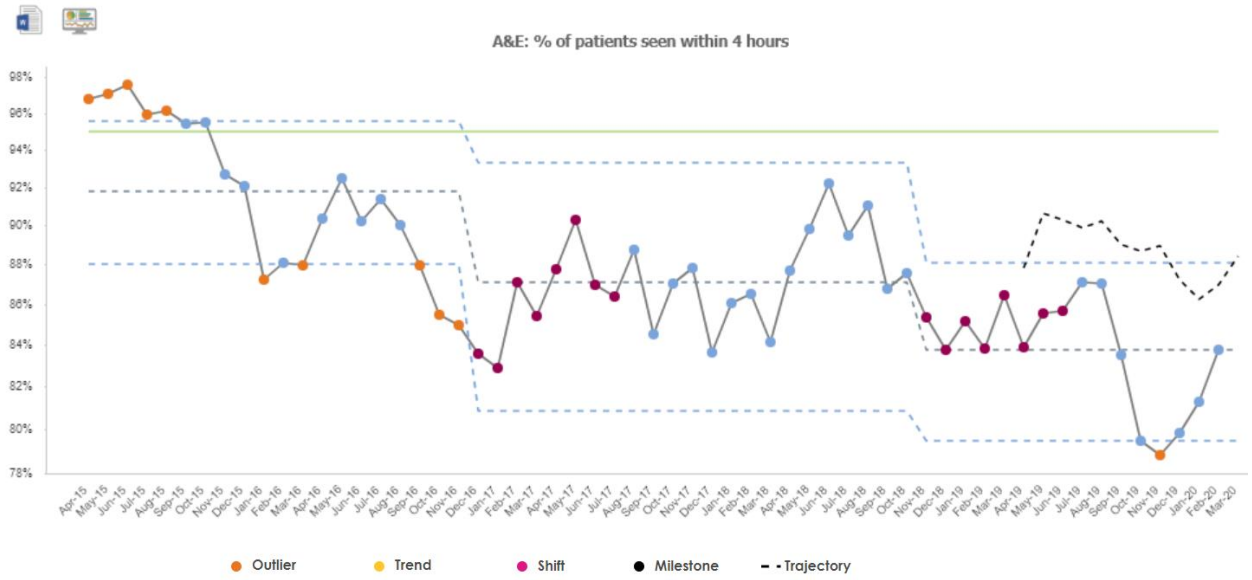
- Commissioning external support to carry out a large scale validation exercise of a stratified sample of the pathways from the Trust's historic data. This work is on track and due to be completed in April 2020.
- Validating and correcting a large number of more recent pathways with our internal validation resource. This work is also on track with the first phase to complete by April 2020.
- Training staff to ensure that all relevant staff understand Referral to Treatment pathways and how to record a patient's RTT status correctly.

The trust is currently reviewing and agreeing with our regulator the remaining actions that are needed to return the trust to national reporting.

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.

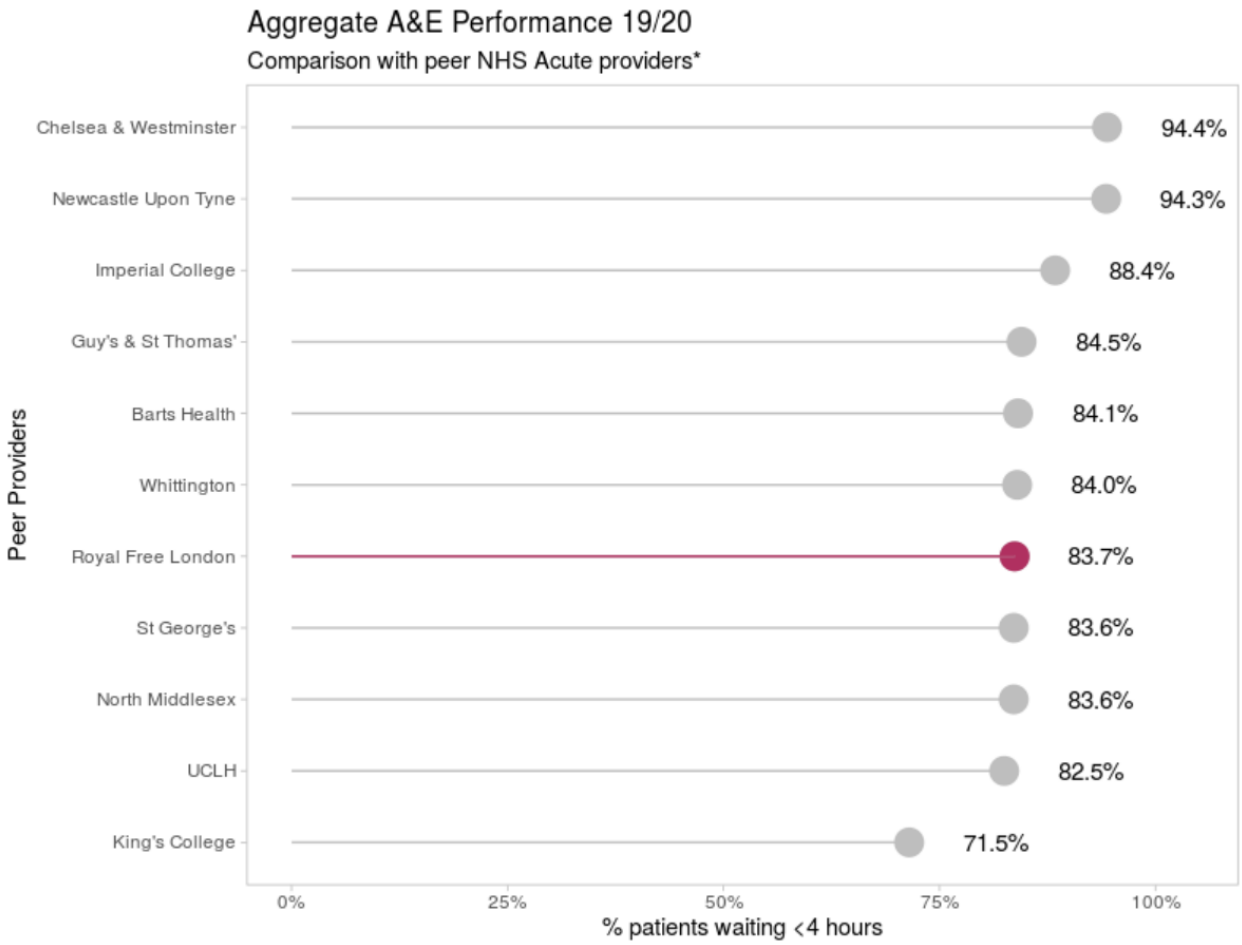
During the period April 2019 to February 2020, the Royal Free London NHS FT achieved an average monthly performance of 83.2%. This is lower than 2018/19 which averaged at 87.4%.



Source: Royal Free London NHS FT 2015-2020

The chart below shows the Royal Free London performance for April 2019 – January 2020 benchmarked against 10 peer providers. This shows that our performance was 3rd lowest compared to similar sized acute trusts. However, two of the trusts, Imperial College and Chelsea & Westminster, ceased reporting in June 2019 which means their performance is based on the aggregate of April and May 2019 only.

Chart: Mean performance against 4 hour A&E standard between April 2019 – January 2020[3]



Source: NHS Digital, 2020

Cancer waits:

The Cancer CPG was established in January 2019 with the aim of driving improvement in delivery of cancer services through a focus on experience, outcomes and waiting times. The Cancer CPG has been created to analyse the cross-sectional themes which underpin cancer pathways, such as cancer MDTs, radiology, histopathology and endoscopy, with a view to optimising processes, removing unwarranted variation and improving outcomes for patients.
The initial stages of the cancer CPG have involved a series of three workshops aimed at bringing together the clinical and operational teams who deliver cancer services across the trust.

The first workshop focussed on cross cutting issues applicable to all tumour sites and relating to outpatients appointment centre, preoperative assessment, pathology, radiology, patient co-design. The second workshop focussed on patient experience, MDT processes and patient related outcomes. The third workshop focussed on: end of treatment summaries and stratified f/up in primary care, pathways from MDT to Definitive therapies (Surgery, Radiotherapy and Chemotherapy), end of life and symptomatic care throughout the cancer pathway.

The cancer CPG also supported a series of focussed task & finish groups at tumour site level throughout 2019. These groups bought together clinical support services, operational & clinical teams and the outpatients service with the core aim of creating a sustainable service model that would enable teams to deliver initial diagnostics/appointments within 7 days of referral. Evidence shows this correlates to improved performance against cancer performance metrics nationally.

[3] Both Imperial College London and Chelsea & Westminster are taking part in trials for the proposed reform of NHS A&E waiting times standards. Therefore, they have not publicly released performance data since June 2019.

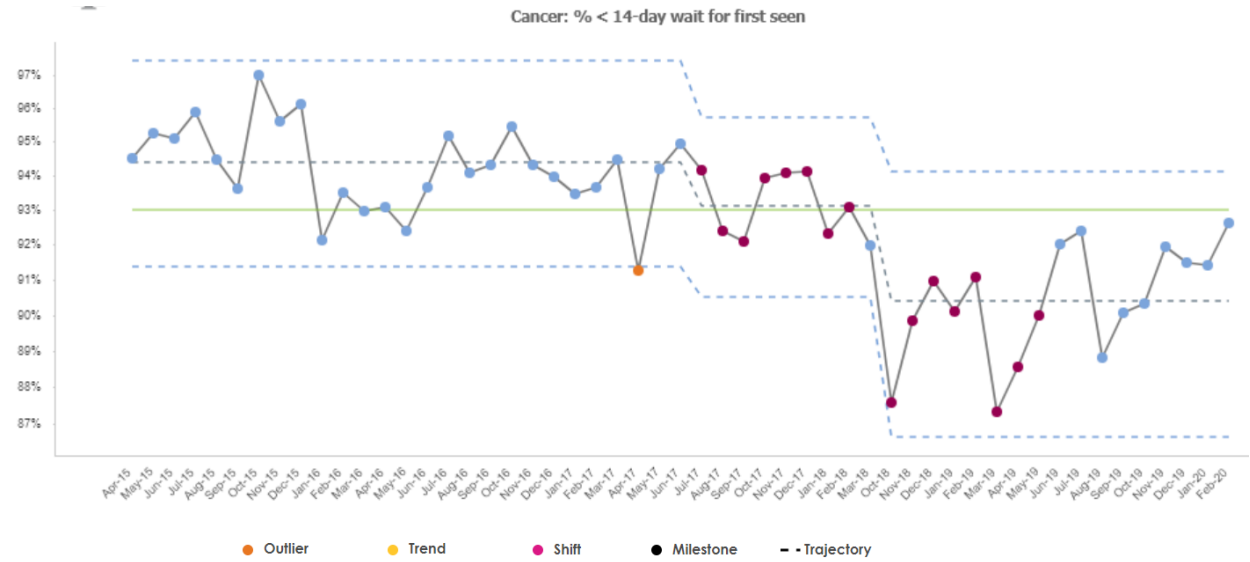
Cancer MDTMs (multi-disciplinary team meetings) form a key part of the cancer pathway that is common across tumour sites and utilise a high volume of clinician time. Alongside the context of national guidance from NHSI/E on MDT streamlining; the Cancer CPG are facilitating workshops which optimise MDT processes and ensure that Cancer MDTMs continue to provide effective clinical management of patient care.

There have been national pilots for cancer multidisciplinary diagnostic centres (MDCs) which have now evolved into rapid diagnostic centres (RDCs). Developing RDCs is a national priority, in order to achieve the ambition of diagnosing 75% of patients with cancer at stage 1 or 2, which the Trust will be required to deliver in close collaboration with the NCL Cancer Alliance. The cancer teams will enable the development of an RDC model through which patients that present with non-present specific systems can be referred into.

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.

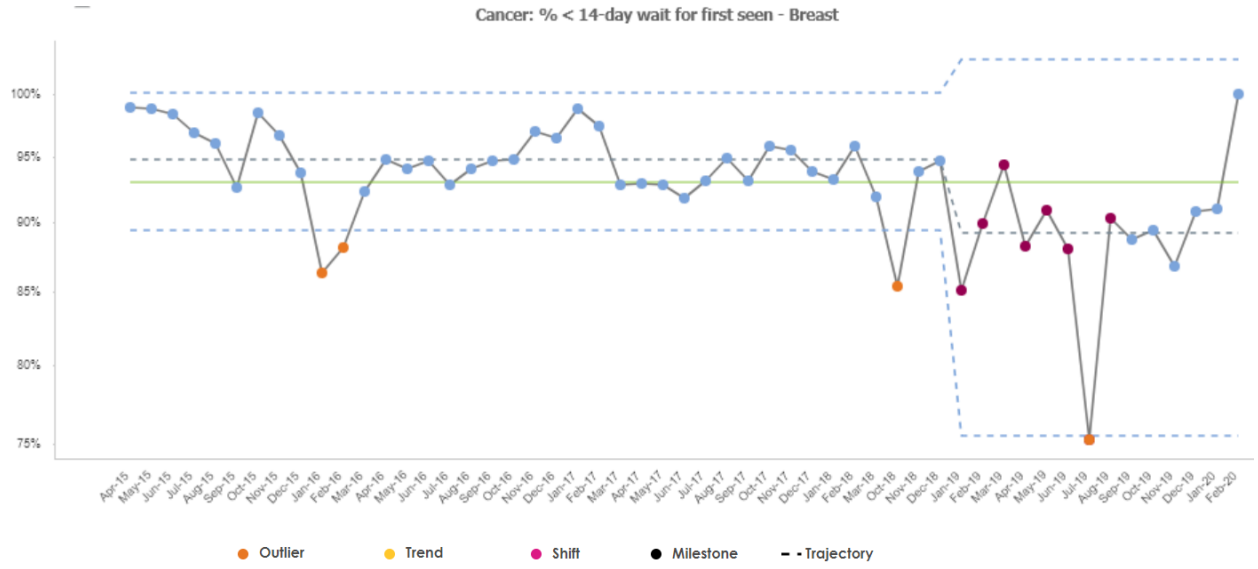
For 2019/20, the trust has failed to meet the standard to see at least 93% of patients within 2 weeks from GP referral, achieving an average performance of 90.9%.



Source: Royal Free London NHS FT 2015-2020

Breast Urgent referral 2 week waits

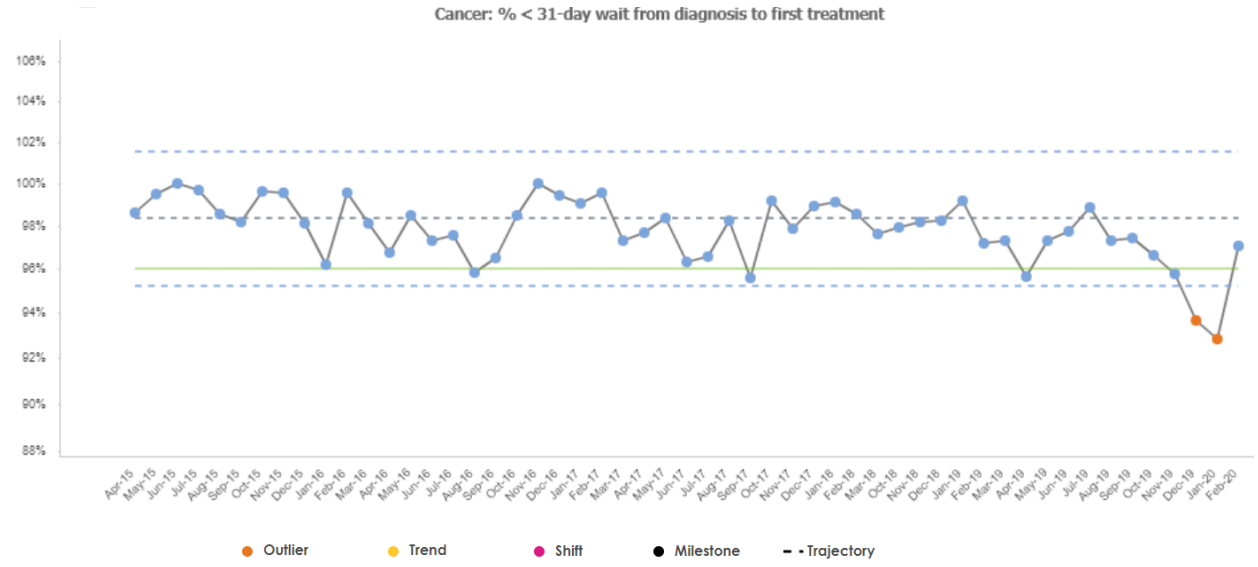
In 2019/20 up to February, the trust saw 89.0% of patients on an urgent (symptomatic) breast referral pathway within 2 weeks, below the national standard.



Source: Royal Free London NHS FT 2015-2020

First definitive treatment within 31 days

In 2019/20, the trust met the standard to see 96% of patients within 31 days for their first definitive treatment for cancer, with an average of 96.4% from April 2019 up to February 2020.

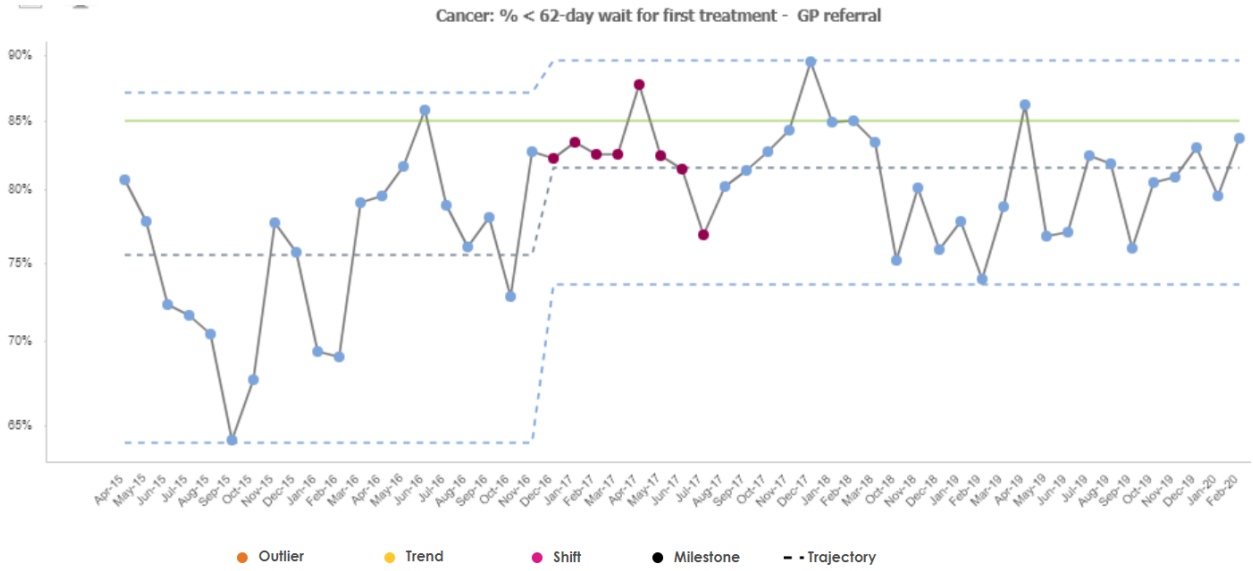


Source: Royal Free London NHS FT 2015-2020

This is similar performance to 2018/19 when we also met the standard.

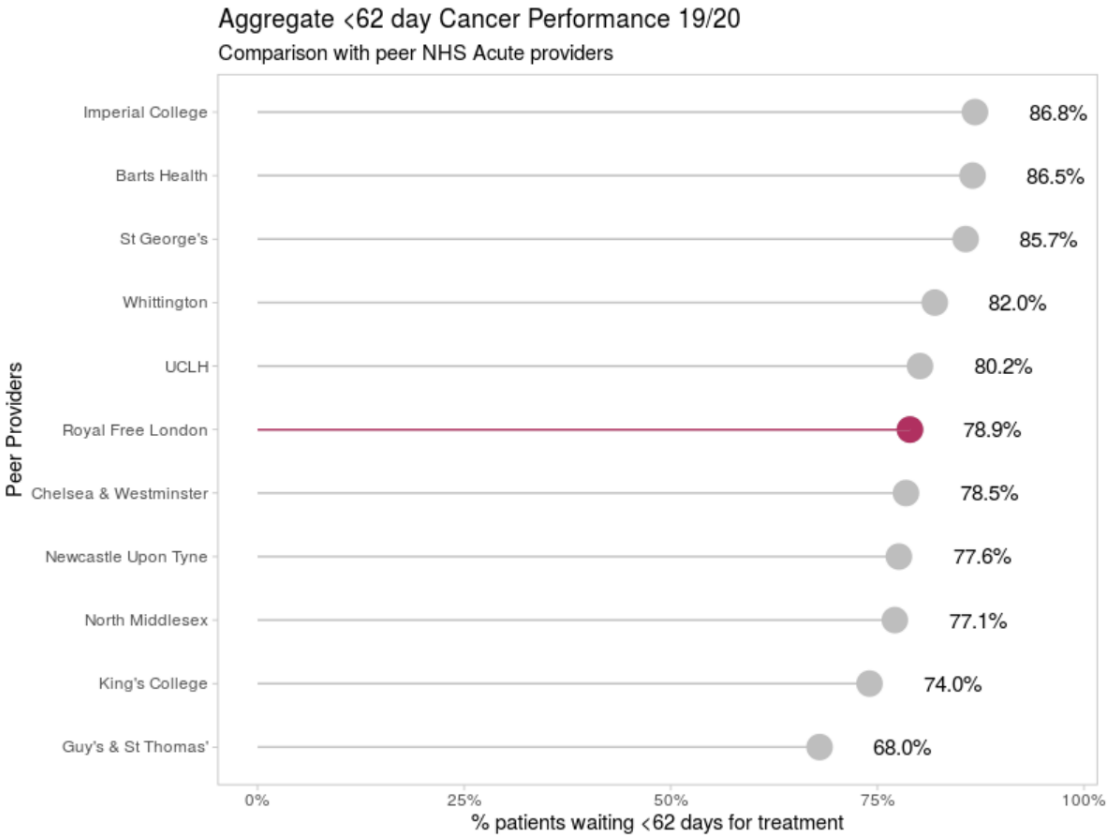
First definitive treatment within 62 days of an urgent GP referral

The trust did not meet the 62 day standard in 2019/20, with 80.7% of patients receiving first treatment within 62 days of a GP referral. This represents a slight deterioration on 2018/19 where 80% of patients were treated within the standard.



Source: Royal Free London NHS FT 2015-2020

Chart: Mean performance against 62 day cancer standard between April 2019 – December 2019

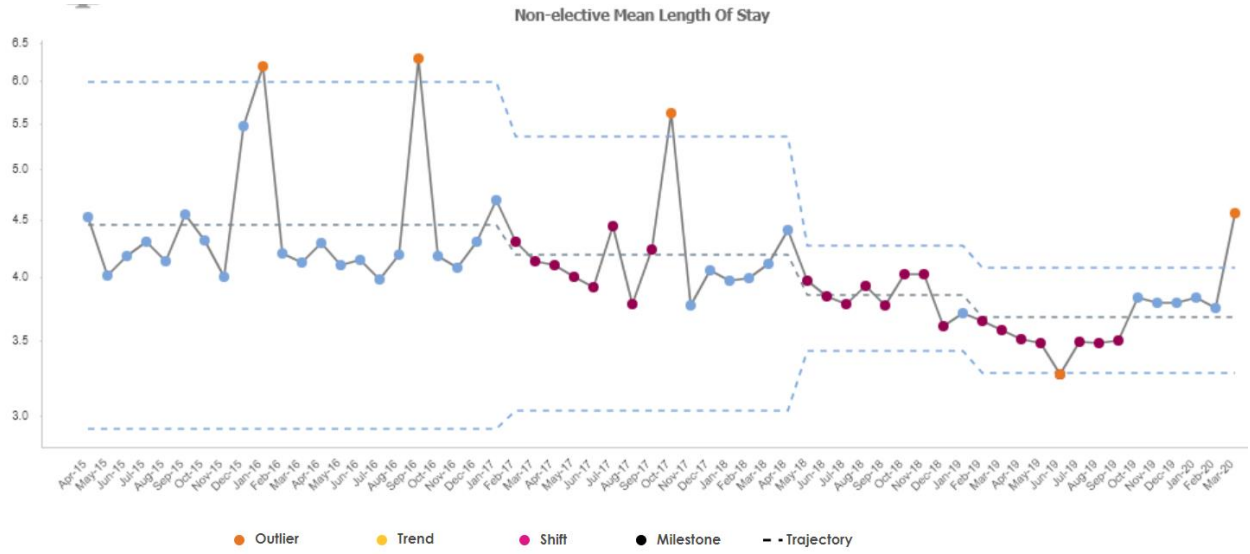


Source: NHS England, 2020

Average length of stay:

Non-elective mean length of stay

The trust average inpatient length of stay for patients admitted as non-elective from April 2019 to March 2020 shows that the trust average length of stay was 3.7 days. This is improved from the average length of stay reported in 2018/19 at 3.9 days and you can see from the chart below we had a positive shift in performance ending in September 2019.

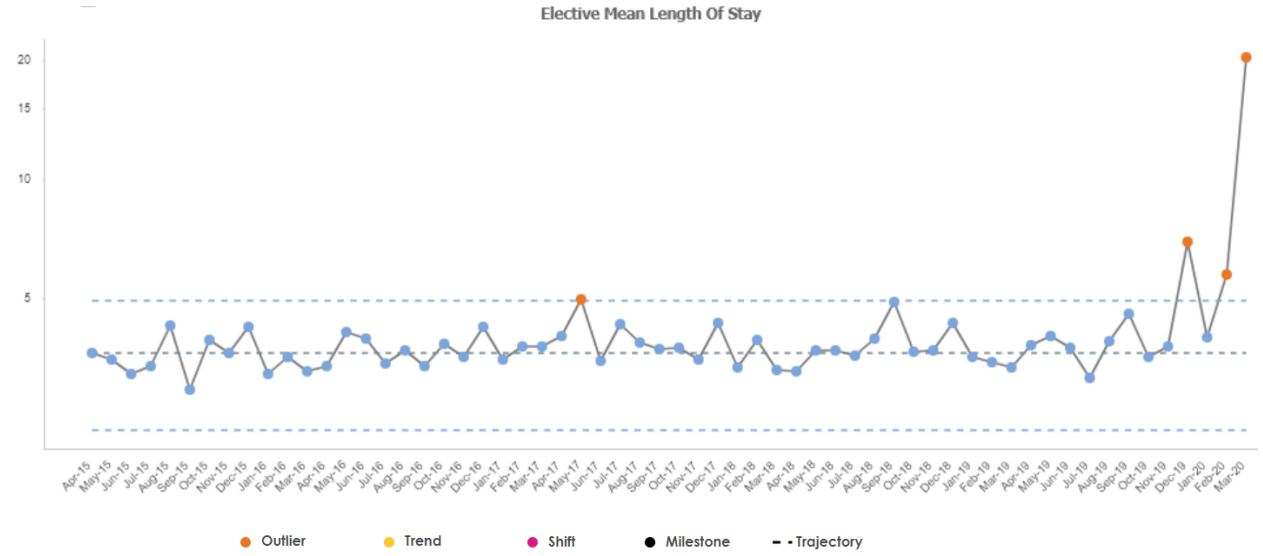


Source: Royal Free London NHS FT 2015-2020

Benchmark information is not available for this measure

Elective mean length of stay

The trust average inpatient length of stay for patients admitted as non-elective to shows that the trust average length of stay in the period April 2019 to February 2020 was 5.6 days.



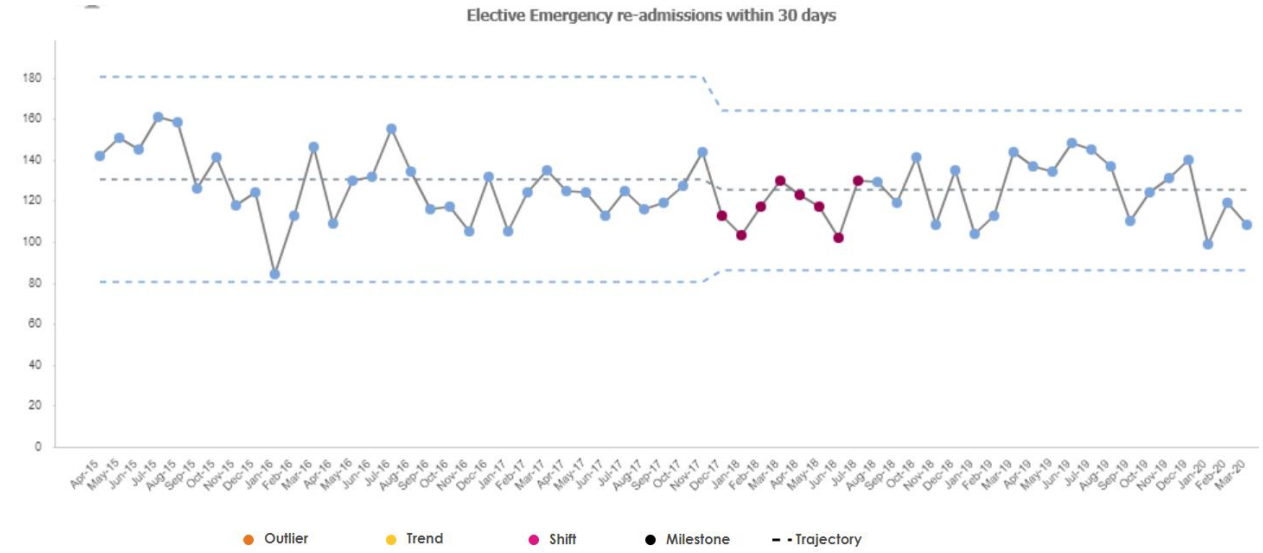
Source: Royal Free London NHS FT 2015-2020

Benchmark information is not available for this measure.

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 2015 and February 2020. The average for April 2019 to March 2020 was 128 and any variation has been within expected limits.



Source: Royal Free London NHS FT 2015-2020

Benchmark information is not available for this measure.

Section 3: Patient experience indicators

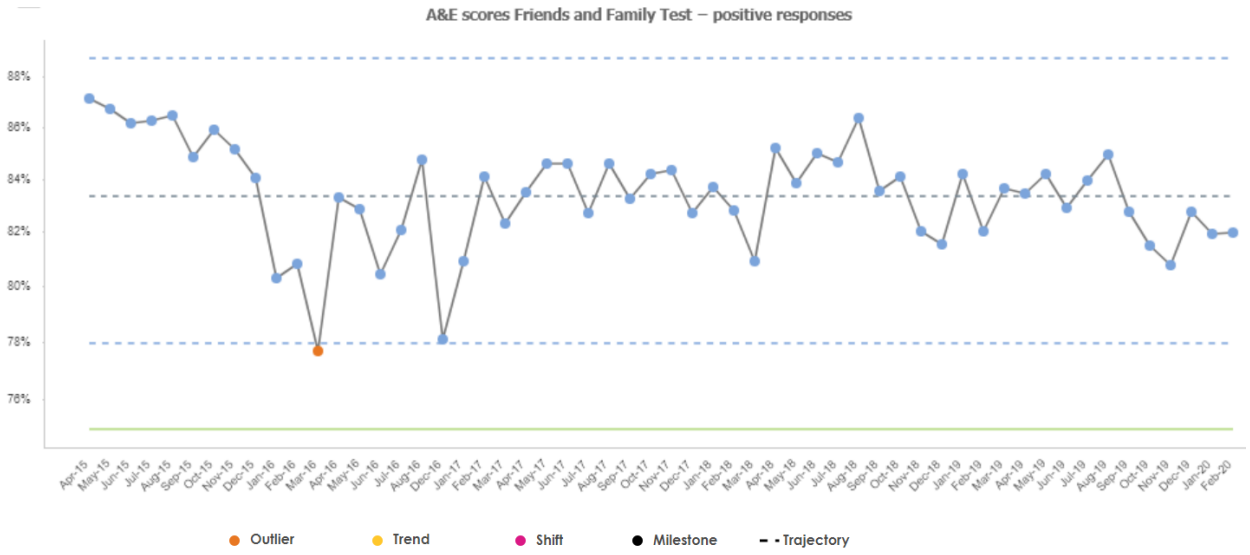
Friends and family test (patients)

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

The data below shows our performance from April 2015 to February 2020 with regards to our A&E, Inpatient, Outpatient and Maternity FFT scores.

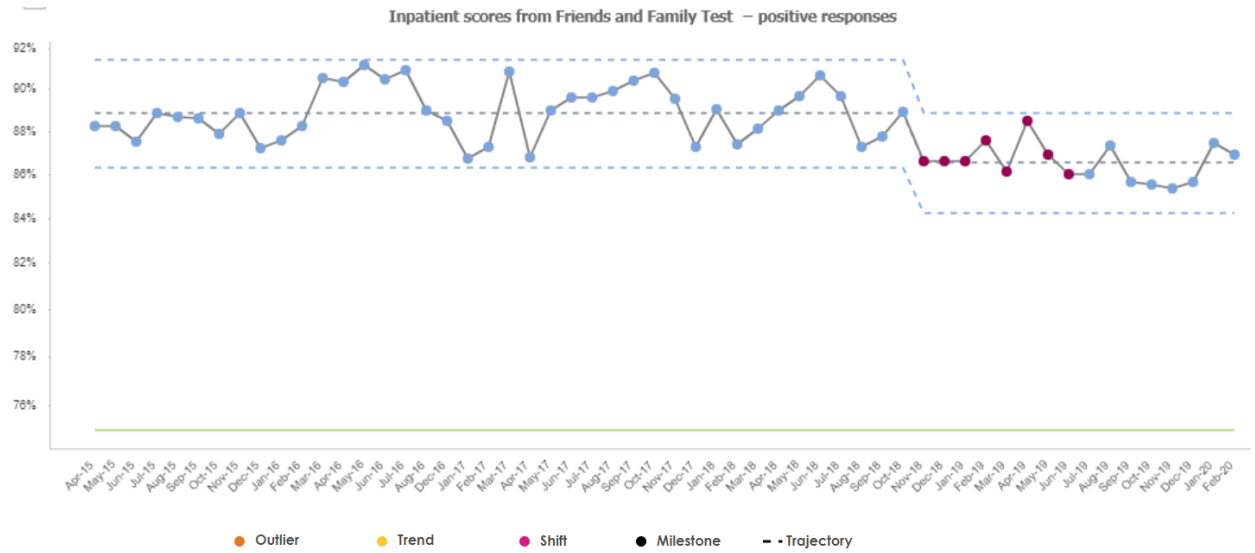
For all areas we have maintained performance over the last year. Whilst we previously did include benchmarking charts for these measures, NHSE recommends that benchmarking is not used to compare providers due to the flexibility of local data collection methods and variation in local population.

The FFT scores for A&E have remained stable above target throughout 2019/20. Any variation has been within expected limits.



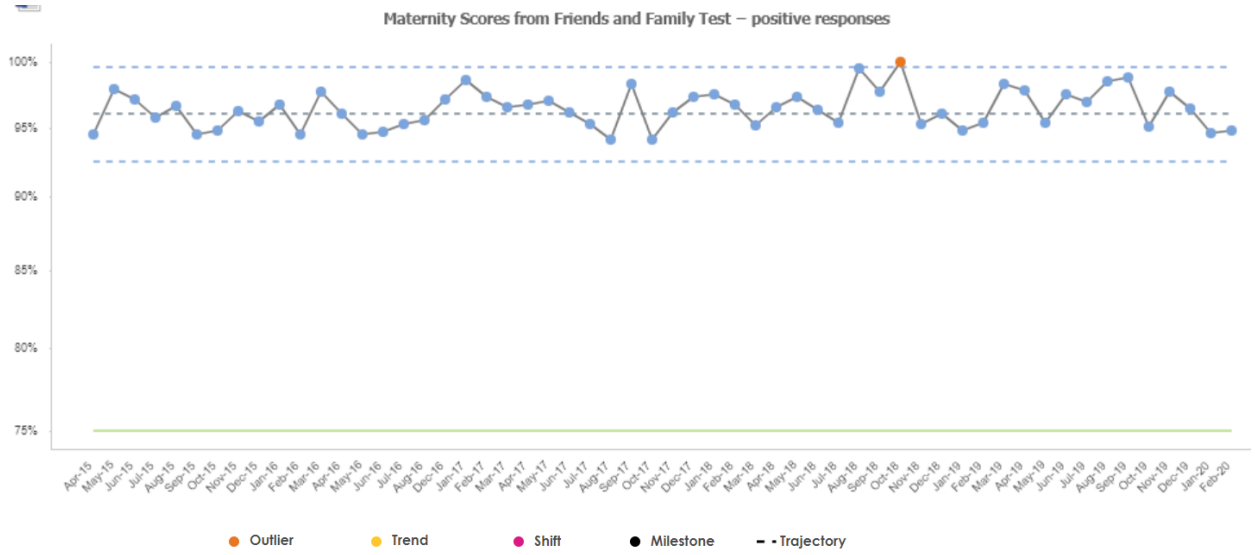
Source: Royal Free London NHS FT 2015-2020

The FFT scores for inpatients have remained above target throughout 2019/20. There was a negative shift in performance starting in November 2018 but performance has remained well above compliance.



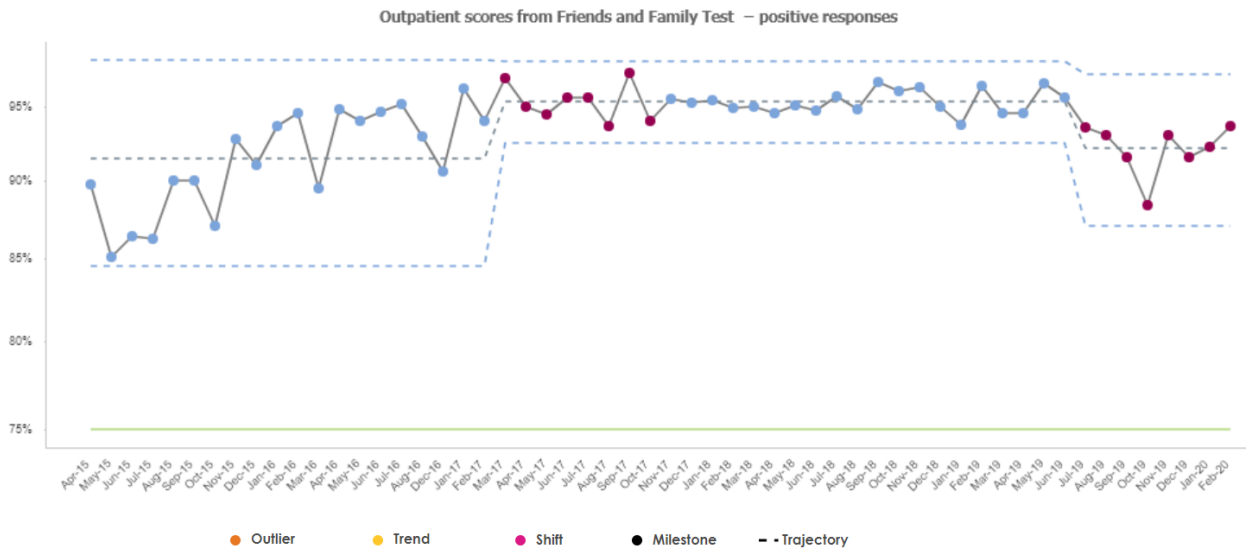
Source: Royal Free London NHS FT 2015-2020

The FFT scores for maternity have remained stable above target throughout 2019/20. Any variation has been within expected limits.



Source: Royal Free London NHS FT 2015-2020

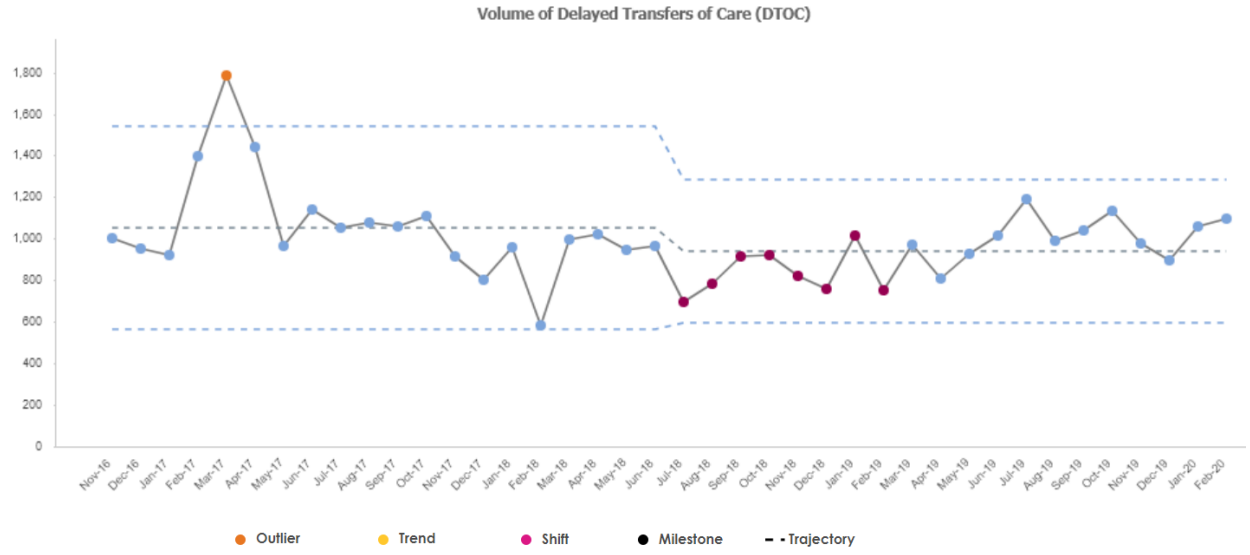
We have seen some variation in the outpatient scores throughout 2019/20, resulting in a negative shift in performance which started in July 2019. However, these months are still well above target.



Source: Royal Free London NHS FT 2015-2020

Volumes of delayed transfers of care

This is the number of bed days per month that the trust lost to patients who were waiting for a transfer to social or NHS community care. Over the course of 2019/20 this has remained stable. We have been working closely with our local commissioners and social and community care providers to continue to reduce the number of delays.

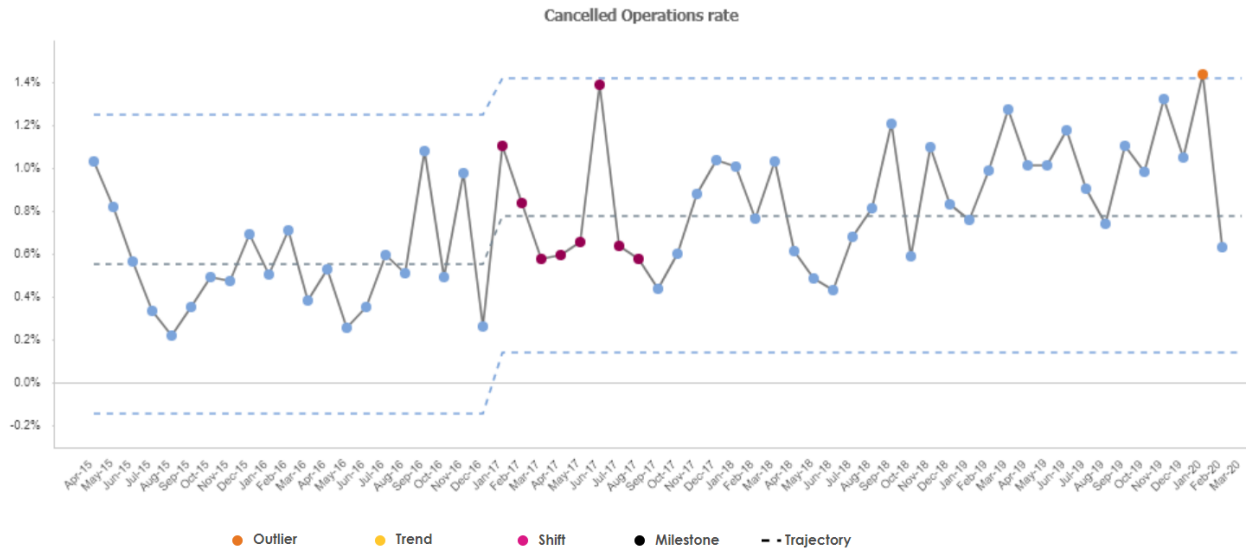


Source: Royal Free London NHS FT 2016-2020

Benchmark information is not available for this measure.

Cancelled operations rate

This is the 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 daycase operations. Over the course of 2019/20, this rate has remained within expected control limits with the exception of a negative outlier in February.



Source: Royal Free London NHS FT 2015-2020

Benchmark information is not available for this measure.

3.2 Performance against key national indicators

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

Indicators of Governance	Target	Q1	Q2	Q3	Q4	
Summary Hospital-level Mortality Indicator	**<100**					
A&E Maximum waiting time of four hours from arrival to admission/transfer/discharge	**≥95%**	**85%**	**85.9%**	**79.4%**		
C difficile number of cases against plan	**<18/Q**	**21**	**17**	**19**		
Maximum 6-week wait for diagnostic procedures	**≥99%**	**93.9%**	**90.8%**	**93.3%**		
Venous thromboembolism (VTE) risk assessment	**≥95%**	**96.4%**	**97.1%**	**96.5%**		
****Cancer: two week wait from referral to date first seen**						
All cancers	**≥93%**	**90.2%**	**90.4%**	**91.2%**		
Symptomatic breast patients	**≥93%**	**89.0%**	**84.8%**	**89.0%**		
**All cancers: 31 day wait from diagnosis to first treatment	**≥96%**	**96.9%**	**97.9%**	**95.4%**		
****All cancer 31 day second or subsequent treatment**						
Surgery	**≥94%**	**93.1%**	**94.5%**	**93.5%**		
Chemotherapy	**≥98%**	**100%**	**99.2%**	**100%**		
Radiotherapy	**≥94%**	**100%**	**100%**	**100%**		
All cancers: 62-day wait for first treatment, from::						
Urgent GP referral for suspected cancer	**≥85%**	**80.0%**	**80.0%**	**81.4%**		
NHS Cancer screening service referral	**≥90%**	**94.7%**	**87.1%**	**91.2%**		

Section 3.4: Our Local Improvement Plans

This section contains an overview on our plans in regards to:

- The Care Quality Commission
- Speaking up: It's safe to speak up
- Implementing seven day hospital services

The Care Quality Commission

Further to our initial report in our 2018/19 accounts regarding our announced CQC inspection across our three hospital sites during 11-13 December 2018; which included the well led and use of resources inspection between 8-10 January 2019.

The inspection focused on the following core services:

- Urgent and emergency care
- Surgery
- Critical care
- Maternity
- Medical

The inspection report which was published in May 2019 rated the trust overall as requires improvement – unfortunately, a drop from our rating of 'good' in 2016.

Over the weeks and months during 2019/20, the trust has been focused on completing our action plans in response to areas of improvement as our priority. We will continue to share progress with the CQC and report our improvement progress through our governance arrangements to our trust board and to commissioning partners and the regulator.

The trust continues to make improvements in the areas identified from the December 2018 CQC inspection, achieving the following improvements in response to the report's 'Should-do's and Must-do's'.

Must-Do Actions: The chief inspector made 93 recommendations 11 of which the trust MUST DO. We have achieved the following 6 “Must Do Actions”. The remaining 5 will be achieved by mid 2020/21

Barnet Hospital – Critical Care

MUST ensure all risks are accurately assessed and regularly monitored with timely mitigating actions taken to address issues, including the safe and secure storage of medicines and intravenous fluids

The Trust undertook a review of the management of risks across the service and developed a standard operation procedure adapted from the Trust risk management policy.

We also reviewed the governance arrangements across the service, implementing a critical care clinical governance meeting.

We developed a critical care dashboard to cover critical care risks for on-going monitoring including medication audit compliance, delayed discharged and out of hours discharges.

Royal Free Hospital – Critical Care

MUST reinforce the use of an up to date risk register that includes all risks and comprehensive mitigations

All ICU risks are reviewed at the monthly ICU governance & performance meeting.

New risks and risks for closure (from all clinical areas) are discussed at the surgery & associated divisional board meetings.

Risk around ICU private patients' priority and long stays - it has been agreed by chief executive, divisional directors and director of finance and private practice unit in March 2019, not to bring in long term overseas patients to ICU if we are outsourcing hepato-billiary surgery..

Chase Farm Hospital – Urgent & Emergency Care

MUST ensure that staff follows the trust’s record management policies concerning safe storage and security of patient and staff records

Documents referred to in the report were removed and placed in to a secure cupboard with swipe access for appropriate staff members only.

A new secure cabinet has been placed in the management office in the urgent care centre for such documents to be stored in future.

A process for collecting papers that require scanning and sending to medical records for scanning on a daily basis has been implemented in the department.

Barnet Hospital – Critical Care

MUST ensure there is a sustainable plan and action is taken to improve the quality of service in relation to delayed discharges, and patient experience staying in an inappropriate environment and discharge transfers out of hours

A critical care task and finish group was set up to develop a strategy for improving the quality of the service in relation to delayed discharges and out of hour transfers, with monthly oversight of the progress via the critical care clinical governance meeting and is monitored by the surgery& associated services divisional board and Barnet Hospital clinical performance & patient safety committee.

Delayed discharges and out of hour transfers to be reviewed weekly by the ITU matron and the clinical director.

Trust-wide

MUST ensure that its restraint policy follows best practice guidance as set out in Positive and Proactive Care:

The trust updated the restraint policy in January 2019 and this was ratified at the Trust integrated safeguarding committee on 17 January 2019.

This has been disseminated to all staff and is available on the trust intranet system.

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Chase Farm Hospital – Urgent & Emergency Care

MUST act to ensure staff follow-up with patients that leave the Urgent care centre before being seen, particularly with vulnerable children and adults

A process for reviewing did-not-attends and informing patient's GPs of any children or known vulnerable adults of the did-not-attend has been put in place.

This will be included in the daily check in the urgent care centre to ensure compliance with the process.

The following 82 recommendations from the chief inspector identified that the trust “Should” undertake actions to improve across the domains of:

- Safe
- Effective
- Care
- Responsive and
- Well Led

1 of the “should do” recommendation no longer is the responsibility of RFLNHS FT as the service has moved to a different provider. The CQC and the new provider were informed in May 2019.
We have achieved a significant amount of these xxx% and we will continue to ensure we complete all our intended actions.

CQC Domain	CQC recommended actions	Trust achievement
SAFE	**The trust should ensure staff have clear guidance and take appropriate action when temperature is outside optimal levels for medicine storage in drug fridges and storage rooms.**	✔
	The trust should ensure contents, including medicines, in transfer bags are regularly checked and records kept.	✔
	The trust should ensure critical care staff receives sufficient training to enable them to confidently use the new hospital EPR system as needed.	✔
	The trust should ensure all staff has up to date adults and children’s safeguarding training at all levels and ensure the trust’s 85% target is met.	✔
	The trust should ensure appropriate checks are undertaken on patients wearing mittens.	✔
	The trust should ensure they review processes for the management of medicines used in emergencies and the systems for the monitoring of temperatures of medicines storage areas.	✔
	The trust should ensure hand hygiene compliance meets the trust targets across all the wards.	✔
	The trust should address the high turnover rate amongst nursing staff and ensure all of the shifts are covered at all times.	✔
	The trust should fill the vacancies for medical staff to ensure there is sufficient number of doctors available to provide patient’s care and treatment.	✔
	The trust should ensure staff understands how and when to assess whether a patient with mental health needs has the capacity to make decisions about their physical care and treatment.	✔
	The trust should ensure action is taken to prevent avoidable patient safety incidents from reoccurring.	✔
	The trust should ensure all five steps of the safer surgery checklist are appropriately completed and documented in line with national guidelines.	✔
	The trust should review processes to provide assurance that medicines are stored at the correct temperatures to remain effective.	✔
	The trust should review security of medicines storage areas.	✔
	The trust should implement a formal process for reception staff to highlight issues in the waiting areas.	✔
	The trust should improve the signage to the entrance to the UCC.	✔
	The trust should monitor medical staffing levels during the expansion of the unit to ensure they meet FICM standards.	✔
	The trust should ensure ward teams fully comply with the Control of Substances Hazardous to Health (COSHH) Regulations (2002) in reference to safe and secure storage of chemicals.	✔
	The trust should ensure the review of Never Events and serious incidents are undertaken by senior clinical staff and robust actions should be documented and monitored.	✔
	The trust should ensure they continue to work with other external agencies to put systems in place to reduce the number of never events taking place.	✔
	The trust should review how medicines were stored and accessed in the operating theatres.	✔
	The trust should ensure that there is consistent record keeping for emergency department patients in the adult assessment unit.	✔

EFFECTIVE	**The trust should ensure they reduce the average length of stay for medical non-elective patients, to meet the England average.**	✔
	The trust should ensure the trust's consent policy is followed and that all stages of the consent process are appropriately documented.	✔
	The trust should ensure policies and guidelines available in hard copies are regularly reviewed and updated.	✔
	The trust should ensure there is an action plan to address 2016/17 Royal College of Emergency Medicine (RCEM) moderate and acute severe asthma and consultant sign-off audit results.	✔
CARING	**The trust should ensure they focus on getting patients a bed on a ward for their speciality to reduce the number of patient moves at night.**	✔
	The trust should improve the reception area in the urgent care centre and paediatric outpatients to ensure patient confidentiality.	✔
RESPONSIVE	**The trust should ensure patients are reviewed by a consultant within 12 hours of admission to critical care.**	✔
	The trust should ensure the data submitted to external bodies is accurate, particularly in relation to delayed discharges and mixed sex breaches.	✔
	The trust should ensure potential trip hazards in corridors are removed across all the wards.	✔
	The trust should ensure they follow best practice and not discharge patients at night. There was a high number of patients being discharged at night which did not reflect best practice.	✔
	The trust should continually review referral to treatment times to ensure it is in line with national standards.	✔
	The trust should review the facilities and service provision on signage, leaflets and translation services so they meet the needs of the patients using them.	✔
	The trust should review the facilities provided in the urgent care centre so they meet the needs of children and patients with visual and hearing impairments or complex needs.	✔
	The trust should ensure service provision meet patients individual needs particularly those with complex needs and disabilities.	✔
	The trust should continue to work towards a system which allows patients to arrive for their surgery in a timelier manner.	✔
	The trust should ensure there are clear lines of medical patient responsibility in the adult assessment unit.	✔
	The trust should ensure the needs of all patients who require additional support are met.	✔
WELL-LED	**The trust should ensure that risks identified on the risk register are being dealt with in a timely way.**	✔
	The trust should ensure they engage with staff effectively.	✔
	The trust should review processes for risk management to ensure all risks are identified and dealt with appropriately.	✔
	The trust should improve the provision arrangement of children in the service and paediatric outpatient area to ensure there are adequate toys and children are safe while waiting in the paediatric outpatient waiting area especially during out of hours.	✔
	The trust should consider developing firm plans to realise the vision for the service.	✔

Across our three main hospital sites we have undertaken and achieved the following improvement actions against each of the CQC five domains as follows:

Completed CQC Should-do findings at Barnet Hospital:

SAFE - Critical Care	
The trust should ensure staff have clear guidance and take appropriate action when temperature is outside optimal levels for medicine storage in drug fridges and storage rooms. (02)	
We have:	✓ ***Undertaken weekly pharmacy medication audits*** ✓ ***Shared medication audit findings with the ward sisters and matrons*** ✓ ***Introduced monthly oversight of the medication audits via the senior nurse meeting, surgery & associated services divisional board and is overseen by Barnet Hospital clinical performance & patient safety committee***
The trust should ensure contents, including medicines, in transfer bags are regularly checked and records kept. (03)	
We have:	✓ ***Implemented a system whereby junior doctors check the transfer bag at each shift, document that this has been done and is embedded by monthly auditing*** ✓ ***Introduced new labelling to be attached to the transfer bag containing the date the earliest drug will expire***
The trust should ensure critical care staff receives sufficient training to enable them to confidently use the new hospital EPR system as needed. (05)	
We have:	✓ ***Introduced a trust wide approach to 'electronic patient record' training for critical care***

SAFE – Urgent & Emergency Care	
The trust should ensure all staff have up to date adults and children's safeguarding training at all levels and ensure the trust's 85% target is met. (17)	
We have:	✓ ***Introduced compliance checks by matrons, clinical directors and service managers to ensure staff members are compliant in adult and children's safeguarding*** ✓ ***Cascaded training via clinical practice educators in each area*** ✓ ***Identified safeguarding link nurses*** ✓ ***Monthly monitoring of adult and children safeguarding training compliance by the medicine & urgent care services divisional board and is overseen by Barnet Hospital clinical performance & patient safety committee and the Barnet Hospital executive committee for monitoring of the medicine & urgent care CQC action plan***
The trust should ensure staff understand how and when to assess whether a patient with mental health needs has the capacity to make decisions about their physical care and treatment. (18)	
We have:	✓ ***Introduced compliance checks by matrons, clinical directors and service managers to ensure staff members are compliant with Mental Capacity Act training*** ✓ ***Weekly audit of patient notes to identify compliance with the policy to be undertaken for at least 3 months in order to achieve 100% compliance*** ✓ ***Monthly monitoring of Mental Capacity Act compliance by the medicine & urgent care services divisional board and is overseen by Barnet Hospital clinical performance & patient safety committee and the Barnet Hospital executive committee for monitoring of the medicine & urgent care CQC action plan***

SAFE – Medical Care	
The trust should ensure appropriate checks are undertaken on patients wearing mittens. (09)	
We have:	✓ ***Reviewed the policy to ensure that there is clear guidance in place that outlines the training and education required to be competent in the assessment and management of patients with mittens in situ***

	✓ *Trained staff in the appropriate checks required for patients wearing mittens* ✓ *Quarterly documentation audits of the checks required for patients wearing mittens three months after embedding the updated policy*
The trust should ensure they review processes for the management of medicines used in emergencies and the systems for the monitoring of temperatures of medicines storage areas. (10)	
We have:	✓ *Undertaken pharmacy monthly medication audits of the following areas: medication security, key storage, ambient temperature, fridge temperature, IV fluids storage to achieve 100% compliance with Trust guidance* ✓ *Shared medication audit findings with the ward sister and matron on a monthly basis* ✓ *Monthly oversight of the medication audits via the senior nurse meeting, medicine & urgent care divisional board and is overseen by Barnet Hospital clinical performance & patient safety committee* ✓ *Provided staff training on the appropriate storage of medication*
SAFE – Medical Care	
The trust should ensure hand hygiene compliance meets the trust targets across all the wards. (11)	
We have:	✓ *Held a hand hygiene campaign across the group in 2019. This will continue to be supported by the medicine & urgent care matrons and clinical directors by monthly audits of hand hygiene via the Perfect Ward app* ✓ *Results monitored by the ward sister and consultant of the week on each ward and monitored at the monthly directorate service performance reviews and divisional board meetings*

SAFE – Surgery	
The trust should address the high turnover rate amongst nursing staff and ensure all of the shifts are covered at all times. (13)	
We have:	✓ *Developed an over-arching action plan to incorporate all strands of work involving nursing recruitment and retention in order to address the high nurse turnover rate* ✓ *Monthly monitoring of the nursing staff turnover rate via the surgery & associated services divisional board and is overseen by Barnet Hospital clinical performance & patient safety committee as part of the monitoring of the Surgery CQC action plan*
The trust should fill the vacancies for medical staff to ensure there is sufficient number of doctors available to provide patient's care and treatment. (14)	
We have:	✓ *Undertaken a recruitment drive to appoint to substantive vacant posts.* ✓ *Undertaken monthly reviews of safe medical staffing* ✓ *Continued to improve process of communicating with Health Education England to prevent last minute gaps in the rota* ✓ *Continued to follow escalation of short notice rota gaps*

EFFECTIVE – Medical Care	
The trust should ensure they reduce the average length of stay for medical non-elective patients, to meet the England average. (45)	
We have:	✓ *Continued to work through the urgent and emergency care improvement programme and progress monitored by the urgent and emergency care and the accident & emergency delivery boards*

CARING – Medical Care	
The trust should ensure they focus on getting patients a bed on a ward for their speciality to reduce the number of patient moves at night. (56)	
We have:	✓ *An overview of the data to be presented at the medicine & urgent care divisional board; this forms part of the multiple LLOS reviews each week*

RESPONSIVE – Critical Care	
The trust should ensure patients are reviewed by a consultant within 12 hours of admission to critical care. (58)	
We have:	✓ ***Validated data, on a monthly basis, and compliance with the standard. This is monitored monthly at the consultants' meeting*** ✓ ***Compliance with the standard is monitored monthly by the surgery & associated services divisional board and Barnet Hospital clinical performance & patient safety committee as part of the monitoring of the critical care CQC action plan*** ✓ ***Changed the ITU electronic patient record system to be made to set a reminder to save the time of the review***
The trust should ensure the data submitted to external bodies is accurate, particularly in relation to delayed discharges and mixed sex breaches. (59)	
We have:	✓ ***The Intensive Care National Audit and Research Centre (ICNARC) data validated on a monthly basis and the compliance with the standards is monitored monthly via the consultants' meeting*** ✓ ***Compliance with the standards for the ICNARC data, in relation to delayed discharges and out of hours discharges, is monitored monthly by the surgery & associated services divisional board and is overseen by Barnet Hospital clinical performance & patient safety committee as part of the monitoring of the critical care CQC action plan***

RESPONSIVE – Medical Care	
The trust should ensure potential trip hazards in corridors are removed across all the wards. (60)	
We have:	✓ ***Instigated environmental audits, on a weekly basis, to identify and mitigate any actual or potential slip and trip hazards***
The trust should ensure they follow best practice and not discharge patients at night. There was a high number of patients being discharged at night which did not reflect best practice. (61)	
We have:	✓ ***An overview of the data presented at the monthly medicine & urgent care divisional board, this also forms part of the multiple LLOS reviews each week***

WELL LED – Medical Care	
The trust should ensure that risks identified on the risk register are being dealt with in a timely way. (73)	
We have:	✓ ***Monitoring for the timeliness of risk reviews via the directorate and divisional board meetings by means of two key performance indicators: number of risks reviewed every three months and number of risks older than one year*** ✓ ***Monthly monitoring of the timeliness of risk reviews via Barnet Hospital clinical performance & patient safety committee by means of two key performance indicators: number of risks reviewed every three months and number of risks older than one year***

Completed CQC Should-do findings at Chase Farm Hospital:

SAFE – Surgery	
The trust should ensure action is taken to prevent avoidable patient safety incidents from reoccurring. (20)	
We have:	✓ ***Ensured actions taken in response to serious incidents are presented back to serious incident review panels for scrutiny and oversight by the Chase Farm Hospital medical director and senior nurses***
The trust should ensure all five steps of the safer surgery checklist are appropriately completed and documented in line with national guidelines. (21)	
We have:	✓ ***The team brief is now recorded on huddle forms. This form contains prompts to ensure consistent briefs are undertaken across all theatres*** ✓ ***A debrief form is used if there are any exceptions to report*** ✓ ***A question confirming that individual patients have been discussed in the team brief has been added to electronic patient record [completion of this section of the electronic patient record is mandatory]***
The trust should review processes to provide assurance that medicines are stored at the correct temperatures to remain effective. (22)	
We have:	✓ ***Temperature monitoring in the operating theatre fluid store. The operating department practitioner checks the fluid store and the fluid warming cupboards, recording the check on a log*** ✓ ***There is a process in place for checking the temperature of medications and escalating when this is out of range. This process has been reiterated to the staff. The ward liaised with pharmacy to add the escalation process and added to the medication temperature check form***
The trust should review security of medicines storage areas. (23)	
We have:	✓ ***Access control swipe lock is installed on to the intravenous fluid store room, to ensure appropriately controlled access***

SAFE – Urgent & Emergency Care	
The trust should implement a formal process for reception staff to highlight issues in the waiting areas. (25)	
We have:	✓ ***Written and distributed the process for reception staff to alert issues to the clinical teams***
The trust should improve the signage to the entrance to the Urgent Care Centre. (26)	
We have:	✓ ***Additional signage has been added to the external entrance to the urgent care centre***

EFFECTIVE – Surgery	
The trust should ensure the trust's consent policy is followed and that all stages of the consent process are appropriately documented. (48)	
We have:	✓ ***Worked with the surgical teams to review the process and policy to ensure that process and policy match***

EFFECTIVE – Urgent & Emergency Care
The trust should ensure policies and guidelines available in hard copies are regularly reviewed and updated. (52)

We have:	✓ *Removed hard copies of policies and guidelines* ✓ *Staff have access to electronic versions of policies and guidelines on the local drive and freenet* ✓ *A 7/24 business continuity computer is available in the department for use in cases of IT system failure*

CARING – Urgent & Emergency Care	
The trust should improve the reception area in the urgent care centre and paediatric outpatients to ensure patient confidentiality. (57)	
We have:	✓ *Reviewed ways to improve confidentiality in the urgent care centre reception area.* ✓ *A new waiting area for urgent care centre paediatrics now in place, so there is no requirement to use the paediatric outpatient waiting area*

RESPONSIVE – Medical Care	
The trust should continually review referral to treatment times to ensure it is in line with national standards. (62)	
We have:	✓ *Undertaken a demand and capacity review* ✓ *A systematic plan to reduce the waiting list of for endoscopy with the use of increased resources both permanent and temporary has been devised* ✓ *Increased the number of permanent doctor sessions to ensure that the service is able to maintain the waiting list to meet referral to treatment targets*

RESPONSIVE – Urgent & Emergency Care	
The trust should review the facilities and service provision on signage, leaflets and translation services so they meet the needs of the patients using them. (63)	
We have:	✓ *The Trust uses a telephone translation service* ✓ *Details of how to access the translation service has been provided to all staff in the urgent care centre*
The trust should review the facilities provided in the urgent care centre so they meet the needs of children and patients with visual and hearing impairments or complex needs. (64)	
We have:	✓ *Worked with the local deaf society to provide deaf awareness training for key staff members*
The trust should ensure service provision meet patients individual needs particularly those with complex needs and disabilities. (65)	
We have:	✓ *Worked with the Trust learning disabilities team to create a discharge form which includes visual aids as well as written aids. A hospital passport has also been created for patients with learning difficulties and is now in use* ✓ *Worked with the local deaf society to provide deaf awareness training for key staff members*

WELL LED – Medical Care	
The trust should ensure they engage with staff effectively. (75)	
We have:	✓ *Listened to staff concerns and undertaken a full review of the endoscopy services across the group*
The trust should review processes for risk management to ensure all risks are identified and dealt with appropriately. (76)	
We have:	✓ *We implemented a new process for reviewing the risk register:* ○ *Each week one service's risk register is reviewed at the serious incident review panel meeting by:* ▪ *Providing time to ensure risks are moving and are escalated as required* ▪ *Ensure that key issues are present on the risk register*

WELL LED – Urgent & Emergency Care	
The trust should improve the provision arrangement of children in the service and paediatric outpatient area to ensure there are adequate toys and children are safe while waiting in the paediatric outpatient waiting area especially during out of hours. (77)	
We have:	✓ ***A new dedicated urgent care centre paediatric waiting area is in place and in use*** ✓ ***Installed CCTV in the new paediatric urgent care centre waiting area*** ✓ ***The feed from this CCTV is monitored in the triage room to ensure that the urgent care centre practitioners have oversight of patients in this area***

Completed CQC Should-do findings at Royal Free Hospital:

SAFE – Critical Care	
The trust should monitor medical staffing levels during the expansion of the unit to ensure they meet FICM standards. (29)	
We have:	✓ ***Recruited to all junior posts*** ✓ ***A fully staffed medical team*** ✓ ***Monthly trajectories for staffing*** ✓ ***Capacity on the specialist high dependency unit adjusted in line with staffing.*** ✓ ***The funded establishment matches Faculty of Intensive Care Medicine standards*** ✓ ***In addition we are:*** ○ ***Developing specialist roles in ICU to attract consultant staff*** ○ ***Developing a fellowship program to attract senior trainees, encouraging them to advance into consultant positions within the Trust***

SAFE – Medical Care	
The trust should ensure ward teams fully comply with the Control of Substances Hazardous to Health (COSHH) Regulations (2002) in reference to safe and secure storage of chemicals. (36)	
We have:	✓ ***New lockable domestic trolleys are on all wards*** ✓ ***Regular spot checks are undertaken to ensure drug rooms are locked at all times per policy by the ward managers and matrons.*** ✓ ***Staff have been made aware of hazardous substances in their working area and have read COSHH risk assessments*** ✓ ***Trained staff in correct practice*** ✓ ***Installed signage on storage room doors*** ✓ ***Monitoring in place using Perfect Ward audits***

SAFE – Surgery	
The trust should ensure the review of Never Events and serious incidents are undertaken by senior clinical staff and robust actions should be documented and monitored. (37)	
We have:	✓ ***A designated lead investigator for all serious incidents declared within the Royal Free Hospital, who is at an appropriate senior level within the organisation. The lead investigator is supported by a member of the quality governance team and all investigation findings are presented to a panel of relevant senior staff, which is chaired by a member of the senior divisional leadership team (medical director, director of nursing/operations)*** ✓ ***Actions agreed by the clinical team, the panel, the safety incident review panel and the trust's commissioners*** ✓ ***All actions from serious incidents added to a serious incident action tracker that the governance team hold, and regular updates on progress are requested from the relevant clinical teams. The action is only closed as completed, once the relevant evidence has been provided*** ✓ ***To strengthen this process, the governance team send the submitted evidence to the action plan owner (usually the clinical lead) for additional assurances that the evidence provided appropriately confirms that the action has been completed*** ✓ ***The never events assurance plan is fully completed and shared with commissioners who are satisfied with the evidence*** ✓ ***Implemented 'Learning in Action' meetings have been following notification of a***

	serious incident
The trust should ensure they continue to work with other external agencies to put systems in place to reduce the number of never events taking place. (39)	
We have:	✓ ***A continuous partnership programme with trust's commissioners in order to strengthen systems and processes*** ✓ ***An overarching never events assurance plan, created in conjunction with commissioners*** ✓ ***Attendance and working in partnerships with other organisations as part of the UCLPartners LocSSIP network*** ✓ ***Implemented the never events risk assessment (shared by Barts Health NHS Trust) to assess clinical areas vulnerability of a never event***

SAFE – Surgery	
The trust should review how medicines were stored and accessed in the operating theatres. (40)	
We have:	✓ ***Swipe access into the pharmacy room***

SAFE – Urgent & Emergency Care	
The trust should ensure that there is consistent record keeping for emergency department patients in the adult assessment unit. (43)	
We have:	✓ ***Improved documentation in the acute admissions unit; this is monitored through Perfect ward and spot checks*** ✓ ***A program has started in acute admissions unit specifically focusing on admission paperwork and basic risk assessments being completed*** ○ ***The program is run by the clinical practice educator and ward manager. There is also a focus on NEWS 2 to ensure observations are completed in a timely manner and escalation completed. Spot checks are completed monthly***

EFFECTIVE – Urgent & Emergency Care	
The trust should ensure there is an action plan to address 2016/17 Royal College of Emergency Medicine (RCEM) moderate and acute severe asthma and consultant sign-off audit results. (54)	
We have:	✓ ***Standardised the streaming process and improved competencies for the nursing team*** ✓ ***Established a 'wheezy child pathway' in collaboration with the paediatric team*** ✓ ***Assigned lead clinicians to sign off audit results*** ✓ ***Instigated an internal audit programme to assure correct sign off***

RESPONSIVE – Surgery	
The trust should continue to work towards a system which allows patients to arrive for their surgery in a timelier manner. (67)	
We have:	✓ ***Reminded surgeons to stagger patients and 'Golden Patient' in board, theatre safety, theatre strategy and theatre productivity boards*** ✓ ***Written a standard operating procedure for staggering lists*** ✓ ***Reorganised design of the day surgery unit, with the 'golden patient' contacted the night before surgery***

RESPONSIVE – Urgent & Emergency Care

The trust should ensure there are clear lines of medical patient responsibility in the adult assessment unit. (69)	
We have:	✓ ***Reviewed the acute assessment unit standard operating procedure; this will be reviewed every 3 months*** ✓ ***Employed 2 additional consultants to work exclusively in the acute assessment unit*** ✓ ***A working group has been set up to oversee development of the area, meeting every 14 days*** o ***Minutes will be kept of meetings*** o ***The acute medical team has overall responsibility for the running and governance of the unit*** o ***A consultant has been appointed to run the unit full time*** o ***The 'acute medical model' is being worked up, including the structure of acute assessment unit***
The trust should ensure the needs of all patients who require additional support are met. (70)	
We have:	✓ ***Learning disability lead nurse has provided a resource box for patients with learning disabilities*** ✓ ***Flash cards have been provided for non-verbal patients*** ✓ ***The dementia lead and learning disability lead are working with the department to provide training guidance and support.*** ✓ ***Supplied an activity box and designated a room for patients who require less distraction or stimulation.*** ✓ ***Picture cards provided to staff from learning disability lead and a resource box in ATA multidisciplinary team*** ✓ ***Linking into 'Coordinate My Care' (CMC), which will allow for care plans to be shared*** ✓ ***Developed staff awareness around how to care for our patients with learning disabilities [this includes information and where to access learning aids and who to contact if needed]*** ✓ ***The acute assessment unit have begun a quality improvement working group regarding falls***

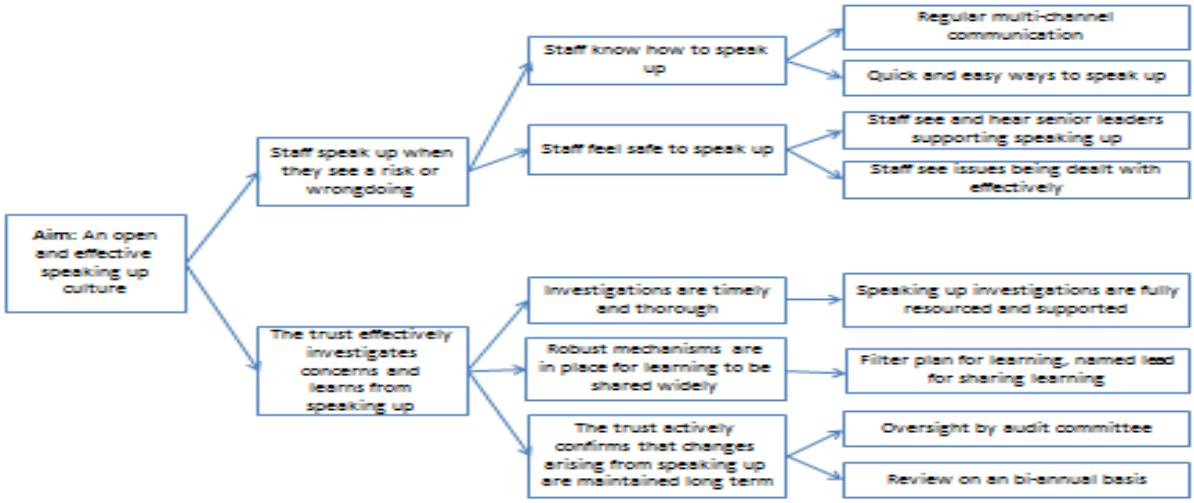
WELL LED – Critical Care	
The trust should consider developing firm plans to realise the vision for the service. (80)	
We have:	✓ ***An ICU strategy has been developed and approved*** ✓ ***The strategy has been circulated to all critical care staff including consultants and is displayed on the notice board***

We will continue to work towards the full completion of all our CQC 2018 recommended improvement actions and anticipate these will be completed in full by the 3 quarter of 2021; specifically those actions which require the introduction of our planned new electronic patient records pathway at our Royal Free Hospital site.

It’s safe to speak up

The trust’s vision for speaking up

A FTSU vision and strategy was developed in 2018. Detailed below is the driver diagram setting out the aim for speaking up, the primary and secondary drivers and the change ideas identified to achieve this. During 2020, the driver diagram will be updated to set out what specific actions will take place within the next 12 months to meet the aim.



The trust is committed to:

- Promoting an open and transparent culture across the organisation to ensure that all members of staff feel safe and confident to speak out.
- Increasing the level of awareness for all staff so they are clear about what concerns they can raise and how to raise them using the appropriate pathways
- Ensuring managers are clear about their roles and responsibilities when handling concerns and are supported to do so effectively
- Providing regular communications to all staff (including those permanently employed on a full / part time basis, temporary workers and volunteers) to raise the profile and understanding of how to raise speaking up concerns
- Sharing good practice and learning from concerns raised
- Actively seeking the opinion of staff to assess that they are aware of and are confident in using local processes

Freedom to Speak Up Champions

Freedom to Speak Up Champions have been appointed throughout the NHS and at the trust. They have a key role in helping to increase the profile of raising concerns in their organisations. They provide confidential advice and support to staff in relation to concerns they have, in particular patient safety.

The role as a **Speaking Up Champion** at the Royal Free London NHS Foundation Trust is to:

- Promote local speaking up processes and sources of support and guidance to staff
- Be available and accessible to staff who may have a concern
- Take immediate appropriate action when matters that people are speaking up about indicate that safety and quality may be compromised
- To ensure that any safety issues raised are addressed and feedback is given to the member of staff who raised it in line with confidentiality agreements
- Communicate with empathy and compassion with other staff about potentially emotive subjects
- Act as a buddy to newer Champions to answer questions
- Good time management skills to balance the Speaking Up role with their existing role

- Work with the Board to create an open culture - listening and learning and not blaming
- Develop ways to encourage staff to speak up
- Work entirely independently of the executive team
- Share learning with the wider Trust to develop the culture
- Review the governance and practice of raising concerns at the Trust
- Ability to turn ‘speak up’ scenarios into learning

Knowledgeable about Freedom to Speak Up matters and local issues, and able to advise staff appropriately about speaking up

Implementing seven day services hospital services

The seven day services programme was developed in 2013 and was designed to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital.

The trust has 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-directed Interventions
• **Standard 8** - On-going review by consultant twice daily if high dependency patients, daily for others

This report provides an assessment of the Royal Free London NHS Foundation seven day services delivery of each of the four priority standards for both weekdays and weekends in order to provide assurance to the Board and identify any gaps in the services delivered to ensure that appropriate actions are taken to address these areas.

Standard 2 - **Time to first consultant review**
Clinical Standard 2: All emergency admissions must be seen and have a thorough assessment by a suitable consultant as soon as possible, but at the latest within 14 hours from time of admission to hospital**.**

The Royal Free London NHS Trust agreed that in order to provide Board assurance the following approach would be taken:

- Specialties which did not meet the 90% standard in the April 2019 seven day services (7DS) audit would be re-audited for standard 2.
- Evidence from a number of other sources would also be used to judge the Trust's delivery of 7DS including consultant's job plans, evidence of systems to support on-going review such as a board round system, system of escalation of deteriorating patients and systems in place for systematic handover of patients.

Standard 5 - Access to diagnostic services
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:
• Within 1 hour for critical patients
• Within 12 hours for urgent patients

Standard 6 - **Access to consultant-directed Interventions**
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.

Standard 8 - **On-going review by consultant twice daily if high dependency patients, daily for others**
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant twice daily. Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

The Royal Free London has made progress in understanding and assessing our ability to deliver seven day services, and has identified, through this Board assurance process, that we are broadly able to do so, and have systems in place, with some gaps identified within some specialities.

The Business Units will develop a follow-up paper outlining the identified actions which will be undertaken for specialties which have been determined as not currently being able to deliver 7 day services. The implementation of the action plan will be monitored via the relevant Clinical Performance and Patient Safety Committees.

Annexes

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

Statements from Commissioners:

Statement from Barnet Clinical Commissioning Group
Barnet Clinical Commissioning Group

This will be added to the final report

This will be added to the final report

Statement from Healthwatch

Response to the Quality Account 2018/19

This will be added to the final report

This will be added to the final report

Statement on Royal Free London NHS Foundation Trust Quality Accounts 2019/20

This will be added to the final report

This will be added to the final report

Statement from Overview and Scrutiny Committees

Comments from the Chair of the LB Camden Health and Adult Social Care Scrutiny Committee

This will be added to the final report

This will be added to the final report

Council of governors

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This will be added to the final report

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

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare quality accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2019/20 and supporting guidance: detailed requirements for quality reports 2019/20;
- 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 2019 to May 2020
  - papers relating to quality reported to the board over the period April 2019 to May 2020
  - feedback from commissioners dated
  - feedback from governors dated
  - feedback from local Healthwatch organisations dated
  - feedback from Overview and Scrutiny Committee dated
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated
  - the latest national patient survey dated
  - the latest national staff survey dated
  - the Head of Internal Audit's annual opinion over the trust's control environment dated
  - CQC inspection report dated
- 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

.....Date.....Chairman

.....Date.....Chief Executive

Annex 3. Limited assurance statement from external auditors

This will be added to the final report

Appendices

Appendix a: Changes made to the quality report

The views of our stakeholders and partners are essential in developing our quality report.

Our report has changed in response to comments received following the distribution of the draft as follows:

This will be added to the final report

Glossary of Terms

Term	Explanation
ASA	The *ASA* physical status classification system is a system for assessing the fitness of patients before surgery adopted by the American Society of Anesthesiologists (*ASA*) in 1963.
Best Practice Tariff (BPT)	A BPT is a national price that is designed to incentivise quality and cost effective care. The first BPTs were introduced in 2010/11 following Lord Darzi's 2008 review. The aim is to reduce unexplained variation in clinical quality and spread best practice.
Cardiotocography (CTG)	Cardiotocography (CTG) is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy. The machine used to perform the monitoring is called a cardiotocograph.
CQC: Care Quality Commission.	The independent regulator of all health and social care services in England.
C-diff: Clostridium difficile.	A type of bacterial infection that can affect the digestive system.
Clinical Practice Group (CPG).	Permanent structures which the trust is developing to address unwarranted variation in care).
CQUIN: Commissioning for Quality and Innovation.	CQUIN is a payment framework that allows commissioners to agree payments to hospitals based on agreed improvement work.
Continuous positive airway pressure (CPAP)	Continuous positive airway pressure (CPAP) is a form of positive airway pressure ventilator, which applies mild air pressure on a continuous basis to keep the airways continuously open in people who are not able to breathe spontaneously on their own
HIMSS	Healthcare Information and Management Systems Society (HIMSS) are a not-for-profit organisation that is based in Chicago with additional offices in North America, Europe, United Kingdom and Asia. Their aim is to be leaders of health transformation through health information and technology with the expertise and capabilities to improve the quality, safety, and efficiency of health, healthcare and care outcomes. HIMSS drives innovative, forward thinking around best uses of information and technology in support of better connected care, improved population health and low cost of care.
Infoflex	InfoFlex is an information management software tool dedicated to managing and improving patient pathways and treatment processes within the NHS. However, it does so differently. Instead of imposing a "system", InfoFlex is modelled to fit the needs of the clinicians, IT staff and management who will use it.
MDT: multi-disciplinary team .	A team consisting of staff from various professional groups i.e. nurses, therapist, doctors etc.

NHS NCL.	NHS north central London clinical network
Never event	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.
NICE: National Institute of Clinical Excellence.	An independent organisation that produces clinical guidelines and quality standards on specific diseases and the recommended treatment for our patients. The guidelines are based on evidence and support our drive to provide effective care.
Patient at Risk & Resuscitation Team (PARRT).	The Patient at Risk & Resuscitation Team (PARRT) is a combined nursing service to provide 24/7 care to patients at risk, including attending medical emergency calls (2222) and reviewing all patients post discharge from intensive care. The team members provide education, training and support to manage life-threatening situations, including in-hospital resuscitation, care of the patient with a tracheostomy and CPAP.
PEWS: paediatric early warning score.	A scoring system allocated to a patient's (child's) physiological measurement. There are six simple physiological parameters: respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness.
SBAR: situation, background, assessment, recommendation.	SBAR is a structured method for communicating critical information that requires immediate attention and action contributing to effective escalation and increased patient safety. It can also be used to enhance handovers between shifts or between staff in the same or different clinical areas.
SHMI: summary hospital-level mortality Indicator.	The SHMI is an indicator which reports on mortality at trust level across the NHS in England using a defined methodology. It compares the expected mortality of patients against actual mortality.
UCLP: University College London Partners .	UCLP is organised around a partnership approach. It develops solutions with a wide range of partners including universities, NHS trusts, community care organisations, commissioners, patient groups, industry and government. (http://www.uclpartners.com/).
VTE: venous thromboembolism.	A blood clot that occurs in the vein