Royal Free London
NHS Foundation Trust

Responding, adapting and delivering high quality care during COVID-19

Royal Free London NHS Foundation Trust

Draft Quality Account 2020/21

Quality Account 2020/21

Part one: Achievements in quality

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

Part three: Overview of the quality of care in 2020/21

Annexes (to add following consultation)

Appendices

Part One: Achievements in quality

1.1 Statement on quality from the chief executive

We would like to open this Quality Account publication with a huge thank you to our staff, and everyone who has supported them, for their incredible efforts over 2020-2021.

For the NHS, its partners and the communities we serve – dealing with the pandemic and its sequela – it has been a year like no other.

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

Of course, we can't cover everything - or even all of the important things - in this document; however, we hope this account gives a faithful impression of the journey we have travelled and the key steps along the paths that lie ahead.

Achievements to highlight

From my perspective, there are five areas I want to highlight very briefly – and which are covered in greater depth in subsequent sections.

1. Our Intensive Care Units

- Despite having to triple bed capacity, train and support new staff members and adapt very quickly to new ways of working, validated data show that our patient outcomes have been amongst the best in the UK.
- Our ICU teams have cared for nearly 1000 COVID patients, of whom over 650 recovered and were able to go home.

2. Virtual visiting

- With hospital visiting only able to take place in exceptional circumstances, our patients have faced distressing separation from their loved ones. Using tablets and phones, staff and volunteers have enabled patients to stay connected, or have provided regular contact to loved ones if the patient is not physically able to.
- This 'Virtual Visiting' programme, which we started in April 2020, has enabled almost 1,400 virtual visits*.

3. Digital Outpatient Consultations

- Having had to cut back patient visits to outpatient clinics in order to limit the spread of COVID, our teams were able rapidly to rollout and adopt the technology for consultations to take place safely and securely via videoconference or phone.
- Currently, over one in three of our outpatient appointments take place via telephone or video, compared to less than one in twenty prior to the COVID pandemic.
- Feedback about our virtual video appointments shows that 84% of patients report either a better experience or no difference, when compared to face-to-face appointments.

4. Research and Development

- Whilst elements of the research and development (R&D) programme were paused during the pandemic, RFL has been at the forefront of COVID 19-related research – contributing to advances in treatment and prevention – and now hosting world-first 'human challenge' trials aimed at understanding infection transmission.
- During 2020/21, we approved 132 new studies and recruited over 13,000 participants to clinical trials – the latter representing a 10% year-on-year increase.

5. COVID Vaccination

- Vaccine clinics at our hospital sites were the first in England to provide the Pfizer / BionTech vaccine, from December 2020 - and the AstraZeneca / Oxford vaccine, from January 2021.
- Those clinics have administered nearly 45,000 COVID vaccines to our own staff, staff from local health and social care providers, and patients.

CQC Concerns

It is also our duty to acknowledge, here, where we have fallen short of what is expected – and to provide assurance that we have addressed the issues of concern.

As part of follow up to a prevention of future deaths coroner's notification received in August 2020, CQC conducted an unannounced inspection of our maternity services at the Royal Free Hospital [Hampstead] site. Following that inspection, a Section 29a warning notice was issued to RFL in November 2020, with two specific areas of improvement and deadlines for their completion:

a) The CQC was not assured that maternity services at the Trust were learning from incidents and improving practice to keep patients safe. We were required to make significant improvements, related to these findings, by 11 December 2020.
b) Patients who attend the hospital maternity services were not able to access appropriate information in languages that are centred around their individual needs. We were required to make significant improvements, with regard to these findings, by 27 November 2020.

The Trust met both deadlines provided by the CQC and details of our improvement actions are set out later in this report.

More broadly, as an organisation, our intention is to be rated Outstanding by CQC – and we are putting in place structures and programmes of work which, over the coming years, will enable us to achieve that.

Looking ahead

We have an immediate challenge to support staff to recuperate, and to ensure we are ready for what lies ahead - the challenges we already know about and those that we don't yet. And, in that regard, I'm really proud of the wellbeing offers we have made available to staff over the last year and will continue to support for the period ahead.

For example, Project Wingman saw airline flight crew make themselves available to talk to staff and help them unwind during or after stressful shifts. And our REST (Resilience and Emotional Support Team) hub, providing psychological support, is one reason that our overall health and wellbeing package was highlighted by staff as strength in the annual NHS staff survey.

It is clear that staff who are cared for are better able to care for others, so there can be no NHS recovery without staff recovery. That's why we have chosen to highlight staff wellbeing here, in our quality account, because of its very direct impacts on care quality. The wider theme of staff inclusion and wellbeing is one of our four organisational delivery priorities for the year ahead.

Providing care for the thousands of our patients who are waiting very long times for consultation or treatment is an enormous challenge - and one we are determined to meet, working with our partners in North Central London. Therefore, reducing the number of patients facing long waits is another one of our four delivery priorities – and achieving it will require innovation, courage and tenacity on the part of all our staff.

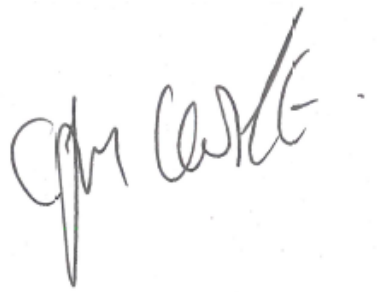
We have seen the impact that information technologies have had on all our lives over the last year – so, ensuring we have the digital infrastructure and solutions to improve patient and staff experience forms our third delivery priority.

Our fourth delivery priority is about our local partnerships. A feature of the NHS response to the pandemic has been the unprecedented breadth and depth of collaboration: whether it has been working with other hospitals to operationalise the London Nightingale, linking with local businesses to make theatre gowns, or welcoming military personnel to our sites to act as porters – the efforts have been inspiring and impactful. We now have, arguably, the strongest platform for partnership working we've ever had – and we are committed to making that work for our patients, for whom it matters most.

Part 2 of this document outlines our more detailed priorities for improvement - what we've achieved over the past year and what we want to progress going forward. Some of these are rolled forward or refreshed from the previous period, whilst others are new.

Part 3 of this document describes performance against selected and key indicators and also gives examples of some of the improvement plans we are putting in place.

I hope you find this Quality Account enlightening and interesting. To the best of my knowledge, it provides accurate information about the quality of care delivered by RFL.



Caroline Clarke
Group Chief Executive
Royal Free London NHS Foundation Trust

1.2 Responding and adapting to COVID-19

The Royal Free London Hospital Quality Account for 2020-21 continues to build on the initial responses, plans and rapid changes in service delivery and patient care that were underway at the start of the COVID-19 Pandemic. The Trust continues to respond and adapt, implementing new ways of working to ensure that we are delivering the best possible care to patients and their families.

Initially the main challenges were to ensure that we had enough skilled staff to care for our patients as well as to ensure that the care being delivered was evidence-based, ensuring the best patient outcomes.

In particular we needed to ensure that the trust was delivering the latest evidence-based practice which was being published on a rapid basis. As such the trust needed to respond immediately, developing local guidelines and adapting practice to support the latest national guidance, new research findings and local needs. The implementation of a COVID-19 Clinical Guidelines Group meant that new guidance was agreed and disseminated to staff in a timely manner to ensure that patients were receiving the latest evidence-based care.

Various changes had to be made rapidly with regards to service allocation, with some elective services being transferred out to the independent sector to allow continuity in elective care whilst the hospital could focus on the COVID patients. Children and young people's services were temporarily transferred to the southern hub at Whittington Health in September 2020. This ensured that we could continue to deliver emergency and planned care for children and young people during the autumn and winter and were an important part of our COVID-19 response. Over recent weeks, the teams have been working through plans to reopen the paediatric emergency and general in-patient wards at the Royal Free Hospital. We are pleased to say that the paediatric emergency department and general inpatient wards reopened at the Royal Free Hospital from Monday 12 April 2021.

In response to having more critical care patients, staff were redeployed (many volunteering), supporting the clinical teams to deliver the care required. Many staff were seeing patients in critical conditions on a scale that has never been seen before and it was absolutely imperative that we supported these teams by introducing a REST staff helpline to access psychological and emotional support, as well as face-to-face care from trained clinicians.

The Trust increased its daily communication updates to help ensure staff were kept fully updated and COVID19 risk assessments was implemented to provide a safe work environment for all staff.

This year's Quality Account highlights some of the work that has been developed and implemented in direct response to the COVID-19 pandemic, to support our patients and their families. It showcases new ways of working and demonstrates how we can respond rapidly and cohesively to ensure that we continue to provide patient care remotely, when appropriate, with virtual outpatient appointments, kept relatives in touch with their loved ones with virtual visiting, and support our bereaved families during such a tragic and difficult time.

1.3 Delivering high quality care during COVID-19

A. Research & Development (R&D)

In normal circumstances prior to the COVID-19 pandemic, there were around 800 research studies running across the Royal Free London NHS Foundation Trust.

The breadth of studies range from complex clinical trials, investigating cutting edge gene therapies in haemophilia and other rare disorders, to observational studies collecting blood samples from large numbers of patients to understand how individual patients might respond differently to treatments for cancer. This diverse portfolio of clinical research is expertly delivered by around 150 investigators and over 80 R&D delivery staff.

Last year, the arrival of COVID-19 presented a number of challenges for R&D at the Trust but at the same time, given that this was a new disease with limited knowledge of its clinical course, no evidence base of effective treatments and no vaccine available, also brought significant opportunity for doing great clinical research and for the trust to make a valuable contribution to the huge Global scientific effort to defeat the pandemic.

Four key priority areas emerged early on in the pandemic for R&D;

- preserving the safety of research participants and research staff;
- providing the opportunity for as many of our COVID-19 patients wishing to participate in COVID related research, particularly the nationally adopted Urgent Public Health (UPH) badged treatment studies, to do so;
- ensuring that other critical life-prolonging or life-saving research could continue where safe and feasible;
- supporting colleagues to deliver the front-line care to our COVID-19 patients.

All of this mandated that in line with National Institute of Health Research (NIHR) guidance, the majority of the trust's non-COVID research portfolio was paused and studies were prioritised for delivery. Urgent Public Health (UPH) badged studies endorsed by the Chief Medical Officer for England were allocated the highest priority followed by critical life prolonging or life extending non-COVID research and finally all, other research.

The Trust COVID-19 Research and Innovation and R&D COVID-19 Trials feasibility committees were rapidly set up by late March to review the multiple research proposals that would start to emerge. The former reviewing in-house research proposals at the feasibility stage with a view of progressing through to full trust R&D approval and the latter focusing on decision making around which UPH badged and other ethically approved COVID research studies could feasibly be delivered at the trust and allocating the requisite resources to do so. By as early as 6th April 2020 the trust had approved its first UPH badged COVID-19 research study and enrolled its first patients, going on to be the leading recruitment centre in Europe for that particular study.

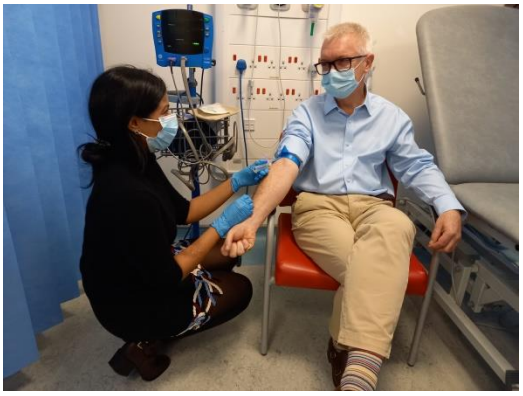
What ensued over the course of the next 12 months was a remarkable concerted effort by all of the trust's R&D teams, investigators, research support departments and most importantly our patients who generously volunteer their time to participate in research and ensure its success. This has allowed the trust to recruit over 2100 patients across 22 UPH badged studies and a total of 8732* patients to all clinical research.

Highlights of the trust's contribution to the UPH portfolio include:

- our participation in the RECOVERY trial, the world's largest treatment COVID-19 treatment trial. This trial has generated the evidence for the use of dexamethasone, a cheap and widely available drug, in effectively treating hospitalised patients seriously ill with COVID-

19. It is estimated to have already saved over a million lives globally[1]. Equally importantly, the trial has produced sufficient evidence to exclude some of the early contenders such as the anti-malarial drug hydroxychloroquine, which had been proclaimed as a viable treatment option early on in the pandemic. The trust recruited over 500 patients into this study across both the Royal Free and Barnet Hospital sites.

- Understanding the human immune response to SARS-Cov2, the virus causing COVID-19, is another key area of research into the disease. The SIREN study is investigating whether prior infection with SARS-CoV2 protects against future infection with the same virus. This study is specifically enrolling healthcare workers and over 200 colleagues from across the trust have volunteered their time to enrol thus far. Once complete, the study will help provide important information about SARS-CoV2 re-infection among staff working in healthcare organisations and provide a stronger evidence base to inform national guidance and policy
- Vaccine research has been a key area of focus in the overall COVID-19 research endeavour. The trust participated in the Novavax vaccine trial recruiting over 600 volunteers at the Royal Free Hospital over a six week period in the autumn. This was the fourth vaccine to report clinical efficacy against COVID-19 and is now with the MHRA for final authorisation before being incorporated into the NHS COVID-19 vaccination programme. The trial now moves into a cross-over phase meaning that all participants will receive active vaccine- work on this phase will begin at the Royal Free Hospital.




Of course the Trust's involvement in COVID-19 research was not only limited to UPH studies. The COVID Research and Innovation (R&I) committee reviewed scores of in-house developed studies and saw some brilliant examples of science and innovation. The work of the committee led to the generous award of £250K from the Royal Free Charity to advance some of the ideas and concepts

and into full-fledged clinical research studies and innovations aimed at bringing benefit to our COVID-19 patients.

The R&I committee has coordinated research with our NHS and University partners, supported rapid uptake and adoption of approved studies and ensured that our patients and staff have optimal access to research and data. The group has worked to support new proposals from concept to implementation in the areas of acquisition and analysis of data to describe and understand the clinical features of COVID-19; acquisition, processing, storage, and analysis of laboratory samples to investigate the underlying pathophysiology and immune response to sars-cov-2; interventional studies of new therapies; and health service research into our clinical delivery of care to patients with COVID-19 in partnership with the National Physical Laboratory. The structure of the R and I group, and subgroups allows potential investigators to formulate hypotheses from their clinical observations. Investigators generating proposals for research are asked to present at the R and I "protocols in design" subgroup which includes the core membership of experienced researchers who provide feedback and support. The Research and Innovation Group has reviewed 71 studies of which 43 have been approved to progress, some of which have now completed, and publications submitted.

Highlights include:

- ***'A pilot, open label, phase II clinical trial of nebulised recombinant tissue Plasminogen Activator (rtPA) in patients with Acute Respiratory Distress Syndrome (ARDS) due to Coronavirus Disease 2019: The Plasminogen Activator COVID-19 ARDS (PACA) trial'***
  This pilot study aims to investigate the potential for clinical efficacy and safety of nebulised blood clot busting agent in patients who are ventilated with COVID-19. This study was designed, approved, and initiated within one week and has recruited well. The intervention appears to be safe in patients with COVID 19 pneumonia.

- ***'COVID-19 consortium (COVIDsortium): Healthcare worker Bioresource and preliminary analysis: Immune Protection and Pathogenesis in SARS-CoV-2.'***
  A study from the COVID-19 Research Strategy Oversight Group: UCLH, Barts Health and Royal Free London NHS Foundation Trust. This study aimed to secure significant sampling of healthcare workers whilst they are well and attending work, with acute sampling if unwell and convalescent samples post illness. These have been used to address specific questions around the impact of baseline immune function, the earliest immune responses to infection. This study recruited 220 participants in 4 days.

- ***'Covalent database'***
  This is a database which collates a full set of data for patients admitted with COVID-19 to RFL hospitals. Clinicians and researchers across the sites have agreed to combine their own datasets to create a unique and unprecedented collaboration. Data base architects from Moorfields created the database and the RF Charity have funded a database manager. This database will support multiple R and I projects, collaborations, publications, and hypothesis generation.

Collaboration with National Physical Laboratory (NPL)

NPL is the UK's National Metrology Institute, developing and maintaining the national primary measurement standards. It is a Public Corporation owned by the Department of Business, Energy, and Industrial Strategy (BEIS). The RFL R&I group has partnered with NPL in 4 projects initiated by RFL clinicians, for the benefit of patients with COVID-19 and those patients displaced as a result of COVID-19 pandemic arrangements.

'Reducing Mortality and Morbidity in Prone Ventilated Patients'

Patients with COVID-19 who are in ITU are turned onto their abdomens for better ventilation. This is labour intensive and physically demanding and has potentially adverse consequences for the patients. This project has developed a' proning board' which reduces the work required to turn patients manually and repeatedly and to use sensors for early detection of adverse pressure consequences.

Driving research ideas from the ground up through data and analytics, mentoring and support (and ultimately time) for NHS-based research will ensure we have a firm foundation to integrate research within our business-as-usual clinical model and grow a new generation of research-active clinicians.

Through the midst of all of the critical COVID-19 research that was carried out at the trust, work on some important non-COVID research continued. The trust recorded its best ever recruitment into NIHR portfolio research last year, with over 8,000 patients recruited. This has been a truly phenomenal achievement and bears testament to the unwavering hard work, commitment and dedication of everyone involved in the conduct of clinical research at the trust.

In the most testing of times, clinical research has brought hope and optimism for the future to mankind. Through the global scientific and research effort we can all now look forward to brighter days ahead. The contribution made to this effort by research teams at Royal Free London has been extraordinary and we are all extremely proud and grateful for their effort. Next year will bring its own challenges; COVID-19 will be with us for the foreseeable future and the research endeavour into the disease will continue, including into some of the new emerging COVID-19 pathologies such as long-COVID. We are committed to continuing our support of new COVID-19 research. We will also need to prioritise the steady resumption of the research that was paused during the past year and begin opening new non-COVID-19 research; all of this will require careful planning and collaboration with our researchers and sponsors. The Royal Free Clinical Research Facility will be operational, providing the trust with the exciting prospect of participating in early-phase experimental medicines research; our ambition is to secure NIHR funding for this facility in the next funding round which opens in June.

Last year's clinical research success has set a unique foundation on which to build for the trust's clinical research future. We look forward to seizing this opportunity and ensuring that clinical research emerges stronger and better for the benefit of our hospitals, staff and the patients that we serve.

*final figure to be determined by end of April

References

1. *NHS England (2021). COVID treatment developed in the NHS saves a million lives.* *https://www.england.nhs.uk/2021/03/COVID-treatment-developed-in-the-nhs-saves-a-million-lives/*

B. In situ simulation

As part of the Trust's COVID response, the Simulation Centre team has been using simulation to prepare and support staff and has developed innovative ways of working.

In situ simulation is a way of teaching using simulated scenarios within the real clinical environment with the people who work there. After the scenario, there is a facilitated debrief for all staff taking

part. This method of education fits into the working day, making learning more accessible and is often the first opportunity for people from different professions and staff groups to learn together.

In situ simulation can improve teamwork, communication skills, and patient safety. It also allows teams to review and reinforce their skills, to problem-solve in the clinical environment and identify hazards and deficiencies in clinical systems and the environment as well as their own learning needs.

During the first COVID surge the team provided simulation sessions of cardiac arrest in COVID patients. The sessions not only enforced the importance of keeping staff safe and allowed them to practice donning PPE; they also empowered staff to challenge others' practice. At the end of the first surge these sessions were debriefed in collaboration with the Project Wingman team, furloughed pilots and cabin crew, who added a wealth of human factors insight from the aviation world. Key themes emerging from these sessions included working in unfamiliar environments, understanding roles, communication challenges and the use of systematic approaches when faced with uncertainty.

Since the start of the pandemic the team has continued to support the delivery of in situ simulation throughout the organisation but has adapted the way it has been delivered at times. This has included filming scenarios to offer virtual simulation and debriefing opportunities on the junior doctors' induction and also in collaboration with blood bank around major haemorrhage.

Virtual simulation on MS Teams

A rise in delirium was noted after the first COVID surge with greater than 50% of patients on some wards receiving enhanced care and staff were feeling burnt out. In collaboration with the HSEP multi-disciplinary team (MDT), focus groups where held with staff to identify key problems and staff concerns when dealing with delirium. Staff reported the challenging impact of relatives not visiting, experience of racist language from delirious patients and telephone aggression from families. To help address this, a simulation programme is in development. So far this has helped develop MDT understanding and collaboration to find ways of working to support staff and patient care delivery.

MDT delirium simulation in collaboration with HSEP

In preparation for the 2nd surge, in situ simulation was used on wards to prepare staff for treating COVID patients again. The team has also facilitated simulation learning in satellite units to address some of the challenges COVID has presented there such as changing PPE requirements and increased patient acuity in outpatient areas.

Multi-disciplinary simulation is now also being used to add to organisational learning following the recent COVID surge using a Human Factors framework to collect learning from staff providing patient facing care in clinical areas across the Trust.

This quote is from a participant in one of these simulations: *"I thought the sim was fantastic. The space to reflect before and after was so useful in the context of COVID. Acknowledging the human factors and emotional impact of COVID was really beneficial. It would have been great to have had the opportunity to do this before the second surge."*

C. Keeping families connected during the pandemic

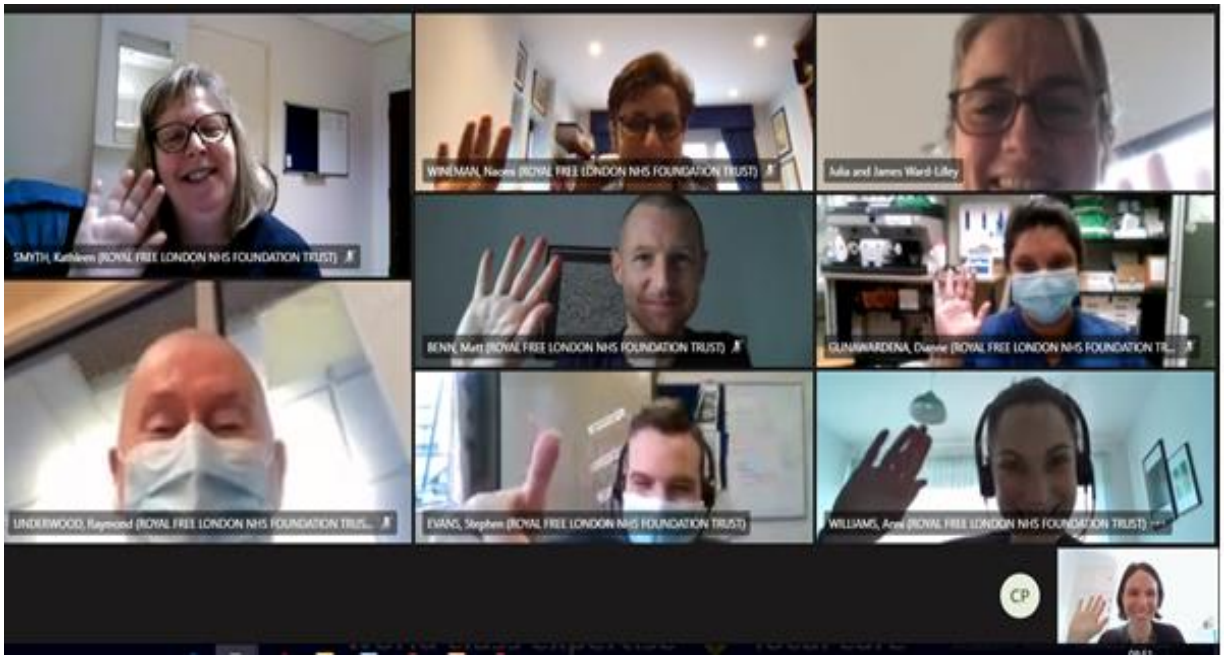
i. Virtual Visiting

Effective communication between patients, their friends and family, and the multidisciplinary staff providing their care, has always been a priority for the Royal Free London NHS Foundation Trust.

The importance of this was amplified by the COVID-19 pandemic and increased anxiety in the public, significantly increased staff workload, and rules preventing visitors from entering our hospitals exacerbated the situation. In response, the virtual visiting and family liaison service was set up to keep our patients connected with their loved ones via facilitated video and phone calls.

Virtual visiting at the Royal Free Hospital and Barnet Hospital is being spearheaded by the head of patient experience and interpreting, the senior improvement adviser, the clinical nurse specialist in pain management and the head of patient experience and involvement.

The head of patient experience and interpreting explained how the service works: “Virtual visiting is a service that has been staffed entirely by redeployed staff from other areas of our hospitals and medical students, and supplemented more recently by volunteers. They visit the wards, meet with patients and offer to arrange video or phone calls with friends or members of their families.



“It was clear very early on in our response to COVID-19 that this would be essential, as patients don’t necessarily have the technology to carry out these calls themselves, or they may need physical support to do so. This was particularly true for the many elderly patients, and those who struggled to communicate for various reasons, who have been admitted to our wards during the pandemic. We also recognised that our clinical teams are under more pressure than ever and don’t necessarily have the time to support this level of communication.”

The senior improvement adviser added: “***This is a service that really matters to our patients. A lot of people tell us how grateful they are, and we’ve heard that it has made all the difference to how they feel. Our staff are also gaining a lot from the experience, and speak about how rewarding it is to be part of the team. More than one hundred staff have come forward to be involved and over a thousand calls have been facilitated for patients.”***

The head of patient experience and involvement shared how important it has been: ***"It's all about providing that little bit of extra human connection throughout the day, which is really important for boosting the mood of our patients and their relatives, and for providing them with reassurance. These calls mean the world to people, and seeing the joy that crosses a person's face when they're able to reconnect has been an absolute privilege."***

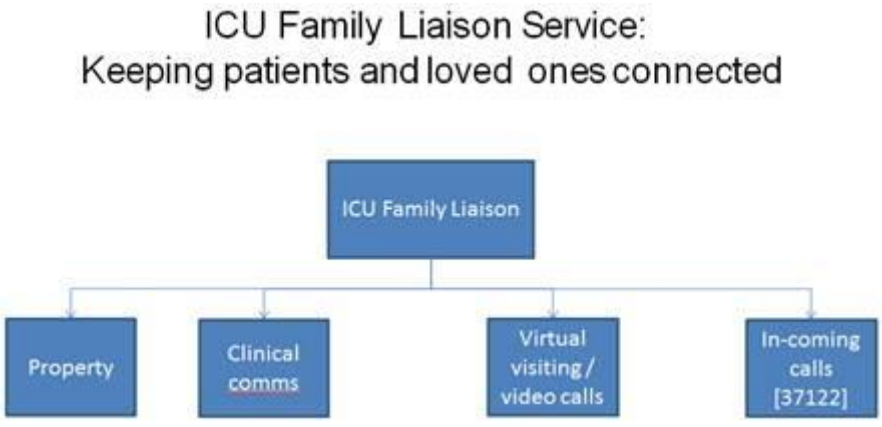
Giving patients a way to see and speak to their loved ones has been essential, but it's just one part of the service. Family members also need to be given clear and compassionate updates about the welfare of their loved one, the care that they're receiving, and any plans for the future. These updates are typically provided by doctors and nurses, but by putting this service in place we have helped to free up their time for other clinical tasks while keeping families fully informed.

This team was staffed by clinical professionals, including medical students as well as consultants who had been redeployed from their usual services. A paediatric consultant who took on this role at Barnet Hospital explained: "Our role is essentially to communicate the medical plan that the doctors have made to the family, and explain what it means in terms of treatment. We're able to go into a little more detail. The people we speak to are often quite anxious, and they may be unsure about what is happening, so we have to navigate that as well and try to reassure them."

It is clear that this service has had a positive impact for our patients, their loved ones and our staff, and the challenge now is to keep them running as visiting restrictions remain in place and redeployed staff return to their usual roles. Similarly we found this to be important for our patients in intensive care (ICU) and below are the details of our initiative in ICU.

ii. Intensive Care Unit Family Liaison Team

The Intensive Care Unit Family Liaison Team (ICU FLT) was established across both sites in response to the pandemic with the aim of keeping patients and their loved ones connected. Due to the great pressure on the ICU team other clinical staff were redeployed to provide clinical updates to patients' families. The ICU FLT also provided the opportunity for family and friends to see their loved ones via video calls whilst restrictions on physical visiting were in place.



The ICU FLT brought together a wide range of professionals from different disciples and organisations. Trainee ophthalmic surgeons, palliative care clinical nurse specialists, consultant oncologists, GPs and medical students are just a few examples of the variety of staff who offered their support at a difficult time. With great team work the ICU FLT was able to provide; an average of 75 clinical update calls per day, four video calls per week for each patient as well as links into psychological and spiritual support for those patients where it was judged to be of benefit.

An important area of development was to ensure the safety of patients' personal belongings, which our ICU team led on.

iii. ICU Properties team

The ICU Properties team was established across both sites to provide a 7 day service to find and secure patients property and work to repatriate it back to patients and their families.

This provided reassurance to families that patients' property was safe and secure and enabled them to arrange drop offs and collections for their loved ones to have sentimental items at their bedside. This reduced the risk of loss, particularly for deceased patient's property and also improved the experience for patients and families, giving us the opportunity to feel with the families of a deceased patient to repatriate their property.

It became evident that this enlightened approach would be valuable to the wards, which were also in the same situation. It proved to be a welcomed service for patients, families and staff.

D. Bereavement Services

One of the significant impacts of COVID-19 was an increase in the number of deaths.

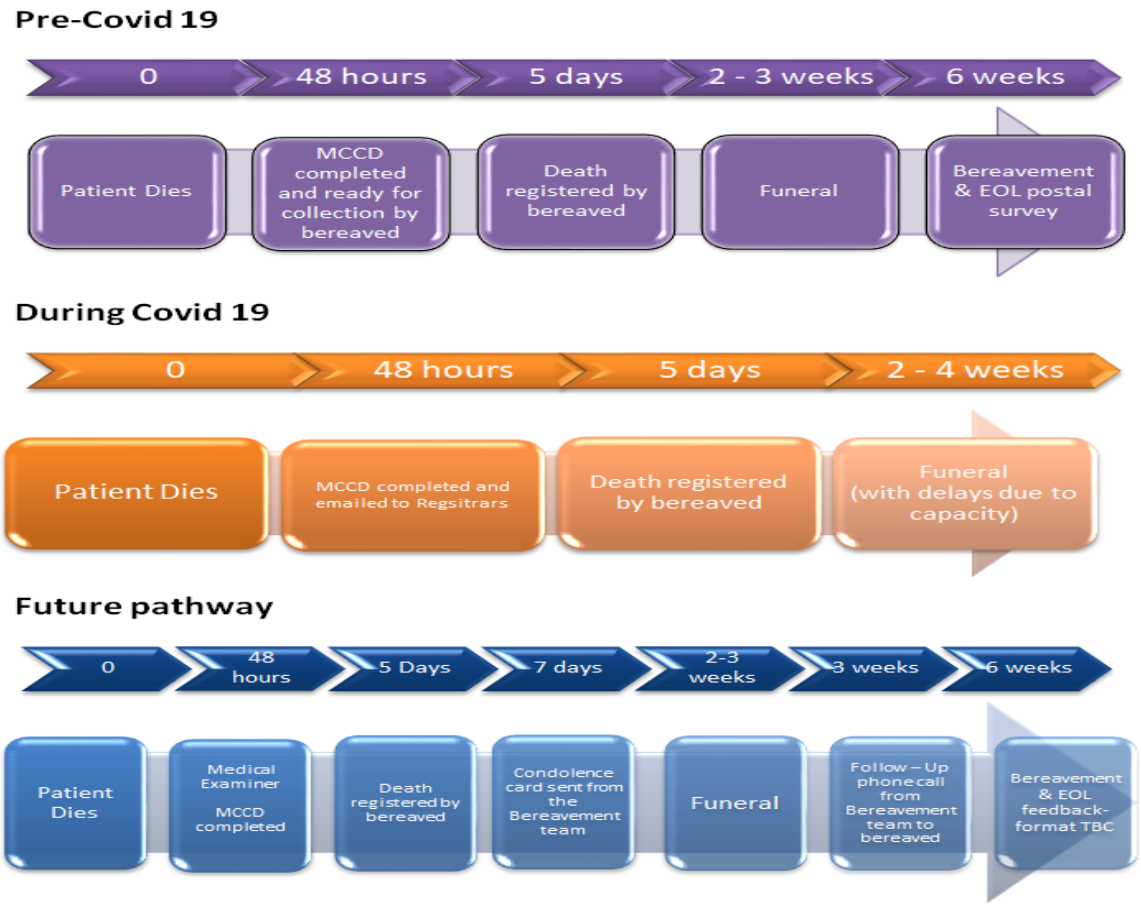
During the first wave of COVID-19, the bereavement team had to move very quickly to mobilise various services, to ensure that the excess of patient deaths was being correctly managed. As the pandemic continued, we sought to work closely with national registration coronial and funeral services, in order to determine how the complete management of deaths could be delivered while ensuing we were keeping people at safe distance amidst the extreme pace and extent of change.

We adopted a rapid flow of implementing emergency death management laws, working with mortality management groups around capacity and resource, which saw us moving to a 7 day service and setting up 24/7 on call. In addition we developed a team of redeployed staff to ensure we provided the most efficient service for our deceased patients and their bereaved families.

One of the main challenges was being able to support the large number of bereaved families adequately due to visiting restrictions. We recognise that the bereavement and mortuary service were providing excellent operational efficiency, however there was a concern that maybe the compassion and care was being compromised.

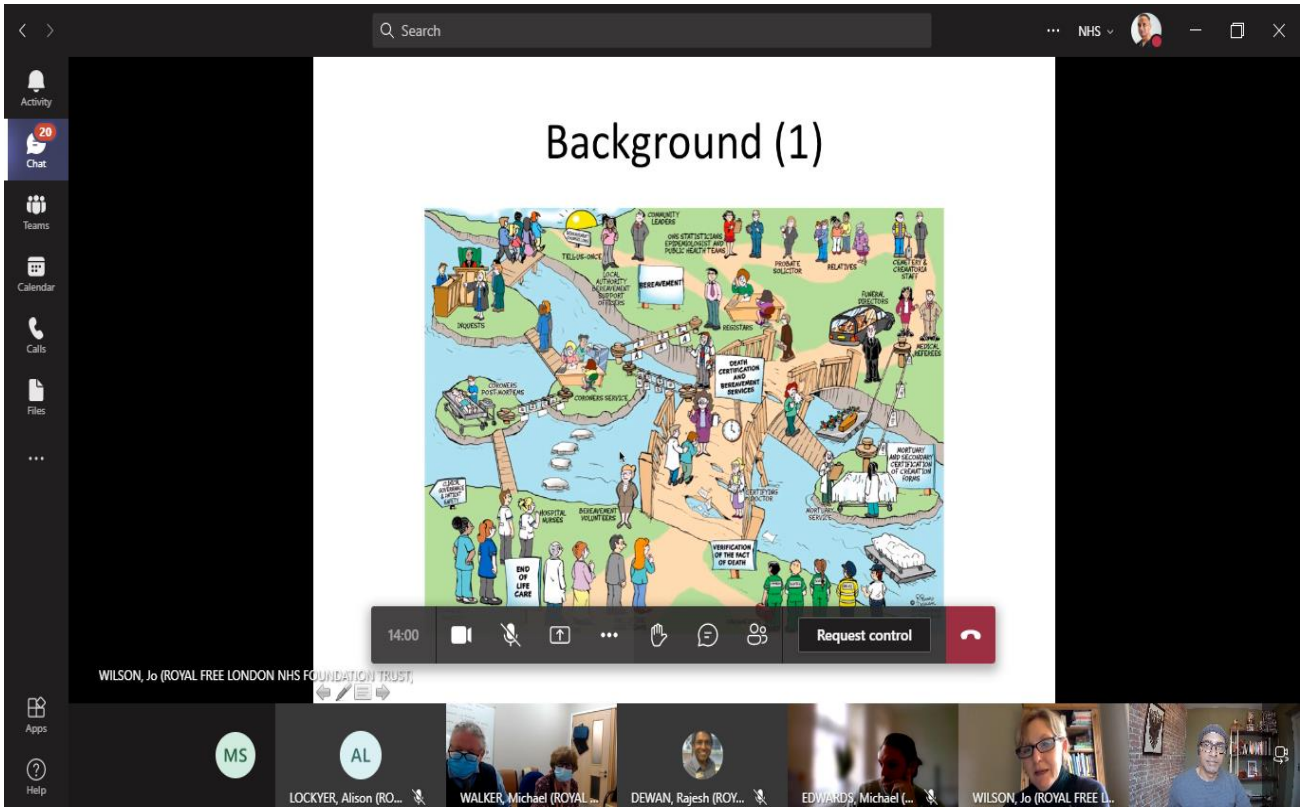
In response, a system was set up to phone bereaved next-of-kin to see how they were managing and to identify any particular difficulties or just to see if they wanted to talk. Feedback from relatives told us that they had unanswered questions, were distressed at not having been able to say goodbye or that they were happy with the care their loved one received. This highlighted that this was something that needed to be a permanent enhancement of care for our bereaved families.

Between March and April 2020, 308 calls were made. 72% of families told us that they were grateful for the call and 17% were referred on to support in their community. Over the next few weeks, an enhanced pathway was presented and approved by the mortality surveillance and end of life steering group.



In conjunction with a local glass artist, Eva Edery, a condolence card was designed and the art was donated to the bereavement service.

A team of callers was recruited and for some of the callers, this role was even added to their job descriptions. The informatics and Datix manager, set up a system to assign, complete and audit calls as part of the deceased patient's record on Datix; this intelligent and responsive system would allow us to really learn from what callers were telling us. With a SOP, escalation plan, a debriefing process and a training program, we prepared callers to take this service forward.



MS Teams phone calls training session (08.04.2021)

Up to and including February 2021, 757 condolence cards have been sent out and 491 phone calls have been made. We are reaching out to bereaved families with kindness to see how they are and how we can help; there is no agenda, just compassion and the feedback from many of the bereaved families tell as that this sentiment is being well received and making a difference.

On receiving calls, bereaved families have said:

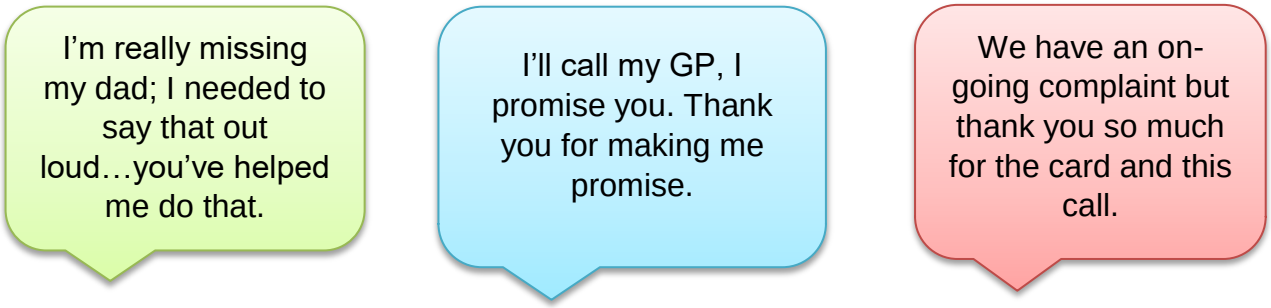
> This is a lovely thing you have just done.

> Chaplaincy and RFH were fantastic…thank you for the call, it was very kind.

> Mum died peacefully and in no pain which is what she feared most, thank you.

> We are so grateful for the work the ward did during the busy Covid time, we have donated to the hospital Covid fund.

> Dad died 2 weeks after mum; you kept them together; that was amazing. Will you thank the staff for me?



This pathway takes a proactive approach which helps the bereaved and also the Trust. In talking the families, we have been able to understand specific challenges that families might be facing and then direct them to specific support services like GPs, funeral fund networks and funeral directors. Families were also able to tell us about what they needed from us at Royal Free London NHS Foundation Trust. If they were unhappy about something, we escalated their concern to the right team so that the family received the help they needed. If a family did not fully understand what had happened to their loved one, we escalated to PALS and the clinical teams so that conversations and clarification could be given. If families were struggling with funeral arrangements, coronial services or multiple deaths, we were able to address these matters promptly to assist the family and support hospital capacity. In the end, we brought kindness, compassion and support to the families rather than making them have to work to find it.

The COVID-19 pandemic year was a year we never imagined we would see, it forced a way of working we never wished for and pushed our personal and professional resilience beyond reasonable boundaries. But COVID-19 also presented us with some very clear learning opportunities and, with a lot of hard work and dedication; some amazing improvements have and are being achieved.

E. Vaccination Programme

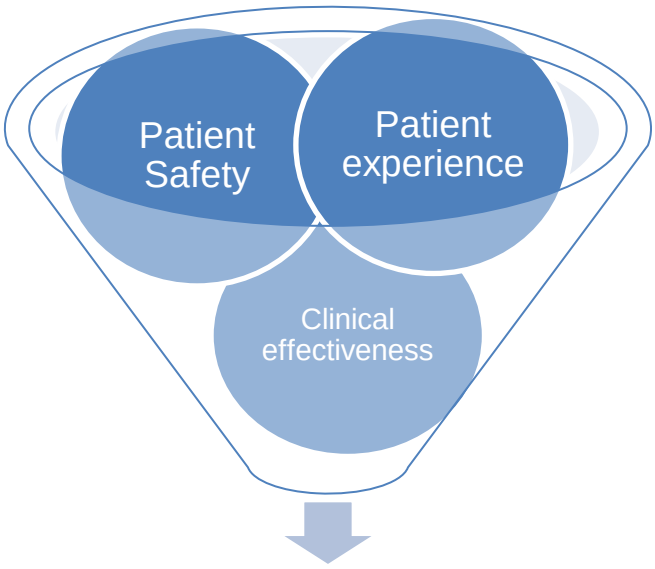
To follow – this will detail our work in the prevention of future COVID-19 infections for patients and staff.

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?*
- ***Patient experience*** *- How was the experience for our patients using our services?*
- ***Clinical effectiveness*** *– What were the outcomes? How successful is the care provided?*



This section describes the following:

- Priorities for improvement: progress made against our priorities during 2020/21
- Outline on our quality priorities for improvement chosen for 2021/22
- 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 2020/21?

Patient Experience	
1	Establish a Dementia Clinical Practice Group (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 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 Joy in Work 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 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 bacteraemia (MRSA) cases.
15	Remain below the mandated threshold for trust-attributed zero Clostridium difficile (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)

Improving Patient Experience: delivering excellent experiences

Priority 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.

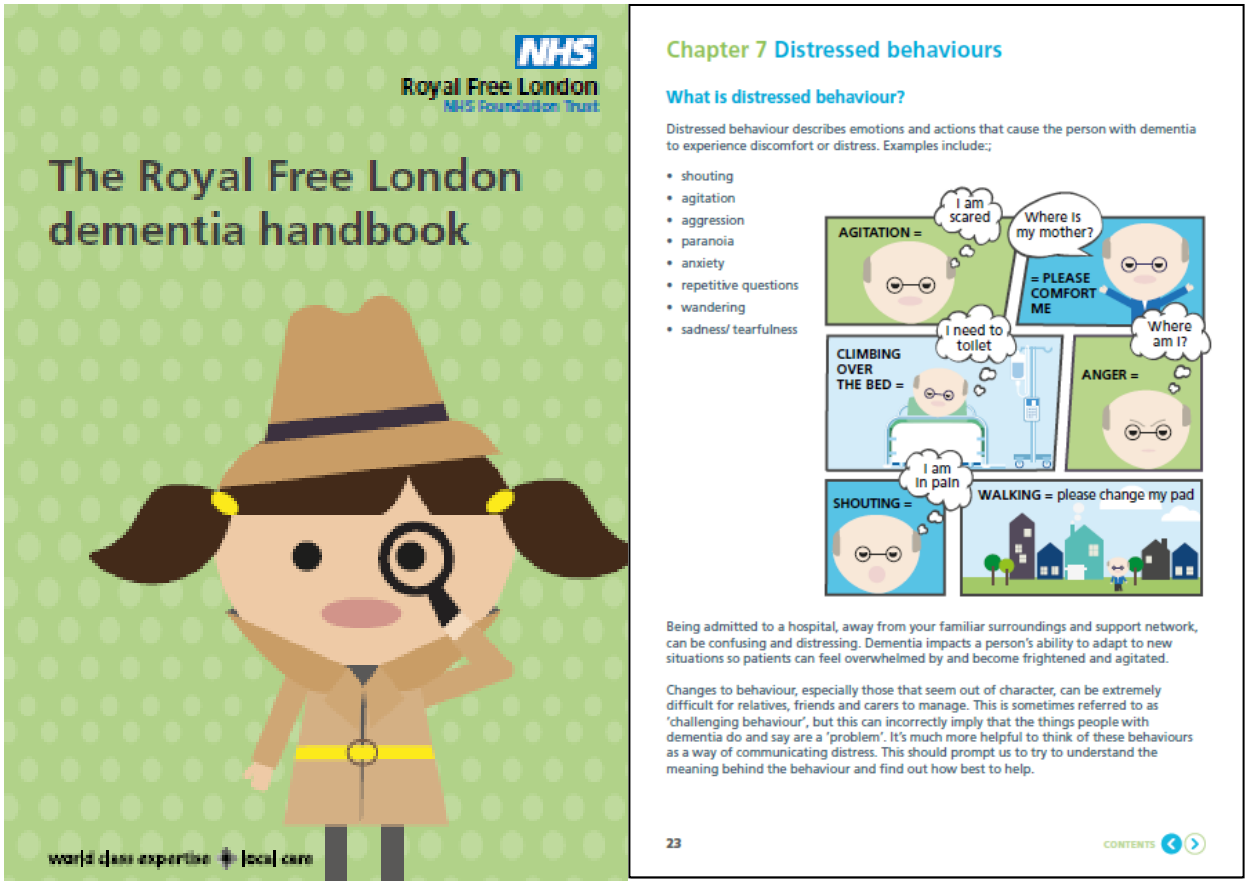
- A multi-site, multi-professional Dementia CPG has been convened which seeks to make meaningful, measurable and patient-centred improvements to dementia care
- Using process-mapping, carer input and a review of national guidance and local data, five key priority areas have been identified; Delirium, Distressed behaviour, Carers, Discharge and Assessment. Together they form our five major workstreams, each of which has a named lead and clear, measurable goals
- The CPG leadership group has oversight of the progress of the CPG and includes on-going carer input

Priority 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.

- During the COVID pandemic, it was noted that episodes of violence and aggression perpetrated by people with dementia and/ or delirium against staff increased significantly, with reported incidences trebling in some areas. Datix and Serious Incident data were collated and analysed in an attempt to identify trends/ triggers so that mitigating steps could be implemented to protect patients and staff.
- Focus group interviews were held in key areas and involved perspectives from patients and carers. We identified that a number of complex factors were likely to be contributing to the increase in distressed behaviour, ranging from heightened anxiety around COVID, reduced presence of carers and volunteers in the wards, to our reduced ability to connect and reassure patients with non-verbal communication due to PPE.
- We set up debrief huddles in areas with specific needs and used the range of perspectives around violence and aggression (patient/ carer/ staff) as well as real-life serious incidents to design an in-situ simulation training bundle to help staff consider the root causes of behaviour and identify opportunities to de-escalate. The pilot in-situ sims were a success and we plan to roll the schedule out across the Trust including digitally via Freenet 2

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

- The Trust Dementia Implementation Group has partnered with Camden and Barnet Carers to host monthly sessions with a group of dementia carers via Zoom. These meetings aim to troubleshoot any clinical issues carers experience whilst undertaking their caring roles and help bridge the “information gap” they are left with following a person’s diagnosis of dementia
- The two borough groups will also combine to form a dementia carer steering group which is represented within the CPG leadership group as well as within the Carers workstream
- Further dissemination/ teaching of the RFL Dementia Handbook amongst community groups



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

- The Non-Clinical Practice Group (NCPG) Programme seeks to reduce waste and unwarranted variation in the patient administrative pathway, resulting in improved patient experience, quality of care, and staff satisfaction. As part of this programme, multiple workstreams are aiming to improve patient appointment and referral communications.
- In August 2020, the Trust launched My RFL Care – which is a website portal that enables patients to access their appointment letters digitally: as of April 2021, over 80,000 patients had signed up to benefit from this service.
- My RFL Care also enables patients to opt out of paper appointment letters in the future - and will, eventually, provide patients with digital access to other types of letters, including clinical letters and discharge summaries.
- By summer 2021, all patients will be able to modify some of their upcoming Outpatient appointments directly via My RFL Care. This will simplify their interactions with the Trust when cancelling or rescheduling appointments, and their updated letters will be available automatically via the portal.

Priority 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.

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 46 members of staff across sites and professional disciplines, which included testimonies from patients. This helped to create a shared understanding of involvement and 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.

The work on the framework was suspended due to COVID19 and we are waiting to recommence once safe to do so.

Whilst the work with the Point of Care Foundation was paused, the Trust continued with its plans in Improving Patient Experience through delivering excellent experiences. The Trust has two strategic priorities for patient experience - dementia care and cancer. Dementia is identified above.

The results of the 2019 National Cancer Patient Experience Survey (NCPES), commissioned by NHS England were published on 25th June 2020. This was the ninth iteration of the survey first undertaken in 2010. The sample for the survey included all NHS patients, aged 16 and over with a confirmed primary diagnosis of cancer, discharged after an inpatient episode or day case attendance for cancer related treatment in April, May or June 2019. 1,551 surveys were sent out and the trust received 834 completed surveys, giving a trust response rate of 54%. The national response rate was 61%.

The survey comprised of 52 scored questions. The case mix adjusted scores have improved within the Trust for 34 questions, and remained the same for 5. This translates to a rise of 22 places in the National Scoreboard.

The Trust has shown steady improvement in NCPES scores, and across all domains measured. We are keen to build upon this progress and accelerate improvements in specific areas of importance highlighted by patients and their families.

A 2 year Cancer Patient Experience strategy has been written and sets out our plan for improvement at the Royal Free London NHS Foundation Trust.

There are 4 key areas of focus to improve cancer patient experience:

Work is on-going in each of the 4 areas. A Cancer CNS review is in progress and 5 cancer support workers (band 4) have been funded by Macmillan Cancer Support who will provide some admin support to the CNSs and also deliver face to face support to patients with a particular focus in supporting the Personalised Care agenda.

To build upon the Let's Talk Cancer work, we are now collaborating with an external agency to produce a web-based interactive training package aimed at all staff groups who come into contact with cancer patients. The training will be based around the six Let's Talk Cancer principles: Introduce, Support, Involve, Confirm, Ask and Provide. It is our intention that the training will be hosted on the Trust's MAST platform alongside other essential learning modules. The Royal Free Charity recently provided a £10,000 grant to support the development of this training package.

With support from Macmillan, in 2018 the Trust appointed its first Personalised Care and Stratified Follow-up Project Manager to initiate Trust-wide implementation of key foundational elements of Personalised Care. As a result of this investment and focus, the numbers of patients who are receiving holistic needs assessments (HNAs) and care plans has further increased in 20/21. Groundwork has commenced with specific tumour-type MDTs to roll out Treatment Summaries, and a rolling programme of Health and Wellbeing Events was launched for patients.

A key pillar of personalised care is Risk Stratified Follow-up pathways, of which Open Access Follow-up is a model. This new and innovative approach to follow-up moves away from traditional 'one size fits all' post-treatment surveillance pathways and instead tailors the frequency of appointments to the risk of recurrence and other salient factors. Implementation of these new stratified pathways is recommended initially for breast, prostate and colorectal cancer, and for patients who have completed treatment with curative intent. Enablers to implement this within the Trust include additional workforce and adequate IT platforms.

We aim to provide access to high quality individualised support to patients and their families including:

1. Information and support
2. Psychology and counselling
3. Welfare benefits advice
4. Nutrition and dietetics
5. Physical Activity / Prehabilitation
6. Peer support via support groups and wellbeing activities (Maggie's)

Key to being able to provide the above is working in partnership with charities. The Trust hosts three Macmillan Cancer Information and Support Centres (one per site), a Maggie's Cancer Support Centre (main RFH site), Macmillan Welfare Benefits Advice Services delivered in partnership with Citizens Advice Bureau across all sites, and a Macmillan Psychological Support service, comprising a clinical psychologist and counsellors. A brand new Maggie's Centre is planned to open in 2022 and will enable expansion of some of the services currently provided.

As a Trust we recognise that we cannot implement our ambitious cancer patient experience strategy alone. We welcome input and action from partners as this is essential to achieve results. We will demonstrate our commitment to engaging consistently with patients, carers, families and the public, by convening a Cancer Patient and Public Involvement Group (C-PPI Group). We envisage that this group will be independent and will have advisory and accountability functions for our programme of work.

Improving Clinical Effectiveness: delivering excellent outcomes

Priority 6: Continue to deploy the Quality Improvement (QI) methodology against the trust priority of Joy in Work 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 Joy in Work framework within their teams.

- Building on the success and learning from the Joy in Work programme, QI methods have now been incorporated into the trust's wider health and wellbeing programme.
- Due to the wave 1 and wave 2 COVID 19 surges, much of the team-level project work was paused: however, it was clear that the philosophy and tools developed through the Joy in Work (JiW) programme helped staff to cope with the significant challenges presented by COVID 19
- The group-wide JiW programme also had to be paused on two occasions due to the COVID surges – and, as a result, fewer staff have been trained: however, RFL has secured the materials with which to support further team training as and when the full QI training offer can be resumed.

Priority 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.

- QI work is now an standing item on the agenda at the Trust Clinical Standards and Innovation Committee – which is sub-committee of the Board, chaired by a Non-executive Director;
- QI team leads provide regular updates to each of the site (BH, CFH and RFH) Local Executive Committee meetings;
- As at end February 2021, the Life QI system had 177 'active' projects registered, with another 35 logged as 'completed'.

Priority 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.

- In October 2020, we launched a virtual 'QI Lunch Club' – the purpose of which was to provide a monthly forum for the QI community to share experiences and learning. Meetings had to pause due to the recent COVID 19 surge: however, we expect those to have resumed in spring 2021.
- QI work has continued to be showcased at Board meetings, Clinical Standards and Innovation Committee meetings and also monthly Chief Exec staff briefings.
- RFL leads have also participated in knowledge sharing networks beyond the organisation – in particular, through the IHI international forums, which have often showcased learning from the RFL.

Priority 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.

- We have digitised 26 pathways –outlined below – with a further 10 pathways planned for the year ahead.
- We have used the CPG methodology to develop over 200 clinical guidelines to help care for patients with COVID. These are accessible on the hospital's COVID Freenet page to support clinicians and multi-professional teams care for patients.
- The CPG team has also worked with ICU (Intensive Care Unit) colleagues to set up the family liaison team, to ensure relatives of patients in ICU are kept updated on a regular basis.

Digital Pathway	Royal Free Hospital	Barnet Hospital	Chase Farm Hospital	Number of patients completed pathway
1. Hip	Paper format	Paper format	√	491
2. Knee	Paper format	Paper format	√	621
3. Non-complex RUQP	Paper format	√	√	211
4. Haematuria	Paper format	√	x	595
5. EPU	√ (EPU OP only)	√ (EPU OP only)	×	2252
6. Wheezy Child	Paper format	Paper format	x	Digital Go-live Scheduled
7. Chest Pain	Paper format	Paper format	x	Digital Go-live Scheduled
8. Upper GI	Paper format	Paper format	x	Digital Go-live Scheduled
9. Pneumonia	Paper format	√	x	94
10. Heart Failure	Paper format	√	x	1793
11. Hot Gallbladder	Paper format	√	x	41
12. Pulmonary Embolism	Paper format	√	x	386
13. Virtual Fracture Clinic	Paper format	√	√	2231
14 Pre-operative Assessment	Paper format	√	√	5471
15 Telederm	N/A			4855
16 KMBT	√	√	x	7602
17. Anaemia	Paper format	√	√	23
18. Prostate	Paper format	√	√	504
19. Induction of Labour	√	√	N/A	1811
20. Lower GI	Paper format	√	√	6580
21. Lung	Paper format	√	x	814
22 HPB Cancer	Paper format	x	x	Digital Go-live Scheduled
23. Shoulder	Paper format	Paper format	√	Digital Go-live Scheduled
24. Gynaecology Cancer	Paper format	√	x	Reporting in development
25. Haematuria (Post-diagnostic)	Paper format	√	x	Reporting in development
26. Hyperemesis	√ (EPU OP only)	√ (EPU OP only)	x	Reporting in development

Improving Patient Safety: delivering safe care

Priority 10: As part of our Safety Strategy 2020-2025, have zero never events, decrease our Avoidable Harm Score from 82 to 66 by 2020/21, and become a zero harm organisation by 2025.

The first measure of success for this patient safety priority was to achieve zero never events by the end of March 2021. Never events are extremely serious and largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place.

Unfortunately, we reported 5 never events during 2020/21, which are summarised in the table below. All never events are investigated as serious incidents. All serious incidents are reviewed at our Board level Clinical innovations and standards committee (CSIC), chaired by one of our Non-Executive Directors where we triangulate serious incidents with incidents, complaints, PALS and litigation to identify themes which might require system-wide work. We publish a weekly précis of serious incidents as they are reported and share further general and speciality-specific newsletters online and by email. We also hold learning events, seminars and workshops in order to disseminate lessons learnt.

Steis	Site	Type	Incident date	Harm
2020/15852	CFH	Nerve block injected into wrong hip	17/08/2020	None
2020/18593	RFH	Wrong size IM nail inserted during orthopaedic surgery	22/09/2020	None
2020/23610	RFH	Intravitreal injection to wrong eye	02/12/2020	Low
2021/4934	RFH	Wrong site surgery in dermatology	06/01/2021	None
2021/5500	BH	Nerve block injected into wrong limb	06/03/2021	None

The second measure of success for this patient safety priority was to decrease our Avoidable Harm Score from 82 to 66 by the end of the 2020/21 financial year.

There is no national definition of avoidable harm and it should be noted that the "NHS Patient Safety Strategy: Safer culture, safer systems, safer patients" published in July 2019, clarifies that for effective safety measurement the terms 'avoidable' and 'unavoidable' are unhelpful for patient safety. However, since June 2017, the Trust has used the likert definitions of avoidability in order to assist in determining our level of response in the investigation of incidents. It follows that the Trust has defined avoidable harm as an incident resulting in moderate, severe harm or death (generically termed moderate+ harm), which is determined to have a likert avoidability score of 1-3 [1) definitely avoidable; 2) Strong evidence of avoidability; 3) probably avoidable, more than 50:50]. The Trust recognises that the determination of level of harm and level of avoidability are subjective and so our decisions are based on the consensus opinion of the multi-disciplinary safety incident review panels (SIRP), chaired by the Medical Directors.

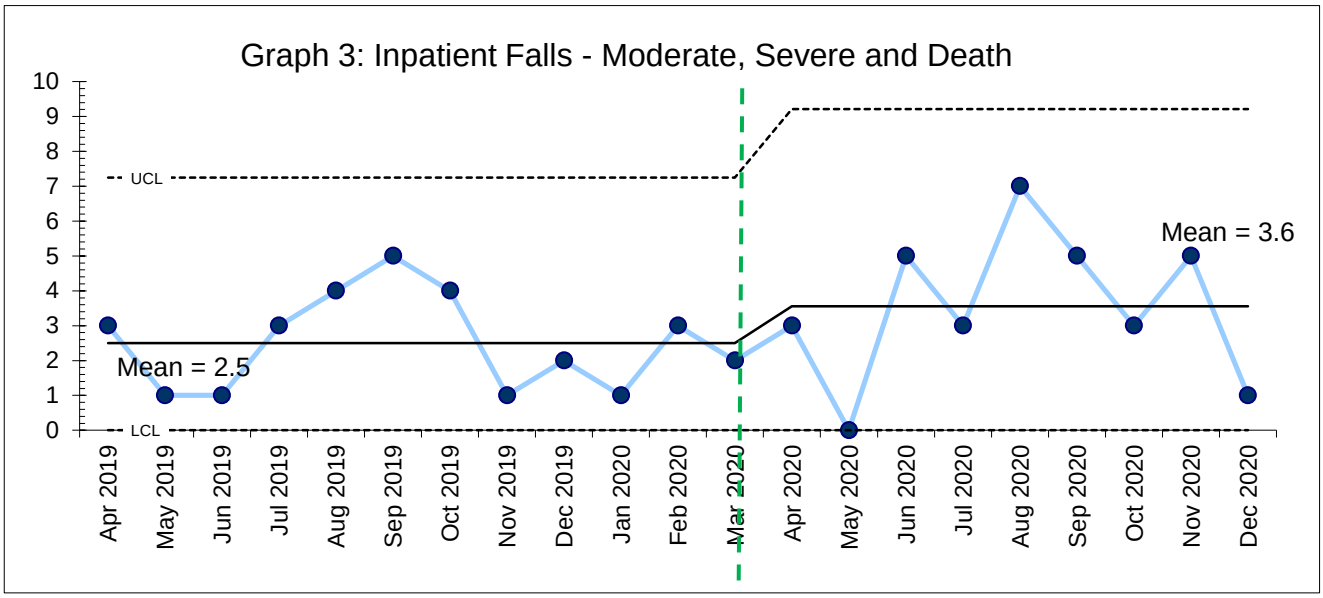
Taking a risk-based approach we have created the RFL avoidable harm score (AHS) for each incident that is moderate+ harm and has a likert score of 1-3. The total AHS for each month is then used as the indicator, with the median used as a baseline indicator.

As at the end of Q3 2020/21, the Trust's average AHS for the financial year was 68, which means that whilst we have not achieved our target of 66, we have nonetheless achieved a significant reduction in the level of avoidable harm (to be updated) .

Priority 11: Decrease the number of falls incidents with moderate or more harm reported by 5% by March 2021.

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

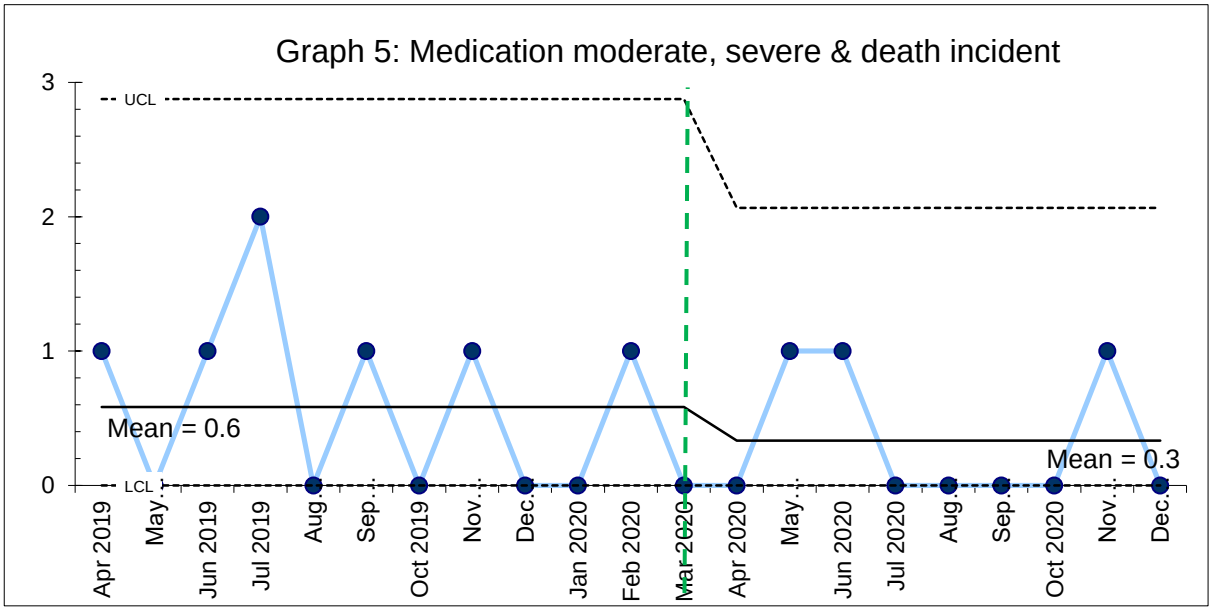
In the 2019/20 financial year, the average monthly number of moderate or greater harm inpatient falls was 2.5. To achieve a 5% reduction the average monthly number for the 2020/21 financial year would need to be 2.375. As shown in the graph below, as at the end of Q3 2020/21, the average monthly number of moderate plus inpatient falls was 3.6, which unfortunately represents an increase and means that we have not achieved this target. (to be updated) The falls that result in moderate or more harm are reviewed regularly at our safety incident review panels, fall panels, Trust-wide nursing and midwifery committee and matron's meetings.



Priority 12: Decrease medication incidents with moderate or more harm reported by 5% by March 2021.

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

In the 2019/20 financial year, the average monthly number of moderate or greater harm medication incidents was 0.6 (there were 7 such incidents during that year). To achieve a 5% reduction the average monthly number for the 2020/21 financial year would need to be 0.57. As shown in the graph below, as at the end of Q3 2020/21, the average monthly number of moderate plus medication incidents was 0.3, which means that we are currently on track to meet this objective. (to be updated)



Priority 13: Increase the number of staff trained in mental health first aid to 100 by March 2021.

The measure of success for this patient safety priority was to increase the total number of staff trained in mental health first aid to 100 by the end of the 2020/21 financial year.

The cumulative total of trained mental health first aiders at the end of 2020/21 was 87, which is less than our objective of 100. Our ability to implement the training was affected by the COVID-19 pandemic, but moreover we are currently reviewing the psychological needs of our staff following on from the pandemic and as such there are no plans to continue mental health first aid training at the moment. In the meantime, the Trust has established a resilience and emotional support team (REST) to help staff during COVID–19.

Priority 14: Achieve zero trust attributed meticillin-resistant Staphylococcus aureus bacteraemia (MRSA) cases.

There have been six attributed cases of MRSA bacteraemia since April 2020, four attributed to RFH and two attributed to BH.

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

Priority 15: Remain below the mandated threshold for trust-attributed zero Clostridium difficile (100 cases 2019/20) and have zero infections due to lapses in care.

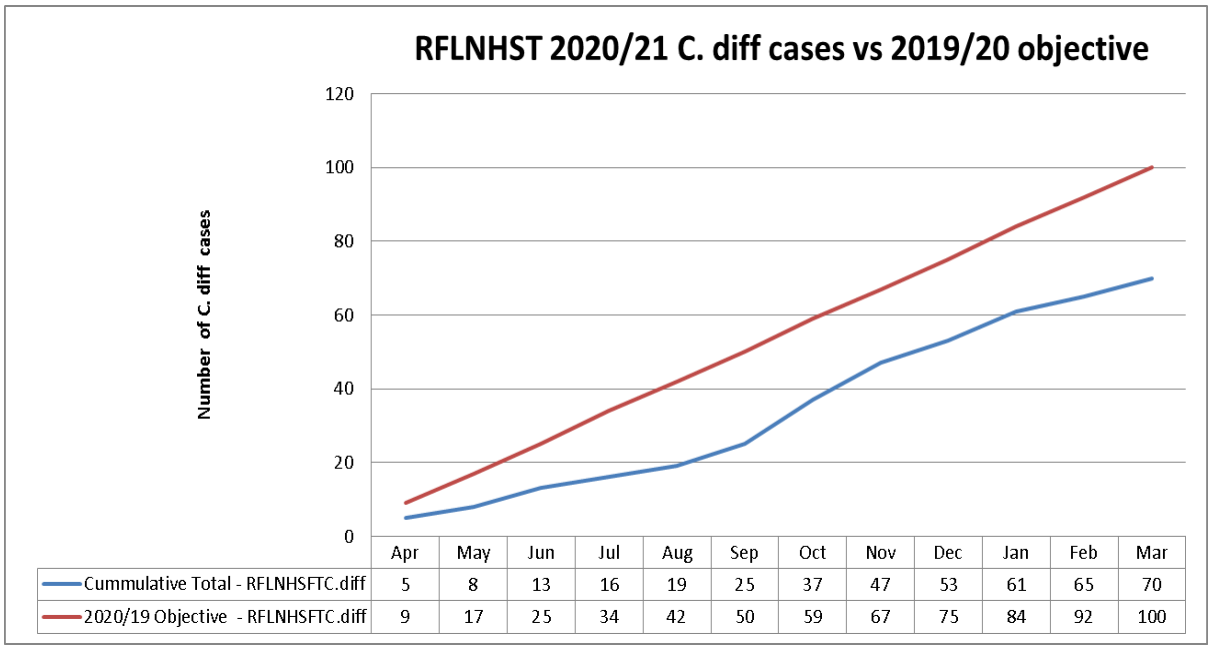
A new C. difficile attribution process was implemented for 2019/20. Acute provider objectives are now set using these two categories:

- HOHA: hospital onset healthcare associated: cases that are detected in the hospital three or more days after admission
- COHA: community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

RFLNHST Attributable C. diff cases in 2020/21

The Trust reported a total of 70 *C.difficile* cases in 2020/21, down from 84 in 2019/2020 which is moving in the right direction. Four cases with lapses in care were identified, with several cases pending confirmation. All cases have a Root Cause Analysis (RCA), with learning fed back through the monthly IPC Divisional Leads group and monthly Clinical Performance and Patient Safety (CPPS) committee.

Learning from the RCA identified two confirmed lapses in care, suggesting that early identification, timely isolation and sampling can be improved.



Priority 16: Reduce Gram negative bacteraemias in line with mandated threshold (-25% reduction by 2021-2022, with the full 50% by 2023-2024)

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

Following a slight reduction in 2019/20 there was an increase in 2020/21. The reduction target has been revised in the NHS Long Term Plan to a 50% reduction by 2024/25.

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

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

Our priorities for improvement for 2021/22

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

The priorities chosen for 2021/22 remain within the quality domain and are drawn from our local intelligence, engagement with the Commissioning for Quality and Innovation (CQUIN), our CQC inspection and compliance improvement plan, performance and feedback following consultation with key stakeholders.

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

Additionally, reports are sent to Trust level Infection Prevention and Control Committee (Chaired by Director for Infection Prevention and Control) 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 Performance and Patient Safety Committee and Clinical Standards and Innovation Committee.

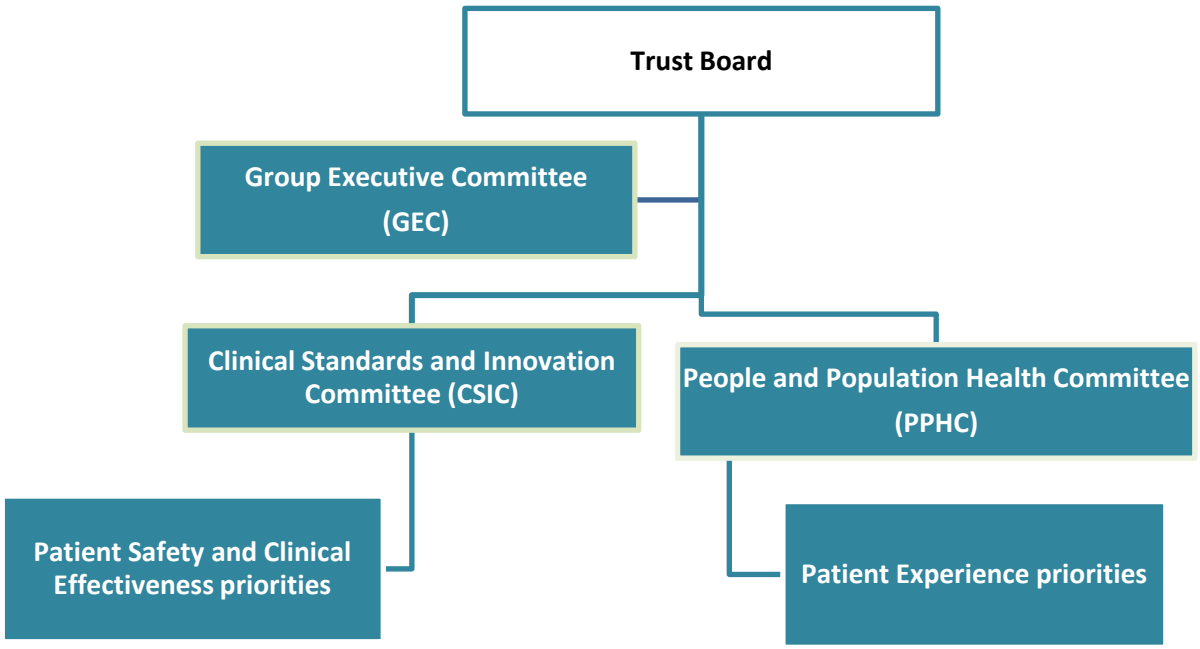


Figure 1: Strategic committees reporting to the trust board

Patient Experience	
1	Deliver Dementia CPG which consists of 5 focussed workstreams; Delirium, Distressed behaviour, Activity-based care, Discharge and Carers. NEW
2	Patients who are recognised as being likely in the last year of life are offered a conversation recognising this. In this conversation their wishes and preferences will be assessed, there will be negotiation of treatment plans, and a comprehensive discharge summary will be written. NEW
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. Continue from 20/21
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. Continue from 20/21
5	Ensure RFL is a welcoming and supporting trust for patients, their carers, families and friends and that kindness is at the centre of improving and sustaining their experience across the trust. NEW
Clinical Effectiveness	
6	Deploy quality improvement methodology, projects and programmes towards at least two of RFL's four delivery priorities. NEW
7	Embed quality improvement expertise, methodology and approaches in RFL's approach to achieving improved CQC ratings. NEW
8	Over the next year the CPG programme will develop and implement an additional 14 digital pathways with particular focus on Trust priority areas in Cancer, Emergency and Ambulatory Medicine, Maternity and Surgery Clinical Practice Groups. Continue from 20/21
9	Develop and embed a clinical pathway group which aims to improve safety and quality of diabetes management both within hospital and in primary care. NEW
10	We will establish a population based approach to improve outcomes for patients with heart failure by developing a fully integrated pathway with our partners in primary and community care. NEW
Patient Safety	
11	As part of our Safety Strategy 2020-2025, have zero never events, decrease our Avoidable Harm Score to 49 by 2021/22, and become a zero harm organisation by 2025. Continue from 20/21
12	Decrease the number of falls incidents with moderate or more harm reported by 5% by March 2022. Continue from 20/21
13	Decrease medication incidents with moderate or more harm reported by 5% by March 2022. Continue from 20/21
14	Achieve zero trust attributed meticillin-resistant Staphylococcus aureus bacteraemia (MRSA) cases. Continue from 20/21
15	Achieve zero Trust attributable C. difficile infection cases with a lapse in care. Continue from 20/21
16	Achieve zero hospital onset definite healthcare associated COVID-19 infections. NEW
17	Reduce Gram negative bacteraemias in line with NHS Long Term Plan reduction objective of 50% by 2024/25. NEW

2.2 Statements of assurance from the board

A. Review of services

During 2020/21 the Royal Free London NHS Foundation Trust provided and/or subcontracted 41 relevant health services.

The Royal Free London NHS Foundation Trust has reviewed all the data available to them on the quality of care in 41 of these relevant health services.

The income generated by the relevant health services reviewed in 2020/21 represents 100% of the total income generated from the provision of relevant health services by the Royal Free London NHS Foundation Trust for 2020/21

B. Participation 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 2020/21 66 national clinical audits and 2 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 97% national clinical audits and 100% national confidential enquiries 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 2020/21 are detailed in Tables 1 and 2 below.

The national clinical audits and national confidential enquiries that the Royal Free London NHS Foundation Trust participated in during 2020/21 are detailed in Tables 1 and 2 below.

The national clinical audits and national confidential enquiries that Royal Free London NHS Foundation Trust participated in, and for which data collection was completed during 2020/21, are listed in Tables 1 and 2 below, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

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

Where 2020/21 data are 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 1: Name of audit, eligibility and participation

Name of Audit	Data collection completed in 2020/21	Trust Eligibility to participate	Participation 2020/21	Case ascertainment
British Association of Urological Surgeons (BAUS): Female stress urinary incontinence audit	Yes	Yes	RFH BH and CFH service not available	RFH: N=9 *2019
BAUS: Nephrectomy audit	Yes	Yes	RFH BH and CFH service not available	RFH: N=874/1067 (82%) *2017 – 2019 combined
BAUS: Percutaneous nephrolithotomy (PCNL)	Yes	Yes	RFH BH and CFH service not available	RFH: N= 20 *2017/18
Cancer: National bowel cancer audit (NBOCA)	Yes	Yes	Reported at trust level, data collected at RFH and BH	RFL: N=116/288 (40%) *2018/19
Cancer: National lung cancer audit (NLCA)	Yes	Yes	Reported at trust level, data collected at RFH and BH CFH service not available	RFL: N =374 *2018
Cancer: National oesophago-gastric cancer audit (NOGCA)	Yes	Yes	Reported at trust level, data collected at RFH and BH CFH service not available	RFL: N=160/150-199 (85-100%) *April 17 to March 19
Cancer: National prostate cancer audit	Yes	Yes	RFH, BH and CFH	RFL: N=541 (100%) *2018/19
Chronic obstructive pulmonary disease (COPD) audit programme: Secondary care	Yes	Yes	Reported at trust level, data collected at RFH and BH CFH service not available	RFL: N=192/440 (44%) *Oct 19 to March 2020
COPD audit programme - Adult Asthma	Yes	Yes	Reported at trust level, data collected at RFH and BH CFH service not	RFL: N= 57/160 (36%) *1 Oct 19 to 31 Mar 20

Name of Audit	Data collection completed in 2020/21	Trust Eligibility to participate	Participation 2020/21	Case ascertainment
			available	
COPD audit programme -Paediatric asthma	No	Yes	BH RFH and CFH service not available	BH registered to participate 30 Dec 2020.
Diabetes: National foot care in diabetes audit (NFCA)	Yes	Yes	RFH and BH CFH service not available	Audit data collection in progress. No report was published in 2020/21.
Diabetes: National diabetes in-patient audit (NaDIA)	Yes	Yes	RFH and BH CFH service not available	N=113 (27.3% of the inpatient beds at RFH) *2019
Diabetes: NaDIA -Harm	Yes	Yes	RFH, BH and CFH	RFH: N=2 *2020/21 (up to 18/03/21)
Diabetes: National pregnancy in diabetes audit (NPID)	Yes	Yes	RFH and BH CFH service not available	Audit data collection in progress. No report was published in 2020/21.
Diabetes: National diabetes audit (NDA) Core	Yes	Yes	RFH and BH	N=1300 Type 1 *2019/20 N=935 Type 2 *2019/20
Diabetes: National diabetes transition audit (NDTA)	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: N = 115 CFH: N = 58 RFH: N= 60 *2018/19
Elective surgery - National PROMs programme	No	Yes	RFH BH and CFH	No contracted PROMs provider in 2020/21.This is currently under review.
Endocrine and thyroid national audit	Yes	Yes	RFH BH and CFH	No report published in

Name of Audit	Data collection completed in 2020/21	Trust Eligibility to participate	Participation 2020/21	Case ascertainment
				2020/2021
Falls and fragility fractures audit programme (FFFAP): Fracture liaison service database (FL-SD)	Yes	Yes	BH RFH and CFH service not available	BH: N=467 * 2020
FFFAP: Inpatient falls	Yes	Yes	Reported at trust level	RFL: N= 4 *2020/21 (up to 18/3/20)
FFFAP: National hip fracture database (NHFD)	Yes	Yes	RFH and BH CFH service not available	BH - 88.7% RFH- 63.4% *2020
FFFAP: Vertebral Fracture Sprint Audit	TBC	Yes	BH RFH and CFH service not available	Audit started in 2021. No report published.
Heart: Cardiac rhythm management (CRM)	Yes	Yes	BH RFH and CFH service not available	BH: N = 727 *2018/19
Heart: Myocardial infarction national audit project (MINAP)	Yes	Yes	RFH and BH CFH service not available	RFH: N=745 BH: N=190 Total N=935/984 (95.2%) *2018/19
National audit of cardiac rehabilitation (NACR)	Yes	Yes	RFH and BH CFH service not available	RFH: 2/7 KPIs submitted BH: 5/7 KPIs submitted *2019
Heart: National audit of percutaneous coronary interventions	Yes	Yes	RFH BH and CFH service not available	RFH: N=1089 (Minimum required is 400) *2018/19
Heart: National heart failure audit (NHFA)	Yes	Yes	RFH and BH CFH service not available	RFH: N=475 BH: N=453 Overall - 80% *2018/19
Intensive Care National Audit and Research Centre (ICNARC): Case mix programme (CMP)	Yes	Yes	RFH and BH CFH service not available	RFH: N=1896 BH: N=1023 *2019/20
ICNARC: National cardiac arrest audit (NCAA)	Yes	Yes	RFH and BH CFH service not available	RFH: N=186 BH: N=60 *2019/20
Inflammatory bowel disease (IBD) registry:	Yes	Yes	RFH	RFH: N=310 * Apr 16 to Oct 20

Name of Audit	Data collection completed in 2020/21	Trust Eligibility to participate	Participation 2020/21	Case ascertainment
Biological therapies audit (Adult)			CFH service not available	
IBD registry: Biological therapies audit (Paediatric)	Yes	Yes	RFH BH and CFH service not available	Partial submission
National audit of breast cancer in older people (NABCOP)	Yes	Yes	Reported at Trust level, data collected at RFH and BH	RFL: 50-69 years N=236 RFL: 70-79 years N=71 RFL: 80+ years N=73 *2018
National audit of dementia	N/A	Yes	RFH and BH CFH service not available	2020 Data collection suspended due to COVID 19
National audit of pulmonary hypertension audit (NAPH)	Yes	Yes	RFH BH and CFH service not available	RFH: N=857 *2019/20
National audit of seizures and epilepsies in children and young people (Epilepsy 12)	Yes	Yes	RFH and BH CFH service not available	RFL: N = 46 (100%) *2018/19
National clinical audit of care at the end of life (NACEL)	N/A	Yes	RFH and BH CFH service not available	2020 Data collection suspended due to COVID 19
National early inflammatory arthritis audit (NEIAA)	Yes	Yes	Reported at trust level, data collected at RFH, BH and CFH	RFL: N=20 *May 2019/May 2020
National emergency laparotomy audit (NELA)	Yes	Yes	RFH and BH CFH service not available	RFH: N=80/115 (70%) BH: N=63 (94.4%) *Dec 2018/Nov 2019
National joint registry (NJR)	Yes	Yes	RFH BH and CFH	BH completed ops = 111 (NJR consent rate = 40%) CFH completed ops = 872 (NJR consent rate = 90%) RFH completed op = 138 (NJR consent rate = 86%) *2019

Name of Audit	Data collection completed in 2020/21	Trust Eligibility to participate	Participation 2020/21	Case ascertainment
National maternity and perinatal audit (NMPA)	Yes	Yes	RFH and BH CFH service not available	Audit data collection in progress. No report was published in 2020/21.
Antenatal and newborn national audit protocol 2019 to 2022	Yes	Yes	RFH and BH CFH service not available	RFH - 100% BH – 100% *2019/20
National neonatal audit programme (NNAP)	Yes	Yes	RFH and BH CFH service not available	RFH -100% BH -100% *2019
National ophthalmology audit (NOD): Adult cataract surgery	Yes	Yes	Reported at trust level, data collected at RFH, BH and CFH	RFL - 50.8% *Sept 2018/August 2019
National vascular registry (NVR)	Yes	Yes	RFH BH and CFH service not available	AAA N=37 (=>85%) *2019 Carotid Endarterectomy N=30 (=>85%) *2019 Lower Limb Angioplasty/Stent (<70%) N=299 *2017/19 Lower Limb bypass N=218 (=>85%) *2017/19 Lower Limb Amputation N=154 (=>85%) *2017/19
Royal College of Emergency Medicine (RCEM) Fractured neck of femur	Yes	Yes	RFH and BH CFH service not available	RFH: N=40 BH: N=66 *As of 18/03/21
RCEM: Pain in children	Yes	Yes	RFH and BH CFH service not available	Data entry does not close until 3 October 2021
RCEM: Infection Control	Yes	Yes	RFH and BH CFH service not available	RFH: N=80 BH: N=22 *As of 18/03/21
Sentinel stroke national audit	Yes	Yes	RFH and BH	RFH: Clinical audit: 99.1%

Name of Audit	Data collection completed in 2020/21	Trust Eligibility to participate	Participation 2020/21	Case ascertainment
programme (SSNAP)			CFH service not available	(Level A) BH: Clinical audit:98.8% (Level A) *2019/20
Trauma audit research network (TARN) –Major trauma audit	Yes	Yes	RFH and BH CFH service not available	RFH - 81% *2020 BH TBC
Surgical site infection surveillance	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	RFL: N=39 *2019
British Spine Registry	Yes	Yes	In 2020 RFL spinal surgeries took place at Royal National Orthopaedic Hospital	BH TBC
Perioperative Quality Improvement Programme (PQIP)	Yes	Yes	RFH and BH CFH service not available	RFH: N= 348 patients *March 17- Aug 19 BH: no data collection in 2019/20 & 2020/21.
Society for Acute Medicine Benchmarking Audit (SAMBA) study	Yes	Yes	RFH and BH CFH service not available	RFH did not participate in 30 Jan 2020 audit. BH: N = 54 patients *2020
Renal Registry	Yes	Yes	RFH BH and CFH	RFL: N=244 *2018
LeDer: Learning disability review programme	N/A	Yes	RFH, BH and CFH	No cases have been allocated in 2020/2021
Perinatal Mortality Surveillance	Yes	Yes	RFH and BH CFH service not	100%

Name of Audit	Data collection completed in 2020/21	Trust Eligibility to participate	Participation 2020/21	Case ascertainment
			available	
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%
Perinatal Mortality Review Tool	Yes	Yes	RFH and BH CFH service not available	100%
National Child Mortality Database (NCMD)	Yes	Yes	RFH and BH CFH service not available	100%

Table 2: National confidential enquires and outcome review programmes: participation and case ascertainment

Name of Programme	Data collection completed in 2020/21	Trust Eligibility to participate	Participation 2020/21	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	Clinical questionnaire: 7/9 Case notes: 6/9 Organisational questionnaire: 2/2
Physical health in mental health hospitals	Yes	Yes	RFH and BH CFH service not available	The trust involvement with this study is submission of a data collection spreadsheet to identify patients who have been transferred from a mental health hospital to our services.

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.

The reports of 20 **national clinical audits** were reviewed by the provider in 2020/21 and the Royal Free London NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Actions to improve the quality of healthcare provided:

- We will continue to scrutinise and share learning from national audit reports at our corporate committees (Clinical Performance and Patient Safety committee and Clinical Standards and Innovation Committee).
- We will use outcomes from national clinical audits to help us prioritise pathway work in our Clinical Practice Groups across new group of hospitals.
- We will continue to make improvements to our clinical processes where national clinical audits suggest care could be improved.

(Some specific actions to improve quality are presented in the table below)

Specific actions undertaken to improve quality	
National clinical audit	**Actions to improve quality**
Chronic Kidney Disease Registry (previously UK Renal Registry)	• Liaise with Registry re likely impact of co-morbidity data and consider whether comorbidity data on new EPR could be used for returns. • Registry team to investigate bicarbonate data returns • On-going programme of competency updates forward nurses for peritoneal dialysis.
Falls and Fragility Fractures Audit programme (FFFAP): Inpatient falls	• Clearly identify directors and their roles • Form working group and plan initial meeting • Ensure all falls incidence in Trust reported per 1000 bed days • Monthly provision via e-mail of falls rates and trends to high incidence wards, and quarterly provision via e-mail of falls rates and trends to departments and directorates • Establish a system for assessing the gap between actual and reported falls • Establish an annual bedrail audit in areas of high use • Education of staff re all hip fractures to be recorded as severe harm • Ensure all wards have RCP written information on falls prevention displayed • Medical and nursing staff to clearly document injury or absence of injury • Education of staff around the use of flat lifting equipment after hip fracture • Investigate cause of delay between recognition of fracture and its treatment
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit and Standards	• Appointment of posts (consultants & 2 nurses) to IBD service and new pharmacy role (showing benefit) • Awaiting funding for admin support for Biologics MDT & Registry. • Regular use of 'Attend Anywhere.', Increasing Flare clinics, Pharmacy led clinics for Biologic monitoring and optimisation • Biologics pathways – pre counselling clinics, dose optimisation clinics, new clinical pathways • Planning for business case for increased dietetic time

Specific actions undertaken to improve quality	
National clinical audit	**Actions to improve quality**
National Lung Cancer Audit (NLCA)	• Work on Cancer-wide pre-hab service within the Trust • Data system already changed to Somerset • Demand and Capacity analysis of services to optimise workforce, some of which have been working unsustainably
National Asthma and COPD Audit Programme (NACAP) - Adult Asthma	• We will actively review case ascertainment for the NACAP audit using Trust data on asthma admissions • Business cases for additional CNS and pharmacy support have been submitted or are in development. We have applied for temporary additional industry funding to try and mitigate current staffing problems.
National audit diabetes Inpatient and Harms	• Changes to the food and timing of meals for people with diabetes to be considered • Re-established targeting support so that we can ensure that we are returning to this mandatory audit.
National audit of care at the end of life (NACEL)	• Liaise with NACEL National Audit team to review the methodology of the audit to take into account that we are using LfD analysis to inform our reporting • As we continue in the COVID period new methods of communication with relatives are being developed and evaluated.
National Cardiac Arrest Audit (NCAA)	• Seeking agreement for specialist 2nd opinion team for complex decisions • Circulate to service leads and encourage them to embed advance care planning at admission
National Emergency Laparotomy Audit (NELA)	• Diversion of resources due to SARS CoV19 pandemic during 2020/1 resulting in delay of previous plans • Quality improvement projects to improve case ascertainment, risk documentation, analgesia management. • On-going discussion on how the forthcoming EPIC unit can support emergency laparotomy pathway • Funding to support these activities using NELA best practice tariff being investigated
National Oesophago-gastric Cancer Audit (NOGCA)	• The oncology service will carry out a retrospective audit of clinical stage 0-3 patients to determine why curative plans were not proposed in a greater number of patients and send out lessons learnt to Upper GI MDT • A new clinical oncology consultant post has been created whose responsibilities will include leading on this audit with clear escalation pathways
National Ophthalmology Audit (NOD)	• Improved utilisation of MediSight at the point of listing patients for surgery, and the point of post-operative review – plan will be communicated to all staff via the newsletter and via email.
National Prostate Cancer Audit (NPCA)	• We are due to commence a rectal spacer programme at RFL which has proven benefits in reducing GI toxicity from EBRT. This will commence March/April 2021.
National Vascular Registry	• Poor access to the hybrid theatre/IRCU has been flagged up at the CPPS meeting. The trust has committed to plan a further hybrid theatre.
Pulmonary Hypertension	• To investigate data entry and transfer errors to ensure data quality. There is also a national effort to evaluate home testing of BNP (about £70 per test).

Specific actions undertaken to improve quality	
National clinical audit	**Actions to improve quality**
Serious Hazards of Transfusion: UK National haemovigilance scheme	• Continue to monitor WBIT frequency and identify contributing factors for action • Establish same method across sites for traceability e.g. reporting % to 2d.p. • Take forward business case for electronic bedside transfusion to reduce never events and go paperless for traceability.
Trauma Audit & Research Network (TARN)	• 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.
UK Parkinson's Audit (Neurology and Elderly Care)	• To continue maintaining key achievements using standardised scales e.g. MOCA, PD NMS Questionnaire as routine. • Incorporate use of non motor symptom questionnaire pre-clinic. • Data base of Care Home residents to facilitate review of care plans for ACP & POA • Routine checklist of key areas to improve when reviewing patient e.g. Signposting to Parkinson's UK as standard on diagnosis and develop annual review proforma to encompass all domain items • Set up a Neuropsychiatry Parkinson's service in liaison with Psychiatry
National paediatric diabetes audit (NPDA)	• Increase the use of pumps and other technological support which are shown to help reduce HbA1c levels for children and young people (CYP) with diabetes. • Improve access to clinicians with expert knowledge to offer better support to CYP with high HbA1c performance. • Improve patient support at the Chase Farm Hospital clinic (particularly in the 16 – 18 year group).
National Neonatal Audit Programme (NNAP)	• Participate in QI projects to improve admission temperature <30 weeks and look at early use of expressed breast milk. • Promote normal temperature on admission for very preterm babies via guideline and simulation training. • Include antenatal steroids in daily huddles and ensure clear documentation surrounding them. • Continue to work with obstetric team to identify eligible women for antenatal magnesium sulphate. • Highlight BadgerNet data entry on junior doctor induction.

Specific actions undertaken to improve quality	
National clinical audit	**Actions to improve quality**
National audit of seizures and epilepsies in children and young people (Epilepsy 12)	• To continue to deliver a good service an action plan is in place focusing on; equality across Trust sites, adequate Epilepsy nurse staffing and mental health support for children with Epilepsy.

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 112 **local clinical audits*** were reviewed by the provider in 2020/21 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 which demonstrated modest to significant improvement through successful plan, do, study, act cycles

(Some specific actions to improve quality are presented in the table below)

Local audits	Actions to improve quality
Improving compliance with Massive Haemorrhage protocol - audit of local protocol	• A switchboard prompt and checklist can be easily introduced. The checklist is useful in auditing times of MH calls to allow assessment of time to product transfusion • Simple interventions can be used to address latent hazards and improve adherence to the MH protocol • On-going measurement of KPIs required to ensure improvements are sustained
Concordance between IV fluid prescriptions and administration	• More prompt review of fluids after procedures and documentation • Handover communication with ICU team should improve • To continue IV fluids in IR department - Non-essential infusions are currently stopped for procedures. Tackling this should also include endoscopic procedures
Closed Fracture Clinic in Plastic Surgery Hand Trauma	• Moving the closed fracture clinic to Tuesday and Friday mornings rather than afternoons to increase capacity • .Introduction of a paediatric closed fracture clinic. • Appointing a trauma coordinator with a hand therapy background to work closely with the doctors in addition to doing the closed fracture clinic.
Surgical Prophylaxis in Breast Implant	• Reiterate Microguide guidelines • Possible staff survey • Possible change to guidelines

Surgery	• Reiterate good practice • Single surgeon touch, change gloves, remove dirty swabs, re-prep site, betadine soaked instruments/ implant, masks, limited theatre staff flow, meticulous haemostasis, nipple shields, remove drains asap • Send micro samples where possible
Cardiac Correlation and Myocardial Injury in COVID-19 Patients	• Troponin to be routinely done in RFH - To continue with work and improve numbers • BNP is not routinely done in RFH - To be included in regular screening
Audit of the accuracy and remunerative implications of clinical coding as related to commonly performed Plastic Surgery Operative Procedures	• Monthly clinician-coder meeting • Index of common procedures including definitions and acronyms for coders • Develop pathway for complex operations to be "flagged" and reviewed with clinical coders • Operative note design recommendation report • Posters for Theatre to guide surgeons on documentation requirements • Update Clinic Procedure sheet to allow OPCS-4 coding of minor procedures carried out in outpatients and Trauma Clinic
An audit of the Stable Glaucoma service	• To use baseline performance to improve standards in stable glaucoma service in future. • To ensure patients are correctly referred into clinic, to prevent future incidents and ensure clinics correctly booked into to optimise patient pathways and prevent delays to treatment and monitoring • To monitor how many patients can be discharged in line with national NICE guidelines update and reduce current capacity issues occurring in glaucoma service. Discussing those patients that are considered suitable for discharge with glaucoma consultant ophthalmologist to decide if can be discharged to local optometry service for future management. • To consider post COVID-19 if re-audit will occur as changes to service currently being undertaken. This audit may be used as baseline for future service improvement and redevelopment of glaucoma service
Operative Outcomes for Wide-Awake local Anaesthesia (WALANT) versus Regional and General Anaesthesia for Flexor Tendon repair	• Optimise theatre time by using WALANT in patients that meet the inclusion criteria Be aware of standard aseptic technique and Surgical Site infection prevention • Ensure Early active Movement regime in followed to achieve good post-operative outcomes
Improving hand fracture management: Imaging and the use of the lateral view	• At the time of referral specifically ask for all 3 views • Write 'all 3 views' when requesting X-rays 'in-house' • If not all views are available in clinic send patient for additional radiographs Call for published guidelines on imaging in hand trauma patients
Evaluation of unplanned admission following day surgery	• All day surgery patients are required to attend a pre-assessment clinic prior to their procedure. • Develop departmental discharge guidelines • Encourage SHOs to prep discharge plan with the operation note

procedures in Plastic Surgery	to avoid delay • Identify social issues on initial assessment e.g. lack of an escort, travel from far • The number of unplanned admissions can be reduced further by introduction of protocols for discharge and post-operative symptom control.
Re-Audit: Operative Outcomes for Flexor Tendon repairs :Wide-Awake local Anaesthesia versus Regional and General Anaesthesia	• Optimise theatre time by using WALANT in patients that meet the inclusion criteria Be aware of standard aseptic technique and Surgical Site infection prevention • Ensure Early active Movement regime in followed to achieve good post-operative outcomes • Increase use of WALANT to increase theatre efficiency
Evaluation of the incidence and clinical pathways for the Management of Necrotising Fasciitis/Fournier's Gangrene in Plastic Surgery: Pre- and Post- Coronavirus Pandemic	• Public education about early presentation for non-COVID related emergencies despite the pandemic • Creation of a direct referral pathway from other facilities with clear information on criteria, COVID protocols (swabs) and the required investigations (blood results, wound swabs, imaging) to avoid duplication or delay.
Single-centre audit of breast free flap complications	• Introduction of new electronic operative note and referral system will allow for incorporation of a template for free flap data and ensure hand over of free flaps esp. with difficulties intra-operatively; this will allow on call Reg to act more rapidly and anticipate problems more readily. • Introduction of bedside handovers in reference to the Proforma. • Encourage documentation of Ischaemic Time
HCQ Virtual Screening Clinic Audit	• Saturday orthop/optom lead diagnostic clinics created to assess low risk retinal patients including HCQ/CQ • VF testing removed from testing set • Undilated patient assessment via Heidelberg and OPTOS to reduce patient waiting time in clinic and more patients per clinic • Scope for AHP to grade imaging and visual field instead of ophthalmologist, possible AI input
Re-Audit BCC and SCC Audit (Basal Cell Carcinoma Incomplete Excision Margins)	• Encourage trainees to self audit excision rates -> improve rates overall • Mandatory teaching/ training for new trainees on how to complete EPS op notes to ensure accurate data • Ensuring clearer operative records of margins • Further re-audit of departmental excision rates
Time to Theatre Audit	• Update & overhaul of Plastic Surgery Induction Handbook for Junior Doctors, to include BSSH Hand Trauma guidelines. • Create a 'Plastics Kit Box' available in Green UTC for minor procedures • Continue the case for a dedicated, FT Trauma Co-ordinator • Encourage documentation of cancellations or delays • Consider adding 'Date of Injury' to PTC Proforma +/- estimated date of surgery

Knee Arthroscopy Service Provision Audit	• Development of 2 pathways: Knee arthroscopy ACL reconstruction patient pathway and Knee arthroscopy Meniscal repair patient pathway
Incidence rate of head and neck infections with a high blood sugar level in undiagnosed diabetes	• BM to be taken for all Head and Neck infections. • Documentation of when the BM is taken i.e fasted, random or 2h post prandial. • Once BM is known, acknowledge and document the plan in the notes. • Re-audit to further investigate this.
Fractured Mandibles Time to Surgery & post-op complications	• To set up a Planned Elective which may be more conducive to better surgical outcomes • Future audits could look at OHI and smoking status of patients and how this correlates with post-op complications • New pathway for Follow ups and management of complications
Waiting times of in house Dento-Alveolar Orthodontic referrals to surgical treatment	• Confirmation of treatment pathway and triage by SPR required • Look at reason behind the variation and snap shot spread sheet
Hysterectomy Audit, 2018 – 2020.	• Clear documentation of Type of Hysterectomy, especially if Laparoscopic and BMI at the time of planning surgery before listing the patient and on advice for weight optimisation. • To consider detailed evaluation of cases pre op for suitability and type of Hysterectomy in clinics by the consultant to minimise conversion rate. • To consider referring patient to Laparoscopic team of surgeons if patients are requesting and suitable for Laparoscopic Hysterectomy. • Theatre lists with a full day Laparoscopic Hysterectomies will provide more opportunity for teaching, training and mentor/mentee relationship. • Trainees/ Senior Doctors should be encouraged to master laparoscopic suturing skills to enhance efficiency at laparoscopic Hysterectomy. • Re-audit in 1-2 years to complete the cycle.

C. Participating in clinical research

The number of patients receiving NHS services provided or sub-contracted by Royal Free London NHS Foundation Trust in 2020/21 that were recruited during that period to participate in research approved by a research ethics committee was 13469.

The above figure includes 8732 patients recruited into studies on the National Institute for Health Research (NIHR) portfolio and 4737 patients recruited into studies that are not on the NIHR portfolio. This figure is higher than that reported last year. A more detailed account of some of the research activity during the COVID-19 pandemic is in section 1.3

The Trust is supporting a large research portfolio of over 800 studies, including both commercial and academic research. 132 new studies were approved in 2020/21. The breadth of research taking place within the trust is far reaching and includes clinical trials of medicines, surgery, medical devices and cells, research involving human tissue and quantitative and qualitative research, as well as observational research.

D. CQUIN payment framework

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

The CQUIN framework was suspended during 2020/21 due to the COVID-19 pandemic and therefore there is no reporting against CQUINs in this year's report.

E. Registration with the Care Quality Commission (CQC)

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

The Care Quality Commission has taken enforcement action against the Royal Free London NHS Foundation Trust during 2020/21. The trust was issued a section 29a Warning notice on 13 November 2020 following the outcomes of an unannounced inspection visit to the Royal Free Hospital site maternity services on 27 October 2020.

The Royal Free London NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during 2020/21.

The Care Quality Commission carried out an unannounced visit to the Royal Free Hospital maternity services on 27 October 2020. The inspection was triggered in response to safety concerns raised following a maternal death in February 2020 and in response to a prevention of future deaths coroner's notification received on the 21 August 2020. Following the inspection an additional 29 further areas of information and data were requested and submitted to the CQC. A

Section 29a warning notice was issued to RFL NHS FT on 13 November 2020 with two specific areas of improvement and deadlines.

The specific areas which inform the basis of the warning notice are in relation to:

1. **The CQC was not assured that maternity services at the Trust are learning from incidents and improving practice to keep patients safe.** As the CQC was not assured that learning from incidents were being completed consistently to keep patients safe and that staff was able to access this learning in a timely way.
2. **Patients who attend the hospital maternity services are not able to access appropriate information in languages that are centred around their individual needs.** The CQC was not assured that the Trust has clear oversight and understanding of how accessible the information in other languages is for women using the maternity services.

We were required to make the significant improvements as identified regarding the quality of healthcare by 11 December 2020 in relation to the first element and by 27 November in relation to the second.

The maternity service is a cross site service. Therefore the leadership team was brought together and undertook focused work, led by the Women's and Children's Divisional Leadership, in relation to the two identified areas of improvement. The Trust has met both deadlines provided by the CQC and participated in a scheduled discussion with the CQC on the 15th December 2020 to review our submitted improvement action plans in relation to the warning notice. The CQC confirmed they were assured by our intended improvement actions in response to the warning notice.

The CQC published the Royal Free Hospital Maternity Service Inspection report on 6 January 2021.
Our rating for this service went down; we are rated as inadequate for our maternity services specifically for the domains of safe and well led. The inspection report makes nine recommendations of actions that must be taken to bring services into line with legal requirements. On 4 February 2021 we provided the CQC with our action plans in response to these nine recommendations, a number of which have been included in our warning notice requirements.

The maternity service has taken seriously all concerns raised by the CQC and have ensured that any Improvement actions required are incorporated into the maternity services improvement action plans developed to date. The Trust is working in partnership with the Clinical Commissioning Group maternity commissioner and the provider arrangements as part of the North Central London system of support and oversight and in addition, we are working closely with our NHS England and NHS Improvement allocated maternity improvement advisor.

The on-going monitoring of the both the inspection report and warning notice improvement plans are reported by the maternity service senior management team to Barnet Hospital Local Executive Committee. The Clinical Standards and Innovation Committee, which has delegated board oversight of the improvement actions' performance and completion, receives a monthly update on the progress of the improvement actions from Barnet Hospital executive team.

The CQC will be returning to undertake an unannounced review of maternity service at any time during 2021, and it is anticipated that they will visit both Royal Free Hospital and Barnet Hospital maternity services at this time.

To date a significant amount of improvement has been undertaken across those areas identified by the CQC and this improvement work and journey continues. We have shared the details of our action plan and its current completion status as part of the appendices. In addition we have continued to focus on the historical improvement requirements as identified from our 2019 Comprehensive CQC Inspection report. Details of our on-going improvement outcomes can be found on page 93 of these accounts.

F. Information on the quality of data

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

I. The patient's NHS number

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

The Royal Free London NHS Foundation Trust submitted records during 2020/21 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:

	2018/19	2019/20	2020/21
For admitted patient care	99.2%	99.2%	99.6%
For outpatient care	99.3%	99.5%	99.5%
For accident & emergency care	97%	97.2%	97.5%

II. General Medical Practice Code

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

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

III. Information Governance (IG)

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

G. Payment by Results

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

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

An external assessment of our data quality took place in early 2021. The report concluded that there was sufficient confidence in our data for the Trust to be able to return to national reporting for RTT.

We now have increased data quality metrics available on Qlikview which are discussed regularly at site performance meetings and circulated on a weekly basis via email. The Trust continues to perform well on the SUS DQ dashboard which monitors key indicators across A&E, inpatient and outpatient datasets.

With the Trust upgrading its PAS in late 2021 a big emphasis has been to correct data that will be migrated across to the new system to ensure it is fit for purpose. Also the new workflows provided by Cerner have been reviewed and tested to make sure they work as intended.

Audits continue to take place across the Trust. Areas that are targeted include maternity, RTT and outpatients. The Data Quality and Elective Access Training teams provide training and guidance to staff where issues have been identified that have led to data errors.

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

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

H. Learning from deaths

Hundreds of patients come through our doors on a daily basis. Most patients receive treatment, get better and are able to return home or go to other care settings. Sadly and inevitably, some patients will die here (approximately 1% 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 2020/21, TBC 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: 731 in the first quarter; 419 in the second quarter; 520 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 2019/20 quarters 3 and 4, as these were not included in last year's Quality Accounts. Likewise review data for 2020/21 quarters 3 and 4 are not available for inclusion in this year's Quality Accounts.

Table Summary of LfD reviews

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 (i.e. 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 (i.e. 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 2019 to December 2019	613	19	4	1	0.16%
Fourth quarter	January 2020 to March 2020	719	48	6	1	0.14%
Total		**1332**	**67**	**10**	**2**	**0.15%**
First quarter	April 2020 to June 2020	733	62	2	0	0.00%
Second quarter	July 2020 to September 2020	423	10	6	0	0.00%
Total		**1156**	**72**	**8**	**0**	**0.00%**
Third quarter	October 2020 to December 2020	520	Not yet completed	Not yet completed	Not yet completed	Not yet completed
Fourth quarter	January 2021 to March 2021	TBC	Not yet completed	Not yet completed	Not yet completed	Not yet completed
Total		**TBC**				

Reporting period 2020/21 (Q1 and Q2)

By 31/03/21, from Q1 and Q2 of 2020/21, 72 case record reviews and 8 serious incident investigations have been carried out in relation to 1156 of the deaths included in the information presented in the Table.

In 8 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 62 in the first quarter; 10 in the second quarter, as shown in the table. Data for Q3 and Q4 are not yet available.

0 representing 0.00% of the patient deaths during the reporting period 2020/21 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: 0 representing 0% for the first quarter; 0 representing 0.00% 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 2019/20 (Q3 and Q4)

By 31/03/21, from Q3 and 4 of 2019/20, 67 case record reviews and 10 serious incident investigations have been carried out in relation to 1332 of the deaths included in the information presented in the Table.

In 10 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 19 in the third quarter; 48 in the fourth quarter, as shown in the table. Data for Q1 and Q2 were presented in last year's Quality Accounts.

2 representing 0.15% of patient deaths during the reporting period 2019/20 Q3 and Q4 are judged to be more like than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of: 1 representing 0.16% for the third quarter; 1 representing 0.14% for fourth quarter, 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)

Table Summary of LfD reviews for previous reporting period 2019/20 (Q1 and Q2) from 2019/20 Quality Accounts

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 (i.e. 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 (i.e. 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	Apr 2019 to Jun 2019	467	21	2	0	0.00%
Second quarter	Jul 2019 to Sep 2019	514	25	8	2	0.39%
Total		**981**	**46**	**10**	**2**	**0.20%**

After 01/04/19, from 2019/20 Q1 and Q2, 46 case record reviews and 10 serious incident investigations have been carried out in relation to 981 of the deaths included in the information presented in the Table.

In 10 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 21 in the first quarter; 25 in the second quarter, as shown in the table.

2 representing 0.20% of the patient deaths during the reporting period 2019/20 Q1 and Q2 are judged to be more like than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of: 0 deaths representing 0.00% for the first quarter; 2 deaths representing 0.39% for the second quarter, 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

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

Good practice	Areas for improvement
• Communication, including appropriate discussions with and involvement of patients and their families in decision-making; • Documentation, including care plans, completion of SPICT/Rockwood scores on admission and addressing patients' nutrition and hydration needs; • Overall care management, including effective working between teams, appropriate involvement of the Palliative Care team and Chaplaincy support;	• Earlier recognition of dying in some cases – impacting on care planning and management and communication with patients and their families; • Documentation, including improvements in the following areas: o risk assessments; o discussions with families regarding changes in patients' conditions and management plans; o discussions with families following patient deaths; o documented assessment of patients' mental capacity. • Communication, including improved use of interpreting services.

Description of actions taken during 2019/20 (Q3 and Q4)

The actions summarised below relate to those patient deaths which were considered likely to be avoidable. From October 2019 to March 2020, we identified 2 patient deaths that were considered likely to be avoidable, both of which were identified and reported as serious incidents:

Incident	FinYear	Quarter	Likert Avoidability
2019/13445	2019/20	Q3	2. Strong evidence of avoidability
2020/3669	2019/20	Q4	3. Probably avoidable, more than 50/50

Following investigation, each serious incident report contains a detailed action plan that is agreed with our commissioners and shared with the relatives. These actions are reviewed so that we have assurance that they are implemented. We have reworded some of the actions, so that our patients and their families are not identifiable.

Actions

- A column for NEWS2 scores to be added to MDT room whiteboard and patients' scores to be discussed as part of the daily Board Rounds.
- Relevant surgical service to trial starting ward rounds by reviewing the sickest patient on the ward, as identified by NEWS2 scores.
- Relevant surgical service to ensure that there are daily Consultant-led ward rounds (or board rounds followed by a delegated review).
- A discussion paper on supporting best practice regarding DNARs and advanced care planning to be presented at the Clinical Performance and Patient Safety Committee (CPPS).
- Staff to be reminded of the requirement to monitor the frequency of contractions during the induction of an intrauterine death.
- Guidelines for induction of an intrauterine death to be amended and for this amended guideline to be shared with staff by a variety of means.
- To explore a possible solution for the improvement of the MEOWS chart in the electronic patient record (EPR) system as part of a long-term goal to improve EPR functionality.
- Reintroduce use of the paper MEOWS chart with compliance to be audited on a regular basis.
- To share the learning as part of a simulation case study incorporating a human factors approach.
- Share lessons learnt with staff involved to facilitate learning at team meetings and with all staff via newsletters and blogs.

Description of actions taken during 2020/21 (Q1 and Q2)

From April 2020 to September 2020, we identified 0 patient deaths that were considered likely to be avoidable, so there are no actions to summarise. *(Subject to change pending updated data)*

Description of proposed actions to take during 2020/21 (Q3 and Q4)

Actions from quarter 3 and 4 reviews when they are completed will be taken forward during 2021/22 and reported on in next year's Quality Accounts.

Assessment of the impact of the actions taken

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 our hospital Clinical performance & patient safety committees and Clinical standards and innovations committee (CSIC) to ensure completion and compliance.

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

Patient Safety Clinical Practice Group (CPG) Advance Care Planning (ACP) workstream

We reported in our 2019/20 Quality Accounts that we were developing an Advance Care Planning (ACP) workstream, as part of the Patient safety CPG, and that we would provide an update on progress in this year's Quality Accounts.

Advance care planning (ACP) offers a clear route to improve the experience of patients as they approach the end of their life and to support their families. This CPG links with other CPGs such as frailty, and dementia, so that we can ensure synergy of effort without duplication. The ACP CPG focuses directly on the earlier recognition of the likely last year of life, the introduction of conversations regarding the patient's wishes and preferences, clear treatment escalation plans,

onward care plans documented on the discharge letter and the use of CMC (Co-ordinate My Care, an online platform which supports decision making and multi-agency data-sharing).

This CPG's work links several systems and processes within the Trust including care of the dying patient, excellence in the last days of life, bereavement services, the medical examiner service, learning from deaths (LfDs) reviews, complaints and incidents. It also links with London wide work such as in the introduction of the "Early identification and personalised care planning toolkit" developed by the London Strategic Clinical Network to support GP practice.

The work of the CPG was affected by the COVID-19 pandemic, including a pause during the second surge between November 2020 and March 2021, but work is now being re-commenced. In the meantime, progress in the last year has included the identification of a patient cohort based on the baseline data and recruitment of multidisciplinary CPG teams for the following clinical specialities:

- Barnet Hospital: geriatric medicine, general medicine and stroke medicine;
- Royal Free Hospital: geriatric medicine, nephrology and stroke medicine.

There is also on-going collaboration with the Health Innovation Network funded project to improve the use of the "Co-ordinate My Care" care plan on our Barnet Hospital site.

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.

1) Summary hospital-level mortality Indicator (SHMI)

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

Royal Free Performance Oct 16 to Sep 17	Royal Free Performance Oct 17 to Sep 18	Royal Free Performance Oct 18 to Sep 19	Royal Free Performance Oct 19 to Sep 20	National Average Performance Oct 19 to Sep 20	Highest Performing NHS Trust Performance Oct 19 to Sep 20	Lowest Performing NHS Trust Performance Oct 19 to Sep 20
0.8679 (lower than expected)	0.8270 (lower than expected)	0.8207 (lower than expected)	0.8501 (lower than expected)	1.0 (as expected)	0.6869* (lower than expected)	1.1795 (higher than expected)

** NHS Digital commentary for this period states that data from this Trust should be interpreted with caution, the SHMI value for the next highest performing Trust is 0.7247*

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 2019-20, the chart above also includes data for 2016-17, 2017-18 and 2018-19.

COVID-19 activity has been excluded from the NHS Digital SHMI data. The SHMI is not designed for this type of pandemic activity and the statistical modelling used to calculate the SHMI may not be as robust if such activity were included. Activity that is being coded as COVID-19 is therefore excluded. For information, data taken from NHS Digital experimental statistics for the same timescale as the SHMI are presented below, indicating that RFL had above the national average COVID-9 activity.

Royal Free Percentage	National Average Percentage	Highest NHS Trust Percentage	Lowest NHS Trust Percentage
Oct 19 to Sep 20	Oct 19 to Sep 20	Oct 19 to Sep 20	Oct 19 to Sep 20
2.4%	1.6%	3.3%	0.4%

Percentage of provider spells with COVID-19 coding (experimental statistics)

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 these data are as described as it has been sourced from NHS Digital.

For comparison purposes the data presented in this report are for 12 months October 2019 to September 2020. During this period RFL NHS FT had a mortality risk score of 0.8501, 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 RFL ranked 10th out of 124 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 16 to Sep 17	Royal Free Performance Oct 17 to Sep 18	Royal Free Performance Oct 18 to Sep 19	Royal Free Performance Oct 19 to Sept 20	National Average Performance Oct 19 to Sept 20	Highest Performing NHS Trust Performance Oct 19 to Sept 20	Lowest Performing NHS Trust Performance Oct 19 to Sept 20
36%	41%	35%	37%	36%	60%	9%

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 these data are as described, the data have 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 has implemented a process whereby it review all discharges each month and identifies patients the team has given care to in order to capture all patient data. 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 was 82nd out of 135 non-specialist acute trusts in ascending order of % coding, and was very close to the national average.

https://digital.nhs.uk/data-and-information/publications/statistical/shmi/2020-10/palliative-care-coding Ⓐ

2) 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 2017/18	Royal Free Performance 2018/19	Royal Free Performance 2019/20	Royal Free Performance 2020/21	National Average Performance 2019/20	Highest Performing NHS Trust Performance 2019/20	Lowest Performing NHS Trust Performance 2019/20
Indicator: Total hip replacement - primary (EQ-5D Index)						
0.42	0.41	0.53	TBC	0.46	0.54	0.35
Indicator: Knee replacement surgery (EQ-5D index)						
0.32	0.299	0.31	TBC	0.33	0.42	0.22

The Royal Free London NHS Foundation Trust considers that these data are 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 the Royal Free London placed 4th best out of 103 submitting providers and better than previous years. 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:

To be updated

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Ⓐ

3) 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 its 30-day emergency readmission rates for elective patients as part of its board key performance indicators.

Royal Free Performance 2016/2017	Royal Free Performance 2017/2018	Royal Free Performance 2018/2019	Royal Free Performance 2019/2020	National Average Performance 2019/2020	Highest Performing NHS Trust Performance 2019/2020	Lowest Performing NHS Trust Performance 2019/2020
Patients aged 0 to 15 years old						
5.2%	10.5%	9.4%	**9.1%**	12.6%	2.2%	38.6%
Patients aged 16 years old or over						
8.3%	12%	13.2%	**13.9%**	11.9%	1.9%	37.7%

The Royal Free London NHS Foundation Trust considers that these data are as described for the following reasons; the data have been sourced from NHS Digital and compared to internal Trust data

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

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

To be updated

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Ⓐ

4) Responsiveness to the personal needs of our patients

Indicator:

The trust's responsiveness to the personal needs of its patients during the reporting period 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 2016/2017	Royal Free Performance 2017/18	Royal Free Performance 2018/19	Royal Free Performance 2019/20	National Average Performance 2019/20	Highest Performing NHS Trust Performance 2019/20	Lowest Performing NHS Trust Performance 2019/20
68.3	67.1	64	**66.7**	67.1	84.2	59.5

The Royal Free London NHS Foundation Trust considers that these data are as described for the following reasons; the data have 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 but above 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:

To be updated

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

5) 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 2017	Royal Free Performance 2018	Royal Free Performance 2019	Royal Free Performance 2020	National Average Performance 2020	Highest Performing NHS Trust Performance 2020	Lowest Performing NHS Trust Performance 2020
74%	73%	71%	**68%**	67%	84%	46%

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

Each year the NHS surveys its staff and one of the questions looks at whether or not staff would 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 performed marginally worse than in previous years and just below average compared to Acute NHS providers.

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/Ⓐ

6) 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 publishes the VTE rate in quarters and this is presented in the table below.

Royal Free Performance Oct 17 to Dec 17	Royal Free Performance Oct 18 to Dec 18	Royal Free Performance Oct 19 to Dec 19	Royal Free Performance Oct 20 to Dec 20	National Average Performance Oct 19 to Dec 19	Highest Performing NHS Trust Performance Oct 19 to Dec 19	Lowest Performing NHS Trust Performance Oct 19 to Dec 19
95.9%	96.5%	96.9%	No new data has been released since Oct-Dec 19? Perhaps paused for COVID?	95.0%	100.0%	71.6%

The Royal Free London NHS Foundation Trust considers that these data are as described for the following reasons; the data have 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 London 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:

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

7) 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 2016/2017	Royal Free Performance 2017/2018	Royal Free Performance 2018/2019	Royal Free Performance 2019/2020	National Average Performance 2019/2020	Highest Performing NHS Trust Performance 2019/2020	Lowest Performing NHS Trust Performance 2019/2020
21.0	21.3	16	**12**	13	0	51

The Royal Free London NHS Foundation Trust considers that these data are as described for the following reasons; the data have been sourced from the 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 better than the national average during and showed an improvement on 2019/20.

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, PPE, social distancing, and other COVID-19-related measures. 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, virology, and occupational health teams continue to implement all aspects of the COVID-19 board assurance framework within their remits.
- The Trust COVID-19 infection prevention and control workstream group meet twice per week design and implement changes to Trust practices and procedures related to the COVID-19 pandemic in response to local, regional, and national epidemiology and guidance.
- 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 and incorporation into EPR.

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

8) 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 to Mar 17	Royal Free Performance Oct 17 to Mar 18	Royal Free Performance Oct 18 to Mar 19	Royal Free Performance Oct 19 to Mar 20	National Average Performance Oct 19 to Mar 20	Highest Performing NHS Trust Performance Oct 19 - Mar 20	Lowest Performing NHS Trust Performance Oct 19 - Mar 20
(a)	6,549 (39.1)	6,527 (38.8)	6,693 (37.7)	**6,150 (36.6)**	5,907 (51.5)	1,271 (15.7)	2,174 (177)
(b)	33 (0.20)	24 (0.14)	19 (0.1)	**16 (0.1)**	19 (0.19)	0 (0)	27 (0.5)

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 these data are as described for the following reasons; the data have been sourced from 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 2019 and Mar 2020 (36.6) compared to the national average (51.5) during the same period.

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

- Launching and implementing our Safety Strategy (2020-2025) with six key drivers that are in line with the National Patient Safety Strategy published in July 2019.
- We have robust processes in place to capture incidents and increase our reporting 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: Overview of the quality of care in 2020/21

This section of the quality report presents an overview of the quality of care offered by the Trust based on performance in 2020/21 against indicators and national priorities selected by the board in consultation with our stakeholders.

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

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

Relevant quality domain	Quality performance indicators
Section 1: Patient safety	• 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	• 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.

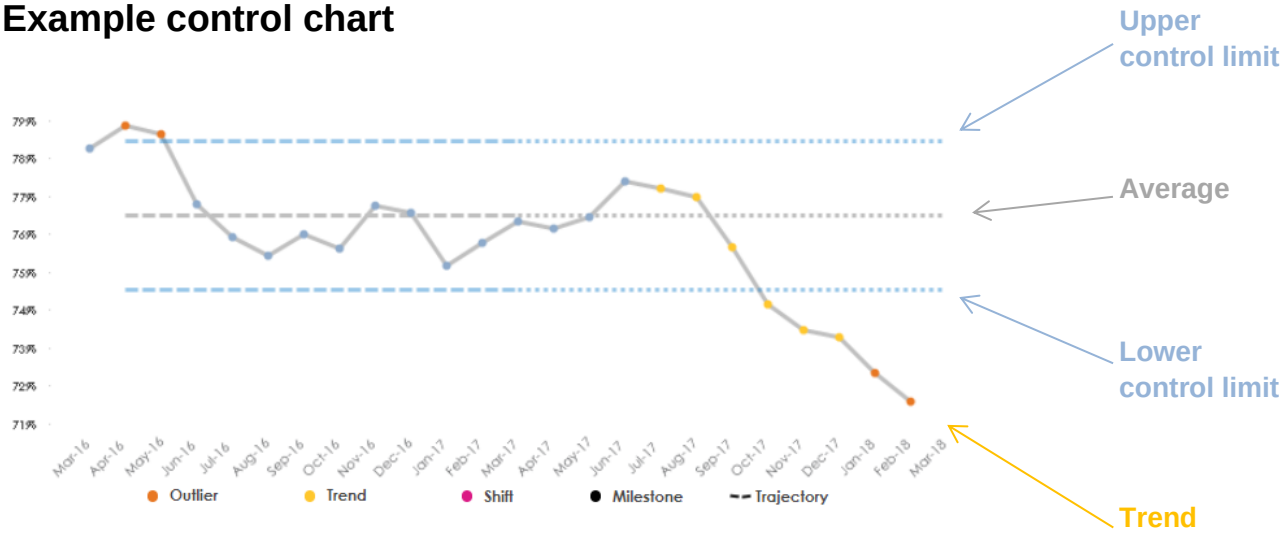
Control charts

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, conclusions can be drawn 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 2020/21 performance, ordered to show the best performing trust at the top, and the worst performing trust at the bottom.

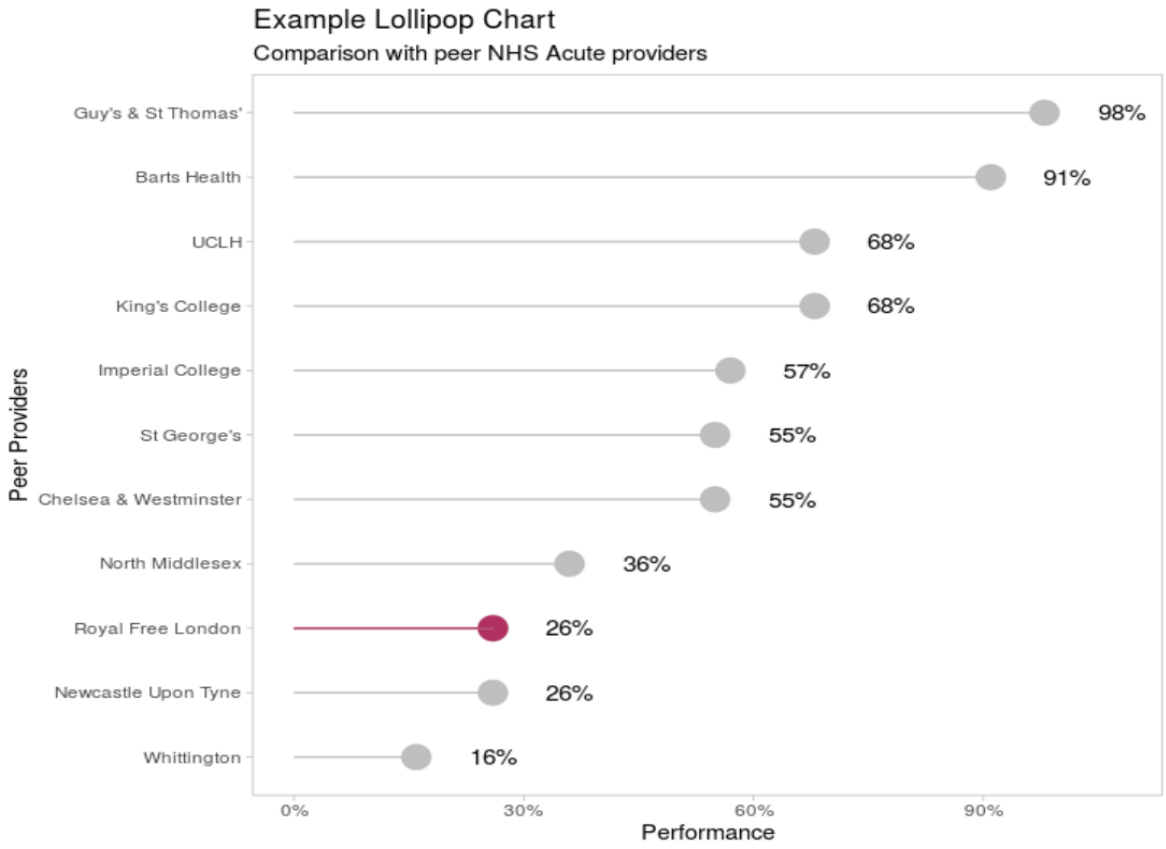
Lollipop charts are essentially bar charts which have been turned on the side, and plot performance from 0 to the overall performance figure for the year. This is calculated as either

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

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.

.

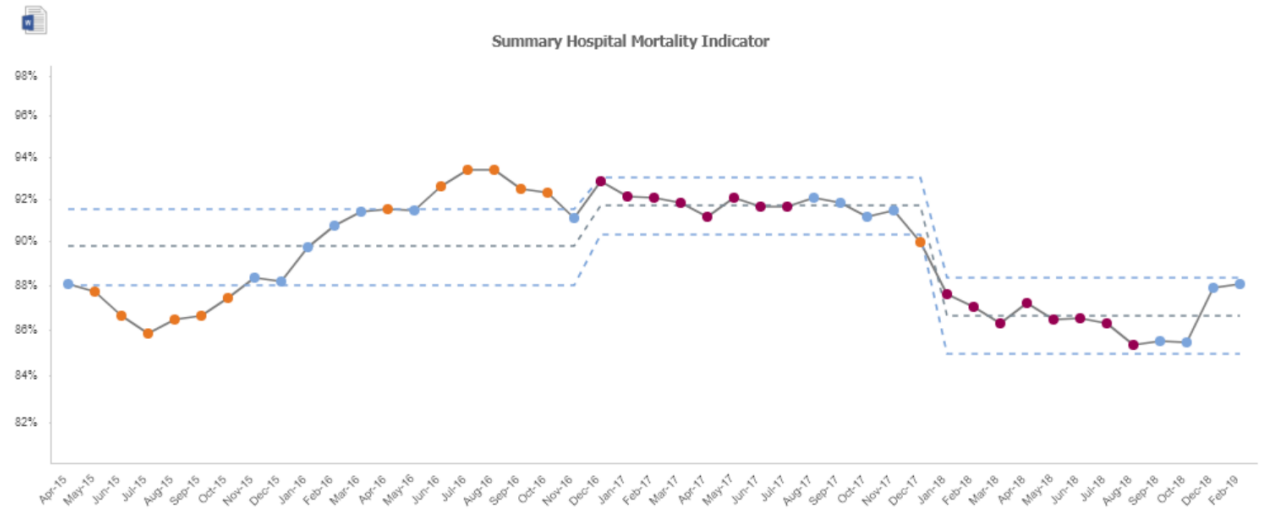
Example lollipop chart



3.1 Performance against nationally selected indicators

Section 1: Patient Safety

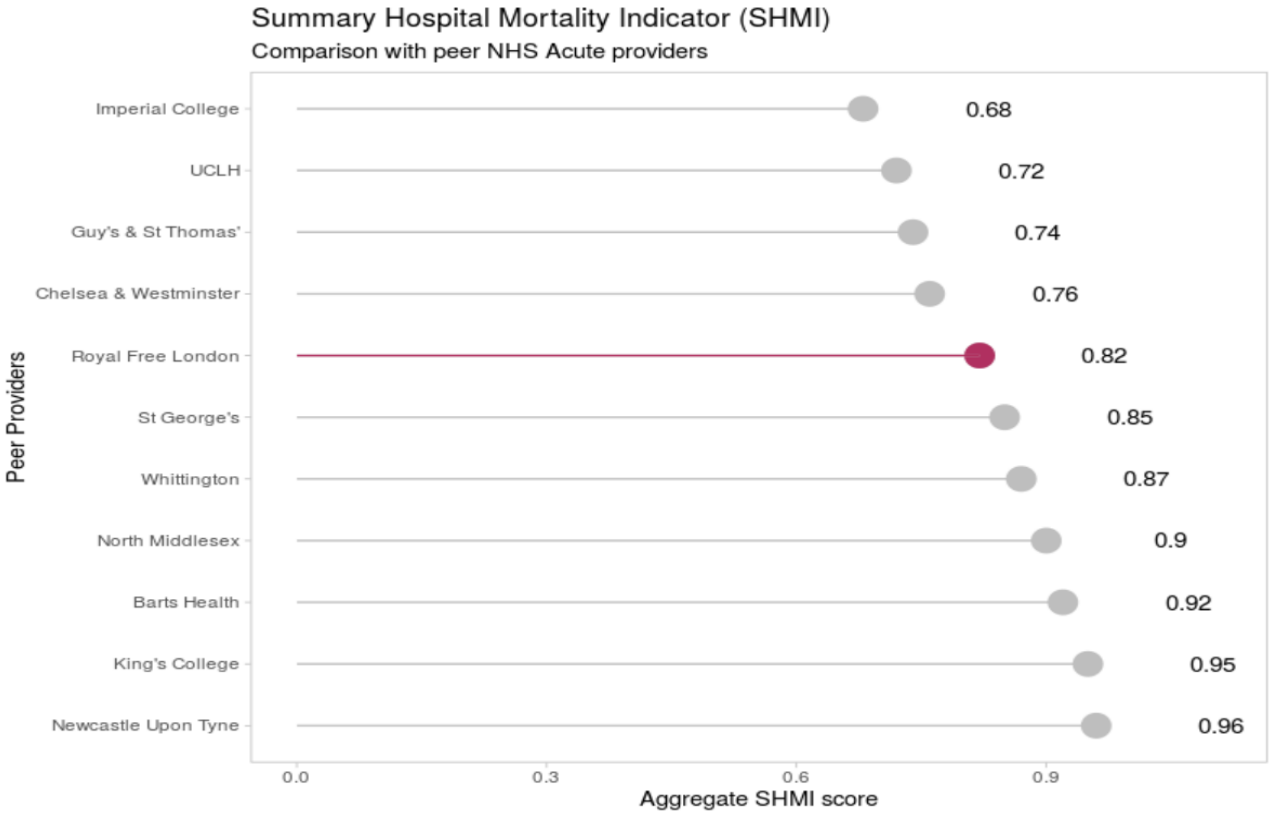
Summary Hospital Mortality Indicator (SHMI)



Source: Royal Free London NHS Foundation Trust 2015-2019

To be updated

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

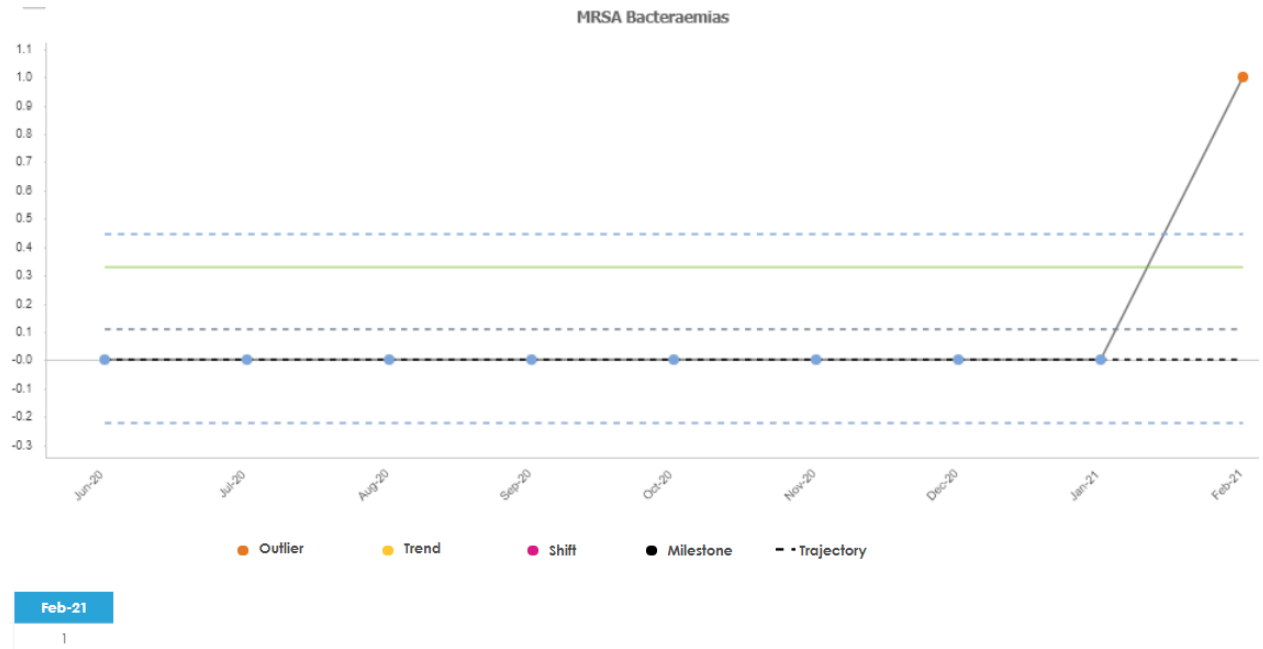


Source: NHS Digital, 2020

To be updated

Methicillin-Resistant Staphylococcus Aureus (MRSA)

To be updated

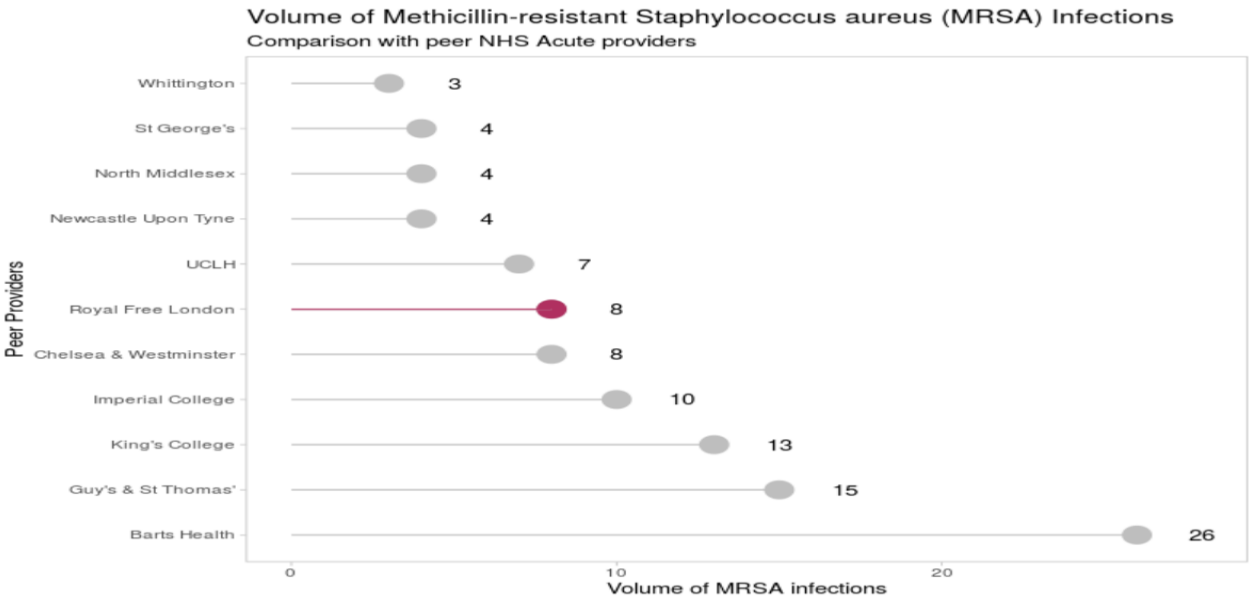


Source: Royal Free London NHS FT TBC-2021

During 2019/20 the Royal Free reported **TBC** 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 TBC cases detected at the Royal Free London, however only TBC remain attributable to the trust.

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

(to be updated)

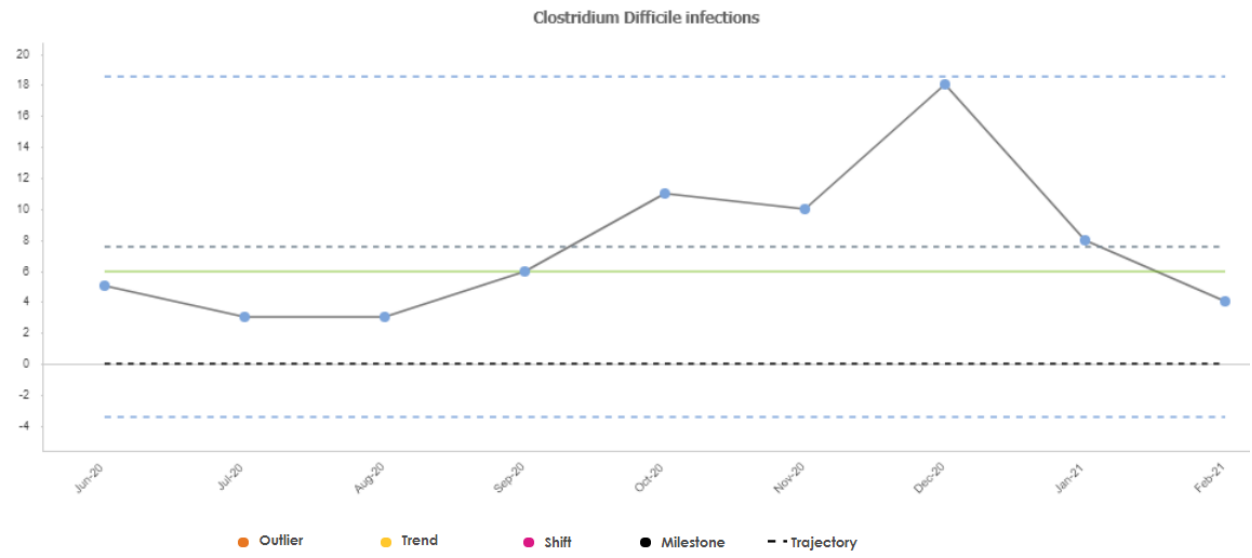


Source: gov.uk, 2020

To be updated

C. difficile

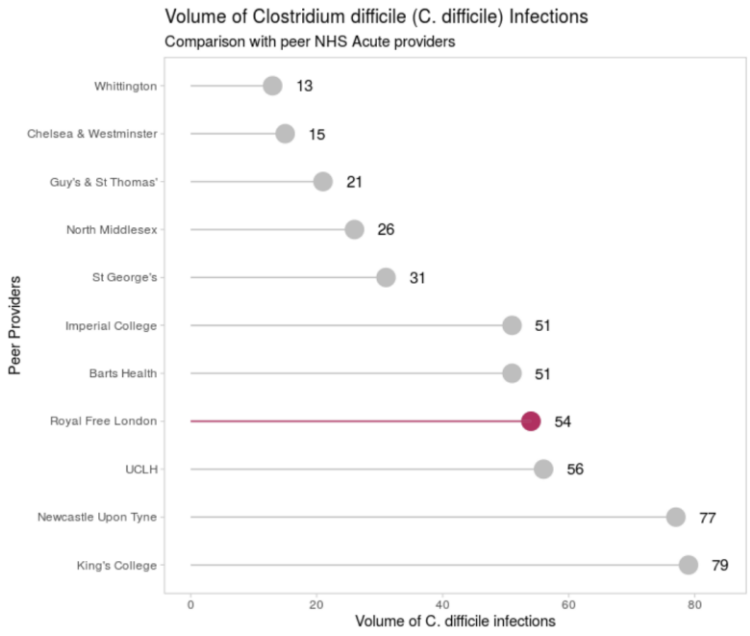
To be updated once data available



Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
5	3	3	6	11	10	18	8	4

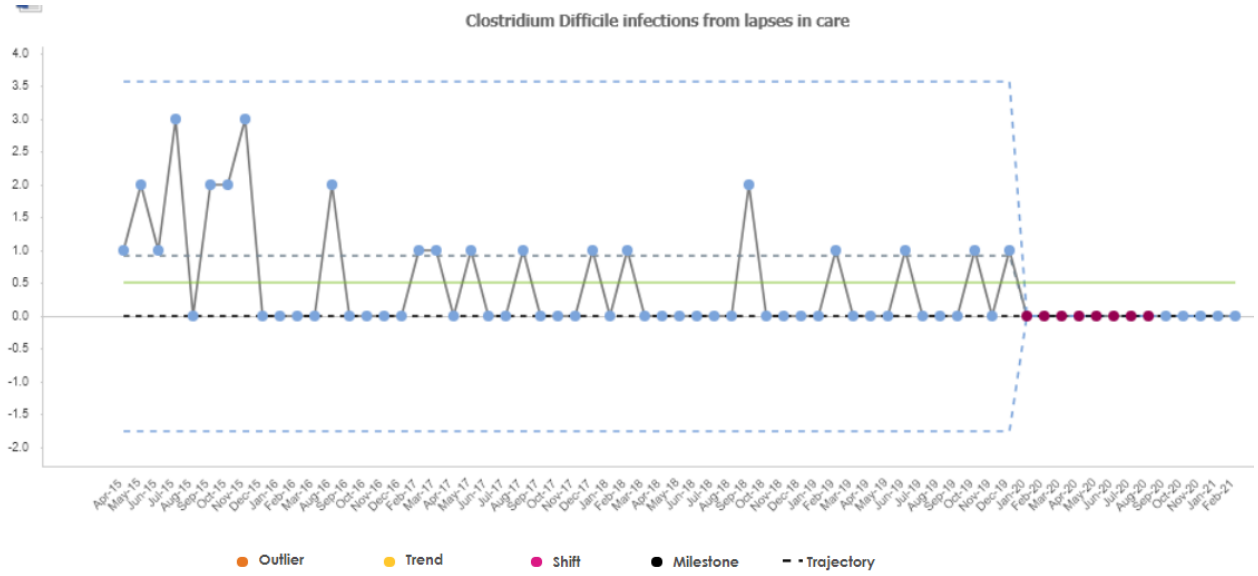
Source: Royal Free London NHS FT TBC-2021

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



Source: gov.uk, 2020

To be updated



Source: Royal Free London NHS FT 2015-2021

Referral to treatment (RTT)

Since March 2019, the Trust has not reported nationally its incomplete Referral To Treatment (RTT) performance due to ongoing concerns regarding the accuracy of information on the Trust Patient Tracking List (PTL). A full scale deconstruction and rebuild of the trust PTL took place in Q1 2019/20. Extensive validation was also undertaken through 2019/20 to ensure that all patients who should be on the PTL were visible. In total 1.2 million pathways were validated. In January 2021 the Trust and North Central London (NCL) jointly commissioned a return to national reporting assessment to assess readiness to commence national reporting. The external assessment was completed in March 2021 and made the recommendation based on the improvements made and quality of data on the PTL to return to national RTT reporting. The Board approved this recommendation and made the decision to return to national reporting in April 2021 submitting March month end performance.

Key successes include:

- New accurate PTL ensuring all patients are visible
- Large scale validation programme undertaken to ensure all patients are being accurately recorded
- Full suite of data quality reports available centrally for operational use
- Increase in volume of administrative staff receiving RTT and job role specific training – reduction in future errors
- Revised RTT governance structure launched

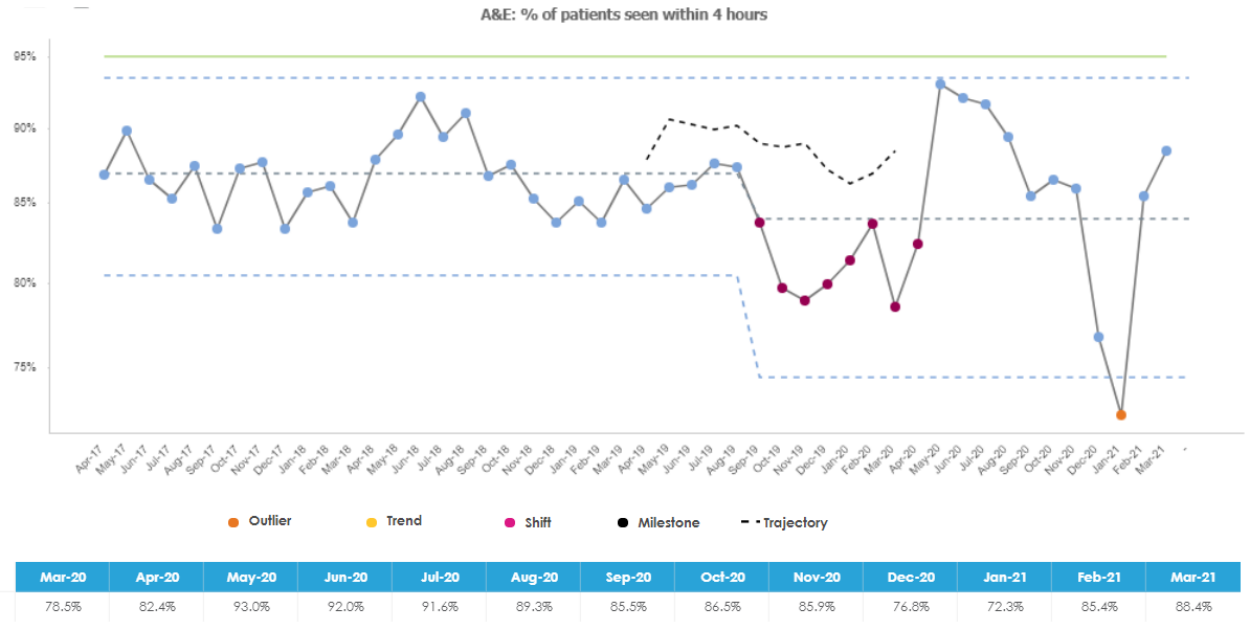
COVID-19 has significantly impacted waiting times throughout 2020/21. As a result of stopping non urgent inpatient and outpatient face to face elective activity, more patients than ever before are waiting greater than 18 weeks to start first definitive treatment. There has also been an increase in the numbers of patients waiting over 52 weeks on the Trust incomplete RTT PTL.

The trust is currently developing recovery plans to improve performance, reduce waiting times through increasing and restoring elective services.

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 2020 to March 2021, the Royal Free London NHS FT achieved an average monthly performance of 85.8%, higher than 2019/20 which averaged at 82.9%.

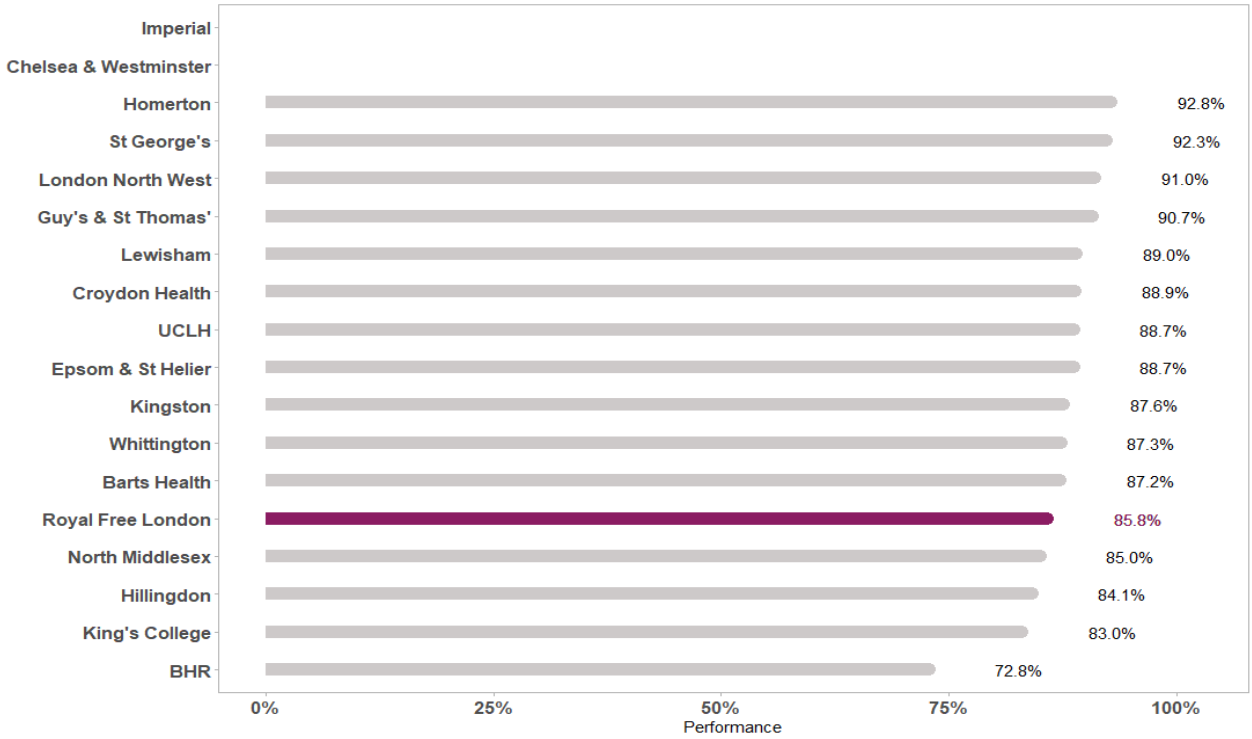


Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
78.5%	82.4%	93.0%	92.0%	91.6%	89.3%	85.5%	86.5%	85.9%	76.8%	72.3%	85.4%	88.4%

Source: Royal Free London NHS FT 2015-2021

The chart below shows the Royal Free London performance for April 2020 – March 2021 benchmarked against 10 peer providers. This shows that our performance was 12th out of 16 peer providers. Two peer trusts, Imperial College and Chelsea & Westminster, ceased reporting in June 2019 due to participation in the waiting times standards review.

Chart: Mean performance against 4 hour A&E standard between April 2020 – March 2021



Source: NHS Digital, 2021

Cancer waits

During the COVID pandemic NHS England have set three key performance indicators for cancer, with the aim to restoring volumes against 2019/20 levels. These three KPIs are:

- restoring Urgent cancer referrals (two-week wait)
- restoring 31 day cancer treatment
- reducing >62 day backlog

The Royal Free London is one of the largest providers of cancer care in the NHS, receiving the second highest suspended cancer referrals (two-week wait) in England. The Trust is performing well against the three priority KPI in COVID recovery.

The Trust was heavily impacted by the first COVID surg, with a dramatic fall in cancer referrals, capacity in diagnostics was restricted and cancer treatments were largely moved out of the Trust's acute hospital sites. Systemic treatments (Chemotherapy and immunotherapy) were moved out of Royal Free Hospital to the Infusion Units at Finchley Memorial and Chase Farm Hospitals, and Cancer surgery was undertaken in the Independent Sector.

The Trust has received approximately 7,000 fewer suspected cancer referrals than in 2019/20, a picture seen across the NHS. The Trust has been working with Primary Care, Commissioning colleagues and Cancer Alliance across NCL to encourage referrals and two-week wait referral volumes have been restored from September 2020 with small reduction during the second surg.

RFL has also been successful in restoring 31 day treatment volumes, this measure captures new cancer treatments from all referrals sources. Treatments were lower during the first COVID surge, but the Trust utilised Independent Sector capacity and maintained systemic and radiotherapy treatments internally with enhanced infection control practices.

The number of patients waiting over 62 days from GP referral for either the all clear or to start cancer treatment was below pre-COVID levels at the end of March 2021.

Delivering against the operational standards has been very challenging due to the COVID pandemic. The Trust performance against 2ww referrals was just below the operational standard through the first three quarters, but recovered to perform above the standard in the last quarter. 62 day performance has been heavily impacted by infection prevention and control measures and other COVID related changes, including implementing a two week isolation period prior to admission, and therefore this standard was not met. Services have performed well against the 31 one day standards which have largely been met.

A new standard is being introduced in 2021/22, the 28 day Faster Diagnosis Standard. This measures the percentage of patients given a definitive diagnosis by day 28. The standard will initially be 75%, which the Trust is expecting to achieve this.

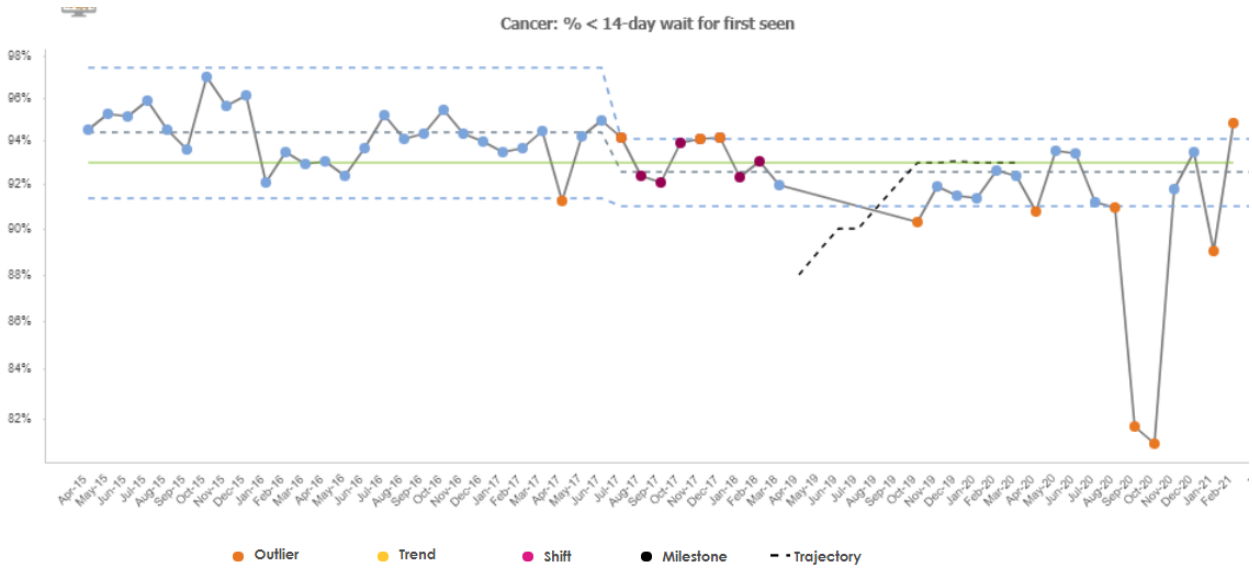
As we have dealt with the impact of COVID-19 over the last 12 months the role of the cancer CPG has transitioned from focussing on the cross cutting elements of cancer pathways to ensuring continuity of cancer services throughout the pandemic. The cancer CPG has:

- worked with clinical teams to capture changes to pathways and document learning from new ways of working
- facilitated the roll out of virtual cancer MDTs
- developed IPC compliant pathways
- helped to co-ordinate the transfer of cancer services across the trust in response to the pandemic
- developed surge plans with input from each of the MDTs

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 2020/21, 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 TBC%.

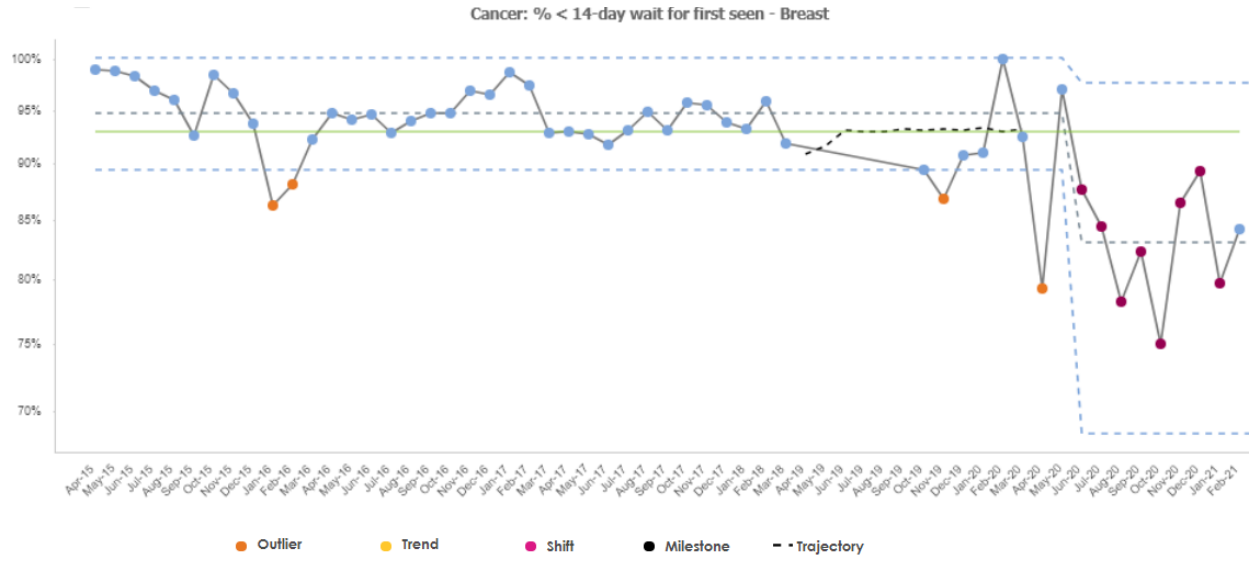


Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
92.39%	90.76%	93.55%	93.38%	91.18%	90.97%	81.65%	80.98%	91.80%	93.47%	89.04%	94.79%

Source: Royal Free London NHS FT 2015-2021

Breast urgent referral 2 week waits

To be updated

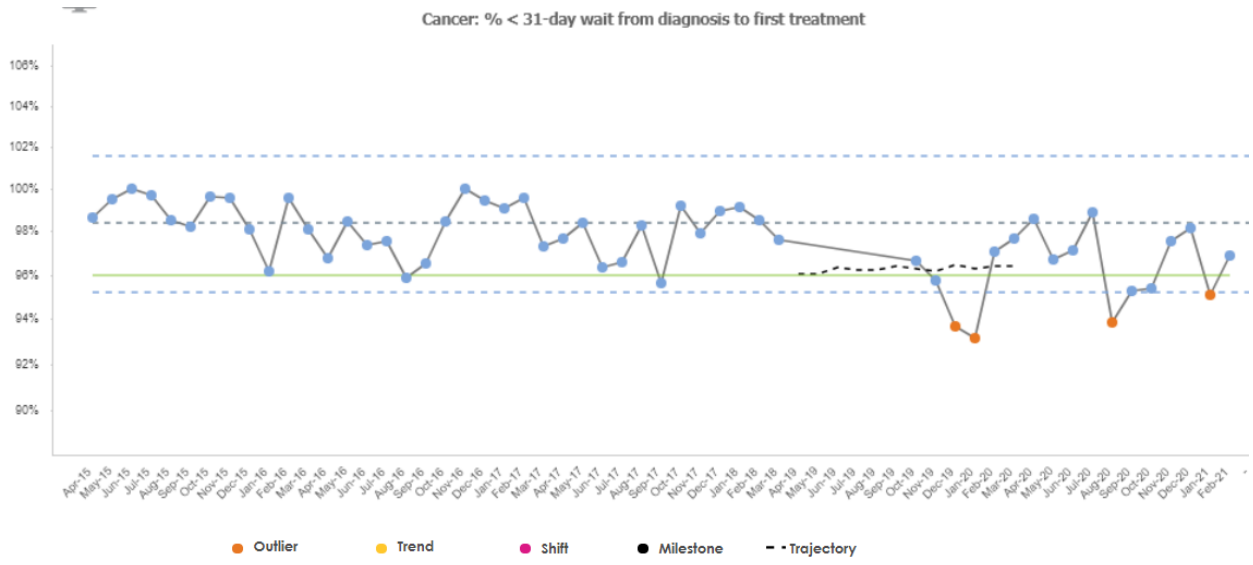


Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
92.52%	79.31%	96.97%	87.69%	84.38%	78.26%	82.35%	75.00%	86.49%	89.29%	79.69%	84.21%

Source: Royal Free London NHS FT 2015-2021

First definitive treatment within 31 days

To be updated

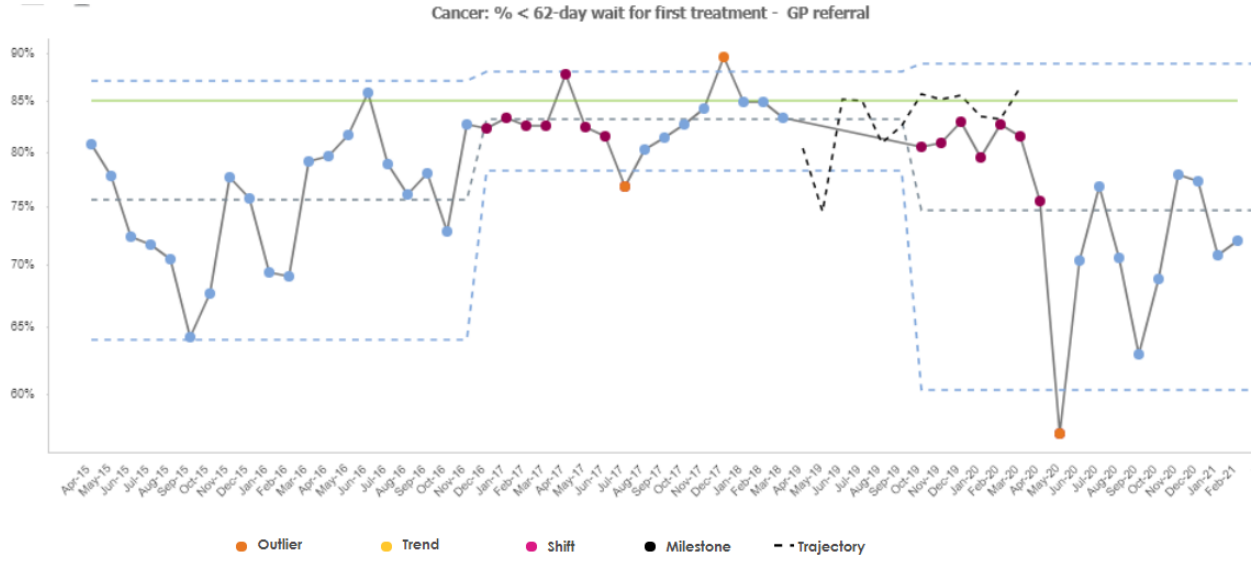


Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
97.64%	98.58%	96.71%	97.14%	98.91%	93.83%	95.26%	95.40%	97.53%	98.17%	95.10%	96.85%

Source: Royal Free London NHS FT 2015-2021

First definitive treatment within 62 days of an urgent GP referral

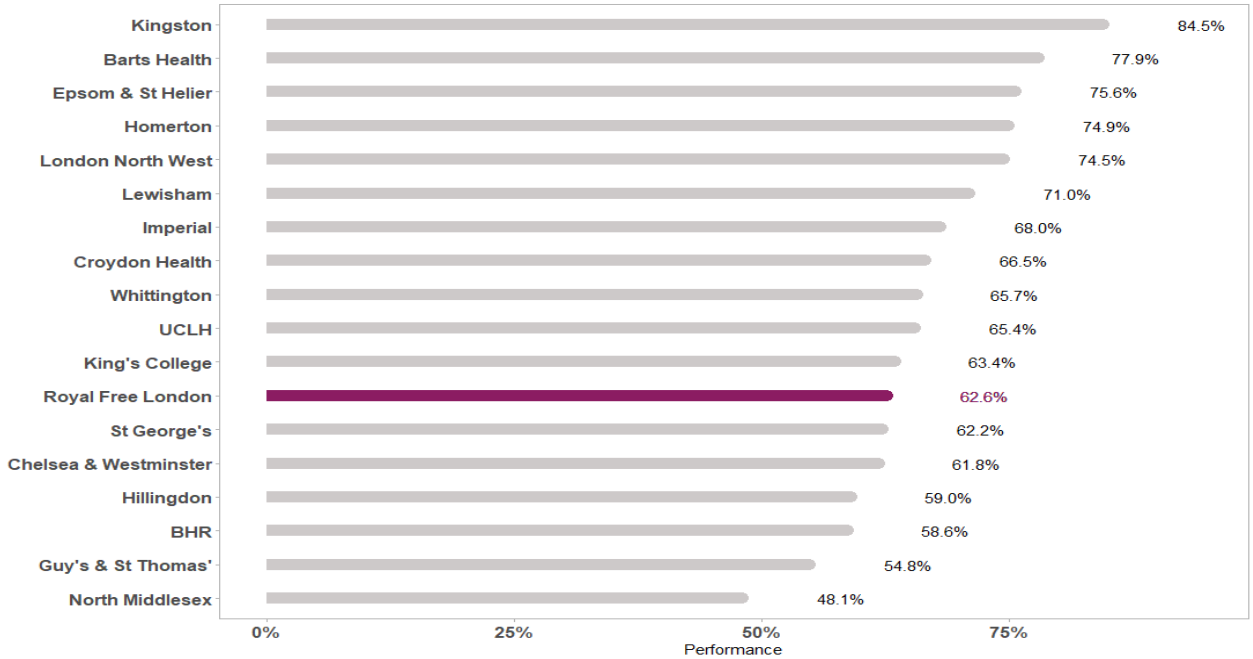
The trust did not meet the 62 day standard in 2020/21, with TBC% of patients receiving first treatment within 62 days of a GP referral. Performance has stabilised since October 2020 and we expect this to continue.



Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
81.53%	75.43%	57.23%	70.25%	76.81%	70.48%	62.83%	68.79%	77.89%	77.29%	70.77%	71.98%

Source: Royal Free London NHS FT 2015-2021

Chart: Mean performance against 62 day cancer standard between April 2020 – February 2021

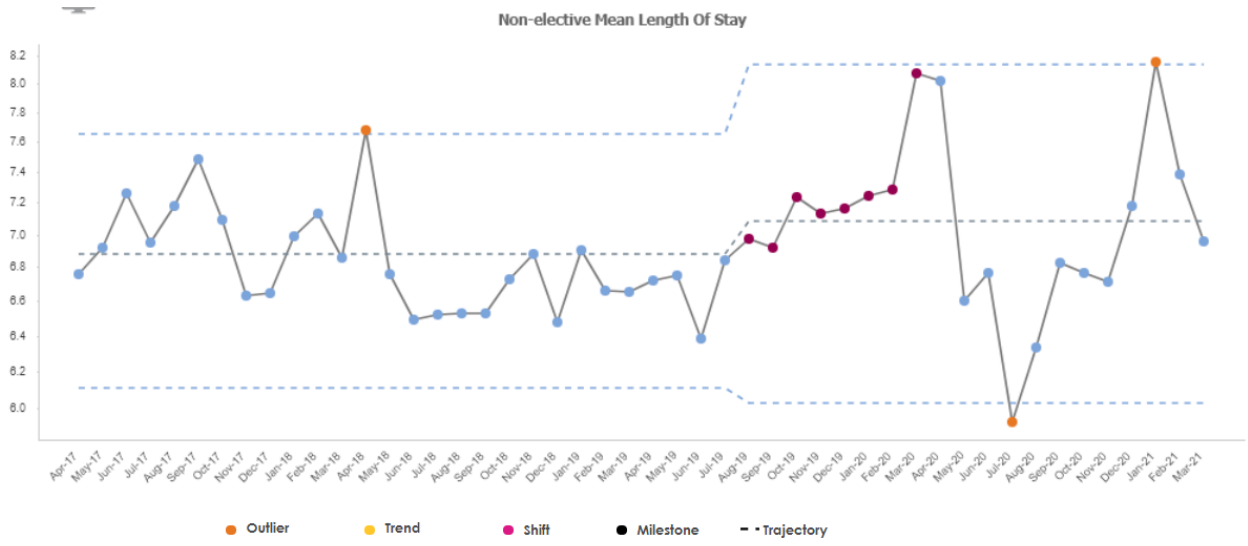


Source: NHS England, 2021

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 2020 to March 2021 shows that the trust average length of stay was 7 days. Variation has been much greater than previous years, and is due to an unusual casemix of COVID patients mixed with the usual emergency cases we would admit throughout the year.

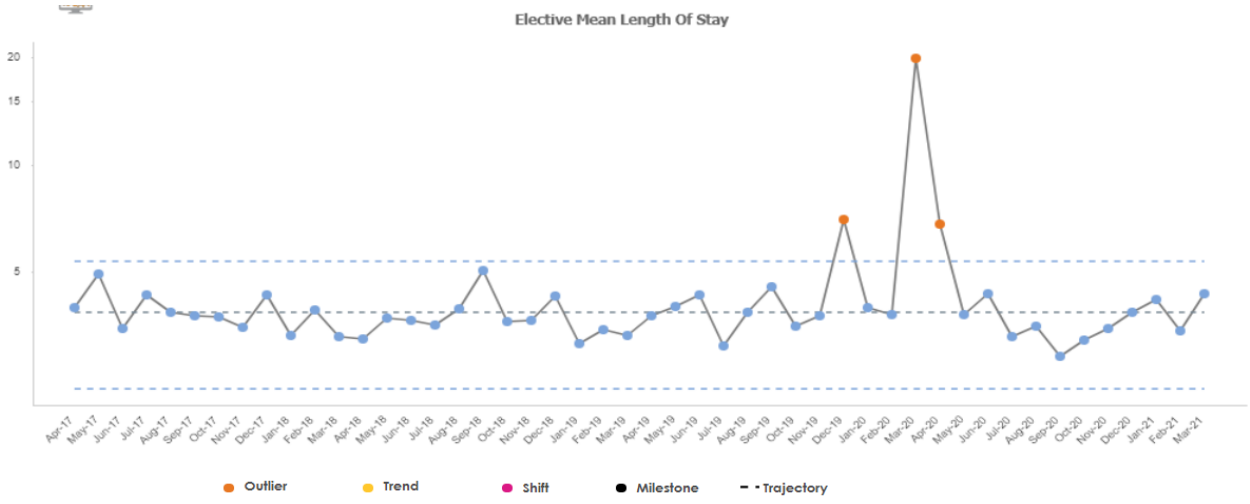


Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
8.1	8.0	6.6	6.8	5.9	6.3	6.8	6.8	6.7	7.2	8.2	7.4	7.0

Source: Royal Free London NHS FT 2015-2021
Benchmark information is not available for this measure

Elective mean length of stay

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



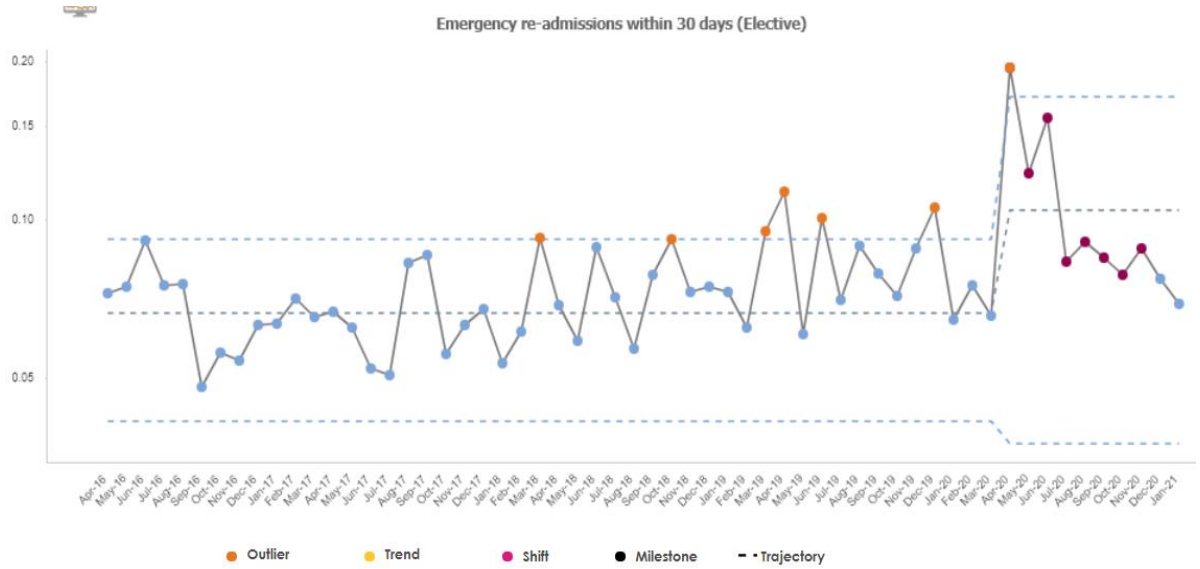
Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
19.8	6.8	3.8	4.3	3.3	3.5	2.9	3.2	3.5	3.9	4.2	3.4	4.3

Source: Royal Free London NHS FT 2015-2021
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 January 2021. We have seen lower numbers than usual due to the pause in elective activity during COVID.



Source: Royal Free London NHS FT 2015-2021

Benchmark information is not available for this measure.

Section 3: Patient experience indicators

Friends and family test (patients)

The friends and family test (FFT) asks patients what their overall experiences of our services are. The collection of this data was temporarily paused at the end of March 2020 due to COVID-19. This, however, allowed the trust to implement a new way of collecting patient experience feedback (including the FFT) which was rolled out across the organisation in September 2020. Our focus has now shifted from achieving high response rates to making real-time changes as a result of patient feedback, which is one of the trust's priorities in 2021/22.

National surveys

In July 2020, the results of the national in-patient survey undertaken in 2019 were published. We would normally also include data from the annual national maternity survey here, but this was cancelled due to the COVID-19 pandemic.

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

In-patient survey results

A total of 38% of patients (up from 34% in 2018) responded to the in-patient survey compared to a national response rate of 45%. All 12 sections of the survey were rated 'about the same' as most other trusts, but three areas questioned were rated as 'worse than'. The charts below show how these areas compared to those from the 2018 survey:

Assistance with meals

2019

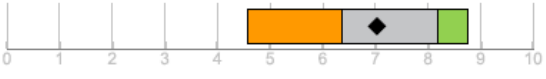
Q21. Did you get enough help from staff to eat your meals?

Worse

RFL score = 6.3, range of scores across England = 5.1 – 9.4

2018

Q21. Did you get enough help from staff to eat your meals?



RFL score = 7.0, range of scores across England = 4.6 – 8.8

How well looked after by non-clinical hospital staff

2019

Q72. Did you feel well looked after by the non-clinical hospital staff?

RFL score = 8.5, range of scores across England = 8.3 – 9.8

2018

Q72. Did you feel well looked after by the non-clinical hospital staff?

RFL score = 8.5, range of scores across England = 7.5 – 9.7

Confidence and trust in nurses

2019

Q27. Did you have confidence and trust in the nurses treating you?

RFL score = 8.4, range of scores across England = 7.9 – 9.7

2**018**

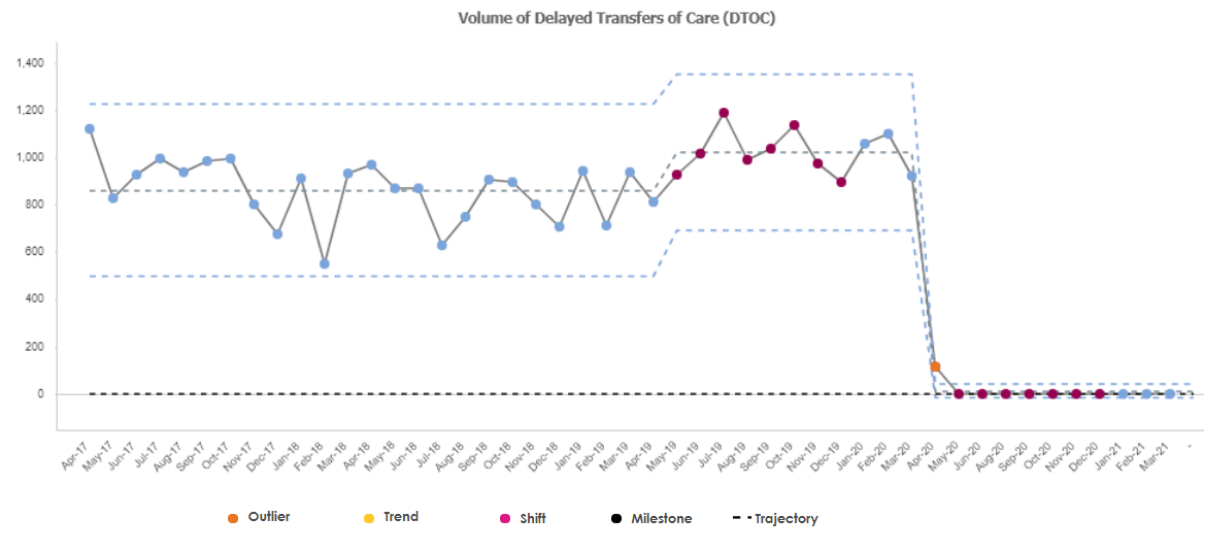
Q27. Did you have confidence and trust in the nurses treating you?

RFL score = 8.5, range of scores across England = 7.7 – 9.6

In response to these 'worse than' most other trust scores, we have incorporated the three questions into the in-patient survey asked via our new electronic devices and web based survey (see FFT section above). This will allow for local monitoring against these questions; in addition local hospitals will develop and implement plans to address these.

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 2020/21 this has reduced to 0. We have been working closely with our local commissioners and social and community care providers to continue to reduce the number of delays.



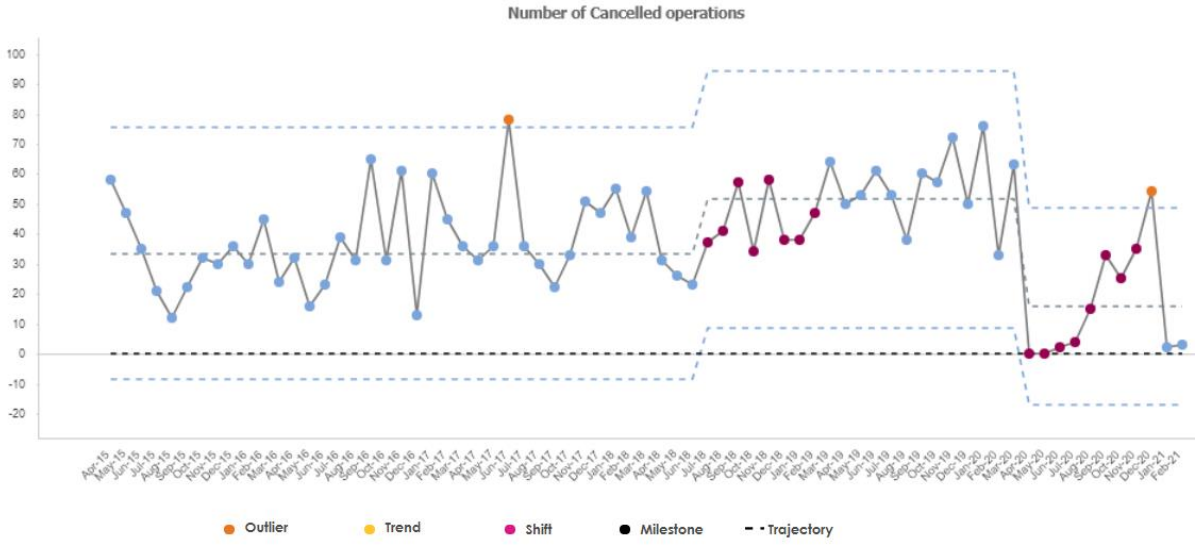
Mar-20	Apr-20
921	114

Source: Royal Free London NHS FT 2016-2021

Benchmark information is not available for this measure.

Number of cancelled operations

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



Mar-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
63	2	4	15	33	25	35	54	2	3

Source: Royal Free London NHS FT 2015-2021

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:

Operational Performance

Key Indicator	Target	Q1	Q2	Q3	Q4	20/21
A&E: <4 hour wait from arrival to admission/transfer/discharge	0.95	0.8913	0.8880	0.8307	0.8203	0.8493
Diagnostics: <6 week wait from request to diagnostic test	0.99	0.3693	0.4547	0.7833	0.8170	0.5869
Cancer: <2 week wait from referral to date first seen (all)	0.93	0.9256	0.8793	0.8875	0.9192	0.9014
Cancer: <2 week wait from referral to date first seen for symptomatic breast patients	0.93	0.8799	0.8166	0.8359	0.8195	0.8397
Cancer: <31 day wait from diagnosis to first treatment	0.96	0.9748	0.9600	0.9703	0.9598	0.9668
Cancer: <31 day wait from diagnosis to subsequent treatment (surgery)	0.94	0.9501	0.9335	0.9872	0.8546	0.9383
Cancer: <31 day wait from diagnosis to subsequent treatment (chemotherapy)	0.98	0.9856	1.0000	0.9847	0.9848	0.9891
Cancer: <31 day wait from diagnosis to subsequent treatment (radiotherapy)	0.94	0.9588	0.9537	0.9549	0.9228	0.9498
Cancer: <62 day wait from referral to first treatment	0.85	0.6764	0.7004	0.7466	0.7138	0.7089
Cancer: <62 day wait from referral to first treatment for screening service referrals	0.90	0.5018	0.3346	0.7801	0.8024	0.5868

Patient Safety

Key Indicator	Target	Q1	Q2	Q3	Q4	20/21
C difficile infections	TBC	23	57	137	194	411
C difficile infections attributable to lapses in care	0	NA	NA	NA	NA	5
MRSA infections	0	0	2	3	1	6

Other key indicators of performance

Key Indicator	Target	Q1	Q2	Q3	Q4	20/21
Non-elective mean length of stay (days)	NA	7.1	6.3	6.9	7.5	7
Elective mean length of stay (days)	NA	5	3.2	3.5	4	3.9
Number of emergency readmissions within 30 days following an elective admission	NA	TBC	TBC	TBC	TBC	TBC

3.3 Our plans for improvement

This section contains an overview of our plans with regard to The Care Quality Commission and also a selection of plans for improvement from each of our main hospital sites, which have the potential to be scaled across the RFL group.

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

A. The Care Quality Commission

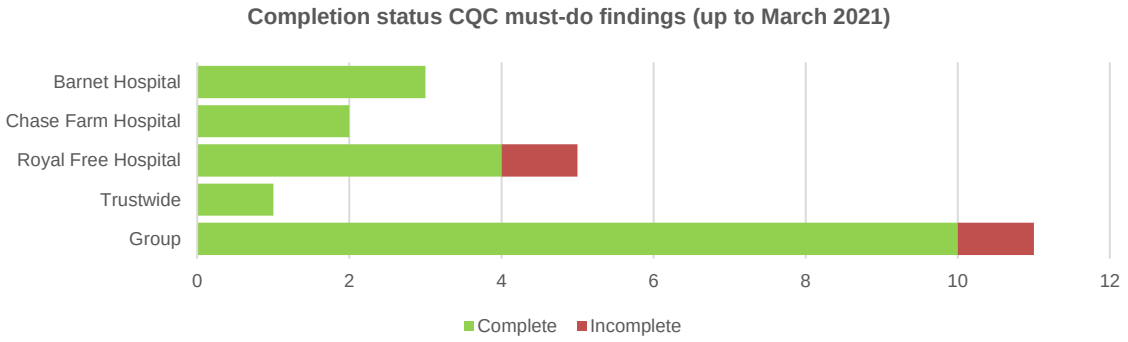
During December 2018, the CQC undertook hospital inspections across our three hospital sites: Barnet Hospital, Chase Farm Hospital and the Royal Free Hospital, and a well-led inspection of the overall trust in January 2019. The CQC issued the inspection findings report to the Trust and publicly in May 2019.

In response to the 11 must-do and 81 should-do improvement requirements, the Trust has implemented a CQC improvement action plan. This was developed, agreed and implemented across each business unit. Progress is monitored by each business unit's local executive committee (LEC), clinical performance & patient safety committee (CPPSC). The group governance team provides a retrospective update to the finance and investment committee (F&I) and Group executive committee (GEC).

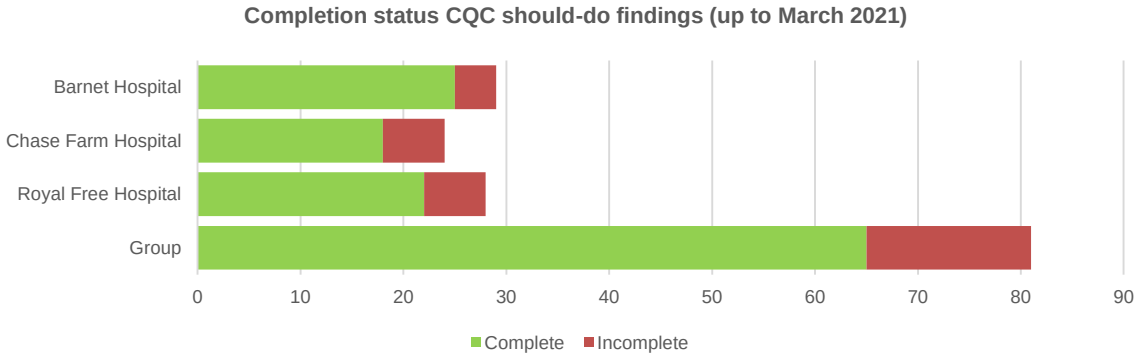
	Safe	Effective	Caring	Responsive	Well-Led	Overall
Group	**Requires improvement**	**Good**	**Good**	**Requires improvement**	**Good**	**Requires improvement**
Barnet Hospital	**Requires improvement**	**Good**	**Good**	**Requires improvement**	**Good**	**Requires improvement**
Chase Farm Hospital	**Requires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

The Trust will remain focused over the forthcoming weeks and months, on completing our action plans in response to areas of improvement as our priority based on the CQC findings. 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.

At the end of March 2021, our position on completing those must-do and should-do actions continue to make continue to make good progress as detailed below:



The incomplete maternity must-do action on the Royal Free site is managed by the Barnet Hospital business unit and remains open until evidence of sustained improvement with documentation of consultant name is achieved.



We will continue to share progress with the CQC and report our improvement through our governance arrangements to our trust board and to commissioning partners and the regulator. Further details of this progress can be found in Appendix B on page 99.

Abbreviations used in this CQC update:

MUC	Medicine & Urgent Care (division)
SAS	Surgery & Associated Services (division)
PPU	Private Practice Unit (division)
TaSS	Transplant & Specialist Services (division)
CPPSC	Clinical Performance & Patient Safety Committee
CSIC	Clinical Standards & Innovation Committee
LEC	Local Executive Committee
BEC	Barnet Executive Committee
MaST	Mandatory & Statutory Training
ESR	Electronic Staff Record

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

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

a) **Barnet Hospital** – Improving patient experience and waiting times for emergency care;
b) **Chase Farm Hospital** – Implementing a 'Learning System' to enable continuous improvement;
c) **Royal Free Hospital** – Tackling violence and aggression in ED to improve the safety and experience of our staff and patients.

We have chosen these three examples, because they illustrate the variety of improvement work being undertaken and, although at this stage are site-led, have significant potential to be scaled across our group in the near future.

Barnet Hospital – Improving patient experience and waiting times for emergency care

Improving patient flow through our hospitals will be a key part of how we address the challenge of reducing the number of patients who are waiting long periods of time for consultation and treatment.

Teams at Barnet Hospital have come together to set up the 'Front Door Flow Improvement Collaborative', which has two main objectives:

a) Improve patient experience in Barnet's Emergency Department and Adult Assessment Unit;
b) Reduce waiting times in Barnet Emergency Department.

Teams are already seeing evidence of improvements in these areas – and believe they are on track to achieve their aim statements by 2022.

Four workstreams have now been established to help achieve those objectives, each focused on key drivers and enablers, as follows:

- **Shared Purpose** – focused on using data and communications to develop a sense of shared purpose and ownership for flow across the hospital;
- **Emergency Department (ED)** – focused on using Quality Improvement methods to optimise key processes in ED;
- **Acute Assessment Unit (AAU)** – focused on using Quality Improvement methods to optimise key processes in the AAU setting;
- **Demand Management** – looking at how we can work with partners, especially through the Barnet Integrated Care Partnership (ICP), to reduce demand for acute services.

Given the resonance of these themes across our group and wider system, the intention is there at the outset to share learning across other acute sites – within and beyond the RFL group.

Chase Farm Hospital – Implementing a 'Learning System' to enable continuous improvement

The ambition is to make tomorrow better than today by implementing a 'Learning System' that proactively identifies opportunities for improvement, recognising that improvements can always be made and good practice can always be shared.

The system empowers staff to make the changes that matter most to them, or to escalate to others, as well as amplifying patient voices so they're utilised by decision-makers. The design of this system ensures that Chase Farm Hospital staff and patients are both the creators and benefactors of this system, with the intention of spreading this across the entire organisation.

The 'Learning System' was successfully deployed at the London Nightingale hospital – where the CFH CEO and Medical Director had been on secondment during spring 2020. On returning to their roles at RFL, both were keen to adapt and implement the approach at CFH.

Two key components of the 'Learning System' are the Learning Coordinator role and the Learning Forum, which are outlined below.

- **Learning Coordinators** – gather insights through observations and speaking with patients and staff. These are fed to the relevant departmental lead and also into the learning forum. After the Learning Forums, coordinators are able to feed progress and outcomes back to staff and patients.
- **Learning Forums** – meetings that occur three times a week, attended by the learning coordinators, service teams, members of the executive team and support functions – such as estates & facilities, patient experience and quality governance. The design of this part of the system reduces the gap between the front line and the executive team and the frequency allows for improvement cycles to be completed quickly.

Since the approach was piloted at CFH in autumn 2020, there have been a number of benefits, for example:

- Identifying that if paediatric outpatient staff could be trained in doing ECGs it would reduce the number of times patients need to come to hospital – therefore, staff will now be trained to do that;
- Flagging that patients, particularly vulnerable and elderly people, were having to wait too long outside the building – which has prompted a redesigned front door screening pathway, so the majority of patients now queue inside the building;
- Highlighting that patients, particularly vulnerable and elderly people, were having to stand in overbooked clinic areas – which has led to the check-in system (InTouch) being programmed to automatically divert patients to less busy waiting areas on the busiest days, to improve patient experience.

Looking ahead, the plan is for the 'Learning System' to be:

- **Enhanced**, through greater focus on the skills Learning Coordinators need to implement changes, alongside escalating insights;
- **Made more resilient**, by supplementing substantive Learning Coordinators with people – for example, existing staff and volunteers – providing additional capacity through ad hoc shifts;
- **Scaled** – to other services and sites within the RFL group.

Royal Free Hospital – Tackling violence and aggression in ED to improve the safety and experience of our staff and patients

Unfortunately, many staff working in the Royal Free Hospital (RFH) Emergency Department have voiced feeling physically and psychologically unsafe and vulnerable at work, due to a wide range of unacceptable behaviours from patients, relatives or other connected persons. These instances can take place in the department or on the phone.

These behaviours can have an impact on staff and patients' experience, making them feel:

- Physically unsafe;
- Psychologically unsafe;
- Vulnerable.

As an organisation, we are clear that these are experiences we do not want for any of our staff or patients.

Many staff indicate that their main options to manage these situations are reporting via Datix (our internal incident report system) or calling security teams and/or police – which are 'after the event' interventions – and may do little to prevent the situations or impacts occurring.

Staff have come together to deliver an improvement project aimed at reducing the weekly number of reported incidences of violence and aggression – currently, averaging 17 per week – by one-third, by the end of 2021.

As a result of this work, one of the first improvement ideas to be tested has been 'conflict resolution training'. This training is intended to help staff identify an escalating situation early on and react appropriately to successfully de-escalate the encounter or remove themselves from an uncomfortable or unsafe situation – so that any potential harm is avoided.

So far, the training has been tested on 8 staff members and has met with an overwhelmingly positive response. Next steps will be to:

- extend the training to the wider ED and assess its impact
- Test other interventions that could help achieve the aims set out
- Explore scaling the successful interventions to our other EDs and settings where violence and aggression have been raised as issues.

Annexes

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

To follow

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

To follow

Appendices

Appendix A: RFL NHSFT CQC Maternity Action Plan

Introduction

The Trust was issued with a Section 29A warning notice on 13 November 2020.

This presentation contains the 3 action plans as an update against issues identified.

The 3 action plans relate to:

- Information and Communication
- IT
- Governance

CQC are expected to return for an unannounced visit in the near future.

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2

Information and Communication – CQC Observations

- Patients who attend the hospital maternity services are not able to access appropriate information in languages that are centred around their individual needs.
- Critical information such as fetal movement and induction of labour leaflets are only available in English.
- The website is difficult to navigate in other languages as the services are listed A-Z by their English name, therefore excluding women / families who do not speak or understand English.
- The Trust must ensure information explaining to Patients how to raise concerns or make a complaint is easily available.

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What we did

- Identified the top five critical information leaflets and top ten languages used by our local population.
- Sourced and made accessible other published information in different languages. e.g Tommy's and UNICEF
- Updated the Maternity platform of our Website

Facilitated briefing sessions for all staff

- Rationale for changes and changes made
- New information available in different languages
- Orientation to our maternity website and provision of information to women on information available
- Use of interpreting service
- Other translation facilities available (Browse Aloud)

Significant Achievements

- Established task and finish group to include service users to progress work
- Buy in from staff in relation to ensuring information accessible
- Changes to maternity platform of our website (Information accessible and much easier to navigate)
- Robust feedback on our current interpreting service to inform future contracts
- Browse aloud
- Provided multiple platforms for users to access information
- Audit trail to ensure women are receiving and understanding conversations
- Complaints process is communicated to women and their families and displayed in all clinical areas

leaflets but on target for completion

- Gestational diabetes leaflet- translated into 7 languages, 3 languages awaiting completion by the Big Word.
- Induction of Labour leaflet – Translated into all 10 languages and uploaded to website
- VBAC leaflet – awaiting for completion from the Big Word
- Strep B leaflet – – awaiting for completion from the Big Word

Actions indicated as complete with the view to build on the work as a priority for next year

- A survey tool for women which will be co-designed with patient representatives and MVP
- To explore whether the externally sourced leaflets should be translated into the languages that are missing from our top ten languages. This will require developing the leaflets internally.
- To co-design a leaflet template that is user-friendly and explore other mechanisms, i.e. animations and videos

IT

The service must ensure electronic and paper patient record systems are suitable and reliable

- The service is not always able to collect reliable data and analyse it due to issues with the electronic patient record system
- On-going issues with computer connectivity to the Wifi network meant that notes could not always be recorded contemporaneously

IT Action Plan Summary 1

Item 1 Closed – 100% of staff cross site have had briefings on the reasons for switching to paper MEOWS on the RFH site.

Item 2a Closed – New EPR computers on wheels and workstations on wheels in place on labour ward and 5 South to ensure that maternity staff have adequate equipment for documentation. IT daily support to labour ward and 5 South and antenatal clinic to support any IT issues.

Items 2b - 2e Closed - All broken / damaged equipment repaired and replaced, maternity on fast escalation pathway to ensure that staff receive a rapid response from the IT helpdesk when they experience any issues. Staff more confident in explaining IT issues to helpdesk.

Item 2f in progress and on target – order has been placed for CCE equipment required. Trunking of loose cables all secured on labour ward and day assessment unit.

Items 2g -2h closed – workstations on wheels labelled and imprivata functioning.

Item 2i complete – White boards fitted on 12/04/21, explicit logons to be provided by access team

IT Action Plan Summary 2

Item 3a closed. User guides and video – emailed to all maternity staff cross site – Education team checking that staff have watched videos. Discussion about videos are included in the staff briefing sessions.

Item 3b closed. Internal comms to all staff on use of patient timeline

Items 3c – 3e –closed. 50 midwives from RF and 100 from BH have had refresher training from IT midwives. Progress at RFH delayed as IT midwife pulled away to manage other issues. RFH matrons ensuring that any issues reported to IT. Digital MEOWS on EPR reinstated on 12.4.21, report going well.

Item 4a-4e Update training completed for Band 7 midwives to be able to cascade to new and junior members of staff. This will be supported by the IT midwives. Additional scanners have been delivered to both labour ward and 5 South (delivery of the mounts awaited). Aiming for an initial 50% increase in scanning compliance at the point of medicine administration.

Item 5a, 5b closed. 5c – Super user training by Digital Midwives in progress. Introduction of single note following MEOWS reintroduction at the end of April 2021.

Item 6a - added to action plan on 3.3.21, The service is not always able to collect reliable data and analyse it due to EPR issues. Awaiting meeting with IM&T to resolve.

Governance 1

We are not assured that maternity services at the Trust are learning from incidents and improving practice to keep patients safe.

We found that learning from incidents was not taking place or was taking place too slowly

Actions include:

- Review Trust incident policy
- Consider a separate maternity risk management policy
- Review line management of 8b Women and children's lead for governance
- Review Duty of Candour policy
- Review quality governance processes
- Review HSIB actions and develop combined action plan
- Update Datix incident form to include immediate actions and identified care service delivery concerns
- Audit HSIB referred cases and undertake thematic quarterly reviews

Governance 1

- Update format and content of SI Action Evidence Monitoring Report
- Complete audit of MEOWS (see IT plan)
- Undertake observational reviews of SBAR handovers
- Resus trolley checks including checking for expired medicines
- Consider reinstatement of duty of candour training across the Trust
- Review areas of practice where audit will help to improve standards of practice and improve learning

Governance Action Plan Summary 1

Of the 21 actions 16 have been completed. All action deadlines have been met, with one action due 30 April 2021. A summary of the remaining 5 actions (not yet due) is outlined below:

Action 4 - Undertake review of Quality Governance Processes across Royal Free London. *(Timescale for completion 03/03/2021 moved to 30/04/2021). Review is underway but final recommendations are to be agreed.*

Action11- Undertake a quarterly thematic review of all completed maternity HSIB investigations detailing how recommendations and lessons are learned monitored and complied with *(30/09/2021)*

Action19- Complete a deep dive into maternity services to identify areas of practice where audit will help to improve standards or practice and support evidence of improvement and learning. *(31/04/2021)*

Governance Action Plan Summary 2

Action 20- Establish a consistent approach for the reporting of clinical effectiveness standards and outcomes and highlighting areas where the Trust is not fully compliant or is identified as an outlier. *(31/06/21)*

Action 21- Recruit into vacant quality governance posts to enable quality governance processes, including internal audit, to function more effectively. *(01/06/21)*

Appendix B: Progress against our 2018 CQC findings

Completed December 2018 CQC must-do findings

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 into 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 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 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 is included in the daily check in the urgent care centre to ensure compliance with the process.

Barnet Hospital – critical care	Royal Free 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	*MUST ensure that equipment has regular preventative maintenance and there is a replacement programme for out-of-date equipment.*
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.	Set up an asset register. Monitor's part of a lease agreement. Recruited two substantive equipment maintenance staff

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.

Barnet Hospital – critical care	Royal Free Hospital – medical care
MUST ensure all medicines are stored safely and securely, and at the correct temperature. Intravenous fluids are never stored in mixed boxes. There is regular checking and timely replacement of out-of-date medicines, including transfer and anaphylaxis kits.	*MUST review escalation processes in the Private Patients Unit for calling the RMO assistance to ensure the RMO is available to attend to patients when required.*
Pharmacy has undertaken weekly medication audits in the following areas: medication security, key storage, ambient temperature, fridge temperature, IV fluids storage and undertaken controlled drugs book documentation audits. Audit findings have been shared with the ward sisters and matrons with oversight by the SAS divisional board and CPPSC. Staff have received additional training on the appropriate storage of medicines and intravenous fluids. A dedicated centralised store for IV fluids is in use. Installation of swipe card access & cooling to treatment rooms.	Reviewed with PPU staff to understand staff experiences in relation to bullying, shouting, insulting communications and interdisciplinary communications. Reviewed and update escalation guideline to ensure clarity of role and responsibilities. RMO attendance at governance meetings

Royal Free Hospital – maternity care *MUST ensure staff follow the trust medication policy and procedures in the safe storage of medicines and safe disposal of expired medicines.*	Pharmacy had undertaken medication audits and controlled drugs book documentation audits. Audit findings have been shared with the Head of Midwifery and Lead Pharmacist for Women's & Children's services with oversight by the divisional board, BEC and Maternity Executive Board.

Incomplete December 2018 CQC must-do findings

Royal Free Hospital – maternity care *MUST ensure medical staff complete consent forms appropriately. All forms must be signed, dated and the role of the doctor must be clearly specified.*	Consent audit findings shared with the maternity unit meeting, consultants meeting and Labour Ward forum and monitored at the maternity risk management meeting. Consent added to divisional risk register **Continued education and reminders to be shared with staff throughout April before re-auditing.** **CQC finding to remain open until evidence of sustained improvement with documentation of consultant name is achieved.**

The should-do actions taken in response to the December 2018 inspection findings at Barnet Hospital.

SAFE: critical care

The CQC said:	We have/are:
The trust should ensure all medical staff complete mandatory training, with compliance monitored.	✓ Reviewed MaST weekly as part of the performance meeting with the clinical director, matron and service manager. ✓ Monitored MaST compliance by the SAS divisional board and Barnet Hospital CPPSC, as part of the monitoring of the critical care CQC action plan. ✓ Human resources team supported staff compliance with MaST training via an improved ESR.
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.	✓ 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, SAS divisional board and is overseen by Barnet Hospital CPPSC.
The trust should ensure contents, including medicines, in transfer bags are regularly checked and records kept.	✓ 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 there is a governance process to ensure most up to date, approved, protocols and guidelines are in circulation and use by staff.	✓ Introduced a trust-wide approach to 'electronic patient record' training for critical care. ***Continuing to validate outstanding guidelines via the approving committee before uploading to the intranet.***
The trust should ensure critical care staff receive sufficient training to enable them to confidently use the new hospital EPR system as needed.	✓ Staff training on the appropriate storage of medication and intravenous fluids by the delivery of four weekly ad-hoc sessions over a one-month period.

SAFE: medical care

The CQC said:	We have/are:
The trust should ensure mandatory training for staff meets the trust target of 85%.	✓ MaST training to be reviewed weekly as part of the performance meetings with the clinical director, matron and service manager. ✓ Monitored MaST compliance at the MUC divisional board, Barnet Hospital CPPSC and BEC, as part of the monitoring of the MUC CQC action plan. ***The human resources team continuing to support staff compliance with MaST training via an improved***

	electronic staff record with a focussed effort to achieve the Trust's MaST target
The trust should ensure appropriate checks are undertaken on patients wearing mittens.	✓ 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 hand hygiene compliance meets the trust targets across all the wards.	✓ Undertaken pharmacy monthly medication audits of the following areas: medication security, key storage, ambient temperature, fridge temperature, intravenous 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, MUC divisional board and is overseen by Barnet Hospital CPPSC. ✓ Provided staff training on the appropriate storage of medication.
The trust should ensure hand hygiene compliance meets the trust targets across all the wards.	✓ Held a hand hygiene campaign across the group in 2019. This will continue to be supported by the MUC 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.
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.	✓ 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 clinical area ✓ Identified safeguarding link nurses. ✓ Monthly monitoring of adult and children safeguarding training compliance by the MUC divisional board and is overseen by the Barnet Hospital CPPSC and the BEC as part of the monitoring of the MUC CQC action plan.

SAFE: surgery

The CQC said:	We have/are:
The trust should ensure all staff complete mandatory training.	✓ Reviewed MaST monthly as part of the matrons meeting. ✓ Monitored MaST compliance by the SAS divisional board and Barnet Hospital CPPSC, as part of the monitoring of the Critical Care CQC action plan. ✓ Monitored MaST for the medical workforce as part of the performance meetings with the clinical director, matron and service manager. ***The Human Resources Team continuing to support staff compliance with MaST training via an improved ESR with a focussed effort to achieve the Trust's MaST target.***
The trust should address the high turnover rate amongst nursing staff and ensure all of the shifts are covered at all times.	✓ 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. ✓ Monitored the overarching action plan at the SAS divisional board and Barnet Hospital CPPSC and BEC. ✓ Monthly monitoring of the nursing staff turnover rate via the SAS divisional board and is overseen by Barnet Hospital CPPSC 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.	✓ 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.
The trust should ensure medicines are stored in accordance with published guidance and there is a system to identify where guidance is not adhered to by staff.	✓ Monthly medication audits, by pharmacy, using the Perfect ward app covering checks of the following areas: medication security, key storage, ambient temperature, fridge temperature, intravenous fluids storage to achieve 100% compliance with Trust guidance. ✓ The medication audit findings sent to the ward sister and matron on a monthly basis ✓ Monthly oversight of the medication audits via the senior nurse meeting, SAS divisional board and Barnet Hospital CPPSC. ✓ Staff training on the appropriate storage of medication by the delivery of four weekly ad-hoc sessions over a one-month period.

SAFE: urgent & emergency care

The CQC said:	We have/are:
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.	✓ 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 clinical area. ✓ Identified safeguarding link nurses. ✓ Monthly monitoring of adult and children safeguarding training compliance by the MUC divisional board and is overseen by the Barnet Hospital CPPSC and the BEC as part of the monitoring of the MUC CQC action plan.
The trust should ensure all staff have up to date mandatory training and ensure the trust's 85% target is met.	✓ Monitoring by matrons, clinical directors and service managers that staff members are MaST compliant. ✓ Undertaken a weekly audit of patient notes to identify compliance with the policy to for at least 3 months in order to achieve 100% compliance. ✓ Monthly monitoring of MaST compliance by the MUC divisional board, Barnet Hospital CPPSC and BEC as part of the monitoring of the MUC 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.	✓ 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 MUC divisional board and is overseen by Barnet Hospital CPPSC and BEC for monitoring of the MUC CQC action plan.

EFFECTIVE: medical care

The CQC said:	We have/are:
The trust should ensure there is proper recording of the decisions for restraint and there is clear guidance for staff on when an application for Deprivation of Liberty Safeguards (DoLS) should be made.	✓ Provided education and training plan, developed with the adult safeguarding team to ensure that all staff members in particular ward sisters, matrons and consultants fully understand how to enact and document DoLS. ✓ Ensured DoLS knowledge and documentation embedded by continuous audit.
The trust should ensure they reduce the average length of stay for medical non-elective patients, to meet the England average.	✓ 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.

EFFECTIVE: surgery

The CQC said:	We have/are:
The trust should develop, and staff should adhere to at all times, a clear procedure for order and priority of patients undergoing emergency surgery.	✓ Developed a standard operating procedure outlining the procedure for the order and priority of patients undergoing emergency surgery to be developed and implemented. ✓ Monthly monitoring of the progress against this action via the SAS divisional board and Barnet Hospital CPPSC as part of the monitoring of the Surgery CQC action plan. ***Undertaking a point prevalence audit of the standard operating procedure to check compliance and ensure procedure is embedded***

EFFECTIVE: urgent & emergency care

The CQC said:	We have/are:
The trust should ensure there is sufficient seating and space in the A&E waiting areas for patients and visitors.	✓ Explored with the estates department alternative options within and outside of Emergency Department and was addressed as part of the Urgent Treatment Centre Reconfiguration

CARING: medical care

The CQC said:	We have/are:
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.	✓ An overview of the data presented at the MUC divisional board; this forms part of the multiple LLOS reviews each week.

RESPONSIVE: critical care

The CQC said:	We have/are:
The trust should ensure patients are reviewed by a consultant within 12 hours of admission to critical care.	✓ 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 SAS divisional board and Barnet Hospital CPPSC 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	✓ The Intensive Care National Audit and Research Centre (ICNARC) data validated on a monthly basis and the

accurate, particularly in relation to delayed discharges and mixed sex breaches.	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 SAS divisional board and is overseen by Barnet Hospital CPPSC as part of the monitoring of the critical care CQC action plan.

RESPONSIVE: medical care

The CQC said:	We have/are:
The trust should ensure potential trip hazards in corridors are removed across all the wards.	✓ 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.	✓ 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: critical care

The CQC said:	We have/are:
The trust should ensure there is a thorough review of medical staffing at weekends and allied health care provision for the service, as part of a wider review of adherence to guidelines for provision of intensive care standards.	✓ Undertaken a review of medical staffing to be undertaken and a critical care standard operating procedure to be developed to cover escalation in relation to medical staffing and increased clinical activity. ✓ Undertaken a gap analysis of allied health professional staffing and to use this to inform the development of a business case for allied health care provision for the service.
The trust should ensure patients, staff and wider stakeholders are involved in developing a critical care strategy and turning it into action.	✓ Developed a critical care strategy, with patient input.

WELL-LED: medical care

The CQC said:	We have/are:
The trust should ensure that risks identified on the risk register are being dealt with in a timely way.	✓ Monitoring of 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 CPPSC by means of two key performance indicators: number of risks reviewed every three months and number of risks older than one year.

WELL-LED: urgent & emergency care

The CQC said:	We have/are:
The trust should ensure waiting times from referral to treatment and decisions to admit patients are in accordance with best practice recommendations.	✓ Continued to work through the urgent and emergency care improvement programme and monitor progress via the urgent & emergency care and accident & emergency delivery boards.

The should-do actions taken in response to the December 2018 inspection findings at Chase Farm Hospital.

SAFE: surgery

The CQC said:	We have/are:
The trust should ensure staff complete mandatory training, including safeguarding training.	✓ Identified errors in the allocation of staff who are not managed by Chase Farm showing in the reports & worked with human resources make corrections. ***The Trust is continuing to make improvements to the overall MaST compliance rates and monitor at the LEC.***
The trust should ensure action is taken to prevent avoidable patient safety incidents from reoccurring.	✓ Ensured actions taken in response to serious incidents and DIMs 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.	✓ 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.	✓ 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.	✓ Access control swipe lock is installed on to the intravenous fluid storeroom, to ensure appropriately controlled access.

SAFE: urgent & emergency care

The CQC said:	We have/are:
The trust should address the high vacancy rates, high sickness rates and high turnover rates for nursing staff and healthcare assistants in the service.	✓ Other ACPS currently in training in the service. ✓ Recruited 3 advanced clinical practitioners including an advanced clinical practitioner from ICU at the Royal Free Hospital. ***Due to the national shortages of advanced clinical practitioners and emergency nurse practitioners, the service has a medium- and long-term plan for reducing the vacancies, improving sickness and turnover. The short-term plan is to continue to use agency staff as is***

	currently in place. ***A QI project to improve recruitment and retention in the service for band 6-8a staff is planned. Ideas for focus are GP spin project, student programme for development, apprenticeships.***
The trust should implement a formal process for reception staff to highlight issues in the waiting areas.	✓ 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 UCC.	✓ Additional signage has been added to the external entrance to the urgent care centre.
The trust should improve staff education of incident reporting.	✓ Governance days to be held yearly to include the importance of incident reporting and provide feedback. ✓ Incident reporting trigger lists displayed in all staff rooms to help staff understand what should be reported as an incident. ✓ Development of a CFH governance team intranet page to share resources and learning ✓ Regular governance attendance at team meetings to feedback learning and promote incident reporting. ***The Trust is developing video guides for incident reporting & the importance of incident reporting, in conjunction with the DATIX team, for the Trust's intranet.***

EFFECTIVE: surgery

The CQC said:	We have/are:
The trust should ensure the trust's consent policy is followed and that all stages of the consent process are appropriately documented.	✓ Worked with surgical teams to review the process and policy to ensure that process and policy match.

EFFECTIVE: urgent & emergency care

The CQC said:	We have/are:
The trust should improve the health promotion provision in UCC.	✓ Clinical staff in the urgent care centre (UCC) have access to health promotion leaflets stored electronically on the services local drive. A log in has been created to ensure that locum staff also have access to this. Leaflets are printed and provided to patients as required. ***The Trust is working towards providing health promotions digitally in the waiting room on information screens.***

The trust should implement a formal teaching programme for medical and nursing staff.	✓ Provided a digital notice board in the new staff room in UCC. Teaching aids and topics of the week will be accessible to all UCC staff via this notice board.
The trust should provide local appraisals for middle grade doctors within the service.	✓ Local appraisals to be undertaken by GP lead for middle grade doctors in CFH UCC.
The trust should ensure policies and guidelines available in hard copies are regularly reviewed and updated.	✓ Removed hard copies of policies and guidelines. ✓ Staff have access to electronic versions of policies and guidelines on the local drive and Trust intranet. ✓ A 7/24 business continuity computer is available in the department for use in cases of IT system failure.

CARING: urgent & emergency care

The CQC said:	We have/are:
The trust should improve the reception area in the urgent care centre and paediatric outpatients to ensure patient confidentiality.	✓ Reviewed ways to improve confidentiality in the urgent care centre reception area. ✓ A new waiting area for urgent care centre paediatrics in place, so there is no requirement to use the paediatric outpatient waiting area.

RESPONSIVE: medical care

The CQC said:	We have:
The trust should continually review referral to treatment times to ensure it is in line with national standards.	✓ 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 CQC said:	We have/are:
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.	✓ 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	✓ Worked with the local deaf society to provide deaf awareness training for key staff members.

impairments or complex needs.	
The trust should ensure service provision meet patients' individual needs particularly those with complex needs and disabilities.	✓ 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.
The trust should ensure people knew how to make a complaints or compliment about their care and treatment.	✓ PALs feedback forms are now available in the UCC with a feedback box which is monitored by the governance team. ✓ Paper friends & family test (FFT) feedback forms are also now available in the UCC. The service will be piloting an electronic capture of FFT. ***Working towards providing information on how to raise a concern, make a complaint or compliment on the electronic information screens in the waiting area once these are available.***

WELL-LED: medical care

The CQC said:	We have/are:
The trust should ensure they engage with staff effectively.	✓ 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.	✓ 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: o Providing time to ensure risks are moving and are escalated as required. o Ensure that key issues are present on the risk register.

WELL-LED: urgent & emergency care

The CQC said:	We have/are:
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.	✓ A new dedicated urgent care centre paediatric waiting area in place and 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.
The trust should improve the patient engagement in the service.	✓ First patient partner has been recruited to patient partnership group. ✓ This group will feed into the staff and patient experience

committee.

A patient partnership group due to be implemented. Patients will be recruited into this group via a formal process. The group will be engaged with changes made in the service.

The should-do actions taken in response to the December 2018 inspection findings at Royal Free Hospital.

SAFE: critical care

The CQC said:	We have/are:
The trust should review the benefits of an electronic patient in ICU that avoids the pitfalls of the system that was introduced and abandoned previously.	✓ The Trust is rolling out an electronic patient record system. ✓ Trust/Board guidance required regarding ICU electronic system, as part of EPR development programme.
The trust should monitor medical staffing levels during the expansion of the unit to ensure they meet FICM standards.	✓ 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: o Developing specialist roles in ICU to attract consultant staff. o Developing a fellowship program to attract senior trainees, encouraging them to advance into consultant positions within the Trust.
The trust should monitor medical staffing levels during the expansion of the unit to ensure they meet FICM standards.	✓ Dedicated recruitment and retention programme in place. This includes the following: ✓ Weekly recruitment meetings chaired by divisional directors of nursing. ✓ Dedicated ICU monthly recruitment days. ✓ Overseas recruitment programme in place. Introduction of two band 6 clinical practice educator posts, to support overseas nurses. ✓ Accredited HDU programme has started. ✓ Trust wide branding programme to attract nurses. ✓ Trialling of 4 months overseas development pathway into ICU/HDU. Currently pathway can last up to 9 months. ✓ Competency booklets are easy to use and are signed off in a timely manner. ✓ To achieve trust vacancy rate target of 10% for band 5 and band 6 posts. ICU recognises this issue, and it is currently on the risk register. ✓ Career pathways for nurses and B5 reviewed to improve support and supervision within the unit. ✓ Working with the unions to explore ways of recruiting and retaining nurses. ***The Trust has continued to recruit throughout the pandemic however, uptake has now slowed.***

The CQC said:	We have/are:
The trust should review the training of security officers and security protocols in the hospital, including patrols and one-to-one patient supervision.	**In MUC:** ✓ Security receive training within Trust. All mental health patients will have nurse allocated to oversee care. ✓ The security officers support the team. ✓ Introduced a security induction for new staff in the emergency department. **In TaSS:** ✓ When a patient is assessed as requiring one to one supervision for physical or mental illness, a risk assessment should be completed to provide continuous observation period for length of time required. Decision should be based on regular assessment of patient's mental and/or physical illness or level of risk. ✓ Meeting arranged with system partners in mental health to clarify process for agreeing one to one, skill and level of competency required. ✓ Current arrangements continue until guideline agreed. Requesting and booking of shifts for one-to-one supervision overseen by matron and requested via e-roster with automatic cascade to agency if shift unfilled. Arrangements for break cover for staff on one-to-one supervision to be clarified at the beginning of the shift by nurse in charge to ensure continuous observation. ✓ The trust needs to develop a guideline for patients requiring one-to-one supervision **In PPU:** ✓ The visiting policy for PPU to be reviewed and updated to incorporate process for ensuring all visitors to the unit are identified and authorised. ✓ Easy use flow sheet to be devised for quick reference of how to escalate if there are concerns regarding visitors and training sessions to be held for all clinical and non-clinical staff, with priority for reception staff and ward clerks. ✓ Poster to be displayed to state all visitors will need to report to reception. ✓ Intercom door system on 12 West ward to be made fully functional. ✓ Review of 1:1 decision making process to be reviewed and incorporated into the admission policy for PPU. ✓ Daily unit safety huddle to include discussion and record of all patients requiring one-to-one care and any safeguarding concerns
The trust should ensure staff have the knowledge and skills to de-	**In MUC:**

escalate threatening or aggressive patients, visitors and relatives.	✓ Monthly meeting with clinical practice educators, matrons and ward managers to review MaST compliance report. ✓ Psychology liaison cover available to the emergency department 24 hours/day. ✓ Caper program continues for both health care assistants as part of the care certificate for new starters and for health care assistants and registered nurses who would like to attend. ✓ The Chicken Shed company will continue to work with the Trust to provide training around dementia and how to best communicate with patients who display challenging behaviours. **In TaSS:** ✓ A quality improvement project in dialysis areas to reduce incidence of violence and aggression. ✓ Identify champions in high-risk areas. ✓ Staff training in de-escalation that enables them to recognise early signs of agitation, irritation, and aggression. ✓ Work with the police and local security specialist for high-risk areas. **In PPU:** ✓ Staff to be fully conversant with how and when to escalate to site team and security team any specific conflict concerns. ✓ Trust policy to be reinforced at team meetings. ✓ PPU will be included in any trust initiatives and training that support ongoing training. ✓ PPU page on the Trust's intranet to include escalation flow chart for raising conflict concerns. ***New conflict training for ward managers and clinical leads will be delivered in 2021/22 as part of a quality improvement programme, with further plans to roll out across the Trust.***
The trust should ensure staff in the PPU wards fully utilise trust safeguarding policies and referral pathways including for international patients.	✓ Teaching and training for all staff for safeguarding in conjunction with Trust's safeguarding lead. ✓ Safeguarding lead to be invited to PPU quality board. ✓ Specific training and emphasis on managing safeguarding concerns for embassy patients to be commenced and include the overseas team as appropriate. ✓ Dedicated safeguarding meeting to be implemented every quarter to discuss historical and ongoing safeguarding issues. Reports from this meeting to be presented at PPU quality board and then to PPU divisional meeting.
The trust should improve staff access to information on securing mental health support for patients.	**In MUC:** ✓ Safe care done daily and daily review by matrons and escalation as needed. ✓ Mental health team are supporting wards with training and

	reviews of patients. ✓ All staff to have CAPER training. ✓ Director of nursing at Royal Free meets with the psychiatric liaison team to discuss support for wards and potential training needs. ✓ Need a review of the current EC risk assessment form on the intranet, to update and engage staff in a simplified version. **In TaSS:** ✓ When a patient is assessed as requiring one to one supervision for physical or mental illness, a risk assessment should be completed to provide continuous observation period for length of time required. Decisions are based on regular assessment of patient's mental and/or physical illness or level of risk. ✓ Meeting arranged with system partners in mental health to clarify process for agreeing one to one, skill and level of competency required. ✓ Current arrangements continue until guideline agreed. Requesting and booking of shifts for one-to-one supervision overseen by matron and requested via e-roster with automatic cascade to agency if shift unfilled. Arrangements for break cover for staff on one-to-one supervision to be clarified at the beginning of the shift by nurse in charge to ensure continuous observation. **In PPU:** ✓ Staffing guidelines to include when and how to request the need for a registered mental health nurse is included in patient care. ✓ Ensure unfilled shifts are highlighted at the Trust wide bed meeting. ✓ Investigated an electronic flagging system to be incorporated into current system. ✓ Review flagging of patients on admission/booking that require mental health input.
The trust should review the processes in place to support staff with effective conflict management.	**In MUC:** ✓ All staff to be 100% compliant with conflict resolution training. ✓ Trust has introduced the bullying & harassment video which is currently available for all trust staff in the division. ✓ Staff experience audits undertaken monthly. ✓ Staff more aware of speak up champions. ✓ Focus groups to be organised for band 2 staff. ✓ Clinical practice educators provide study days for band 2. **In TaSS:** ✓ Conflict resolution training has been put in place.

	✓ Early resolution of issues identified and access to speaking up champions ✓ Divisional Staff Experience plan: o Triumvirate visits listening to staff and focusing on staff experience, patient safety and quality improvement. o Facilitated discussion sessions of bullying and harassment to address and challenge poor behaviour/promotion of world class care values videos. o Leadership Development away days ✓ There has been a focus on: o Staff wellbeing and flexible working. o Mindfulness on 11 West and 11 East wards. **In PPU:** ✓ The PPU bleep holder and ward managers are aware of the process for booking a registered mental health nurse and the escalation process to the site team. ✓ Reviewed employment relationship issues, timescales and response times in order to gain an accurate assessment of issues specific to PPU. ✓ Review staff survey for comments relating to culture and staff escalation processes ✓ Work with human resources on retention and engagement of staff.
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.	✓ 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 CQC said:	We have/are:
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.	✓ 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 medical and nursing staff have access to mandatory training.	**In SAS:** ✓ Human resources share MaST and appraisal reports. ✓ Appraisal/MaST rates shared at divisional board meetings and service line meetings. ✓ Incorporated MaST into audit days, including fire training and resuscitation. **In TaSS:** ✓ Promotion of forward planning appraisal dates for all staff. ✓ Weekly reports sent out on MaST and Appraisal reviewed. ✓ Weekly TASS senior nursing meeting. ✓ 6 weekly TASS performance reviews for each directorate. ✓ TASS divisional board and local directorate meetings.
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.	✓ 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.
The trust should review how medicines were stored and accessed in the operating theatres.	✓ Swipe access into the pharmacy room.
The trust should develop a rolling programme of equipment replacement.	✓ Monitors in ICU are now leased. ✓ Capital plan in place, all equipment replaced with a plan for replacement of pumps 2020/21.

SAFE: urgent & emergency care

The CQC said:	We have/are:
The trust should ensure that mandatory training rates including safeguarding training, for nursing and medical staff are compliant with the trust standard.	✓ Human resources share appraisal and MaST compliance reports. ✓ Appraisal/MaST rates shared at divisional board meetings and service line meetings. ✓ Hot spot areas identified and HR work collaboratively with managers to support with putting action plans in place to increase MaST rates, to support managers with any training required and resolve any queries. ***The Trust is monitoring and continuing to make improvements to the overall MaST compliance rates.***
The trust should ensure that there is consistent record keeping for emergency department patients in the adult assessment unit.	✓ Improved documentation on the acute admissions unit (AAU), monitored through the Perfect Ward app. ✓ A program has started in AAU 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. ✓ Monthly spot checks.

EFFECTIVE: surgery

The CQC said:	We have/are:
The trust should ensure all staff have access to an annual appraisal.	✓ Validated compliance and booking of the next date of appraisal at the time of completion of the latest appraisal.

EFFECTIVE: urgent & emergency care

The CQC said:	We have/are:
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.	✓ Standardised Streaming process and improved competencies for the nursing team. ✓ Established a wheezy child pathway collaborative with the paediatric team. ✓ Undertaken repeat audits for compliance.
The trust should ensure that appraisal rates for nursing and medical staff are compliant with the trust standard.	✓ Ongoing drive to improve compliance supported by senior leads. ✓ Band 7s complete appraisals for their team members and to plan ahead for the ones who are due in a months' time. ✓ A system in place to organise in advance for nursing to do before due and publicise when due and plan ahead. ***The Trust is continuing to make progress towards the Trust appraisal rate target.***

RESPONSIVE: surgery

The CQC said:	We have/are:
The trust should continue to work towards a system which allows patients to arrive for their surgery in a timelier manner.	✓ Reminded to surgeons to stagger patients. ✓ Golden patient in board, theatre safety, theatre strategy and theatre productivity boards. ✓ Run perfect operating days to reinforce good practice. ✓ Identified the need for and written a SOP for pre-admission & staggered lists ✓ Reorganised design of the day surgery unit. ✓ Contact the golden patient the night before surgery.
The trust should ensure patients are cared for in the recovery area for the minimal amount of time. Patients should not be experiencing overnight stays in the recovery for non-clinical reasons.	✓ Weekly long length of stay rounds. ✓ Followed up on actions and themes, including working with: o Community partners. o Consultant daily review of patients. o Bi-monthly MADE events. o Free Flow Week. o Daily oversight of discharges. o Ensure golden patient identified and discharge lounge used.

	○ Opening of escalation ward.

RESPONSIVE: urgent & emergency care

The CQC said:	We have/are:
The trust should ensure there are clear lines of medical patient responsibility in the adult assessment unit.	✓ The AAU standard operating procedure is under continued review and will continue to be reviewed every 3 months. ✓ A working group has been set up to oversee development of the area, meeting every 14 days. ✓ Minutes will be kept of meetings. ✓ The acute medical team has overall responsibility for the running and governance of the unit. ✓ A consultant has been appointed to run the unit full time. ✓ The acute medical model is complete, including the structure of AAU
The trust should ensure the needs of all patients who require additional support are met.	✓ Worked with dementia lead to supply activity box and designated room for patients who require less distraction or stimulation. Picture cards provided to staff from learning disabilities lead and a resource box in ATA multidisciplinary team. ✓ There continues to be a significant focus, by the matrons, to develop 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). ✓ AAU have begun a quality improvement working group regarding falls.

WELL LED: critical care

The CQC said:	We have/are:
The trust should embed the collection of feedback from patients and relatives to improve patient experience.	✓ Patient information booklets. ✓ Monthly follow up clinics to be run by multi-disciplinary team as per NICE Guideline 83.
The trust should consider developing firm plans to realise the vision for the service.	✓ A strategy discussed and approved at SAS divisional board.

The CQC said:	We have/are:
The trust should implement strategies to address the strict hierarchies that staff described, which affect morale, performance and patient safety.	**In MUC:** ✓ Bullying & harassment videos to be shown and discussed in all teams. ✓ Evidence recorded of events held with employment relations support. ✓ Developed 'Speaking Up' champions within division. ✓ A focus group for junior staff (mainly health care assistants, administration staff and junior doctors to understand the issues in the CQC and staff experience surveys better). ✓ Ensured training is available for all staff groups including junior staff. **In TaSS:** ✓ Provided conflict resolution training. ✓ Early resolution of issues identified and access to speaking up champions. ✓ From the divisional staff experience plan: o Triumvirate visits listening to staff and focusing on staff experience, patient safety and quality improvement. o Facilitated discussion sessions of bullying and harassment to address and challenge poor behaviour/promotion of world class care values videos. o Leadership Development away days. o Focussed on staff wellbeing and flexible working. o Mindfulness on 11 West and 11 East wards. **In PPU:** ✓ As part of staff engagement, ensured staff understand and are supported to escalate and challenge any concerns they have working in a consultant led service. ✓ Included consultants in staff training and engagement to manage expectations ✓ Promoted career progression for health care assistants within PPU. ✓ Ensured staffing establishments are devised to incorporate changes to health care assistant grading and posts following training so there are more opportunities available. ✓ Quarterly PPU health care assistant forum.

WELL LED: surgery

The CQC said:	We have/are:
The trust should ensure work continues to move to a full electronic patient records system.	✓ Work continues to roll out a full electronic patient record system.
The trust should ensure staff do not experience bullying by any other member of staff.	**In SAS:** ✓ Launched the Trust bullying and harassment videos and has been shown at directorate and department meetings. ✓ Recruited 'Speaking Up' champions in theatres. ✓ NHS Elect development programme for band 7s in place. **In TaSS:** ✓ Provided conflict resolution training. ✓ Early resolution of issues identified and access to speaking up champions. ✓ A divisional staff experience plan: o Triumvirate visits listening to staff and focusing on staff experience, patient safety and quality improvement. o Facilitated discussion sessions of bullying and harassment to address and challenge poor behaviour/promotion of world class care values videos. o Leadership development away-days. o Focussed on staff wellbeing and flexible working. ✓ Provided mindfulness sessions on 11 West and 11 East wards. ***The Trust is currently reviewing the bullying & harassment toolkit for accessibility and usefulness.***

Appendix B: Changes made to the quality report

To follow

Appendix C: Glossary of definitions and terms used in the report

Term	Explanation
Acute Kidney Injury (AKI)	A sudden episode of kidney failure or kidney damage that happens within a few hours or a few days
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
Care Quality Commission (CQC)	The main independent regulator of all health and social care services in England
Clostridium difficile (C-diff)	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)
Commissioning for Quality and Innovation (CQUIN)	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
Healthcare Information and Management Systems Society (HIMSS)	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
Hospital Episode Statistics (HES)	A database containing details of all admissions, A&E attendances and outpatient appointments at NHS hospitals
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
Learning from Deaths (LfD)	National guidance for NHS trusts on how they should support, communicate and engage with bereaved families and carers following a death of someone in their care
Multi-disciplinary team (MDT)	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
National Institute of	An independent organisation that produces clinical guidelines and quality standards on

Clinical Excellence (NICE)	specific diseases and the recommended treatment for our patients. The guidelines are based on evidence and support our drive to provide effective care
National Institute for Healthcare Research (NIHR)	A central part of the UK research landscape, collaborating in national activities to improve research and supporting NHS research performance.
Patient at Risk and 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
Paediatric early warning score (PEWS)	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
Patient Reported Outcome Measures (PROMs)	Measure of health gain in patients undergoing hip replacement, knee replacement (and up to September 2017, varicose vein and groin hernia surgery) based on responses to questionnaires before and after surgery
Summary hospital level mortality indicator (SHMI)	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
University College London Partners (ULCP)	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/).
Urinary Tract Infection (UTI)	Infections that affect different parts of the urinary tract, including the bladder (cystitis), urethra (urethritis) or kidneys (kidney infection)
Venous thromboembolism (VTE)	A blood clot that occurs in the vein