Royal Free London
NHS Foundation Trust

The next chapter:
Improving quality of care

Royal Free London NHS Foundation Trust

Comprising of:

Barnet Hospital, Chase Farm Hospital, Royal Free Hospital

Quality Account 2021/22

Quality Account 2021/22

Part one: Achievements in quality

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

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

Annexes

Appendices

Part One: Achievements in quality

1.1 Statement on quality from the chief executive

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

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

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

Achievements to highlight

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

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

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

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

Our objectives

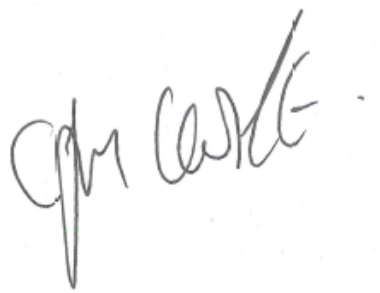
	Excellent health outcomes	Outstanding experience of care	Outstanding experience for our people	Be a sustainable organisation
Five-year goal	Achieve an overall 'Outstanding' CQC rating	The experience that our patients and carers have is amongst the best in the world	Joy at work - shared decision making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

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

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

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

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



Caroline Clarke
Group Chief Executive
Royal Free London NHS Foundation Trust

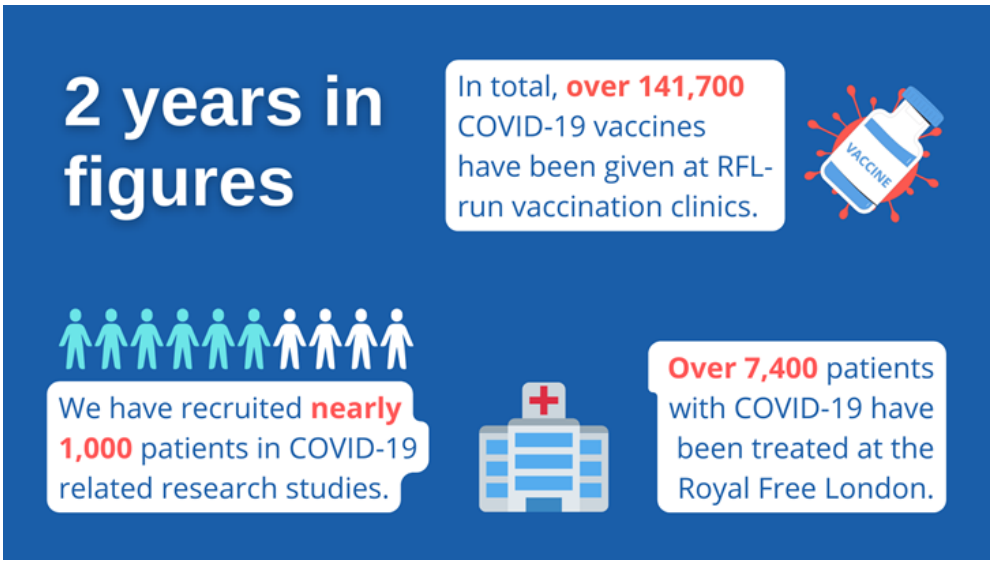
1.2 Recovery from the pandemic

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

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

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

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



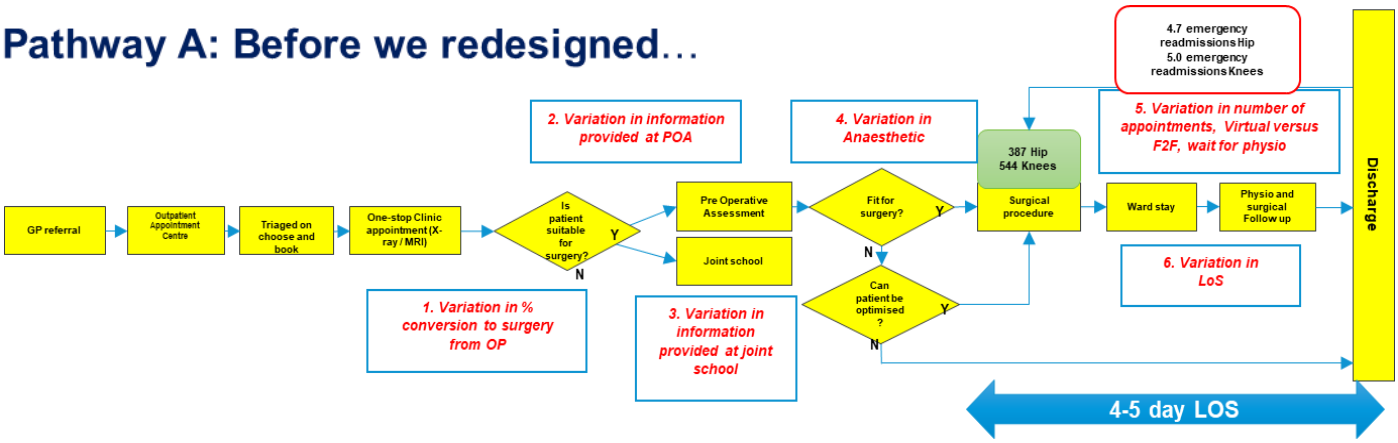
This year's Quality Account highlights the work done across the organisation to move on from the pandemic using the lessons learnt over the past year by staff at the Royal Free London.

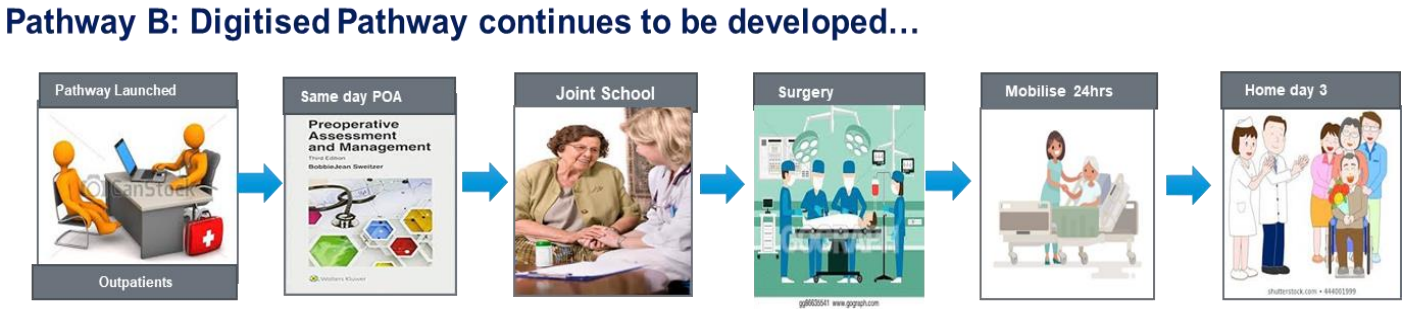
1.3 Delivering high quality care

Clinical Practice Groups

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

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





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

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

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

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

Research and Development

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

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

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

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

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

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

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

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

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

Maternity Services

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

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

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

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

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

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

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

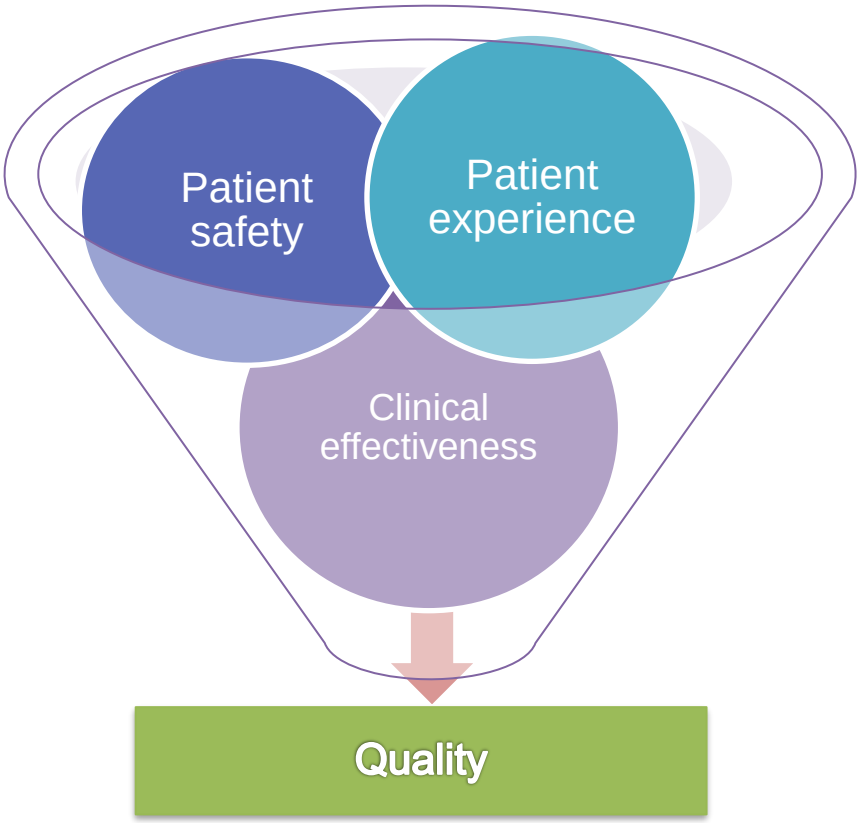
Part two: Priorities for improvement and statements of assurance from the board

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

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

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

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



This section describes the following:

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

2.1 Priorities for improvement

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

Improving Patient Experience: delivering excellent experiences

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

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

Delirium

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

Distressed behaviour

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

Assessment

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

Discharge

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

Carers

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

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

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

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

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

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

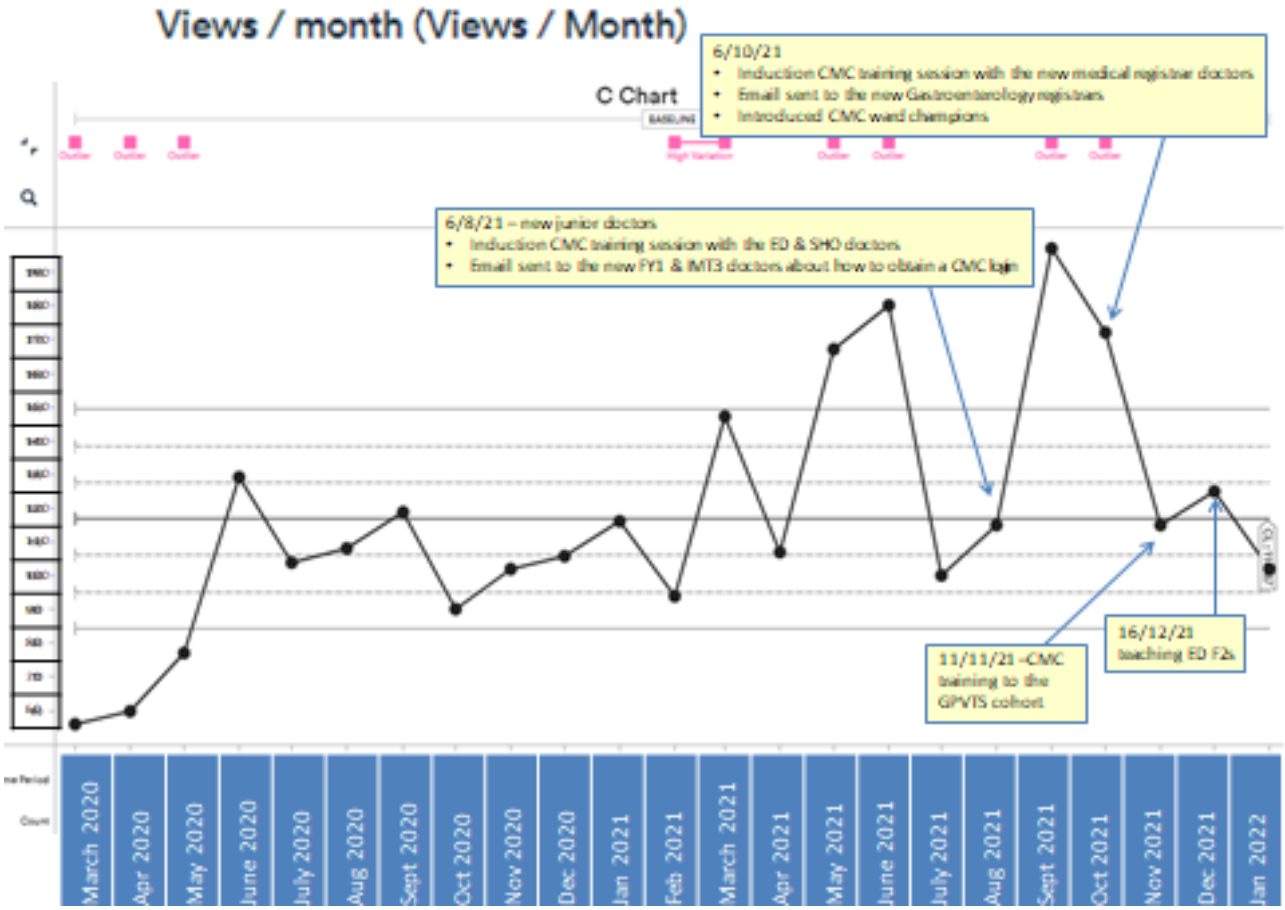
The advance care planning work also links to good patient and family communication, the care of the dying, and excellent discharge planning. In 2021-2022 we have provided seven, two day advance communications skills courses for nearly 80 senior clinicians. These courses have been well evaluated. On average,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

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

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

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

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



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

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

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

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

Partnership – working alongside patients, families and carers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Improving Clinical Effectiveness: delivering excellent outcomes

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

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

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

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

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

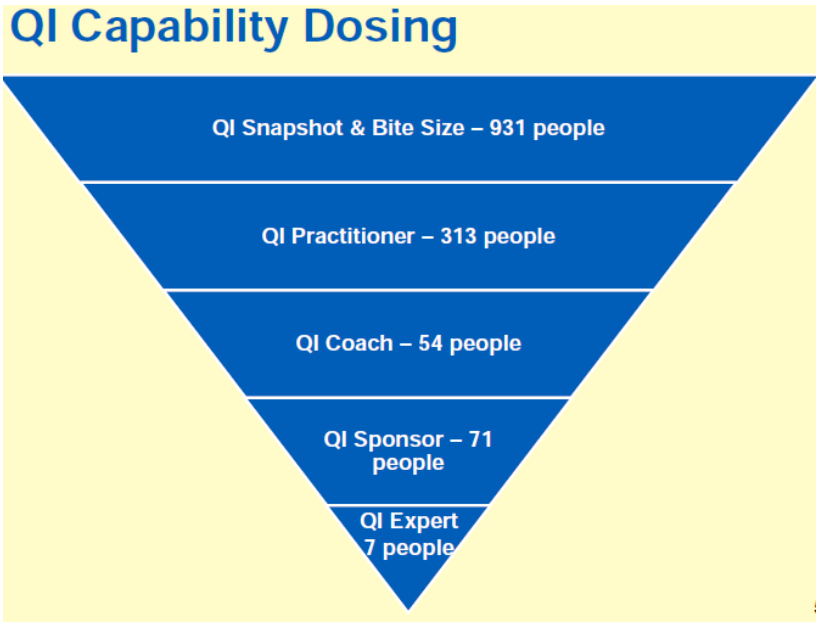
- Group-wide – Equitable Access programme
- Group-wide – Vanguard 2 programme, aimed at improving health and wellbeing of staff in [Agenda for Change] Bands 1 to 5

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

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

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

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



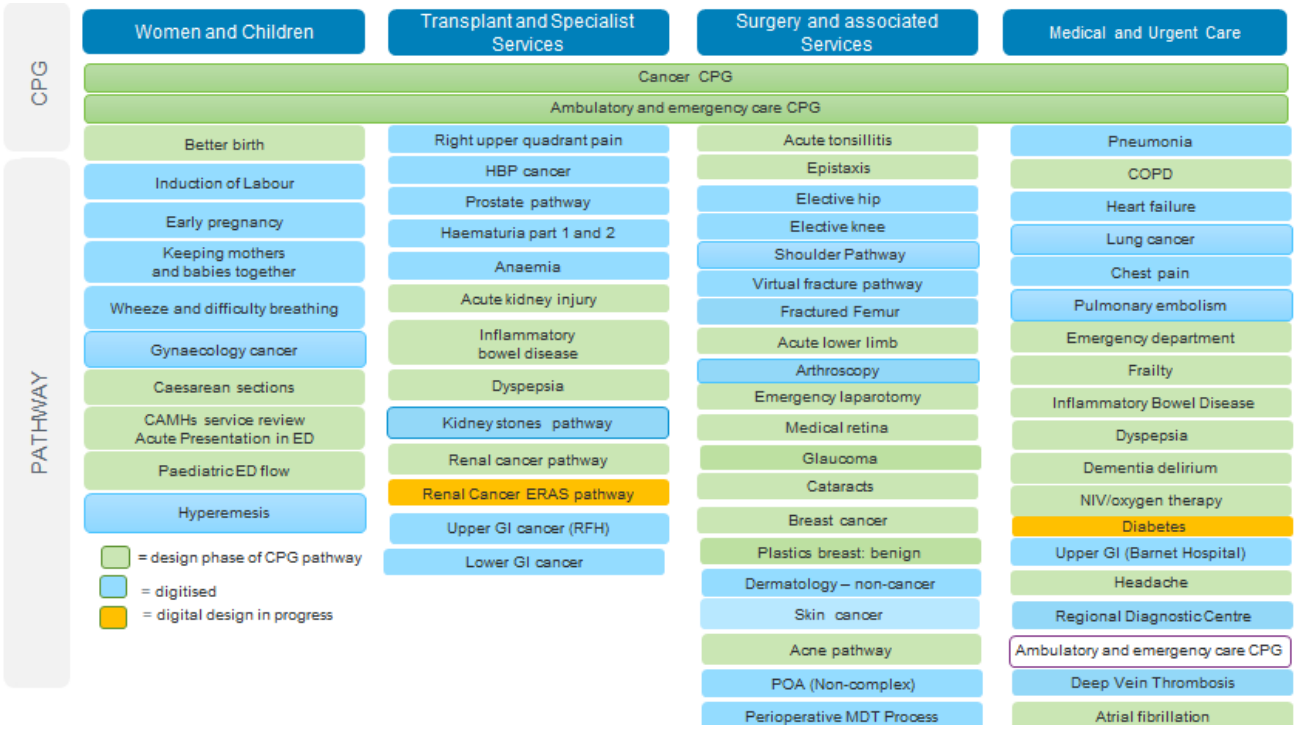
The QI Team is currently actively involved in the following forums and programmes:

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Improving Patient Safety: delivering safe care

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

The first measure of success for this patient safety priority was to achieve zero never events by the end of March 2022. Never events are extremely serious and largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place.

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

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

Never Event reported in 2021/22

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

The key actions taken to prevent recurrence include:

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

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

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

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

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

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

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

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

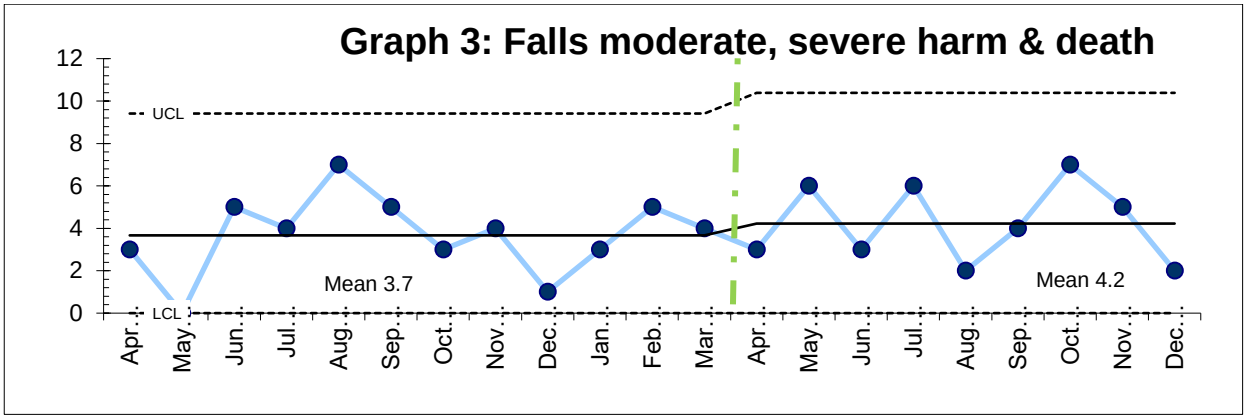
The measure of success for this patient safety priority was to reduce the number of inpatient falls resulting in moderate, severe harm or death by 5% by the end of the 2021/22 financial year.

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

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

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

Further information to be included once Q4 data has been reviewed



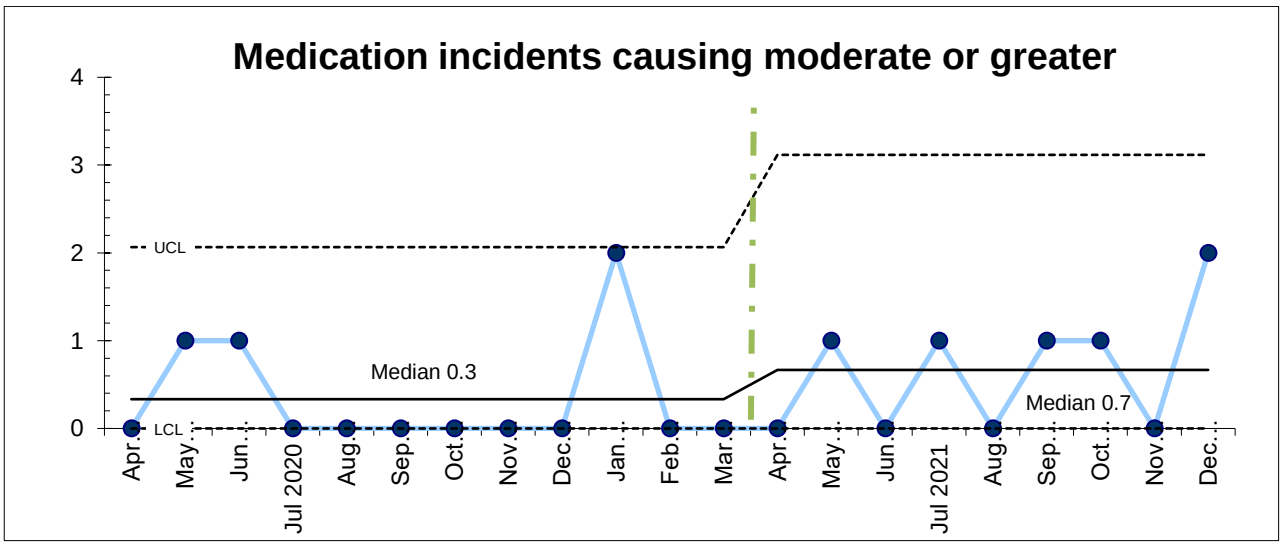
Priority 15: Decrease medication incidents with moderate or more harm reported by 5% by March 2022.

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

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

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

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



Further information to be included once Q4 data has been reviewed

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

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

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

Further information to be included once Q4 data has been reviewed

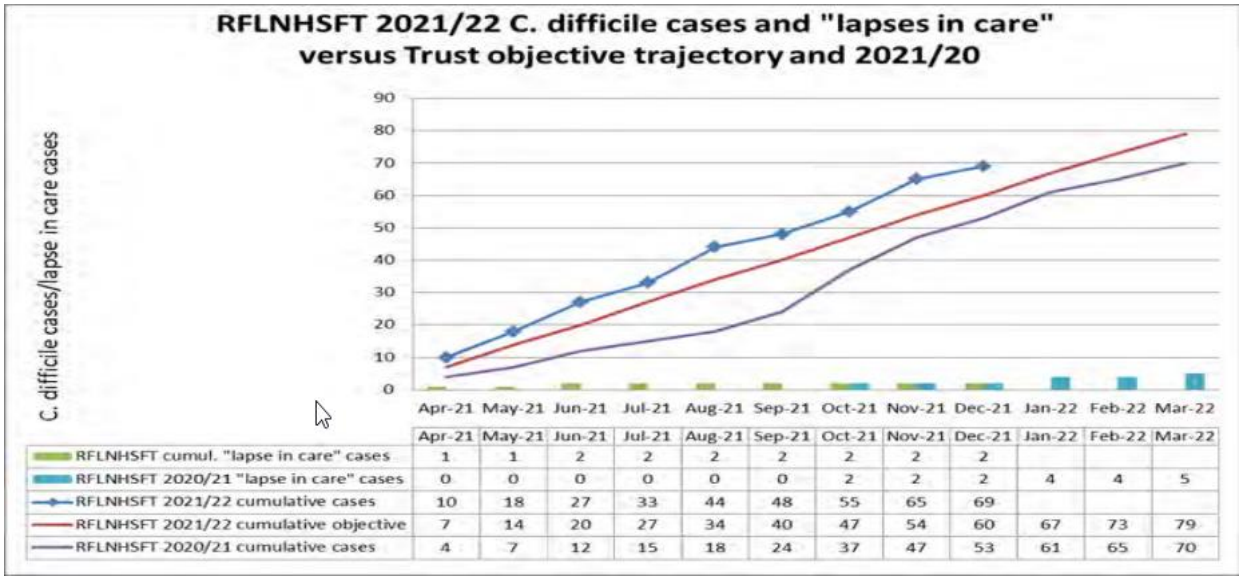
Priority 17: Achieve zero trust attributable Clostridium difficile (C. diff.) infection cases with a lapse in care.

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

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

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

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



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

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

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

Further information to be included once Q4 data has been reviewed

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

COVID-19 outbreaks for Q3 – Oct to Dec:

Barnet: 13 wards declared covid19 outbreaks

CFH: nil declared

RFH : eight wards declared covid19 outbreaks

Further information to be included once Q4 data has been reviewed

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

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

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

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

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

Our priorities for improvement for 2022/23

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

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

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

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

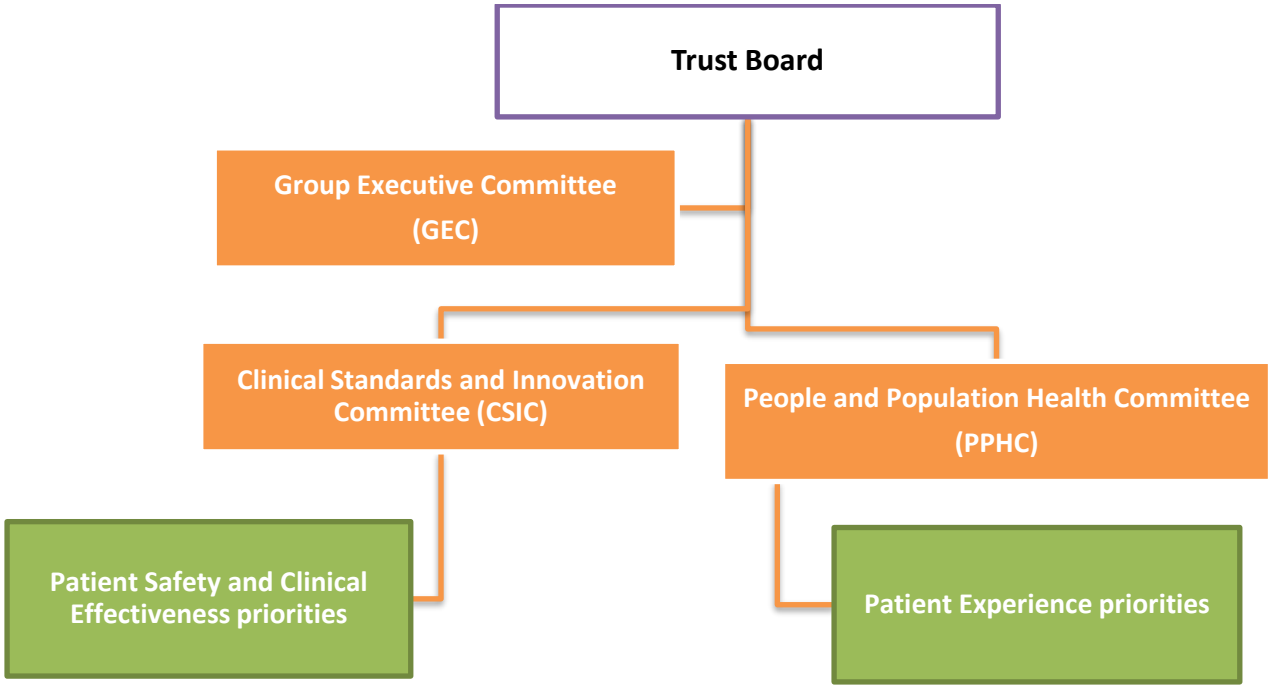


Figure 1: Strategic committees reporting to the Trust Board

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

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

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

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

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

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

2.2 Statements of assurance from the board

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

A. Review of services

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

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

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

B. Participation in clinical audits and national confidential enquiries

During 2021/22 54 national clinical audits and 5 national confidential enquiries covered relevant health services that the Royal Free London NHS Foundation Trust provides.

During that period, the Royal Free London NHS Foundation Trust participated in 97% national clinical audits and 100% national confidential enquiries for which it was eligible to.

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

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

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

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

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

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

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

Table 1: Name of audit, eligibility and participation

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

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

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

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

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

Table 2: National confidential enquires: participation and case ascertainment

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

The trust continues to review National Confidential Enquiries into Patient Outcomes and Death (NCEPODs) on an annual basis until they are fully implemented. Progress is reported at both business unit and group levels.

The reports of TBC **national clinical audits** were reviewed by the provider in 2021/22 and the Royal Free London NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Actions to improve the quality of healthcare provided:

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

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

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

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

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

C. Participating in clinical research

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

D. CQUIN payment framework

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

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

E. Registration with the Care Quality Commission (CQC)

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

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

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

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

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

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

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

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

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

F. Information on the quality of data

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

I. The patient's NHS number

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

II. General Medical Practice Code

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

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

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

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

III. Information Governance (IG)

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

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

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

G. Payment by Results

The Royal Free London NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period 2021/22 by the Audit Commission.

H. Learning from deaths

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

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

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

Further information to be included once Q4 data has been reviewed

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

Table Summary of Learning from deaths (LfD) reviews

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

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

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

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

Further information to be included once Q4 data has been reviewed

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

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

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

Likert avoidability Scale:

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

Summary of lessons learnt

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

Good practice	Areas for improvement

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

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

Further information to be included once Q4 data has been reviewed

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

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

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

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

I. Seven day hospital services

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

Standard 2 - Time to first consultant review

Standard 5 - Access to diagnostic services

Standard 6 - Access to consultant-led interventions

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

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

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

Further information to be included once annual report has been reviewed

2.3 Reporting against core indicators

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

Areas covered will include:

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

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

1) Summary hospital-level mortality Indicator (SHMI)

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

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

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

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

The Royal Free London NHS Foundation Trust participates in the HSCIC NHS Choices / Clinical Indicator sign off programme whereby data quality is reviewed and assessed on a monthly and quarterly basis. No significant variance between the data held within Trust systems and data submitted externally has been observed.

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

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

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

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

The percentage of patient deaths with palliative care coded at either diagnosis or specialty level is included as a contextual indicator to the SHMI indicator. This is on the basis that other methods of calculating the relative risk of mortality make allowances for palliative care whereas the SHMI does not take palliative care into account.

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

2) Patient reported outcome measures scores (PROMS)

The NHS asks patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards. The difference between the two sets of responses is used to determine the outcome of the procedure as perceived by the patient.

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

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

3) Emergency readmissions within 28 days

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

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

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

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

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

4) Responsiveness to the personal needs of our patients

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

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

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

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

5) Staff recommendation to friends and family

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

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

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

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

6) Venous thromboembolism (VTE)

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

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

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

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

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

7) Clostridium difficile (C. diff.)

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

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

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

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

8) Patient safety incidents

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

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

Every 12 months, NHS Improvement publishes official statistics on the incidents reported to the National Reporting and Learning System (NRLS). These reports give NHS providers an easy-to-use summary of their current position on patient safety incidents reported to NRLS, in terms of patient safety incident reporting and the characteristics of their incidents. The information in these reports should be used alongside other local patient safety intelligence and expertise to support the NHS to deliver improvements in patient safety.

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

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

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

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

Further information to be included once Q4 data has been reviewed

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

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

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

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

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

Definitions

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

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

Notes on the charts

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

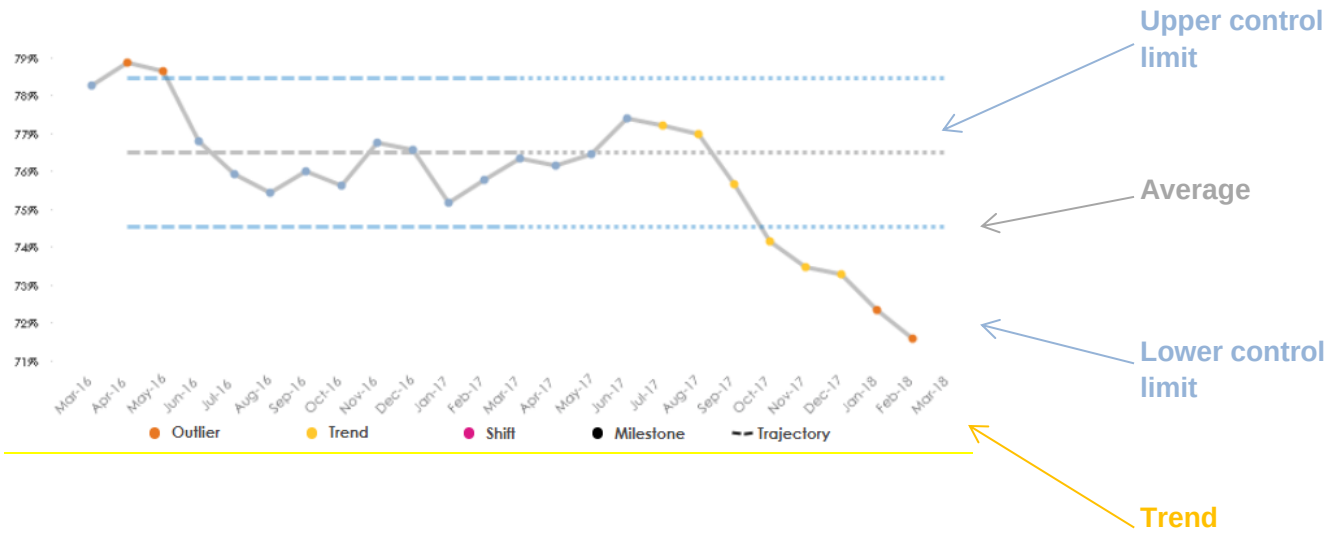
Control charts

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

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

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

Example control chart



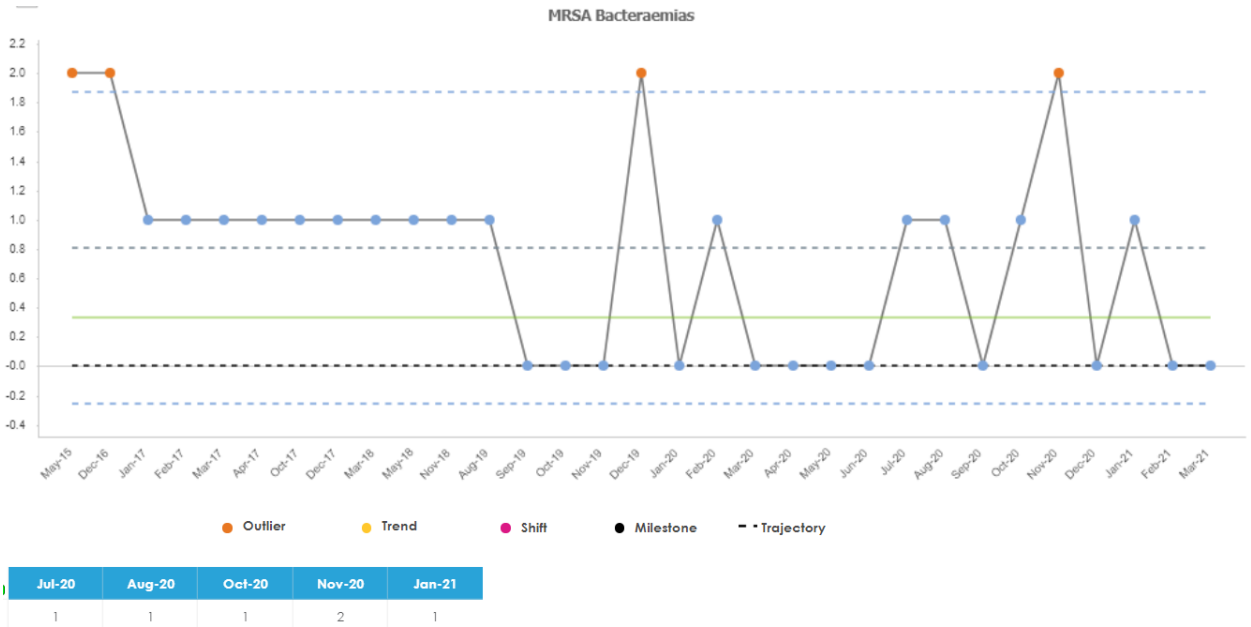
[1] http://asq.org/learn-about-quality/data-collection-analysis-tools/overview/control-chart.html

3.1 Performance against nationally selected indicators

Section 1: Patient Safety

Methicillin-Resistant Staphylococcus Aureus (MRSA)

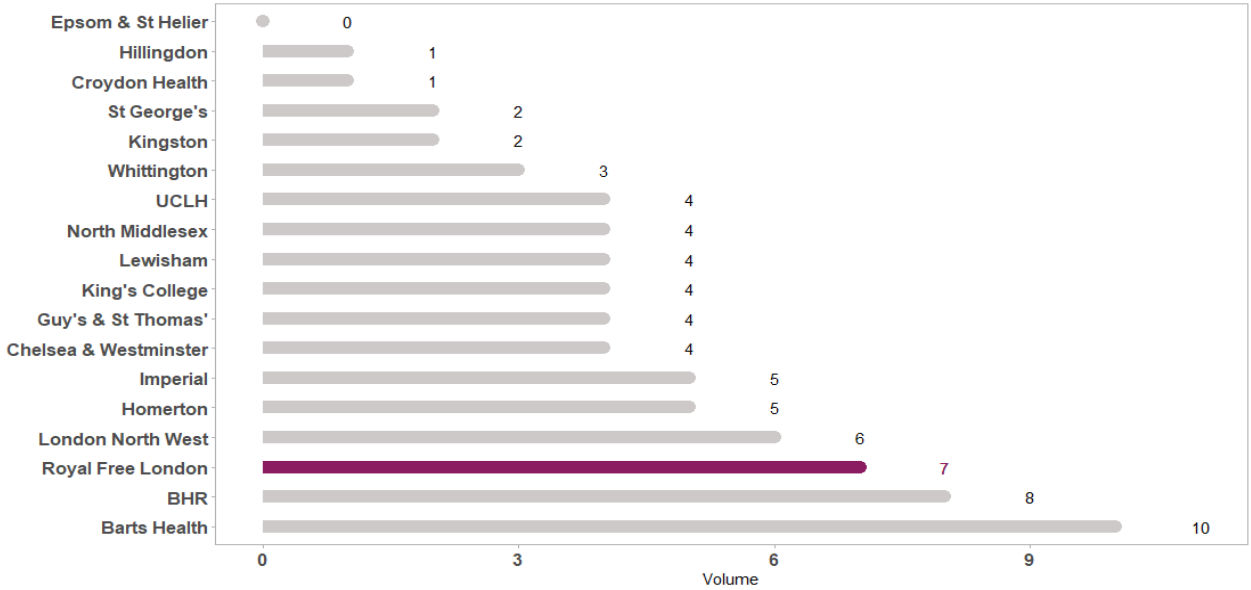
MRSA is an antibiotic resistant infection associated with admission to hospital. The infection can cause an acute illness, particularly when a patient's immune system may be compromised due to an underlying illness. Reducing the rate of MRSA infections is vital to ensure patient safety and is indicative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



Source: Royal Free London NHS FT 2015-2021

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

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

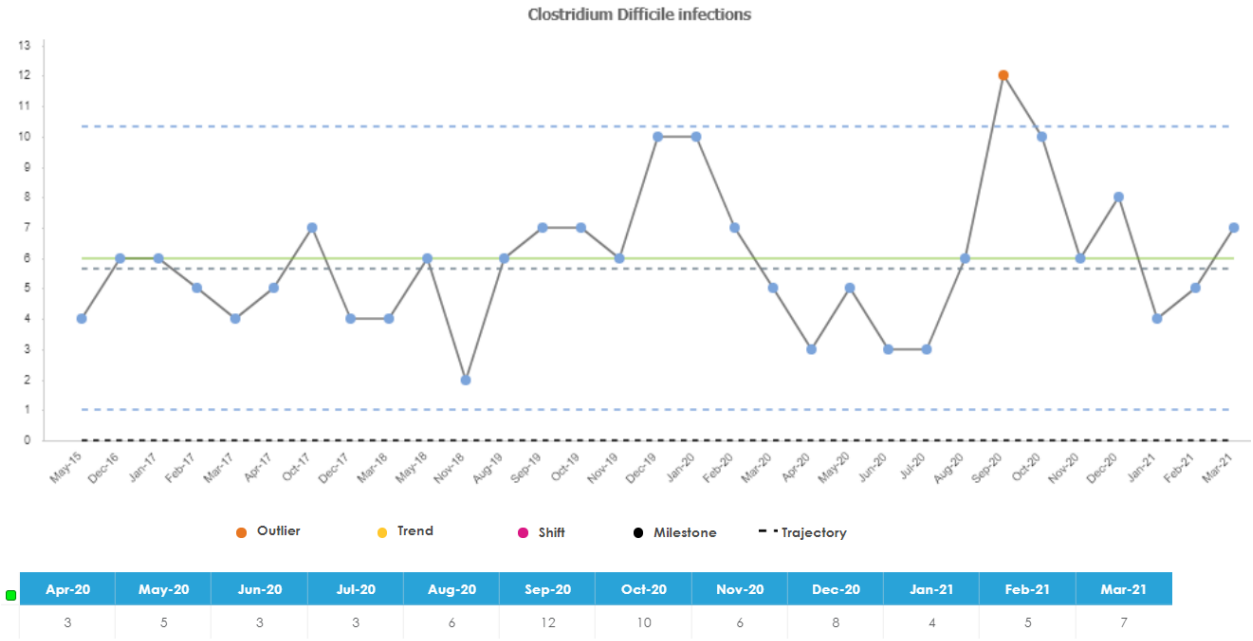


Source: https://www.gov.uk/government/statistics/mrsa-bacteraemia-monthly-data-by-location-of-onset

C. difficile

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

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

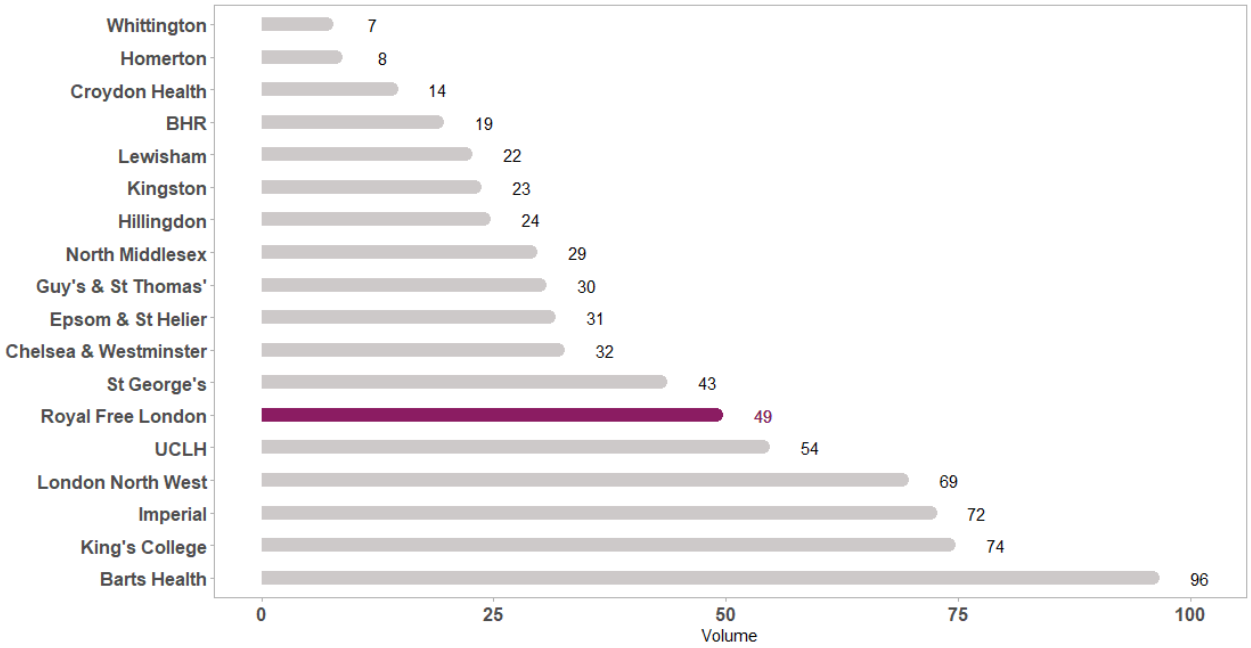


Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
3	5	3	3	6	12	10	6	8	4	5	7

Source: Royal Free London NHS FT 2015-2021

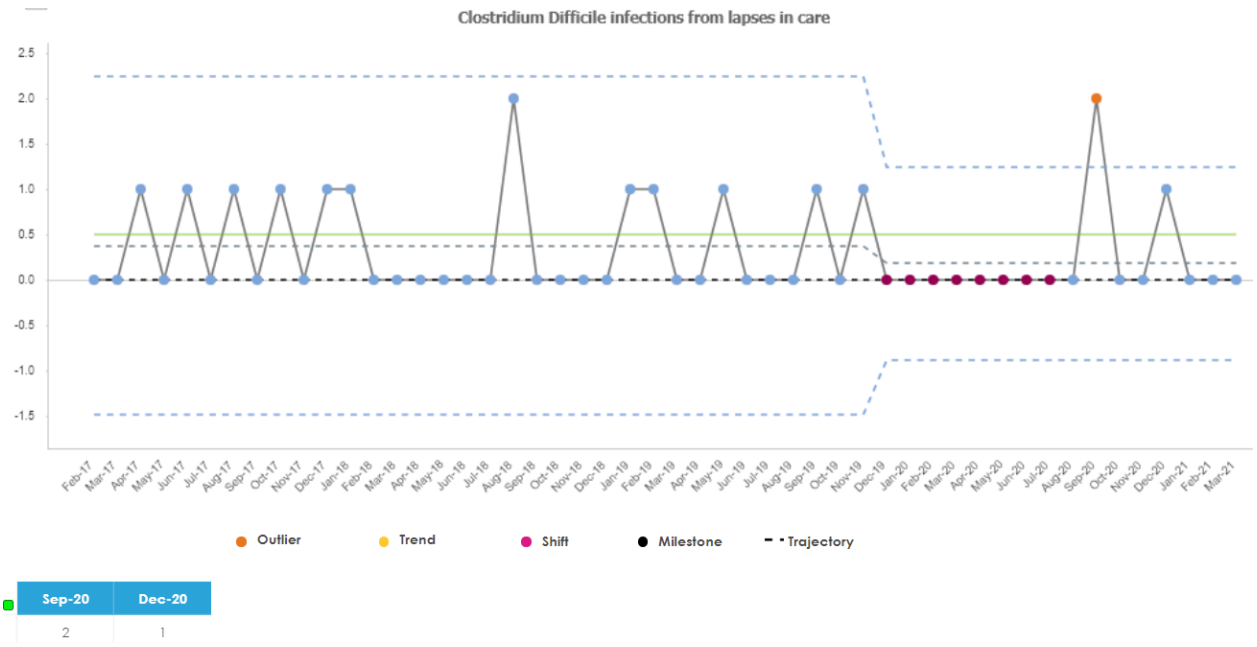
Benchmarking data is available only up to March 2019. Over this time period, the Royal Free London reported 49 infections, the 4th highest compared to the 10 benchmark providers.

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



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

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



Source: Royal Free London NHS FT 2017-2021

Section 2: Clinical Effectiveness

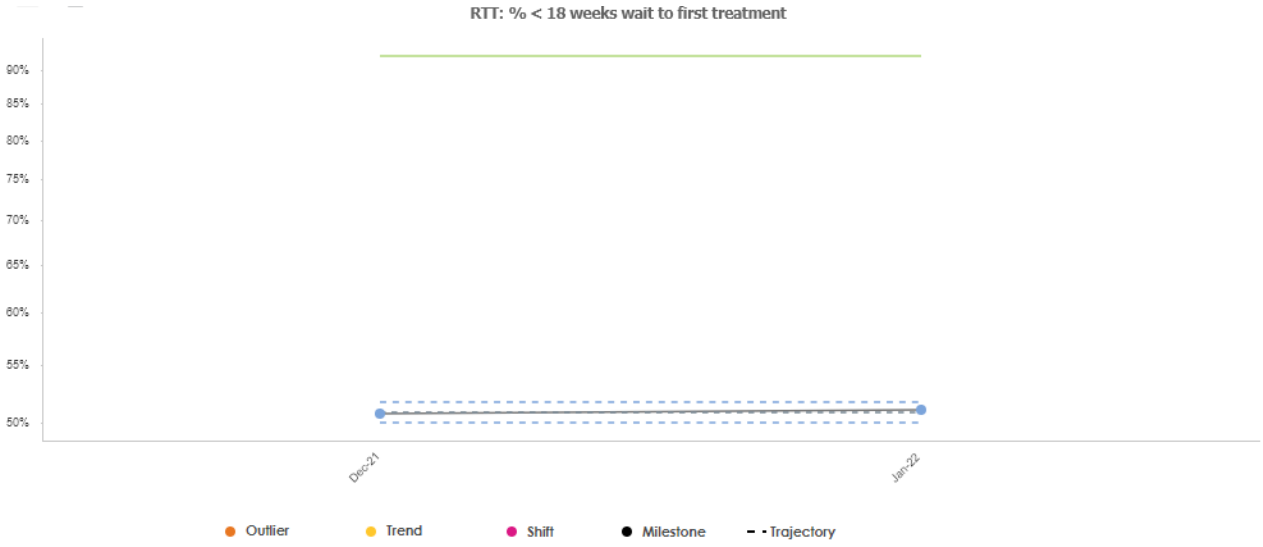
Referral to treatment (RTT)

18-week waiting times

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

Key improvements made include:

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

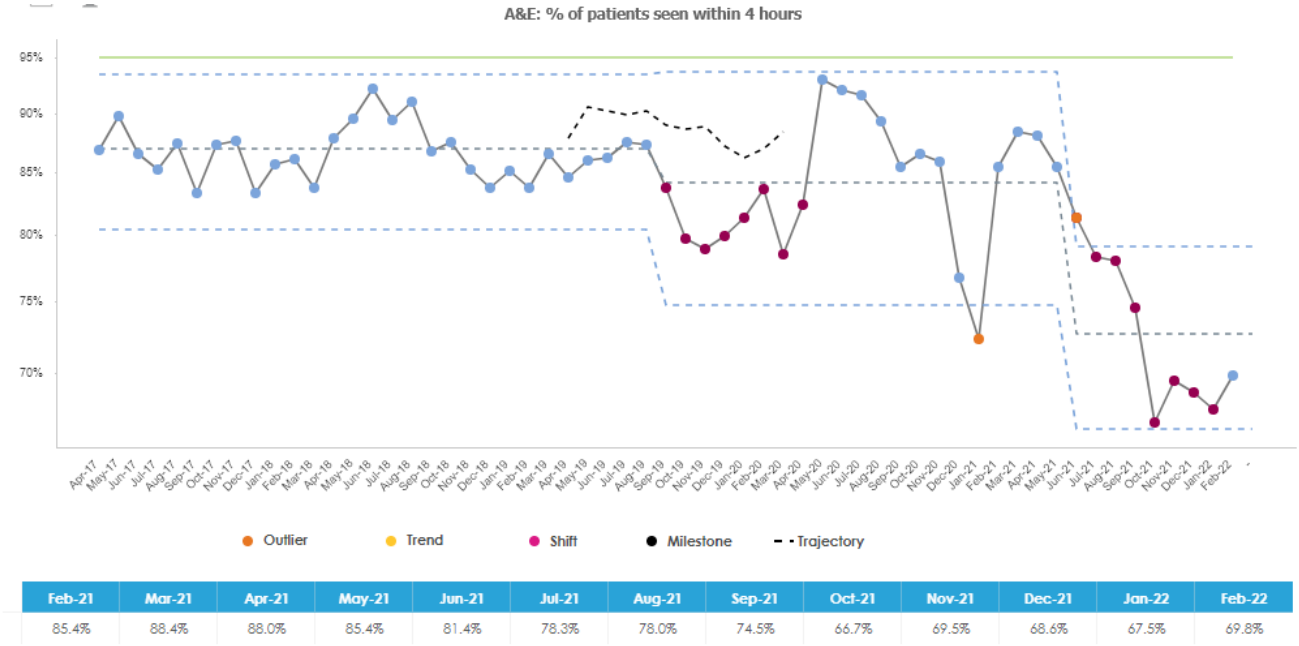


Dec-21	Jan-22
50.7%	51.1%

Accident and Emergency performance

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

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

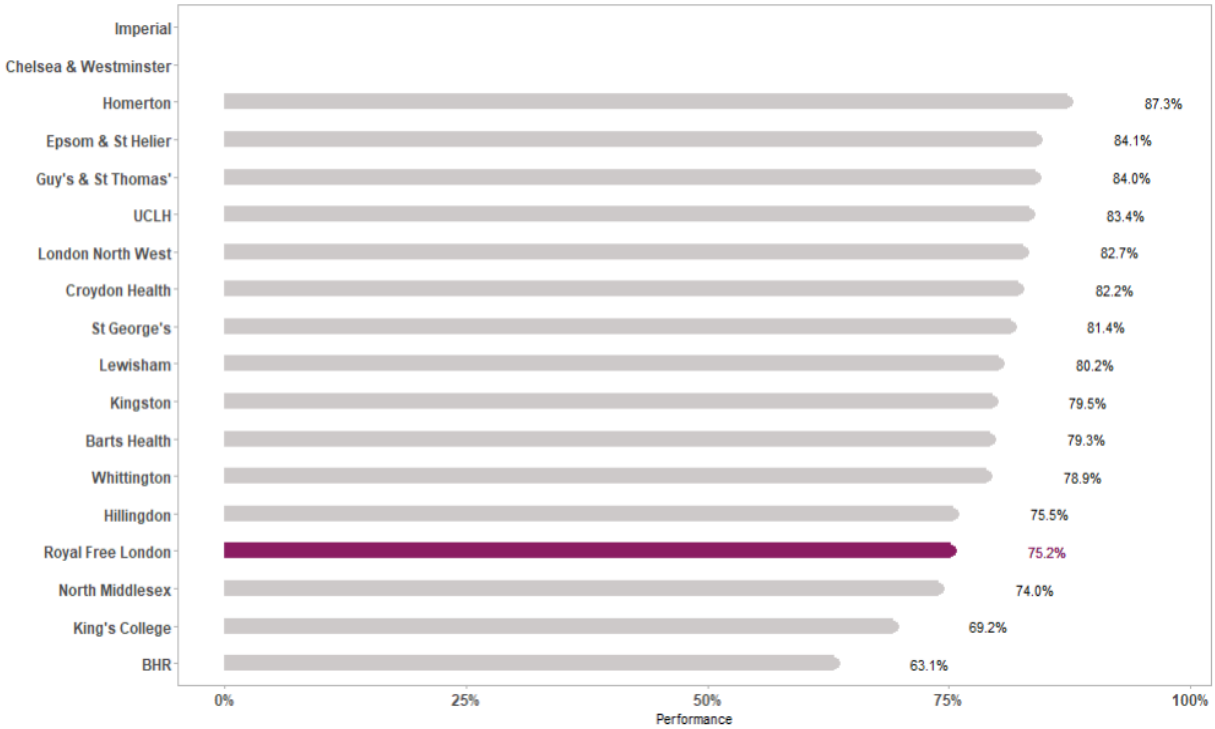


Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
85.4%	88.4%	88.0%	85.4%	81.4%	78.3%	78.0%	74.5%	66.7%	69.5%	68.6%	67.5%	69.8%

Source: Royal Free London NHS FT 2015-2022

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

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



Source: NHS Digital, 2021

Cancer waits

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

NHS England set three key performance indicators for cancer:

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

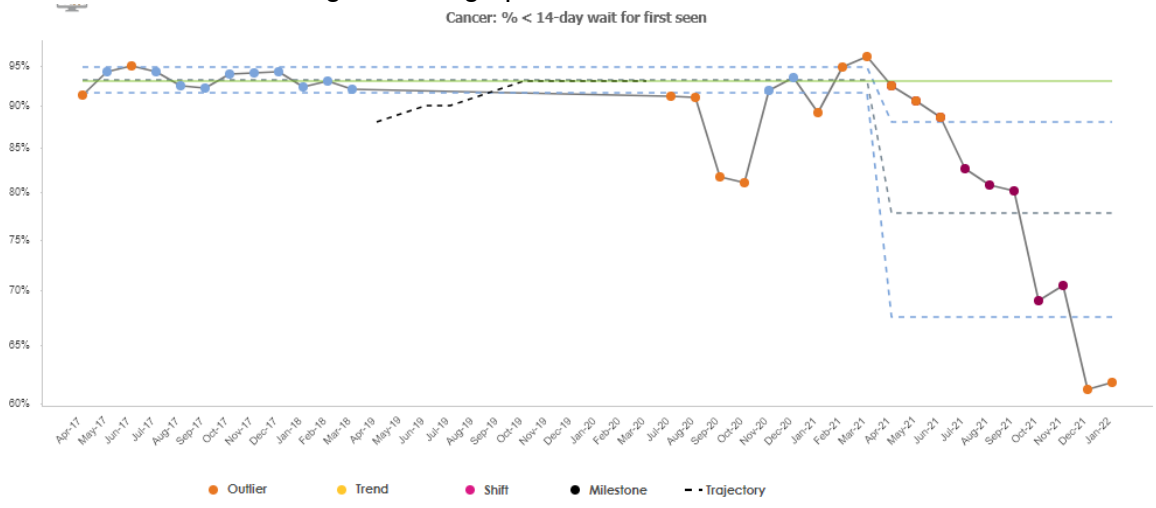
Royal Free London is one of the largest providers of cancer care in the NHS, receiving the second highest suspected cancer referrals (two-week wait) in England.

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

All cancer 2 week waits

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

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

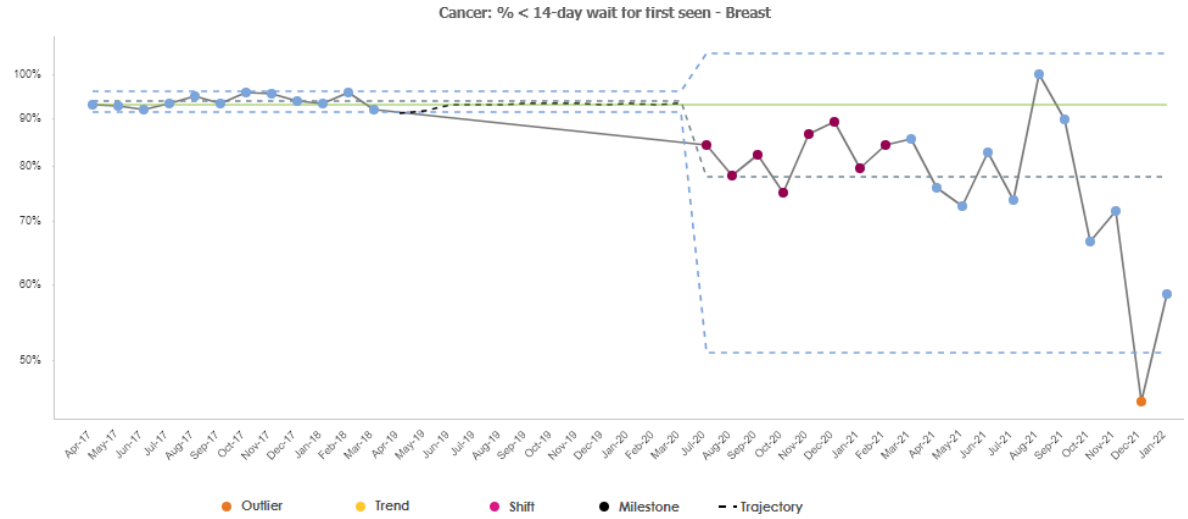


Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
94.86%	96.14%	92.38%	90.54%	88.59%	82.56%	80.81%	80.16%	68.97%	70.41%	61.18%	61.70%

Source: Royal Free London NHS FT 2017-2022

Breast urgent referral 2 week waits

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

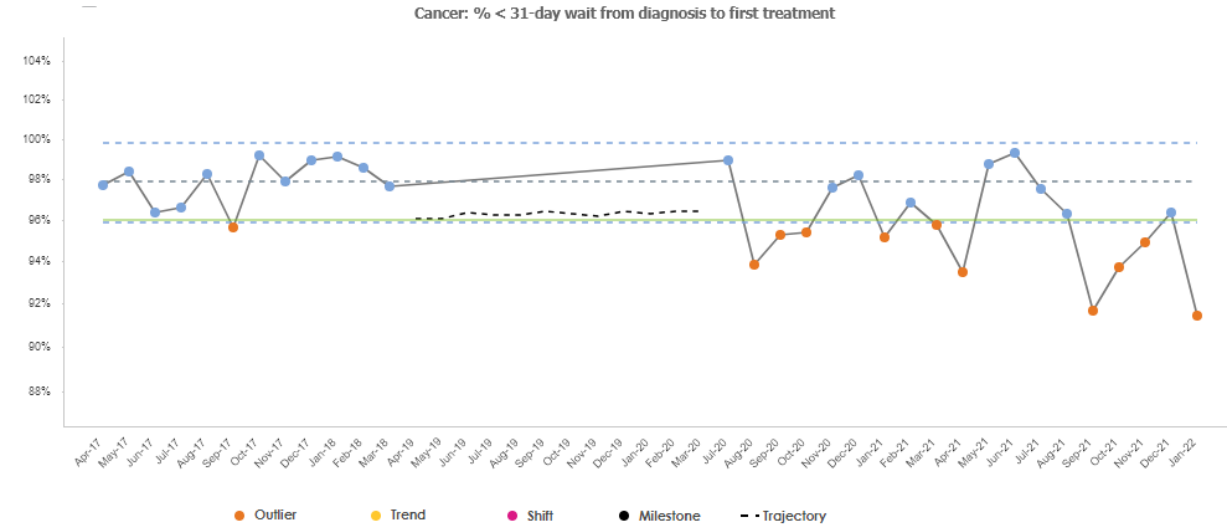


Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
84.21%	85.40%	75.90%	72.66%	82.86%	73.68%	100.00%	89.80%	66.67%	71.83%	45.16%	58.62%

Source: Royal Free London NHS FT 2017-2022

First definitive treatment within 31 days

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

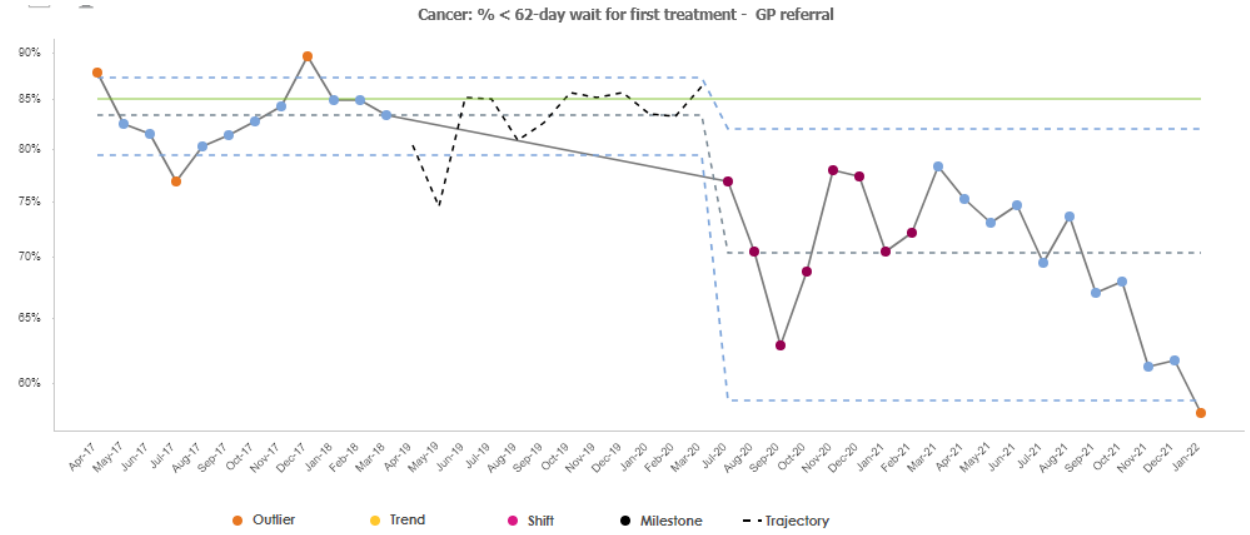


Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
96.85%	95.71%	93.48%	98.75%	99.26%	97.53%	96.28%	91.64%	93.70%	94.88%	96.32%	91.41%

Source: Royal Free London NHS FT 2017-2022

First definitive treatment within 62 days of an urgent GP referral

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



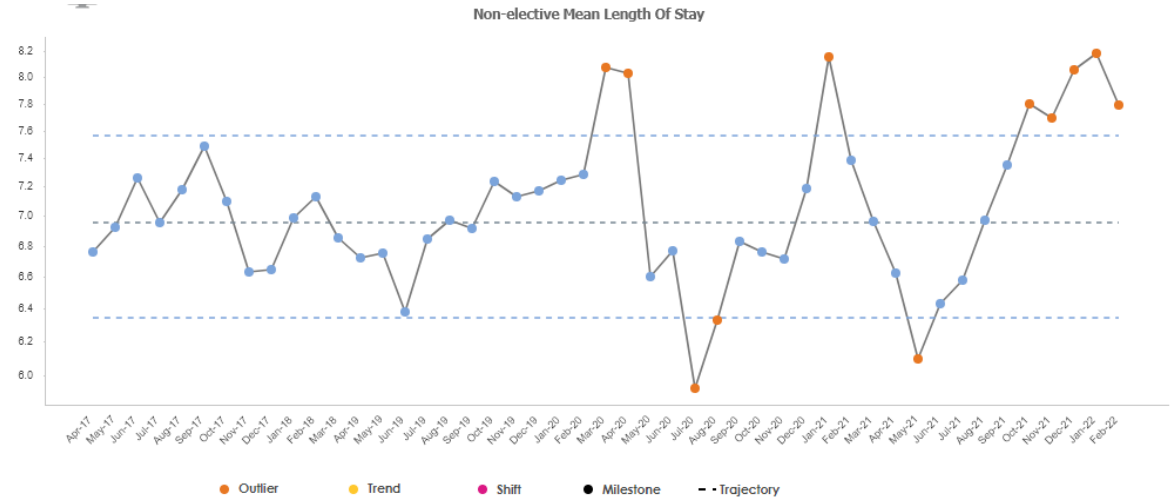
Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
72.10%	78.25%	75.19%	73.05%	74.55%	69.49%	73.57%	66.99%	67.95%	61.21%	61.69%	57.84%

Source: Royal Free London NHS FT 2015-2021

Benchmark information is not available for this measure

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

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



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

Source: Royal Free London NHS FT 2017-2022

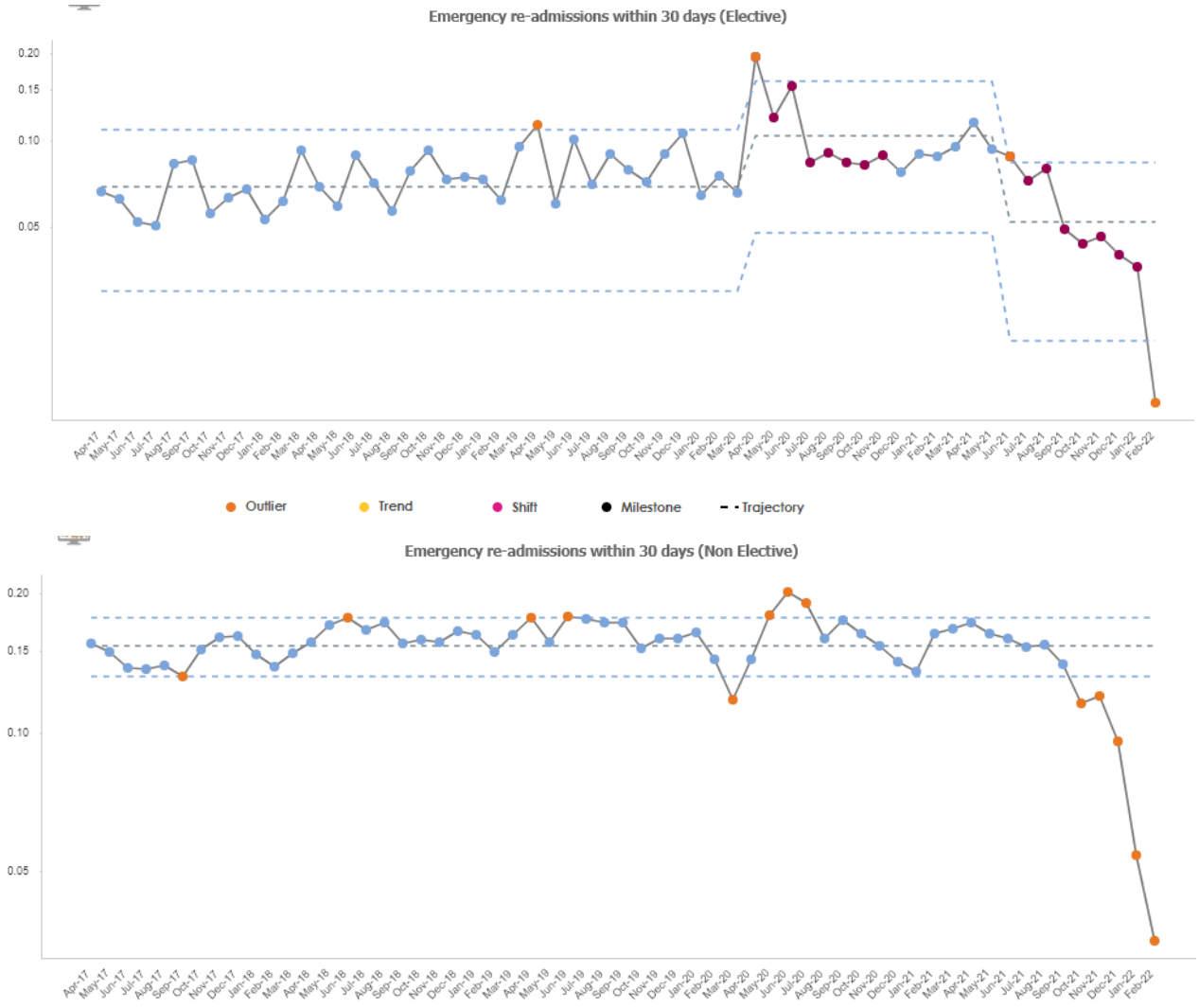
Average length of stay: Elective mean length of stay

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

Emergency re-admissions:

30 day emergency re-admissions following an elective admission

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



Source: Royal Free London NHS FT 2017-2022

Benchmark information is not available for this measure

Section 3: Patient experience indicators

National surveys

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

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

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

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

Urgent and emergency care survey

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

Type one report

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

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

Type three report

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

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

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

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

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

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

Adult in-patient survey

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

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

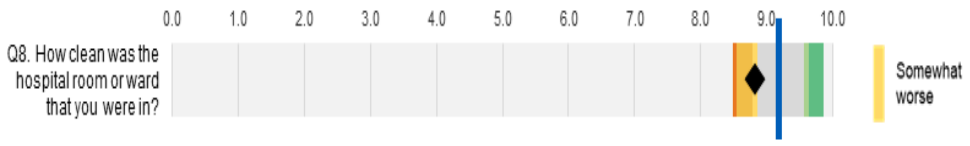
Much worse	Worse	Somewhat worse	About the same	Somewhat better	Better	Much better

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

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

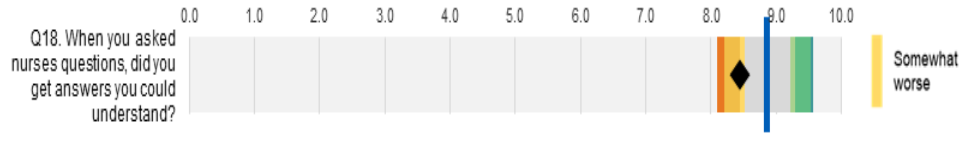
The trust did not score better than most other trusts in any question, but scored 'somewhat worse' than expected compared to other trusts in three.

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



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

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



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

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

Children and young people's patient experience survey

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

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

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

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

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

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

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

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

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

Maternity survey

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

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

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

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

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

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

National cancer patient experience survey

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

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

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

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

Friends and Family Test (FFT)

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

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

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

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

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

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

Learning Disability Improvement Standards Survey

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

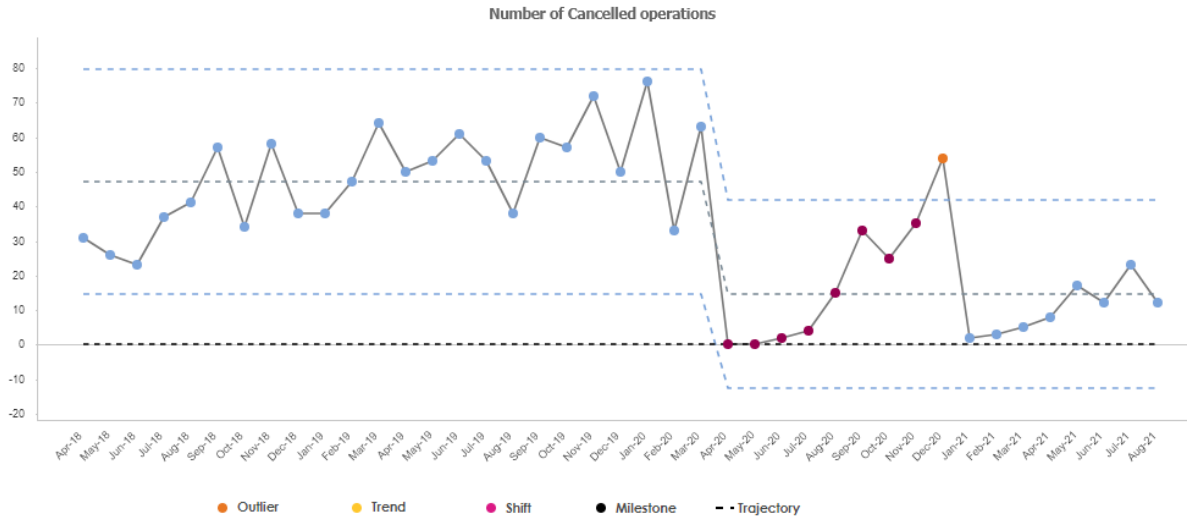
During the covid-19 pandemic the trust ensured that reasonable adjustments were made for people with learning disabilities and or autism by ensuring that those who required visiting of carers/family while in hospital continued to receive this. If required carers and family members are permitted to stay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

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

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

Volume of cancelled operations

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



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

3.2 Performance against key national indicators

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

Operational Performance

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

Patient Safety

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

3.3 Our plans for improvement

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

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

A. The Care Quality Commission

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

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

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

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

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

Cross site inspection findings and actions

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

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

Barnet Hospital inspection findings and actions

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

Royal Free Hospital inspection findings and actions

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

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

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

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

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

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

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

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

CQC must-do findings:

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

CQC should do findings and actions:

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

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

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

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

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

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

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

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

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

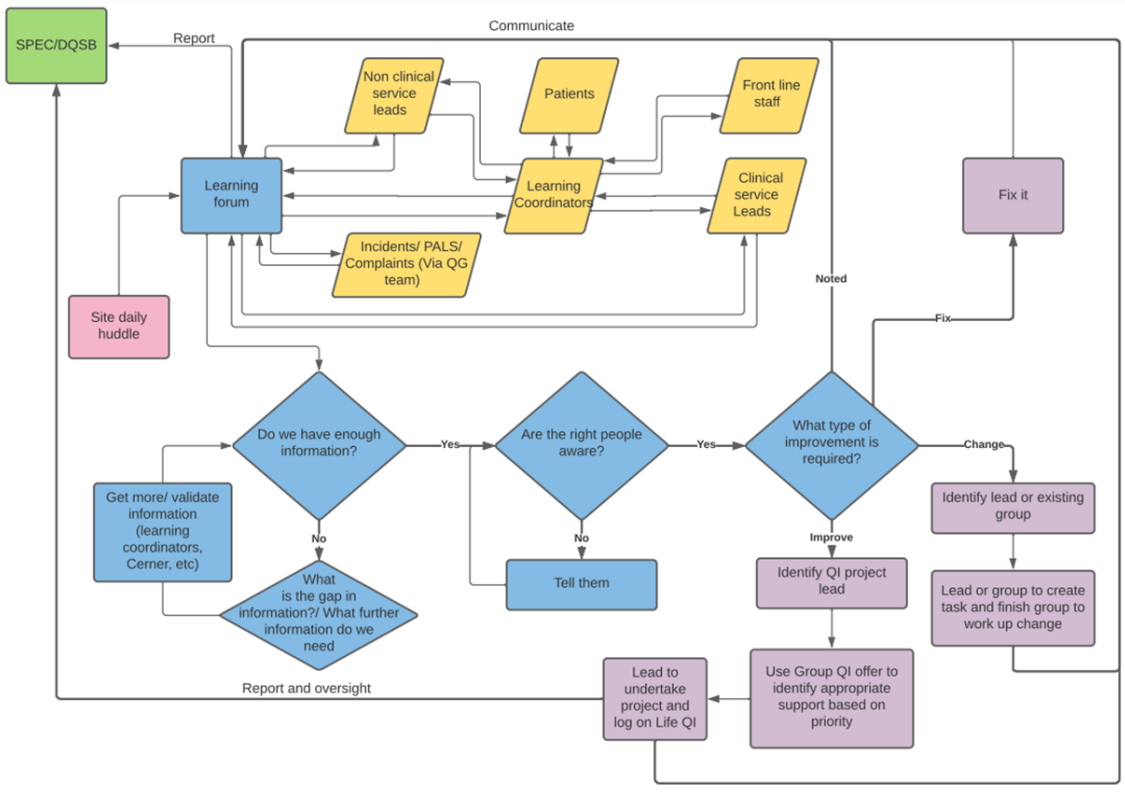
The Barnet patient experience Twitter account (@barnet_ptep) was launched to coincide with WMTY, which has established a new platform for the team to engage with staff and patients and vice versa.

b) Chase Farm Hospital – Learning Health System

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

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

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



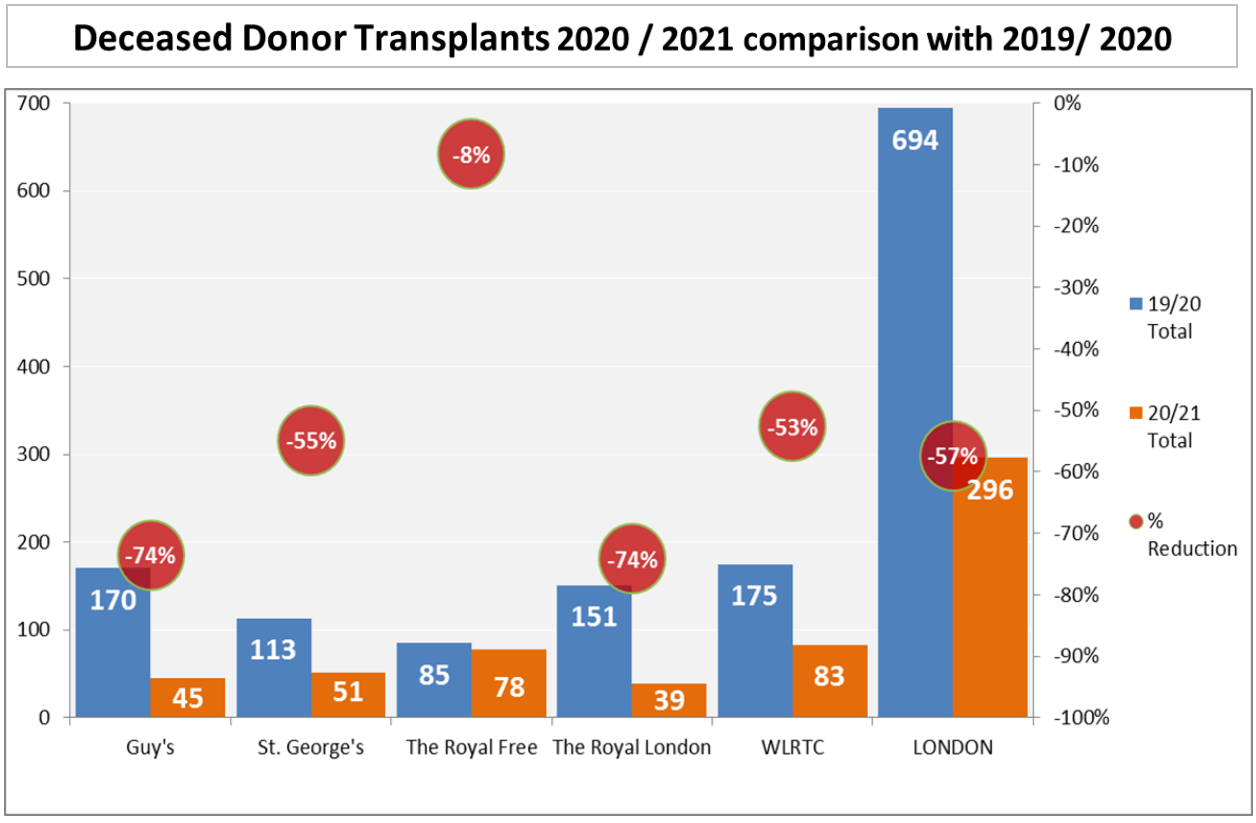
c) Royal Free Hospital – Restarting Kidney Transplantation at the Royal Free

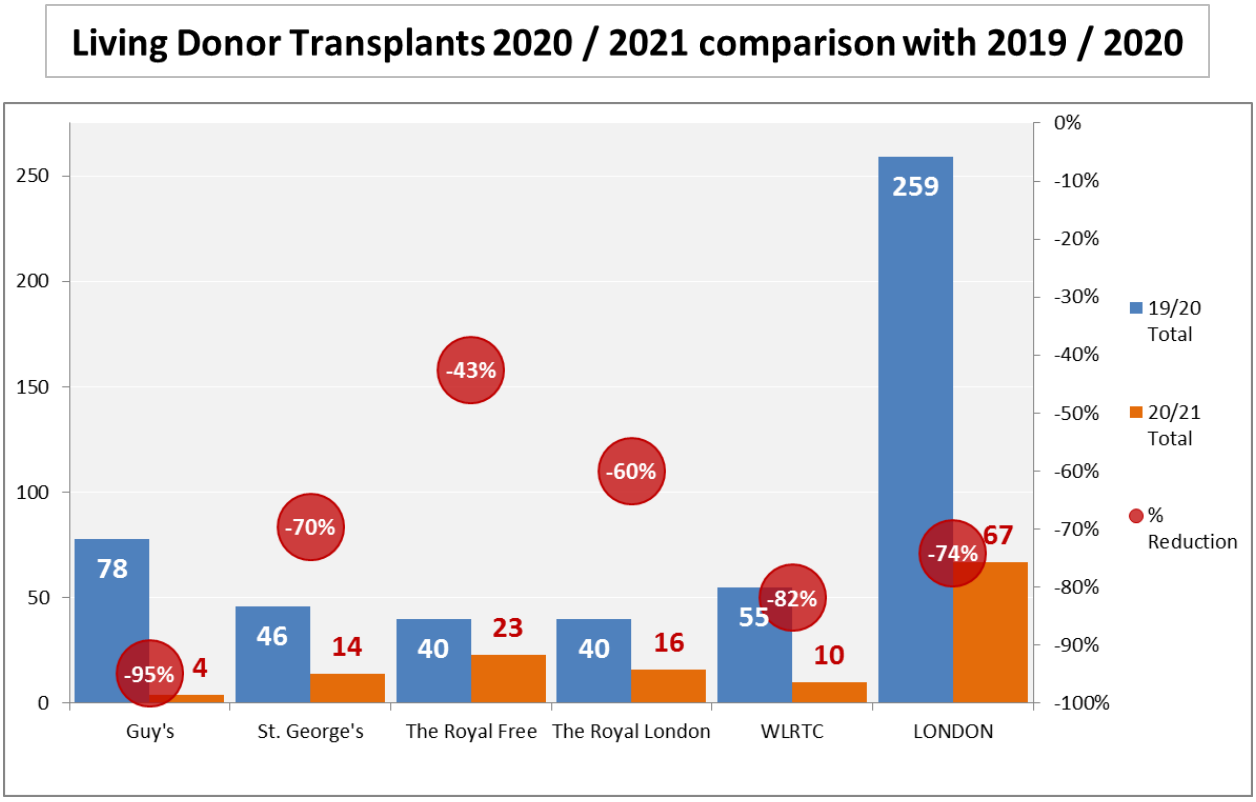
The catchment area for our transplant unit covers much of North Central London and extends up into Hertfordshire. Currently there are around 200 people on the active waiting list for a transplant. Prior to the pandemic, approximately 120 transplants were done each year, with over 1000 patients being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

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

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

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





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

Annexes

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

Statements from Commissioners:

Statements from Healthwatch organisations:

Statements from Overview and Scrutiny Committees:

Statement from the Council of Governors:

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

This section will be completed in full by final submission

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2021/22 and supporting guidance: detailed requirements for quality reports 2021/22;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2021 to March 2022
  - papers relating to quality reported to the board over the period April 2021 to March 2022
  - feedback from commissioners dated 25 May 2021 and 27 May 2021
  - feedback from governors dated 02 June 2021
  - feedback from local Healthwatch organisations dated 06 May 2021 and 28 May 2021
  - feedback from Overview and Scrutiny Committees dated 27 May 2021
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated July 2020
  - the latest national patient survey dated July 2021
  - the latest national staff survey dated March 2022
  - CQC inspection report dated June 2021
- the quality report presents a balanced picture of the RFL's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions and is subject to appropriate scrutiny and review; and

- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board:

Appendices

Appendix A:

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

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

Royal Free Hospital inspection findings and actions:

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

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

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

Appendix B: Progress against CQC inspection findings

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

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

CQC must-do findings

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

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

CQC should do findings and actions

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

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

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

Appendix C: Changes made to the quality report