

Improving quality

Improving care

Improving outcomes

Royal Free London NHS  
Foundation Trust

Quality Account  
2019/20

# Quality Account 2019/20

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## Part One: Statement on quality from the chief executive

We are delighted to publish our quality account for 2019/20. The Royal Free London seeks continuously to improve the care we offer patients and results for patients, while also using the resources we receive from the taxpayer and our charitable supporters ever better.

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



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

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

The three priority areas around which our account is structured span patient safety, effectiveness and patient experience. In the quality account which follows, we present our progress against the quality priorities for 2019/20 agreed last year in consultation with patients, staff and external stakeholders as well as our priorities for 2020/21.

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

- **Improve patient experience and to streamline pathways by co-designing and co-producing care with patients and families:** Our work in this theme has been far reaching and wide-ranging. Taking dementia care as a priority example, we have refurbished several wards to be "dementia friendly" and introduced the NHS's first performance theatre space in a hospital. Last year saw a range of creative arts therapies for patients and families, including drawing and music, plus a new "Sundowner" hour on hospital radio, playing classic tunes at dusk when patients living with dementia often become more agitated. Other initiatives, improving both patient experience, flow and efficiency have included strong participation in the "Keep me Mobile" and #EndPJparalysis campaigns. We are adopting co-production and co-design more broadly as an approach and are working on this with the Point of Care

Foundation, a charity which exists to help organisations listen and be responsive to patients' perspectives. During the past year we have trained over 40 staff as peer-trainers in co-production techniques across all our divisions and major hospital sites. Finally, we have adopted the simple and beautifully effective technique of asking "What Matters to You", not only on the international day promoting and celebrating this, but year-round with the aim of personalising patient care, and attending to their concerns

- **Using information and digitisation to drive improvements in care and reduce unwarranted variation in the care patients receive:** Over the past year we have digitised 13 pathways and linked to care redesign and application of quality improvement methods through our Clinical Practice Groups (CPG) driven substantial improvements in access, safety and effectiveness, often also reducing admissions and length of stay in the process
- **Improve patients' access to our services:** Using the techniques of redesign, improvement and digitisation, with co-design/co-production, we have made substantial improvements in access in numerous areas of care, for example in several cancers and in urgent and emergency care. But too many of our patients still wait too long to be seen, especially in the Emergency Department, and we continue to focus squarely on this
- **Invest in our people:** so that our 10,500 staff are all able to bring the best of themselves to work every day. The last year has seen redoubled activity across multiple staff networks including our BAME and LGBT+ networks, and new occupational health and education initiatives, for example the launch of a trust-wide collaboration across 15 teams using quality improvement methodology to improve staff Joy in Work. This is grounded in the "What Matters" methodology, starting by supporting staff to ask and answer this as a team. This collaboration is on going and is already showing significant improvements not just in staff experience, but also in reduced sickness and staff turnover as well as direct benefit to patients, such as improved access. We are continuing to skill-up our people in our method of quality improvement and to support them to apply these skills to our biggest priorities. Working in partnership with the Institute for Healthcare Improvement (IHI) we have trained over 1,100 of our staff in our method of QI and were delighted that IHI's CEO, Derek Feeley delivered the trust and Royal Free Association's annual Marsden Lecture in October 2019 on the topic of innovating for better care
- **Improving safety – reducing harm to zero:** We remain one of the hospitals with the lowest mortality in the NHS, and the only safety goal we believe we can set is zero avoidable harm. While we are not yet at our goal, we have made significant progress across several dimensions of patient safety, including a reduction to 6 "never events" in the year past versus 13 in the previous year. We are also using safety tools and methods to focus on and spread excellent practice, for example using Datix reporting to highlight and celebrate excellent practice: "Greatix".

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

The past year has been particularly notable in digital. Our upgraded electronic patient record went live at four hospital sites, and its successful deployment represented extraordinary efforts from staff to transition (essentially overnight) from paper-based to electronic ways of working. The new system ends mountains of patient notes (and hunting for notes), documents clinical details including patients' vital signs into the care record, and ensures scans and other test results are readily and reliably

available when needed. Chase Farm Hospital was officially opened in May 2019 nearly paperless, and quickly obtained HIMSS Level 6 certification, the highest level of digital maturity of any NHS hospital. This accreditation reflects our clear goals and processes on patient safety, reducing errors and patient workflow. The digital nurse call system developed at Chase Farm and patient 'way finding' systems were both nominated for national awards. The "Streams" app, now supporting care is live on our clinicians' phones. Streams detects Acute Kidney Injury (AKI) a common and potentially fatal condition in seconds by comparing sequential blood tests and flagging the alert in real time to the right clinician. Too often going undetected or untreated in health systems around the world, AKI accounts for over £1b of NHS cost and contributes to around 100,000 deaths in UK per year. Streams helps our clinical teams detect and intervene at the earliest opportunity, saving lives, saving time in hospital and saving the NHS money. I was delighted to see this work acknowledged, with the team being deserving winners of the annual Health Service Journal Patient Safety award. Beyond our hospitals we continue to work on sharing information to support better care and on population health across North Central London.

The quality account also presents the priorities we have agreed in consultation for the coming year, 2020/21. We have made multi-year commitments in digital, CPGs and QI, reflecting the complexity and importance these have to results for our patients, population and staff. To reach our full aspirations will take several years. Reflecting this, our goals and priorities for the coming year are mostly further and ambitious steps on the same themes as last year. Some goals however are newly-framed to long-standing priority areas: for example, our goals in patient safety reflect a new national patient safety strategy focusing on learning and human factors, which we are pleased to support.

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

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

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

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



**Caroline Clarke**  
**Group Chief Executive**  
**Royal Free London NHS Foundation Trust**

## 1.2 Early response to the COVID-19 pandemic

As an infectious disease specialist centre, in February 2020, RFL was among the first hospitals in the UK to care for patients with COVID-19. Our preparation and response had started in earnest in January, and by the time the whole NHS transitioned to a COVID footing in March 2020 RFL had already begun to establish additional intensive care capacity and to work differently on a number of dimensions.

The whole RFL community – staff, volunteers, patients and families - have responded amazingly to the pressures. This was clearly illustrated by the widely-acclaimed BBC “Hospital” programmes, shown on national prime-time TV in May. These documentaries, showing the Royal Free in action during March and April 2020, captured well the expertise, flexibility, kindness and compassion which characterize the RFL community.

The 2nd phase which we are now entering is even more challenging than the first: while continuing to care for patients with COVID and to prepare for possible future COVID surges we are discovering how to return to providing a full range of services while living with COVID’s continued presence. Doing this requires major changes to how patients and families access hospitals, how (and sometimes where) services are provided, as well as major changes in how care is delivered – for example, extensive testing of staff and patients, a continuing need for personal protective equipment, and constraints on visiting.

There have been a huge number of fantastic initiatives to support patients, families and staff, many of which would not have been possible without the generosity and skills of the Royal Free Charity. Illustrating this with just one example: the “Free at the Free” supermarket, based at the RFH site Rec Club and 10 other sites. Planning for this started on 24 March. Between its opening on 3 April until it closed on 29 May, over 50,000 staff visits were made to obtain essential food and other supplies, supported by over 50 volunteers and staff.

Through all this, everyone has ‘kept calm and carried on’. We have all heard many stories of people going above and beyond their usual roles, and rapidly forming new teams with real common purpose across traditional boundaries. We have also all heard that people have generally been kinder to each other, and listening better even as pressures have risen.

As we move into the second phase of living and working with COVID and beyond, our platform for future success will be built on these themes, combined with greater focus on coproduction with patients and families, understanding “what matters most” to people, and ensuring we improve week by week.

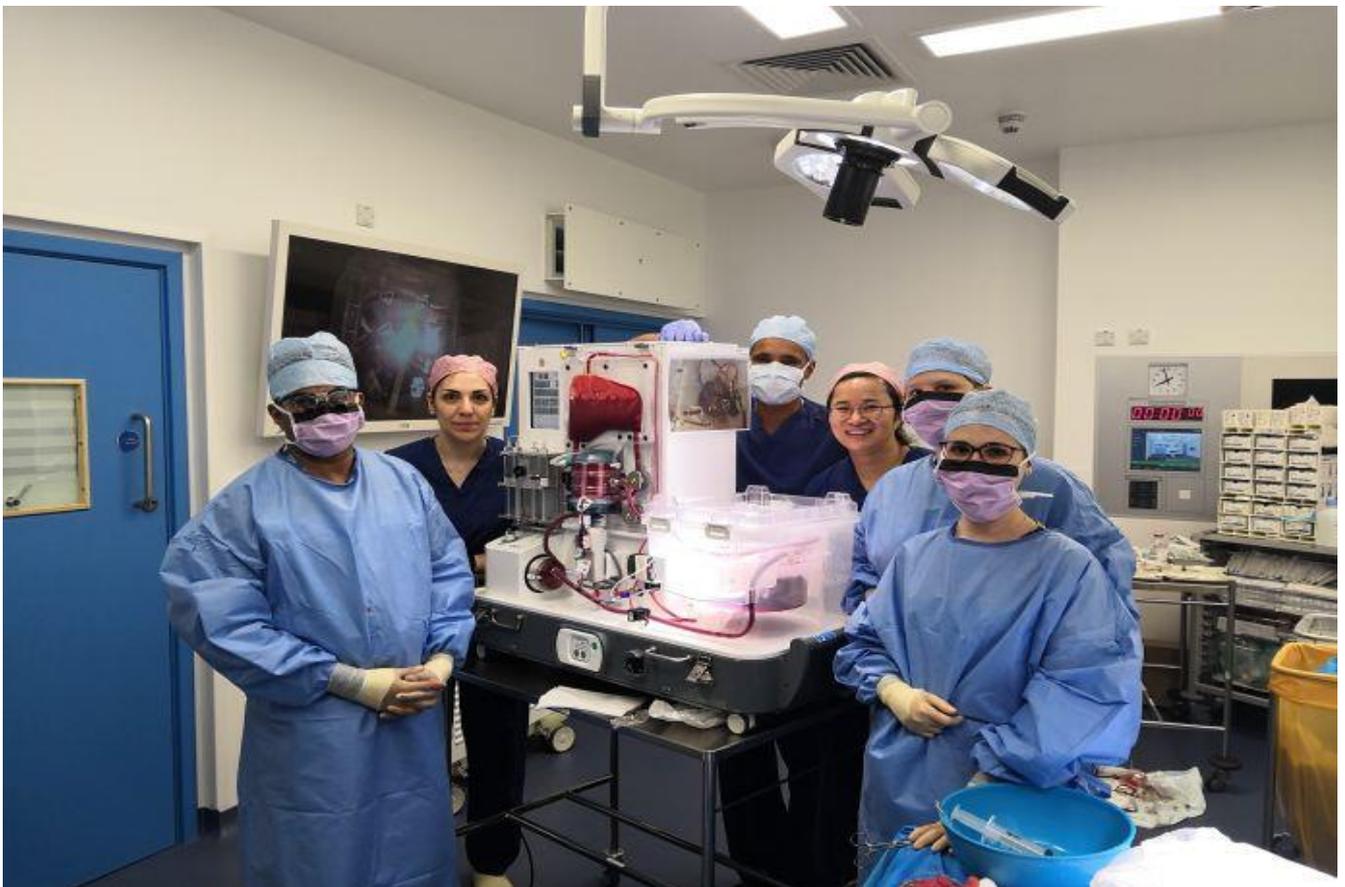
A series of “lessons learned” exercises is underway and we will provide a fuller report on our COVID and wider learnings in the 2020-21 quality account.

## 1.3 Highlights of key achievements

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

Two successful liver transplants took place at the Royal Free Hospital following a life-saving device and liver being 'blue-lighted' by ambulance in a 90-minute rush from Birmingham to London. The OrganOx machine has been used regularly for facilitating liver transplants at the Royal Free Hospital since April 2019. Simulating the conditions of the body, it keeps the liver alive and active; allowing doctors to more effectively assess whether the transplantation is suitable. OrganOx allows the liver to be kept for an additional 24 hours outside the human body but only one liver can be attached to it at any one time.

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



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

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



Professor Pollok, who assisted his consultant surgeon colleague Mr David Nasralla in the first transplant and carried out the second transplant, said: *“I’d like to thank our multi-disciplinary team that worked so hard to enable these two transplants to take place and for the support of our NHS colleagues in Birmingham. These transplants really show the power of partnerships and the collaborative spirit of the NHS. If we hadn’t been able to borrow the OrganOx we would have been unable to accept the second liver which would have meant our patient missing out”.*

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

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

Up to 60 doctors and nurses at Barnet Hospital can now receive alerts on their mobile devices when patients are at risk, resulting in treatment being delivered rapidly, improving outcomes for patients and potentially saving lives.

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

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



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

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

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

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



This section describes the following:

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

## 2.1 Priorities for improvement

What were our quality priorities for 2019/20?

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

# Improving Patient Experience: delivering excellent experiences

## Priority 1: To further enhance and support dementia care

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

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





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

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

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

The five work streams are:

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

# Improving Patient Experience: delivering excellent experiences

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

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

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

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

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

Patient transportation is a difficult issue for the trust and for patients. We are extremely sorry that patients have found the eligibility assessment process frustrating, and have sometimes been left unhappy with the outcome.

The eligibility criteria being used by the trust is in line with Department of Health guidelines and compliant with best practice. However new assessment questions were introduced 4 years ago as a result of the criteria not been applied as it should have been by the trust's previous transport providers. This resulted in a significant rise in the number of patients using hospital transport, and a resultant need to ensure a consistent and fair application of the eligibility criteria to provide transport to those patients who do not have any other means of transport.

Patients' eligibility is assessed every 4 weeks, and in recognition of feedback received we are working with our transport provider to review how information about patients' long-term conditions is used to streamline the assessment process. We endeavour to make patient transport an on going priority in order to improve our trusts' performance and our patients' experiences.



# Improving Clinical Effectiveness: delivering excellent outcomes

## Priority 3: To build capability in the workforce

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

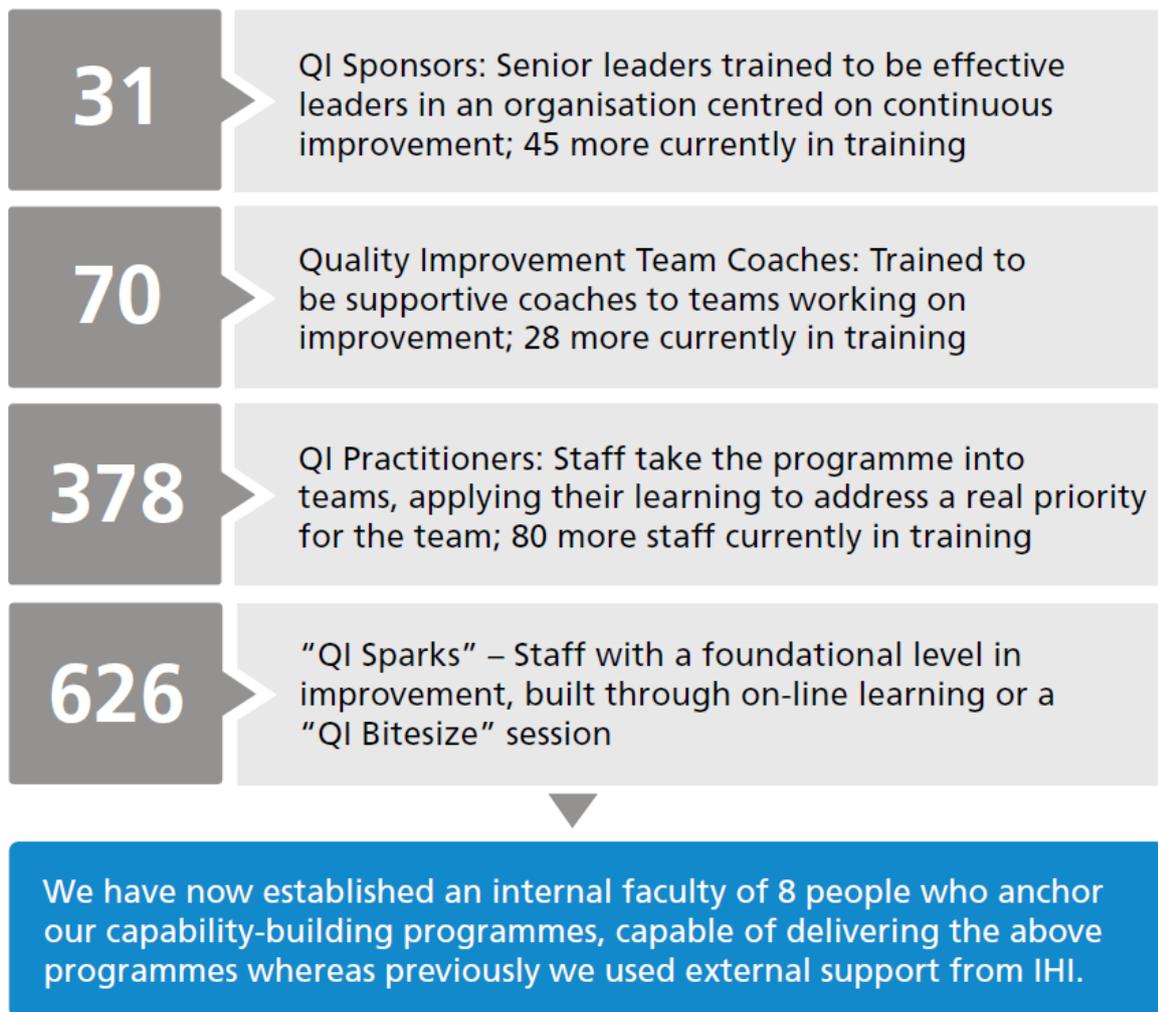
(1) Increase Joy in Work for teams participating in the collaborative by 50% above baseline measures by 31 May 2020

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



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

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



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

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

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

# Improving Clinical Effectiveness: delivering excellent outcomes

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

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

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



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

CPG	Women and Children	Transplant and specialist services	Surgery and associated services	Medical and urgent care
	Better birth	Right upper quadrant pain	Acute tonsillitis	Pneumonia
Introduction of Labour	HBP cancer	Epistaxis	COPD	
Early pregnancy	Prostate pathway	Cataracts	Heart failure	
Keeping mothers and babies together	Haematuria	Elective hip	Lung cancer	
Wheeze and difficulty breathing	Dermatology – non-cancer	Elective knee	Chest pain	
Gynaecology cancer	Anaemia	Plastics breast: benign	Pulmonary embolism	
Caesarean sections	Acute kidney injury	Pre-operative assessment	Emergency department	
CAMHs service review Acute Presentation in ED	Inflammatory bowel disease	Acute lower limb	Frailty	
Paediatric ED flow	Dyspepsia	Lower GI cancer	Inflammatory bowel disease	
	Skin cancer	Virtual fracture pathway	Dyspepsia	
	Acne pathway	Shoulder pathway	Dementia delirium	
	Kidney stones pathway	Fractured neck of femur	NIV/oxygen therapy	
	Upper GI cancer (RFH)	Emergency laparotomy	Upper GI (Barnet hospital)	
	Renal cancer pathway	Medical retina	Headache	
		Breast cancer	Ambulatory and emergency care CPG	
			Atrial fibrillation	

■ Designed  
■ Digitised

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

# Improving Patient Safety: delivering safe care

## Priority 5: To improve safer surgery

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

We have implemented and embedded a number of LocSSIPs into practice in 2019/20 and the monitoring of these important quality standards is now established within the trust's governance processes. Overall compliance with all steps of the LocSSIPs in our target areas is 89% which was achieved during 2019/20.

Unfortunately, there were 6 never events during 2019/20. These have been investigated as serious incidents to enable learning and we will continue with the annual monitoring of the Never Event patient safety alert risk assessments as part of our Safety Strategy for 2020 to 2025.



# Improving Patient Safety: delivering safe care

## Priority 6: To improve our Learning from Deaths

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

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

During 2019, we worked with our staff and patient partners, in line with the National Patient Safety strategy to co-design our Safety Strategy for 2020-2025. From the national strategy we know that getting this right across England could save almost 1,000 extra lives and £100 million in care costs each year from 2023/24.

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

We will be implementing the Medical Examiner process from April 2020 which will support the LfD process.



# Improving Patient Safety: delivering safe care

## Priority 7: To improve Infection Prevention and Control

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

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

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

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



# Our priorities for improvement for 2020/21

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

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

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

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

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

Our 2020/21 priorities are aligned to the five correlating CQC domains.

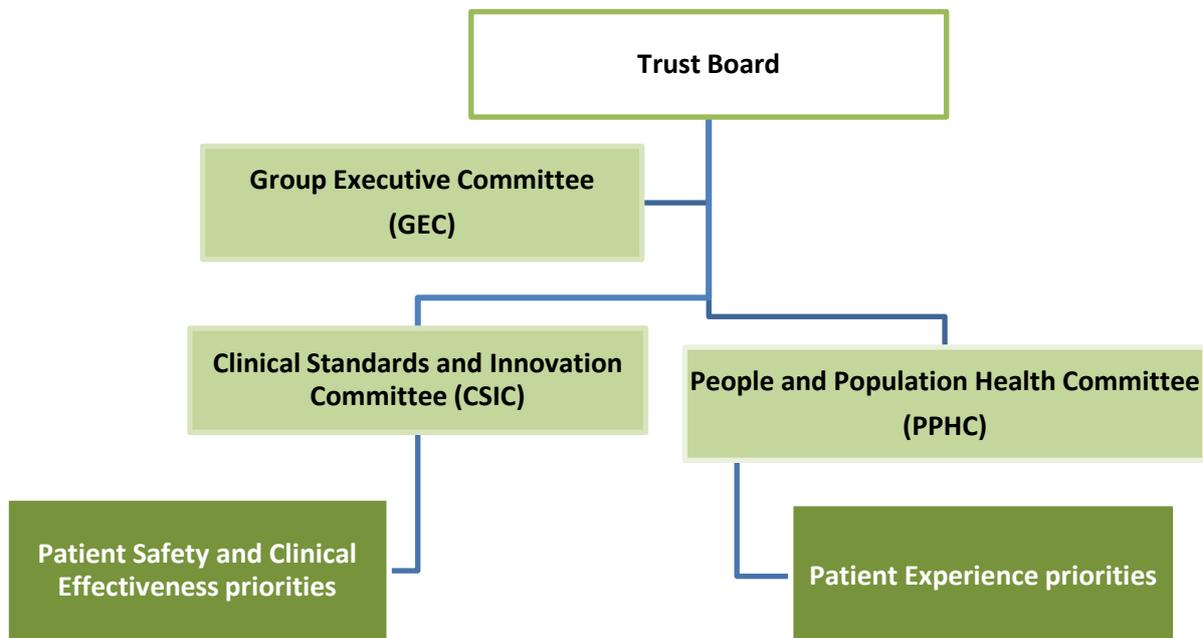


Figure 1: Strategic committees reporting to the trust board

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

## 2.2 Statements of assurance from the board

### Review of services

During 2019/20 the Royal Free London NHS Foundation Trust provided and/or subcontracted 40 relevant health services.

The Royal Free London NHS Foundation Trust has reviewed all the data available to them on the quality of care in 40 of these relevant health services.

The income generated by the relevant health services reviewed in 2019/20 represents 100% of the total income generated from the provision of relevant health services by the Royal Free London NHS Foundation Trust for 2019/20.

### Participating in clinical audits and national confidential enquiries

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

During 2019/20 67 national clinical audits and 8 national confidential enquires covered relevant health services that Royal Free London NHS Foundation Trust provides.

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

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

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

The national clinical audits and national confidential enquiries that Royal Free London NHS Foundation Trust participated in, and for which data collection was completed during 2019/20, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

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

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

**Key:**

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

**Table 1: Name of audit, eligibility and participation**

Name of audit	Data collection completed in 2019/20	Trust eligibility to participate	Participation 2019/20	Case ascertainment
<b>British Association of Urological Surgeons (BAUS): Female stress urinary incontinence audit</b>	Yes	Yes	RFH (BH and CFH service not available)	N=4 *2016/17
<b>BAUS: Nephrectomy audit</b>	Yes	Yes	RFH (BH and CFH service not available)	RFH 116 % *2016/18
<b>BAUS: Percutaneous nephrolithotomy (PCNL)</b>	Yes	Yes	RFH (BH and CFH service not available)	N= 80 *2016/17 and 18 combined
<b>Cancer: National bowel cancer audit (NBOCA)</b>	Yes	Yes	Reported at trust level, data collected at RFH and BH	N=244/287 (85%) *2017/18
<b>Cancer: National lung cancer audit (NLCA)</b>	Yes	Yes	Reported at trust level, data collected at RFH and BH CFH service not available	N =364 *2017
<b>Cancer: National oesophago-gastric cancer audit (NOGCA)</b>	Yes	Yes	Reported at trust level, data collected at RFH and BH CFH service not available	75-84% *2016/18
<b>Cancer: National prostate cancer audit</b>	Yes	Yes	RFH, BH and CFH	N=428 *2017/18
<b>Chronic obstructive pulmonary disease (COPD) audit programme: Secondary care</b>	Yes	Yes	RFH and BH (CFH service not available)	RFH: N=242 *2017/18 – Site specific percentage not reported on
<b>COPD audit programme Secondary Care – Adult Asthma</b>	Yes	Yes	RFH and BH CFH service not available	RFH: N=56 *2018/19 – Site specific percentage not reported on
<b>Diabetes: National foot care in diabetes audit</b>	Yes	Yes	RFH (BH and CFH service not available)	RFH: 1.6% *2017/18
<b>Diabetes: National diabetes in-patient audit</b>	Yes	Yes	RFH and BH (CFH service not available)	NaDia inpatient report in May 2019 reported on

Name of audit	Data collection completed in 2019/20	Trust eligibility to participate	Participation 2019/20	Case ascertainment
(NaDIA)			available)	hospital characteristics only. Data not yet available
<b>Diabetes: NaDIA - Harm</b>	Yes	Yes	RFH and BH (CFH service not available)	RFH: N=9 *2019/20 (up to 3/3/20) BH: N=5 *2019/20 (up to 3/3/20) NaDIA Harms report published in May 2019 shows level of participation and number of submissions of harm at national level only
<b>Diabetes: National pregnancy in diabetes (NPID) audit</b>	Yes	Yes	RFH and BH (CFH service not available)	Audit data collection in progress
<b>Diabetes: National diabetes audit (NDA)</b>	Yes	Yes	RFH, BH and CFH	N = 1460 Type 1 *2018/19 N = 1310 Type 2 * 2018/19
<b>Diabetes: National diabetes transition audit</b>	Yes	Yes	RFH and BH (CFH service not available)	Audit extracts data from NDA and NPDA submission. Data reported at national level only
<b>Diabetes: National paediatric diabetes audit (NPDA)</b>	Yes	Yes	RFH, BH and CFH	BH = 107 *2017/18 CFH = 59 *2017/18 RFH= 60 *2017/18
<b>Elective surgery (National PROMs programme)</b>	Yes	Yes	RFH, BH and CFH	Pre-operative questionnaires N= 734 (80%)*2017/2018 Post-operative questionnaires N=399 (59%) *2017/2018
<b>Endocrine and thyroid national audit</b>	Yes	Yes	RFH, BH and CFH	No report published in 2019/2020
<b>Falls and fragility fractures audit programme (FFFAP): Fracture liaison service database</b>	Yes	Yes	BH (RFH and CFH service not available)	N=310 *2018
<b>FFFAP: Inpatient falls</b>	Yes	Yes	RFH (BH and CFH service not available)	RFH = 34 *2017
<b>FFFAP: National hip fracture database</b>	Yes	Yes	RFH and BH (CFH service not available)	BH =394 *2018 RFH= 185 *2018
<b>Heart: Cardiac rhythm management (CRM)</b>	Yes	Yes	RFH and BH (CFH service not available)	RFH: N = 139*2016/17 (most procedures undertaken at BH) BH: N = 621*2016/17
<b>Heart: Myocardial infarction national audit project (MINAP)</b>	Yes	Yes	RFH and BH (CFH service not available)	RFH and BH: N=1012 103.5%*2017/18
<b>National audit of cardiac rehabilitation (NACR)</b>	Yes	Yes	RFH and BH (CFH service not available)	RFH 2/7 KPI's submitted *2019 BH 4/7 KPI's submitted *2019
<b>Heart: National audit of percutaneous coronary interventions</b>	Yes	Yes	RFH (BH and CFH service not available)	N=1087*2017/18
<b>Heart: National heart failure audit</b>	Yes	Yes	RFH and BH (CFH service not available)	RFH: N=315 *2017/18 BH: N=418 *2017/18

Name of audit	Data collection completed in 2019/20	Trust eligibility to participate	Participation 2019/20	Case ascertainment
<b>Intensive Care National Audit and Research Centre (ICNARC): Case mix programme: Adult critical care</b>	Yes	Yes	RFH and BH (CFH service not available)	RFH: N=1725 *2017/18 100% data completeness
<b>ICNARC: National cardiac arrest audit (NCAA)</b>	Yes	Yes	RFH and BH (CFH service not available)	RFH: N=320 222 calls solely for cardiac arrest N = 177 cardiac arrests attended by the team that met the scope of NCAA *2018/19
<b>Inflammatory bowel disease (IBD) registry: Biological therapies audit (Adult)</b>	Yes	Yes	RFH (CFH service not available)	RFH: N=23
<b>IBD registry: Biological therapies audit (Paediatric)</b>	Yes	Yes	RFH and BH (BH and CFH service not available)	Partial submission
<b>National audit of breast cancer in older people</b>	Yes	Yes	Reported at Trust level, data collected at RFH and BH	50-69 years N=237 70+ years N=157 *2017
<b>National audit of dementia</b>	Yes	Yes	RFH and BH (CFH service not available)	RFH: N=56 case note 100% *2018/19
<b>National audit of pulmonary hypertension audit (NAPH)</b>	Yes	Yes	RFH (BH and CFH service not available)	N=791*2018/19
<b>National audit of seizures and epilepsies in children and young people (Epilepsy 12)</b>	Yes	Yes	RFH and BH (CFH service not available)	Submission of data for 2018-2020 in progress
<b>National Audit of Seizure Management in Hospitals (NASH)</b>	Yes	Yes	RFH and BH (CFH service not available)	Awaiting publication
<b>National clinical audit of care at the end of life (NACEL)</b>	Yes	Yes	RFH and BH (CFH service not available)	RFL participated in the organisation audit and quality survey of bereaved relatives
<b>National early inflammatory arthritis audit (NEIAA)</b>	Yes	Yes	Reported at trust level, data collected at RFH, BH and CFH	RFL: N=26 15% (national annual median per unit is 17%)
<b>National emergency laparotomy audit (NELA)</b>	Yes	Yes	RFH and BH (CFH service not available)	RFH: N=83 (71%)*2017/18
<b>National joint registry (NJR)</b>	Yes	Yes	RFH BH and CFH	BH completed ops = 114 (NJR consent rate = 38%) *2019 CFH completed ops = 877 (NJR consent rate = 89%) *2019 RFH completed ops= 138 (NJR consent rate = 86%) *2019
<b>National maternity and perinatal audit (NMPA)</b>	Yes	Yes	RFH and BH (CFH service not available)	BH = 100% *2016/17 RFH=100% *2016/17
<b>National neonatal audit programme (NNAP)</b>	Yes	Yes	RFH and BH (CFH service not available)	BH = 100%*2018 RFH=100%*2018

Name of audit	Data collection completed in 2019/20	Trust eligibility to participate	Participation 2019/20	Case ascertainment
<b>National ophthalmology audit (NOD): Adult cataract surgery</b>	Yes	Yes	Reported at trust level, data collected at RFH, BH and CFH	RFL: 47.6% *2017/18
<b>National vascular registry</b>	Yes	Yes	RFH (BH and CFH service not available)	RFH: 66% *2017
<b>Royal College of Emergency Medicine (RCEM) Fractured neck of femur</b>	Yes	Yes	RFH and BH (CFH service not available)	To be undertaken in 2020/21
<b>RCEM: Pain in children</b>	Yes	Yes	RFH and BH (CFH service not available)	To be undertaken in 2020/21
<b>RCEM Mental Health-Care in Emergency Departments</b>	Yes	Yes	RFH and BH (CFH service not available)	RFH: N=177
<b>RCEM Assessing Cognitive Impairment in Older People /care in Emergency Departments</b>	Yes	Yes	RFH and BH (CFH service not available)	RFH: N=155
<b>RCEM Care of Children in Emergency Departments</b>	Yes	Yes	RFH and BH (CFH service not available)	RFH: N=244
<b>Sentinel stroke national audit programme (SSNAP)</b>	Yes	Yes	RFH and BH (CFH service not available)	RFH= Clinical audit: 99.1% (Level A) *2018/19
<b>Trauma audit research network (TARN) –Major trauma audit</b>	Yes	Yes	RFH and BH (CFH service not available)	RFH = 74% *Jan18 - Jul19
<b>UK Parkinson’s audit</b>	Yes	Yes	RFH, BH and CFH	RFH Neurology: Case note: 27 patients. PROMS: 17 patients *2019 RFH Elderly Care: Case note: 21 patients. PROMS: 0 patients *2019
<b>BTS - National Adult Community Acquired Pneumonia audit</b>	Yes	Yes	RFH and BH (CFH service not available)	RFH: N=71
<b>BTS - National Adult NIV Audit</b>	Yes	Yes	RFH and BH (CFH service not available)	RFH: N=13
<b>Surgical site infection surveillance</b>	Yes	Yes	RFH, BH and CFH	All applicable cases were submitted
<b>Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)</b>	Yes	Yes	RFH, BH and CFH	All applicable cases were submitted
<b>Mandatory Surveillance of bloodstream infections and clostridium difficile</b>	Yes	Yes	RFH BH and CFH	All applicable cases were submitted

Name of audit	Data collection completed in 2019/20	Trust eligibility to participate	Participation 2019/20	Case ascertainment
<b>infection</b>				
<b>Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme</b>	Yes	Yes	RFH BH and CFH	All applicable cases were submitted
<b>BTS- National Smoking Cessation Audit 2019</b>	Yes	Yes	RFH and BH (CFH service not available)	Not applicable as smoking cessation service provided by Camden
<b>Perioperative Quality Improvement Programme (PQIP)</b>	Yes	Yes	RFH and BH (CFH service not available)	RFH: N= 348 patients *March 17/Aug 19 BH: N= 10 patients *March 17/Aug 19
<b>Society for Acute Medicine Benchmarking Audit (SAMBA) study</b>	Yes	Yes	RFH and BH (CFH service not available)	RFH: N= 13 patients *2018

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

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

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

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

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

Name	Data collection completed in 2019/20	Trust eligibility to participate	Participation 2019/20	Case ascertainment
<b>National Confidential Enquiry into Patient Outcome and Death (NCEPOD)- Medical and surgical clinical outcomes review programme</b>				
Dysphagia in Parkinson's Disease*	Yes	Yes	RFH and BH (CFH service not available)	Organisational questionnaire: 2 Case notes: 6/9 Clinical questionnaire: 7/9
Acute Bowel Obstruction	Yes	Yes	RFH and BH	Organisational questionnaire: 2 Case notes:4/4 Clinical questionnaire: 9/13
In-hospital management of out-of-hospital cardiac arrest	Yes	Yes	RFH and BH (CFH service not available)	Organisational questionnaire: 2 Case notes: 10/10 Clinical questionnaire: 8/8
Physical health in mental health hospitals	Data collection 2020/21	Yes	N/A	Enquiry in development
<b>National Confidential Enquiry into Patient Outcome and Death (NCEPOD)- Child health clinical outcomes review programme</b>				
Long-term ventilation in children, young people and young adults	N/A	No	N/A	N/A
<b>Learning disability mortality review programme</b>				
LeDer: Learning disability review programme	Yes	Yes	RFH, BH and CFH	Cases allocated via local area contact in relevant boroughs. 3 cases have been allocated in 2019/2020
<b>MBRRACE-UK (Mothers and Babies – Reducing Risk through Audits and Confidential Enquiries across the UK) - National Maternal, Newborn and Infant Clinical Outcomes Review Programme</b>				
Perinatal Mortality Surveillance	Yes	Yes	RFH and BH (CFH service not available)	100%
Perinatal morbidity and mortality confidential enquiries	Yes	Yes	RFH and BH (CFH service not available)	100%
Maternal Mortality surveillance and mortality confidential enquiries	Yes	Yes	RFH and BH (CFH service not available)	100%
Maternal morbidity confidential enquiries	Yes	Yes	RFH and BH (CFH service not available)	100%

\* This study was open at the time of this report, and the figures have not been finalised

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

The reports of 46 national clinical audits were reviewed by the provider in 2019/20 and the Royal Free London NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

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

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

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

<b>Specific actions undertaken to improve quality</b>	
<b>National clinical audit</b>	<b>Actions to improve quality</b>
<b>National lung cancer audit (NLCA)</b>	The trust is among the best 1 year survival rates in the country at 48% (43.7% when adjusted for PS/age/stage etc) compared to the national average of 36.7%. We have a surgical resection rate of 30%, during a national campaign by UKLCC to increase this to 25% by 2025
<b>National Oesophago-gastric cancer audit (NOGCA)</b>	The oncology service will carry out a retrospective audit of clinical stage 0-3 patients to determine why curative plans were not proposed and send out lessons learnt to Upper GI MDT. A business case has been proposed for a clinical oncology consultant whose responsibilities will include leading on this audit with clear escalation pathways.
<b>Chronic obstructive pulmonary disease (COPD) audit programme: Secondary care</b>	We are participating in the NACAP and our case ascertainment is better than average. Our mortality is lower, but our length of stay and re-admissions are higher than national figures. Like other units, we have a challenge to access diagnostic spirometry from primary care. We are engaged with a new UCLP Network designed to assist in QI around use of discharge bundles in COPD and working on developing COPD care within the COPD CPG
<b>Heart: Cardiac rhythm management(CRM)</b>	There has been a considerable increase in pacing work between years and above the levels required and immediate complication rates are low. Improvement in data completeness such as NYHA class in required, although data completeness more recently has increased and was previously hampered by ECGs not going from one hospital to another with the patient. This will be resolved fully once the trust has electronic ECG capture via EPR
<b>Myocardial infarction national audit project (MINAP)</b>	Generally the RFH Heart Attack service works very well and our data show a performance above the national average in key areas. Work has been completed on the new CPG Chest Pain pathway, which is a key component in further improvement work. However, implementation is currently on hold until EPR is introduced at the RFH. The rate of referral to cardiac rehabilitation programme will be reviewed to ensure data quality on this metric is being maintained
<b>National heart failure audit</b>	Rates have improved compared to last year's audit data in all but one area and we continue to perform well in certain targets such as drug prescribing and access to acute diagnostic provision. In the areas where we have not reached the average there is a significant improvement compared to the previous year's audit findings in the vast majority of cases. BH are planning to open a diuretic lounge for admission avoidance and to facilitate early discharge and trust continues work on the implementation of the Heart Failure CPG, which is a key enabler in order to for us to improve our performance
<b>Intensive Care National Audit and Research Centre (ICNARC): Case mix</b>	Trust performance has been highlighted as better than national average in: discharge to ward, discharges direct to home, non-clinical transfers to another unit and risk adjusted acute hospital mortality. The trust has been highlighted as an outlier in high risk admissions from the ward and since NEWs is now fully embedded, there is work on-going with PARRT to re-audit the ICU admission process

<b>programme: Adult critical care</b>	
<b>ICNARC: National cardiac arrest audit (NCAA)</b>	There is evidence to suggest that some of the patients we attempt resuscitation on are not appropriate for CPR and that clinicians are unclear about families' role in DNAR decisions and need support. We propose to: increase the use of Co-ordinate My Care plans, improve MDT working and QI work on a number of wards and aim reading material on DNAR decisions for patients and families
<b>National audit of breast cancer in older people (NABCOP)</b>	We are positive outliers for patients who are receiving chemotherapy and surgery, however we have challenges with data recording and are therefore changing templates in order to provide 90% one stop services for all patients. We also aim to implement a single MDT for all three sites so uniform management is provided and data recording is more robust. CPG pathway group meetings are in progress in order to address all the above issues.
<b>National audit of dementia</b>	These results are huge improvement from our previous audit results. Improvement work was implemented by the Dementia Implementation Group and we see those efforts reflected in recent results. We are now amongst the top 10 performing trusts in the UK in 4 out of 7 domains (1 <sup>st</sup> in 2 of those) Our lowest score related to "Discharge" where the auditors were looking for evidence that early conversations relating to discharge were being had amongst colleagues and with families and carers. The performance here could in part be due to the fact that these conversations take place in board meetings and MDT meetings which are usually not documented in medical notes and therefore were not picked up in the case note audit. The Dementia CPG has been convened and one of the major work streams is "Discharge" whereby a cross-site MDT will be working in this area using a QI approach which we hope will make lasting improvements and reduce unwarranted variation
<b>National clinical audit of care at the end of life (NACEL)</b>	RFH scored higher than national outcomes for 5 out of the 6 applicable themes and BH scored higher for 6 out of the 9. Outcomes for the communication with families and others at RFH were lower than nationally recorded, and similarly hospital for needs of families and others, Individual plan of care and families' and others' experience of care themes at BH. We aim to merge the Mortality Surveillance Group and End of Life Care Steering group, and establish four working groups (advance care planning, care of the dying, care of the deceased and continue with Learning from Deaths group) An Advance Care Planning CPG has been established and an End of Life Care Plan for the Dying is in development. This will be built into Cerner and RFH will have an interim paper document, all supported with a robust education plan
<b>National emergency laparotomy audit (NELA)</b>	Overall good performance with excellent surgical presence in theatre when risk of death > 5% and postoperative critical care admission for high risk cases for predicted risk of death >10%, Improved pre-operative input by a consultant anaesthetist when risk of death was >5% and surgical and Anaesthetic Consultant led service throughout the perioperative period. Plan to roll out MDT emergency laparotomy pathway cross-site (CPG) and on going QI projects to improve case ascertainment and risk documentation. The trust remains a UCL Partners Emergency Laparotomy Collaborative to share learning and improvement experiences with more regular feedback of local and AHSN data
<b>National ophthalmology audit (NOD): Adult cataract surgery</b>	Rate of adjusted posterior capsular rupture (PCR) in the trust (0.8%) lower than national average (1.1%) and full compliance achieved with management of cataracts in adults. However case ascertainment was below the 85% threshold. We aim to ensure that all staff are trained to input data on Medisite thus allowing for a better capture rate of data and that case complexity is matched by the performing surgeon's grade and experience with a possible review of audit data halfway through the year to ensure that compliance is being met in all areas
<b>National vascular registry (NVR)</b>	Clinical outcomes which are at or above national average in all disease groups except carotid disease. Carotid outcomes likely biased by sampling error, as the volume detailed seems smaller than our stated volume of procedures. In all disease areas, the waiting time or delay for intervention is worse than the national average, which puts our patients at risk, and has been flagged as a serious patient safety issue. This is due, largely, to a lack of theatre capacity for vascular procedures, This issue has been escalated to the trust executive who have committed to a cardiovascular strategy which prioritizes the needs of vascular patients
<b>Sentinel stroke national audit programme (SSNAP)</b>	RFH overall audit compliance score is 99.1%, which is an improvement of 10% from the previous report and also 6% above the national compliance score. Regular communications with our partner units throughout the NCL Stroke sector need to be maintained in order to ensure that the necessary flow of data along the stroke pathways is kept to an optimal level so that our overall SSNAP scoring is maintained
<b>Trauma audit research network (TARN) –Major trauma audit</b>	The trust is one of the best performing in London in terms of data accreditation and ascertainment. TARN data is now > 90 % accurate for 5 years and has made meaningful conclusions to evaluate trauma care at the trust. Improved note keeping across the board is required to improve the trusts ability to perform well at data accreditation. From recording observations, to documenting grade of medical personnel attending and time of clinical evaluation, grade of surgeon attending. A separate CT in Trauma audit is managed by the ED as part of the CPG work in improving access to the CT scanner by improving patient flow, prioritisation for portering and CT urgency for trauma patients over inpatient scans and constant staff training including improving awareness. Since the last Trauma Peer Review

	(2019) the trust has now agreed to provide rehabilitation prescriptions which will be recorded for patients managed in the trust. This will highlight the trusts absolute compliance with standards in rehabilitation prescriptions against national benchmarks
<b>BTS - National Adult NIV Audit</b>	Low mortality rate compared to national average, and a follow up plan/decision re long term NIV was made for all patients. An escalation plan was made for 77% of patients and 85% of cases showed improved outcomes. However, only 40% of patients had an ABG taken within an hour of starting NIV and 54% of patients were seen by a specialist 4 hours after starting NIV. We have made significant improvements since the last audit in line with NCEPOD recommendations, however there are areas that could be improved including specialist review, ABGs and nursing ratios. The acute NIV CPG plan to address some of these issues
<b>Perioperative Quality Improvement Programme (PQIP)</b>	Good case ascertainment of major hepatobiliary surgical patients and the establishment of an enhanced recovery (ERAS) programme for both liver and pancreatic resections. On-going implementation of this programmes with PQIP data used to assess key outcome metrics and on-going work to assess existing or develop new risk scoring systems to better predict post-operative morbidity in liver resection patients. Local QI project to investigate wound infections as source of post-operative morbidity

**Table 3: Details of specific actions undertaken from national confidential enquiry and outcome reviews 2019/20**

<b>National confidential enquiry</b>	<b>Actions to improve quality</b>
<b>Know the score</b> <i>Pulmonary Embolism</i>	<p>RFL was compliant to 10/13 recommendations.</p> <p>Partially compliance was achieved for calculating the clinical probability of pulmonary embolism in all patient presenting to hospital with a suspected new diagnosis of pulmonary embolism using a validated score, such as the 'Wells' Score' (Recommendation 7) It is recognised that adherence to this standard needs to be improved. The requirement to complete the Wells Score is included in the pathway, and all suspected PE ambulatory patients now have a Wells Score calculated via a sticker.</p> <p>CPG work on this pathway continues. It is being digitised at Barnet currently and may bring some improvements, however it cannot be fully implemented at the Royal Free until EPR is place.</p> <p>Partially compliance was achieved in ensuring that there is a robust system in place to alert the clinician who requested a CTPA or V/Q scan or V/Q SPECT scan of any amendments or updates to the report (Recommendation 9) This is in line with the Royal College of Radiologist's communication standards for radiology reports 2016.</p> <p>Amendments to V/Q reports are visible in Cerner and as per usual practice, significant findings are alerted to clinicians via phone or email. There is no specific protocol for nuclear medicine but this can be implemented.</p>
<b>Delay in transit</b> Acute bowel obstruction	Review in progress

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

The reports of 53 local clinical audits\* were reviewed by the provider in 2019/20 and the Royal Free London NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

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

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

\* the local audits undertaken relate to the quality improvement projects previously described which demonstrated modest to significant improvement through successful plan, do, study, act cycles

Local audits	Actions to improve quality
<p><b>Testing for mismatch repair abnormalities in colorectal adenocarcinoma at RFH</b></p>	<p>By testing for MMR on colorectal resections rather than diagnostic biopsies 19% of patients were missing out on MMR testing all together. Furthermore, new RCPATH guidelines specifically recommend MMR testing on biopsies if possible. MMR testing has been done on all patients who missed out on testing where appropriate, and supplementary reports issued.</p> <p>Actions:</p> <ol style="list-style-type: none"> <li>(1) MMR testing to be done on all biopsy's diagnostic of colorectal adenocarcinoma. If there is insufficient material for testing or high-grade dysplasia suggestive but not diagnostic of adenocarcinoma a comment should be made in the report indicating this and advising MMR testing on the surgical resection if this is due to be done</li> <li>(2) If the results of molecular pathology testing are indicative of possible underlying Lynch syndrome (eg: no MLH1 hypermethylation, BRAF is wild type or PMS2 / MSH2 / MSH6 are defective) an interpretive comment to be included in the report recommending referral for clinical genetics and this to be highlighted at the MDT meeting</li> </ol>
<p><b>An Audit of Platelet Transfusion at the Royal Free Hospital</b></p>	<p>93% compliance achieved with platelet transfusion approval in line with British Society of Haematology guidelines, and transfusion practitioner (TP) is present at audit meetings to discuss results with team.</p> <p>Actions:</p> <ol style="list-style-type: none"> <li>(1) Improve documentation details by TP in the cases of Haematology medical team authorisation to allow data to be analysed retrospectively</li> <li>(2) Re-education of TP team to ensure platelets not given in the case of an ascitic drain or in a DIC (disseminated intravascular coagulation) patient who is not bleeding</li> </ol>

Local audits	Actions to improve quality																																				
<p><b>National heart failure audit</b></p>	<p>The rates of ACE/ARB prescription and beta-blocker prescription are higher than national figures (86% and 94% respectively compared to 83.8% and 89.3% nationally) and an improvement on 2016/17 data.</p> <p>There are also higher than average rates of echocardiography during IP stay (93% compared to 88% nationally) which represents an improvement on 2016/17 data.</p> <p>Admission to cardiology ward compares nationally (50.2% vs 46%) and again is an improvements on 2016/17 performance (50.2% vs 41.9%)</p> <p>There was an increase in the number of referrals to cardiac rehabilitation (15% compared to 5% in 2016/17) in line with national figures (15%) but overall low volumes are still low.</p> <p>Comparisons with previous year audit results and national average (England &amp; Wales) are listed below:</p> <table border="1" data-bbox="408 488 1433 667"> <thead> <tr> <th></th> <th></th> <th>Admissions</th> <th>Input from Specialist team</th> <th>Commenced on MRA</th> <th>Received discharge planning</th> <th>Referral to HF CNS for FU</th> <th>Referral to HF CNS for FU only</th> <th>Referral to cardiac rehabilitation</th> </tr> </thead> <tbody> <tr> <td>2017-18</td> <td>E&amp;W</td> <td>-</td> <td>82%</td> <td>54.70%</td> <td>91.90%</td> <td>57.90%</td> <td>72.90%</td> <td>15.20%</td> </tr> <tr> <td>2017-18</td> <td>RFH</td> <td>305</td> <td>68.10%</td> <td>47.90%</td> <td>48.60%</td> <td>52.10%</td> <td>59.60%</td> <td>15.50%</td> </tr> <tr> <td>2016-17</td> <td>RFH</td> <td>329</td> <td>47.1%</td> <td>50%</td> <td>82.40%</td> <td>23.50%</td> <td>39.10%</td> <td>5.10%</td> </tr> </tbody> </table> <p>Actions:</p> <ol style="list-style-type: none"> <li>(1) The heart failure CPG continues to be a key enabler in order to for us to improve our performance. The following service improvements have been introduced this year: An increase in the workforce establishment with 3 WTE CNSs in post and the introduction of a dedicated Heart Failure SCF. This has increased the number of patients receiving a specialist review and increased capacity for early follow up in the OP clinic</li> <li>(2) A significant increase in data reporting so that real time assessment of performance can take place</li> <li>(3) The introduction of the diuretic lounge to allow early discharge of patients or admission avoidance under specialist review and 3 specialist Heart Failure consultants providing input on the IP management of patients reviewed by the CNS/SCF team</li> <li>(4) Ongoing plans for the CPG include: Rapid testing with NT-pro-BNP, increased consultant workforce with the potential to deliver specialist ward rounds, testing and digitisation of the pathway</li> <li>(5)</li> </ol>			Admissions	Input from Specialist team	Commenced on MRA	Received discharge planning	Referral to HF CNS for FU	Referral to HF CNS for FU only	Referral to cardiac rehabilitation	2017-18	E&W	-	82%	54.70%	91.90%	57.90%	72.90%	15.20%	2017-18	RFH	305	68.10%	47.90%	48.60%	52.10%	59.60%	15.50%	2016-17	RFH	329	47.1%	50%	82.40%	23.50%	39.10%	5.10%
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<p><b>Audit on ER in Breast Cancer</b></p>	<p>All primary cancers tested and documented at multi-disciplinary team meetings and positivity rates comparable to the national average published by NEQAS and by LCA.</p> <p>Actions:</p> <ol style="list-style-type: none"> <li>(1) In case of significant variation amongst individual positivity rates, individual and lab procedures to be reviewed to ensure compliance with national guidelines, including procedures for sample handling and fixation</li> <li>(2) A specific Winpath code for Breast cancer resections, biopsies and receptor status to facilitate search for future audits</li> </ol>																																				
<p><b>Audit of nurse led HIV clinic</b></p>	<p>100 forms were randomly selected to review completion of data sheets. Overall, although data collection could be improved (37% other medication recorded, 15% current smoking status) the standard of recording was better than that of clinicians in a recent BHIVA audit</p> <p>Actions:</p> <ol style="list-style-type: none"> <li>(1) Although patients are correctly selected for the clinic, recording of information can be improved</li> <li>(2) New referrals have decreased, and the clinic is an under-utilised resource, hence clinicians to be reminded of referral pathways to be made simpler, together with other methods of streamlining and increasing the service</li> </ol>																																				

## Participating in clinical research

The number of patients receiving NHS services provided or sub-contracted by Royal Free London NHS Foundation Trust in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 12176.

The above figure includes 4483 patients recruited into studies on the National Institute for Health Research (NIHR) portfolio and 7769 patients recruited into studies that are not on the NIHR portfolio. This figure is higher than that reported last year.

The trust is supporting a large research portfolio of over 800 studies, including both commercial and academic research. 155 new studies were approved in 2019/20. The breadth of research taking place within the trust is far reaching and includes clinical and medical device trials, research involving human tissue and quantitative and qualitative research, as well as observational research.

## CQUIN payment framework

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.

A proportion of the Royal Free London NHS Foundation Trust income in 2019/20 was conditional upon achieving quality improvement and innovation goals agreed between the Royal Free London NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2019/20 and for the following 12-month period are available electronically at: (<https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/>)

**Table 4: CQUIN scheme priorities 2019/2020**

<b>CQUIN scheme priorities 2019/2020</b>	<b>Objective rationale</b>
<b>Antimicrobial Resistance – Lower Urinary Tract Infections in Older People</b>	In support of a major Long Term Plan priority of antimicrobial resistance and stewardship, four steps outlined for UTI will bring reduced inappropriate antibiotic prescribing, improved diagnosis (reducing the use of urine dip stick tests) and improved treatment and management of patients with UTI.
<b>Antimicrobial Resistance – Antibiotic Prophylaxis in Colorectal Surgery</b>	Implementing NICE guidance for Surgical Prophylaxis will reduce the number of doses used for colorectal surgery and improve compliance with antibiotic guidelines. Improvement is expected to deliver safer patient care, increase effective antibiotic use, which is expected to improve both patient mortality and length of stay.
<b>Staff Flu Vaccinations</b>	Staff flu vaccinations are a crucial lever for reducing the spread of flu during winter months, where it can have a significant impact on the health of patients, staff, their families and the overall safe running of NHS services.
<b>Screening and brief advice for tobacco and alcohol use in an inpatient setting</b>	To support people to change their behaviour to reduce the risk to their health from alcohol and tobacco. Screening and brief advice is expected to result in 170,000 tobacco users and 60,000 at risk alcohol users receiving brief advice, a key component of their path to cessation.
<b>Hospital Falls</b>	<p>Taking these three key actions as part of a comprehensive multidisciplinary falls intervention will result in fewer falls, bringing length of stay improvements and reduced treatment costs.</p> <ul style="list-style-type: none"> <li>• Lying and standing blood pressure to be recorded</li> <li>• No hypnotics or anxiolytics to be given during stay OR rationale documented</li> <li>• Mobility assessment and walking aid to be provided if required.</li> </ul> <p>For a typical medium sized acute provider this would equate to around 250 fewer falls, including four fewer hip fractures and brain injuries.</p>
<p><b>Eligible patients to be managed in a same day setting (SDEC)</b></p> <ul style="list-style-type: none"> <li>• Pulmonary Embolus</li> <li>• Tachycardia with Atrial Fibrillation</li> <li>• Community Acquired Pneumonia</li> </ul>	<p>These three conditions are all from the top 10 conditions with which patients present in a SDEC setting. Each have been selected due to focus on a limited set of clear actions to be taken by providers. Improved same day treatment will reduce pressure on hospital beds, improving length of stay and patient experience.</p> <p>The rollout of Same Day Emergency Care is one of the commitments from the Long Term Plan.</p>
<b>Towards Hepatitis C (HCV) Elimination</b>	The trust is a lead provider in reducing harm from Hepatitis C. This is a continuing CQUIN that forms part of a long term project with the end goal being the elimination of Hepatitis C as a major health concern by 2030.
<b>Medicines optimisation</b>	Optimising the use and management of medicines is a significant and realisable opportunity for the NHS. This CQUIN indicator aims to support trusts and Specialised Commissioners to realise the benefits of this opportunity through a series of procedural and cultural changes.
<b>Screening</b>	Improving the uptake of breast cancer screening through the implementation of text reminders using mobile phone numbers from GP clinical systems. Faster diagnosis standard, cancer waiting times data, completion and exception reporting.

In 2019/20 a total of £8,250,000 of the trust's income was conditional upon achieving quality improvement and innovation goals. Our CQUIN payment framework was agreed with NHS North East London Commissioning Support Unit and NHS England. The monetary total for 2018/19 was £11,625,000.

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

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

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

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

The Care Quality Commission has not taken enforcement action against the Royal Free London NHS Foundation Trust during 2019/20.

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

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

The trust has several areas for improvement defined as either must-do or should-do actions. There are 11 must do actions for improvements and a further 82 areas considered as should do. Further details and update of our actions are provided later on in this account.

## Information on the quality of data

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

### The patient's NHS number

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

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

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

	2017/18	2018/19	2019/20
<b>For admitted patient care</b>	98.8%	99.2%	99.2%
<b>For outpatient care</b>	99.2%	99.3%	99.5%
<b>For accident &amp; emergency care</b>	95.7%	97%	97.1%

### General Medical Practice Code

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

	2017/18	2018/19	2019/20
<b>For admitted patient care</b>	99.8%	99.8%	99.8%
<b>For outpatient care</b>	99.9%	100%	99.9%
<b>For accident &amp; emergency care</b>	100%	100%	100%

## Information Governance (IG)

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

	2016/17	2017/18	2018/19	2019/20
<b>Information governance assessment score</b>	66%	68%	Not scored	To be confirmed
<b>Overall grading</b>	Green	Green	Not graded	To be confirmed

## Payment by Results

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

## Data quality

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

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

- The Data Quality team will be working with underperforming teams to ensure agreed KPIs are being met. Action plans will be put in place to resolve issues and any issues will be escalated to divisional management if required.
- A new Data Improvement Group has been set up to discuss, prioritise and oversee the work required to support data quality improvement across the Trust.

The data quality dashboard will continue to be monitored and new KPIs will be added to ensure that we detect early any issues with our internal and external submissions.

- The Workflow Group continues to create workflows for areas where there is incorrect data recording taking place. They will create workflows to ensure staff are recording all the necessary information which in turn will help solve data quality issues.

## Learning from deaths

Hundreds of patients come through our doors on a daily basis. Most patients receive treatment, get better and are able to return home or go to other care settings. Sadly and inevitably, some patients will die here (approximately 1.02% of all admissions). While most deaths are unavoidable and would be considered to be “expected”, there will be cases where sub-optimal care in hospital may have contributed to the death. The trust is keen to take every opportunity to learn lessons to improve the quality of care for other patients and families.

During 2019/20, 2083 of the Royal Free London NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 463 in the first quarter; 487 in the second quarter; 535 in the third quarter; 598 in the fourth quarter.

Due to differences in the reporting periods for Learning from deaths (LfD) reviews and the Quality Accounts, for completeness data are included here (Table 5) for 2018/19 quarters 3 and 4, as these were not included in last year’s Quality Accounts. Likewise review data for 2019/20 quarters 3 and 4 are not available for inclusion in this year’s Quality Accounts.

**Table 5: Summary of LfD reviews (meeting criteria 27 in the Quality Accounts prescribed information)**

Reporting period		Number of deaths (27.1)	Number of reviews completed (27.2)	Number of serious incident investigations	Number of the patient deaths considered likely to be avoidable (ie are judged to be more likely than not to have been due to problems in the care provided to the patient) (27.3)	Percentage of the patient deaths considered likely to be avoidable (ie are judged to be more likely than not to have been due to problems in the care provided to the patient) (27.3)
Third quarter	Oct 2018 to Dec 2018	576	25	4	3	0.52%
Fourth quarter	Jan 2019 to Mar 2019	506	21	5	2	0.40%
<b>Total</b>		<b>1082</b>	<b>46</b>	<b>9</b>	<b>5</b>	<b>0.46%</b>
First quarter	Apr 2019 to Jun 2019	463	12	1	0	0%
Second quarter	Jul 2019 to Sep 2019	487	13	5	2	0.41%
<b>Total</b>		<b>950</b>	<b>25</b>	<b>6</b>	<b>2</b>	<b>0.21%</b>
Third quarter	Oct 2019 to De	535	Not yet completed	Not yet completed	Not yet completed	Not yet completed

Reporting period		Number of deaths (27.1)	Number of reviews completed (27.2)	Number of serious incident investigations	Number of the patient deaths considered likely to be avoidable (ie are judged to be more likely than not to have been due to problems in the care provided to the patient) (27.3)	Percentage of the patient deaths considered likely to be avoidable (ie are judged to be more likely than not to have been due to problems in the care provided to the patient) (27.3)
	2019					
<b>Fourth quarter</b>	Jan 2020 to Mar 2020	598	Not yet completed	Not yet completed	Not yet completed	Not yet completed
<b>Total</b>		<b>1133</b>				

## Reporting period 2019/20 (Q1 and Q2)

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

In 5 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review and an investigation was carried out was: 52 in Q1, 19 in Q2, as shown in the table. Data for Q3 and Q4 are not yet available.

5 representing 0.41% of patient deaths during the reporting period 2018/19 Q1 and Q2, are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of: 3 representing 0.40% for the first quarter; 2 representing 0.42% for the second quarter as shown in the table. Data for Q3 and Q4 are not yet available.

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

Likert avoidability Scale:

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

## Previous reporting period 2018/19 (Q3 and Q4)

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

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

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

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

**Table 6: Summary of LfD reviews for previous reporting period 2018/19 (Q1 and Q2) from 2018/19 Quality Accounts**

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

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

There were 3 patient deaths, representing 0.30 % of the patient deaths during the reporting period 2018/19 Q1 and Q2, that were considered likely to be avoidable. These patient deaths were also

identified as incidents prior to the Learning from deaths (LfD) process, and reported as serious incidents.

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

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

## **Summary of lessons learnt (27.4)**

The lessons learnt summarised below relate to all patient deaths which were reviewed as part of this process. We have included examples of good practice and areas for improvement; it should be noted that these do show differences in care for our patients and we continue to work to ensure that patient care is consistent and of high quality. During 2019/20, we updated our Incident Management Policy to include our Learning lessons from near misses, serious incidents and deaths communications plan. Some of our approaches include:

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

## **Patient safety Clinical Practice Group (CPG) Advance Care Planning (ACP) workstream**

We are developing our Advance Care Planning (ACP) workstream as part of the Patient safety CPG. This will improve the experience of patients and families and ensures that there are links with other CPGs such as frailty to ensure synergy of effort without duplication.

Advance Care Planning (ACP) encompasses:

- Earlier recognition of a patient's likely last year of life
- The introduction of conversations regarding the patient's wishes and preferences
- Clear treatment escalation plans
- Onward care plans documented on the discharge letter
- The use of CMC (co-ordinate my care, an online multi-agency data sharing platform)

This work links a number of systems and processes within the trust including: the Care of the Dying Patient – Excellence in the last days of life, Bereavement services, the Medical Examiner system, Learning from Deaths (LfDs) reviews, complaints and incidents. This workstream is one of the drivers for our 2020-2025 Safety Strategy, and as such will be reported on in next year's Quality Accounts.

Key stakeholder meetings have been completed and we are identifying the best data to help us identify the appropriate patient cohort and understand where improvements are made.

## Summary examples of learning from 2019/20 (Q3 and Q4)

Good practice	Areas for improvement
<b>Patient care</b>	
<ul style="list-style-type: none"> <li>Holistic multidisciplinary care</li> <li>Overall the care received was impeccable from start to finish</li> </ul>	<ul style="list-style-type: none"> <li>If a trainee doctor is asked to write up iv fluids, they should review the patient.</li> <li>VTE assessment and treatment</li> </ul>
<b>Communication</b>	
<ul style="list-style-type: none"> <li>Full discussion about risk/benefits of orthopaedic operations, with family</li> <li>Involvement of the patient and significant other, who also has learning difficulties, as well as the family was respectful and appropriate.</li> <li>GP informed</li> <li>Excellent multidisciplinary and multi-professional working, excellent communication with family and patient, excellent communication between drs, nurses and therapists</li> </ul>	<ul style="list-style-type: none"> <li>Where a patient is under 'joint care', consultants must agree and specify with nursing staff, who is responsible for what.</li> <li>If there is considerable discrepancy between a family's views and clinicians, concerning active treatments, it is sensible to get a second consultant opinion</li> </ul>
<b>End of life palliative care</b>	
<ul style="list-style-type: none"> <li>Prompt DNAR and referral to palliative care</li> <li>Palliative care team closely involved in end of life care</li> </ul>	<ul style="list-style-type: none"> <li>DNAR discussion could have happened sooner.</li> </ul>
<b>Escalation when a patient deteriorates</b>	
<ul style="list-style-type: none"> <li>This patient's overall poor health and limited life expectancy were recognised in a timely fashion</li> </ul>	<ul style="list-style-type: none"> <li>Staff should have a low threshold for involving PARRT</li> <li>response to deterioration not timely enough</li> <li>Earlier escalation to ITU</li> </ul>
<b>Documentation</b>	
<ul style="list-style-type: none"> <li>Good documentation of discussions with family</li> <li>Documentation of the sacral ulcer in ED was good</li> <li>Good post take ward round document</li> </ul>	<ul style="list-style-type: none"> <li>better documentation of the patients deterioration</li> <li>Need explicit documentation re discussions regarding DNAR</li> <li>MCA was not formally recorded in the clinical records although it was noted that the patient was aphasic and unresponsive.</li> </ul>

## Summary examples of learning from 2019/20 (Q1 and Q2)

Good practice	Areas for improvement
<b>Patient care</b>	
<ul style="list-style-type: none"> <li>Daily ward round and review by consultant orthopaedic surgeon</li> <li>Timely IV antibiotics and IV fluids administered</li> <li>Timely CT PA performed</li> <li>There are many examples of good practice here such as daily ward round and review by consultant orthopaedic surgeon, discussion in the trauma meetings, honest and elaborate discussion with patient regarding risk and benefits of conservative and operative management.</li> </ul>	<ul style="list-style-type: none"> <li>Reinforce relevant radiological search strategies for detecting pulmonary emboli on CT scan at the radiology discrepancy meeting.</li> <li>Patient remained in CDU until the operation, instead of a surgical ward</li> <li>Giving critical-care based medications to increase the blood pressure confused the situation and confused the family. It is not clear what the purpose was.</li> </ul>

Good practice		Areas for improvement	
<b>Communication</b>			
<ul style="list-style-type: none"> <li>Discussion in the trauma meetings, honest and elaborate discussion with patient regarding risk and benefits of conservative and operative management</li> </ul>		<ul style="list-style-type: none"> <li>Family MDT may have been helpful in this situation.</li> </ul>	
<b>End of life palliative care</b>			
<ul style="list-style-type: none"> <li>Pain relief was completed promptly and effectively</li> </ul>		<ul style="list-style-type: none"> <li>There was a lack of recognition that the patient was dying and the commencement of aggressive fluid resuscitation was not appropriate</li> </ul>	
<b>Escalation when a patient deteriorates</b>			
<ul style="list-style-type: none"> <li>Doctors were appropriately informed about patient's high BP and treatment was initiated with antihypertensive medication</li> <li>Subsequent deterioration in clinical condition was appropriately addressed</li> </ul>		<ul style="list-style-type: none"> <li>Sudden unexpected deterioration should have prompted recognition that whatever has happened, this was now a terminal event, and the focus of care should have shifted to comfort care, rather than active management</li> </ul>	
<b>Documentation</b>			
<ul style="list-style-type: none"> <li>Clear verbal and written communication and documentation</li> </ul>		<ul style="list-style-type: none"> <li>There is no documentation of any orthogeriatric review at any point</li> <li>Blood tests showed chronic hyponatremia but this was not commented on in the notes.</li> </ul>	

## Description of actions taken during 2018/19 (Q3 and Q4) (27.5)

The actions summarised below relate to those patient deaths which were considered likely to be avoidable. From October 2018 to March 2019, we identified 5 patient deaths that were considered likely to be avoidable, all of which were identified and reported as serious incidents:

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

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

### Actions

- Clarify the process and importance of the use of interpreting services
- Clarify the process to support and refer a woman with an extremely preterm delivery
- Create a training slide set of the case with emphasis on speaking up and challenging colleagues in relation to the management of deteriorating patients.

- Develop a standard operating procedure for contacting women where an urgent ultrasound scan is required
- Include falls risk assessment process clearly within new staff induction training
- Incorporate clear guidance on the responsibility of the consultant obstetrician particularly in relation to escalation and support of junior staff in the MDU setting.
- Introduce the use of clinical Apps as a method for the documentation of handovers between shifts.
- Remind staff that recommendations made on the ICU handover form are also documented in the patient's notes and added to the medical handover sheet for follow up.
- Share lessons learnt via newsletters and blogs
- Share the report with staff as a case study to facilitate learning and enable discussion at team meetings
- Share the report with the patient/family.
- Submit change request to alter the EPR (electronic patient record)
- Undertake the following audits to identify any gaps in practice:
  - critical results phoning process
  - falls risk assessments and staff understanding of the process
  - observation charts
- Undertake reflective practice in the clinical environment to support learning
- Update and circulate the procedure/policy for:
  - Management of hypertension and clinical decision making with regard to hypertension in early pregnancy
  - Management of women where there is an abnormality on an antenatal CTG and the escalation pathway
  - The use of Dawes Redman criteria for further obstetric review
  - Antenatal fetal monitoring
  - Fetal Growth Assessment and Diabetes in pregnancy guidelines

## Description of actions taken during 2019/20 (Q1 and Q2)

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

Incident	Year	Quarter	Likert Avoidability
2019/25322	2019/20	Q2	2 Strong evidence of avoidability
2019/21001	2019/20	Q2	3 Probably avoidable, more than 50/50
2019/16403	2019/20	Q2	4 Possibly avoidable but not very likely, less than 50/50
2019/16414	2019/20	Q2	4 Possibly avoidable but not very likely, less than 50/50
2019/9142	2019/20	Q1	4 Possibly avoidable but not very likely, less than 50/50
2019/16779	2019/20	Q2	6 Definitely not avoidable ie unavoidable

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

## Actions

- Develop the new urology stent register to:
  - Monitor stent insertion/removals
  - Track patients from Interventional radiology
  - Review the consistency of compliance with updates

- Teach new doctors the process on induction
- Develop a simulation training bundle to aid understanding of: team communication and listening, situational awareness and the recognition of a child whose compensatory mechanisms may be failing.
- Share lessons learnt via newsletters and blogs
- Share the report with staff as a case study to facilitate learning and enable discussion at team meetings
- Share the report with the patient/family.
- Undertake reflective practice in the clinical environment to support learning

## Description of proposed actions to take during 2019/20 (27.5)

Actions from quarter 3 and 4 reviews when they are completed will be taken forward during 2019/20 and reported on in next year's Quality Accounts.

## Assessment of the impact of the actions taken (27.6)

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

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

## Never events

Never events are extremely serious and largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place. The trust takes Never Events seriously and a full investigation is undertaken with the final report discussed at the Serious Incident Review Panel where final actions are agreed.

Unfortunately, we reported 6 never events during 2019/20.

STEIS	Site	Type	Incident date	Harm
2019/10977	BH	Fed via misplaced NG tube	12/05/2019	Moderate
2019/15127	RFH	ABO-incompatible blood component	07/07/2019	Low
2019/25700	RFH	Wrong sized breast implant	18/11/2019	Moderate
2019/25922	CFH	Wrong sized hip liner	27/11/2019	Moderate
2020/2079	RFH	Retained tampon post-episiotomy	24/01/2020	Low
2020/4724	CFH	Wrong site pain injection	18/02/2020	Low

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

All serious incidents are reviewed at our Board level Clinical innovations and standards committee (CSIC), chaired by one of our Non-Executive Directors where we triangulate serious incidents with incidents, complaints, PALS and litigation to identify themes which might require system-wide work.

## 2.3 Reporting against core indicators

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

Areas covered will include:

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

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

### Summary hospital-level mortality (SHMI)

#### Indicator:

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

Royal Free Performance Oct 15 to Sep 16	Royal Free Performance Oct 16 to Sep 17	Royal Free Performance Oct 17 to Sep 18	Royal Free Performance Oct 18 to Sep 19	National Average Performance Sep 18 to Aug 19	Highest Performing NHS Trust Performance Sep 18 to Aug 19	Lowest Performing NHS Trust Performance Sep 18 to Aug 19
0.9086 (as expected)	0.8679 (lower than expected)	0.8270 (lower than expected)	0.8207 (lower than expected)	1.0 (as expected)	0.6979 (lower than expected)	1.1877 (higher than expected)

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

The SHMI score published in this report has been calculated by NHS Digital and uses finalised HES data. In addition to data for 2018-19, the chart above also includes data for 2015-16, 2016-17 and 2017-18.

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

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

The latest data available covers the 12 months October 2018 to September 2019. During this period the Royal Free had a mortality risk score of 0.8207, which represents a risk of mortality lower than expected for our case mix. This represents a mortality risk statistically significantly below (better than) expected with the Royal Free ranked 8th out of 129 non-specialist acute trusts.

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

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

<https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi><sup>Ⓐ</sup>

## Patient deaths with palliative care code

### Indicator:

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

Royal Free Performance Oct 15 to Sep 16	Royal Free Performance Oct 16 to Sep 17	Royal Free Performance Oct 17 to Sep 18	Royal Free Performance Oct 18 to Sep 19	National Average Performance Oct 18 to Sep 19	Highest Performing NHS Trust Performance Oct 18 to Sep 19	Lowest Performing NHS Trust Performance Oct 18 to Sep 19
27.3%	35.5%	40.8%	35%	37%	59%	12%

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

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

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

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

investigated with a feedback report provided to the trust board and the clinical performance committee at their next meetings.

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

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

<https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi><sup>(A)</sup>

## Patient reported outcome measures scores (PROMS)

### Indicator:

The NHS asks patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards. PROMs measure health gain in patients undergoing hip replacement, knee replacement and up to September 2017, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.

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

Royal Free Performance 2016/17	Royal Free Performance 2017/18	Royal Free Performance 2018/19	Royal Free Performance 2019/20	National Average Performance 2019/20	Highest Performing NHS Trust Performance 2019/20	Lowest Performing NHS Trust Performance 2019/20
<b>Indicator: Groin hernia surgery</b>						
Low number rule Applies	0.05	No longer being reported				
<b>Indicator: Varicose vein surgery</b>						
0.12	0.11	No longer being reported				
<b>Indicator: Total hip replacement - primary (EQ-5D Index)</b>						
0.43	0.42	0.41	Low number rule Applies	0.47	0.55	0.39
<b>Indicator: Knee replacement surgery (EQ-5D index)</b>						
0.31	0.32	0.299	Low number rule Applies	0.35	0.44	0.26

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

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

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

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

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

## Emergency readmissions within 28 days

### Indicator:

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

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

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

The Royal Free carefully monitors the rate of emergency readmissions as a measure for quality of care and the appropriateness of discharge. A low, or reducing, rate of readmission is seen as evidence of good quality care. The table above demonstrates that the 28 day readmission rate at Royal Free London NHS Foundation Trust compares favourably with the rate amongst the 167 non-specialist providers in England; with a lower than average readmission rate observed at Royal Free London Foundation NHS Trust in both paediatric and adult cohorts.

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

- carefully monitoring the rate of emergency readmissions as a measure for quality of care and the appropriateness of discharge. A low or reducing rate of readmission is seen as evidence of

good quality care. (In relation to adults the re-admission rate is lower (better) than the peer group average)

- undertaking detailed enquiries into patients classified as readmissions with our public health doctors, working with GP's and identifying the underlying causes of readmissions

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

## Responsiveness to the personal needs of our patients

### Indicator:

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

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

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

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

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

- Developing site-based experience strategies that identify local issues for patients
- Continuing to deliver and monitor the patient experience strategy goals of cancer and dementia:
  - Cancer experience
    - Commenced the cancer clinical practice group across all tumour types where cancer patient experience will be a key focus
    - Established a cancer CNS community of practice for all cancer nurses
    - Piloting a new app which will gather real-time patient experience metrics split by tumour site
  - Dementia experience
    - 2 elderly care wards (8 West and 10 North) have undergone dementia friendly refurbishment
    - Publication of RFL Dementia Handbook for carers

- 100 members of staff joined Chickenshed theatre company to complete an innovative study day in advanced communication for dementia
- Over 600 members of staff have completed specialist CAPER Anchor training

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

## Friends and Family test (Staff)

### Indicator:

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

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

The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the official NHS Staff Survey. Each year the NHS surveys its staff and one of the questions looks at whether or not staff would recommend their hospital as a care provider to family or friends. Trust performance is similar to the national average for acute trust providers on this measure. The Royal Free London NHS Foundation Trust performed marginally worse than in previous years and just above average compared to 85 Acute NHS providers. The Royal Free London NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

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

<http://www.nhsstaffsurveyresults.com/><sup>(A)</sup>

## Venous thromboembolism (VTE)

### Indicator:

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

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

Royal Free Performance Oct 16 to Dec 16	Royal Free Performance Oct 17 to Dec 17	Royal Free Performance Oct 18 to Dec 18	Royal Free Performance Oct 19 to Dec 19	National Average Performance Oct 19 to Dec 19	Highest Performing NHS Trust Performance Oct 19 to Dec 19	Lowest Performing NHS Trust Performance Oct 19 to Dec 19
95.9%	95.9%	96.5%	<b>96.9%</b>	95.0%	100.0%	71.6%

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

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

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

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

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

- The trust reports its rate of hospital acquired thromboembolism (HAT) to the monthly meeting of the trust board and the quarterly meeting of the clinical performance committee. Any significant variations in the incidence of HAT are subject to investigation with a feedback report provided to the trust board and clinical performance committee at their next meetings.
- The Thrombosis Unit conduct a detailed clinical audit into each reported case of HAT with finding shared with the wider clinical community.

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

## C difficile

### Indicator:

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

Royal Free Performance 2015/2016	Royal Free Performance 2016/2017	Royal Free Performance 2017/2018	Royal Free Performance 2018/2019	National Average Performance 2018/2019	Highest Performing NHS Trust Performance 2018/2019	Lowest Performing NHS Trust Performance 2018/2019
17.8	21.0	21.3	16	12	0	80

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

Clostridium difficile is an infection which can cause severe diarrhoea and vomiting and has been known to spread within hospitals, particularly during the winter months. Reducing the rate of Clostridium difficile infections is a key government target.

Royal Free London NHS Foundation Trust performance was worse than the national average during 2018/19, however is an improvement on 2017/18. Very few of these infections have been attributed to lapses in care by the trust.

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

- The trust is ensuring that all staff adhere to the trust's infection control policies, including hand hygiene and dress code. Delivery of educational programmes, comprehensive antibiotic policies, good bed management with early isolation of symptomatic patients and enhanced environmental cleaning.
- The microbiology, infection, prevention and control and pharmacy teams continue to perform Clostridium difficile ward rounds to ensure that all elements of the care and treatment of patients with C. difficile are being appropriately managed.
- The trust C.difficile 'action log' incorporates activity across the trust and is driven through the fortnightly divisional lead/C.diff action group.
- Learning from antimicrobial audits has provided evidence for a revised patient prescription chart with enhanced antimicrobial section. This has now been rolled-out across the trust and elements are being audited to focus on embedding as best practice.

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

## Patient safety incidents

### Indicator:

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

	Royal Free Performance Oct 16 to Mar 17	Royal Free Performance Oct 17 to Mar 18	Royal Free Performance Oct 18 to Mar 19	Royal Free Performance Oct 19 to Mar 20	National Average Performance Oct 19 to Mar 20	Highest Performing NHS Trust Performance Oct 19 - Mar 20	Lowest Performing NHS Trust Performance Oct 19 - Mar 20
(a)	5,915 (36.5)	6,549 (39.1)	6,527 (38.8)	6,693 (37.7)	5,841 (46.1)	1,278 (27.7)	22,048 (48.4)
(b)	26 (0.44)	33 (0.20)	24 (0.14)	19 (0.1)	19 (0.19)	1 (0.01)	72 (0.16)

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

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

NHS Improvement regards the identification and reporting of incidents as a sign of good governance with organisations reporting more incidents potentially having a better and more effective safety culture. The trust reported a lower volume of incidents per 1,000 bed days between Oct 2018 and Mar 2019 (37.7) compared to the national average (46.1).

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

Launching our 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 11% year on year. However there are risks at every trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on every incident being reported. Whilst we have provided training to staff and policies in place relating to incident reporting, this does not provide full assurance that all incidents are reported. We believe this is in line with all other trusts.

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

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

## Part three: Overview of the quality of care in 2019/20

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

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

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

Relevant quality domain	Quality performance indicators
<p><b>Section 1:</b> <b>Patient safety</b></p>	<ul style="list-style-type: none"> <li>• Summary hospital mortality indicator (SHMI)</li> <li>• Methicillin-resistant staphylococcus aureus (MRSA)</li> <li>• C. difficile Infections</li> </ul>
<p><b>Section 2:</b> <b>Clinical effectiveness</b></p>	<ul style="list-style-type: none"> <li>• Referral to treatment (RTT)</li> <li>• A&amp;E performance</li> <li>• Cancer waits</li> <li>• Average length of stay (elective and non-elective)</li> <li>• 30-day emergency readmission rates for elective patients</li> </ul>
<p><b>Section 3:</b> <b>Patient experience</b></p>	<ul style="list-style-type: none"> <li>• Friends and family test</li> <li>• Volume of delayed transfers of care (DTCs)</li> <li>• Cancelled operations not readmitted within 28 days</li> </ul>

## Definitions

The following table sets out the definition for each performance measure. These are, to the best of our knowledge, consistent with standard national NHS data definitions. The calculation for cancer 62 day performance has changed since April 2019 and the definition has been updated below. There has been no change in the basis for calculation for any other measures since 2015/16.

Indicator / Metric	Description / Methodology	Source
Summary Hospital Mortality Indicator (SHMI)	These measures use routinely collected data to calculate an overall "expected" number of deaths if the trust matched the national average performance. The result is a ratio (calculated by dividing the observed number of deaths by the expected deaths).	NHS Digital
MRSA	The count of meticillin resistant Staphylococcus aureus (MRSA) bacteraemias attributed to the trust.	Datix system
C. Difficile infections	Number of Clostridium Difficile infections reported at the trust	Datix system
C. Difficile Lapses in care	Number of Clostridium Difficile infections due to lapses in patient care	Datix system
RTT Incomplete Performance - % waiting less than 18 weeks	Percentage of patients on the incomplete RTT patient tracking list waiting 18 weeks or less for treatment or discharge from referral.	Cerner system
Accident and Emergency – 4hr standard	Percentage of A&E attendances where the patient was admitted transferred or discharged within 4 hours of their arrival at an A&E department.	Cerner system
2 Week Wait - All Cancer	Percentage of patients referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment or diagnostic.	Infoflex system
2 Week Wait - symptomatic breast	Percentage of patients referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for their first outpatient appointment.	Infoflex system
31 day wait diagnosis to treatment	Percentage of patients waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers.	Infoflex system
62 day wait - from urgent GP referral	Percentage of patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer. There are new reallocation rules which have been in place since April 2019. These affect pathways which are shared between providers, and allocate breaches based primarily on: a) whether the referring provider has sent the appropriate referral within 38 days and b) whether the treating provider has started treatment within 24 days	Infoflex system
Average length of stay (non-elective and elective)	Mean length of stay for all inpatients based on whether their mode of admission was elective or non-elective. This includes patients with a 0-day length of stay.	Stethoscope
30-day re-admission rate following elective or non-elective spell	Number of emergency re-admissions within 30 days of discharge as proportion of total discharges following an elective admission And Number of emergency re-admissions within 30 days of discharge as a proportion of number of discharges following an elective admission	Stethoscope
Friends and Family IP, A&E and maternity scores	The number of responses that scored likely and extremely likely as a percentage of the total number of responses to the IP, A&E and maternity friends and family tests. (Neither Likely or not likely excluded from responses)	Cerner system
Volume of delayed transfer of care (DTCs)	This is the number of bed days lost in a month to patients who are awaiting a transfer of care to social or NHS community care.	Cerner system
Cancelled operations	Volume of last minute (on the day of surgery or following admission) cancellations for non-clinical reasons as a proportion of all elective inpatient and day-case operations.	Cerner system

## Notes on the charts

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

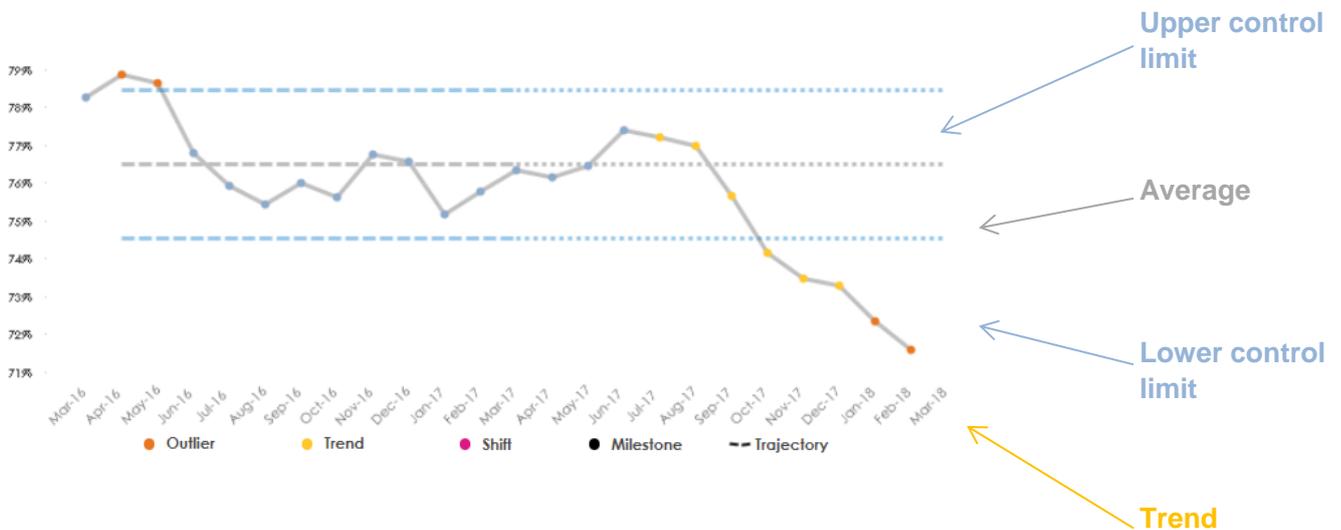
## Control charts

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

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



<sup>1</sup> <http://asq.org/learn-about-quality/data-collection-analysis-tools/overview/control-chart.html>

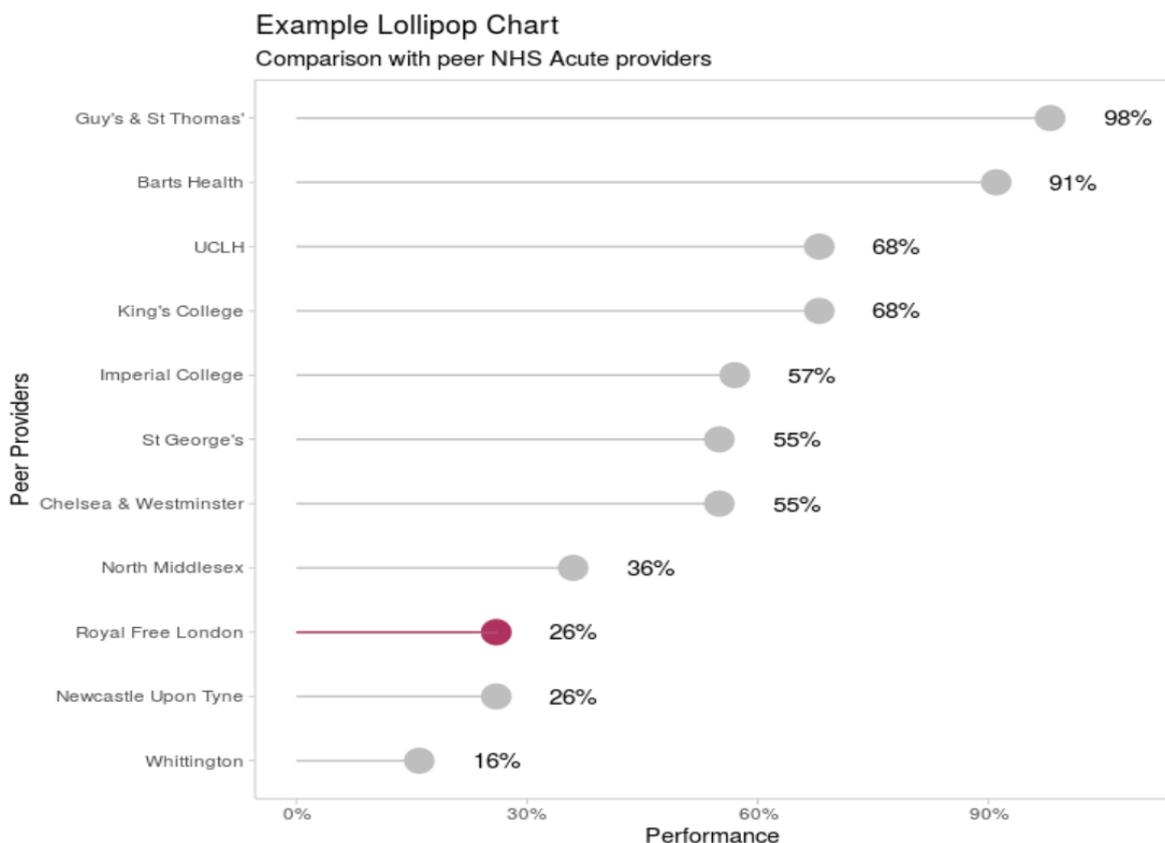
## Lollipop charts

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

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

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

## Example lollipop chart



<sup>2</sup> <https://model.nhs.uk/>

# 3.1 Performance against nationally selected indicators

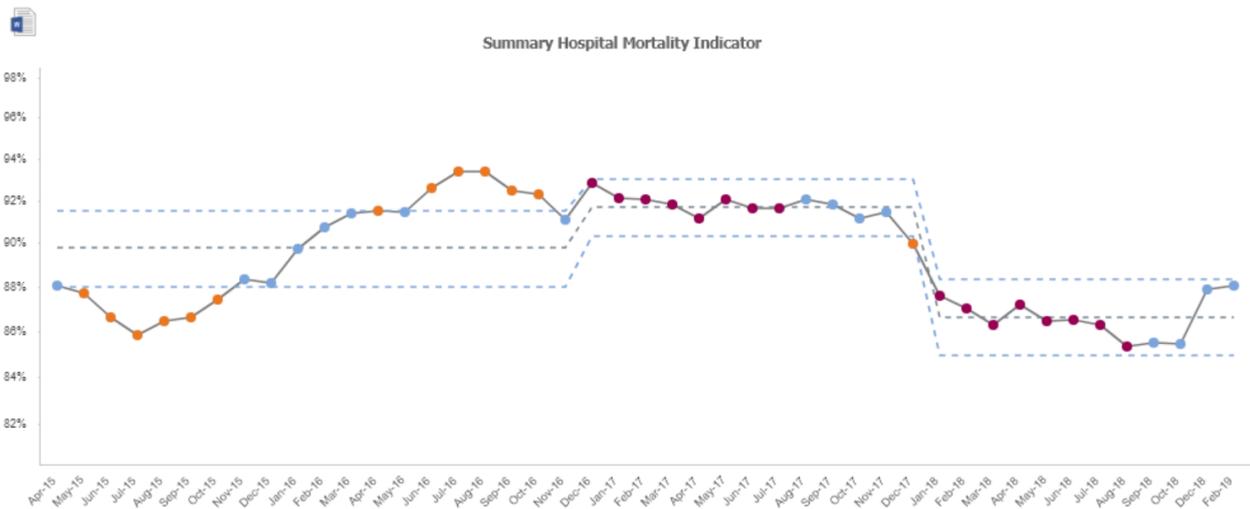
## Section 1: Patient Safety

### Summary Hospital Mortality Indicator (SHMI)

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

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

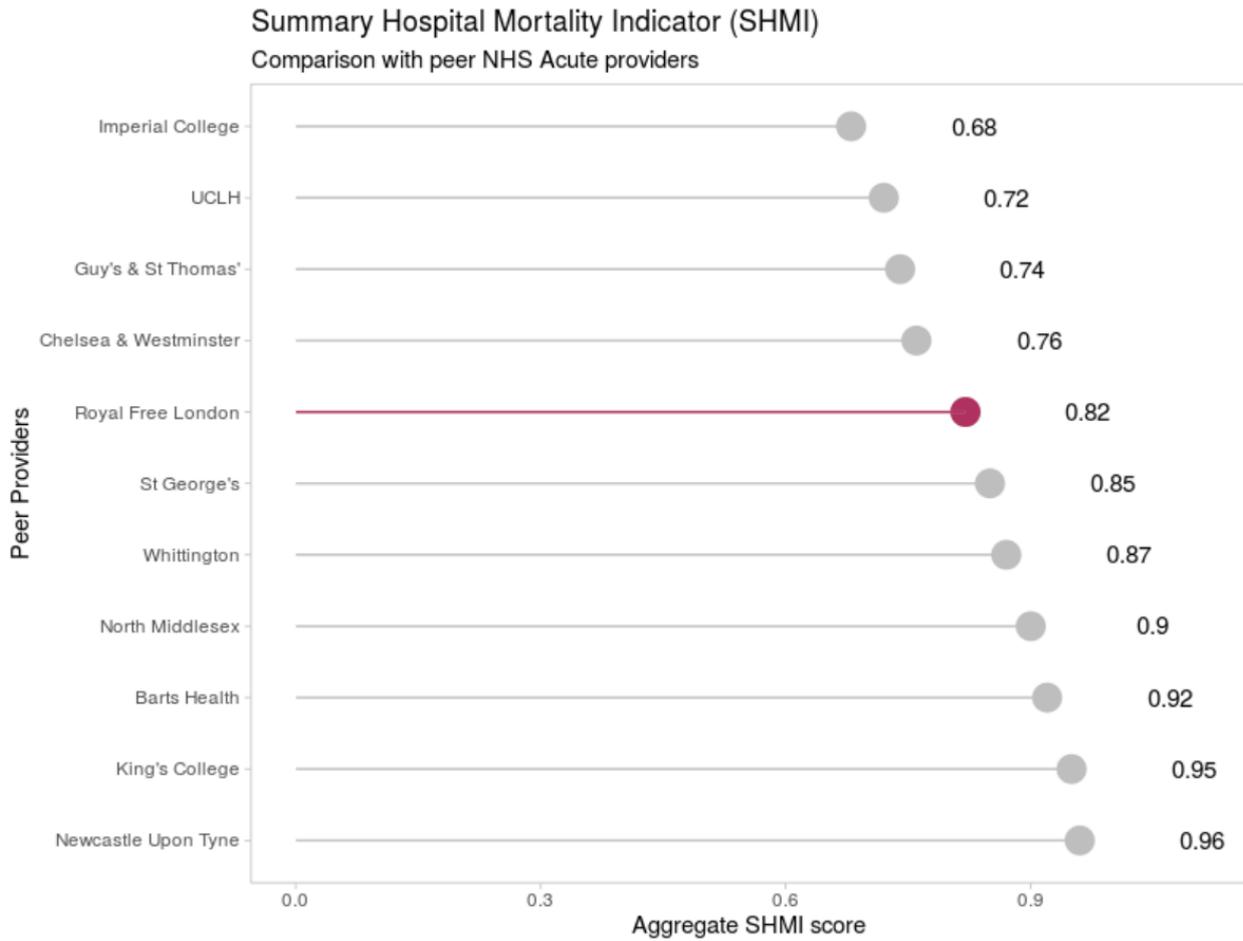
SHMI data is presented below for April 2015 to February 2020. This shows a recent improvement in the trust's score, with a positive shift in performance in January 2018.



Source: Royal Free London NHS Foundation Trust 2015-2019

The chart below shows the Royal Free London SHMI performance benchmarked against peer providers between December 2018 and November 2019 (the latest for which information is currently available). The Royal Free SHMI was 5<sup>th</sup> lowest (best) compared to 10 benchmark peer providers and was statistically 18% lower than expected.

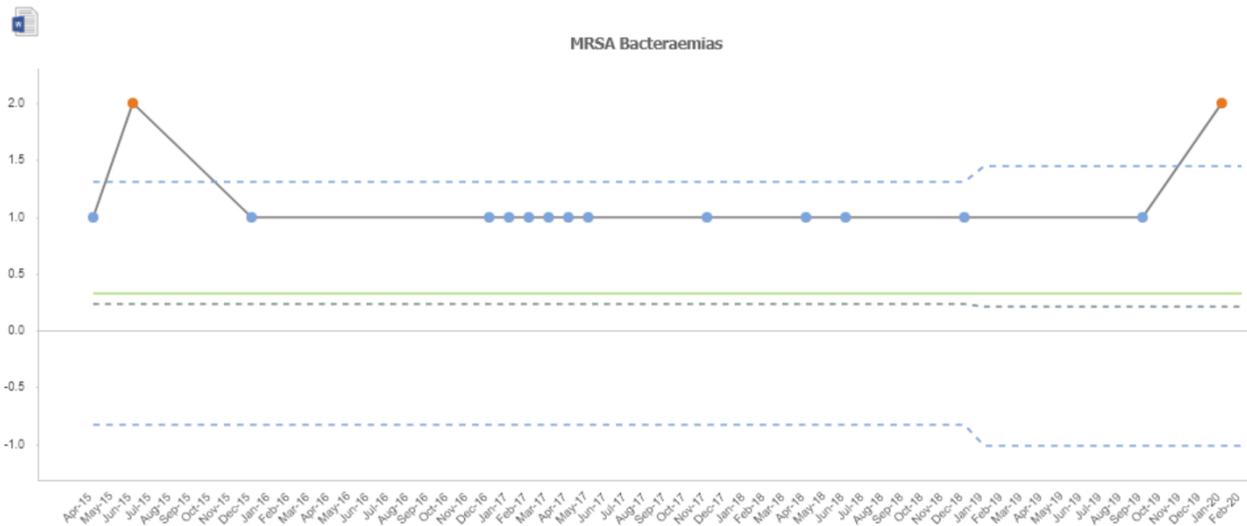
## Chart: Summary Hospital-level Mortality Indicator by NHS acute trust



Source: NHS Digital, 2020

## Methicillin-resistant staphylococcus aureus (MRSA)

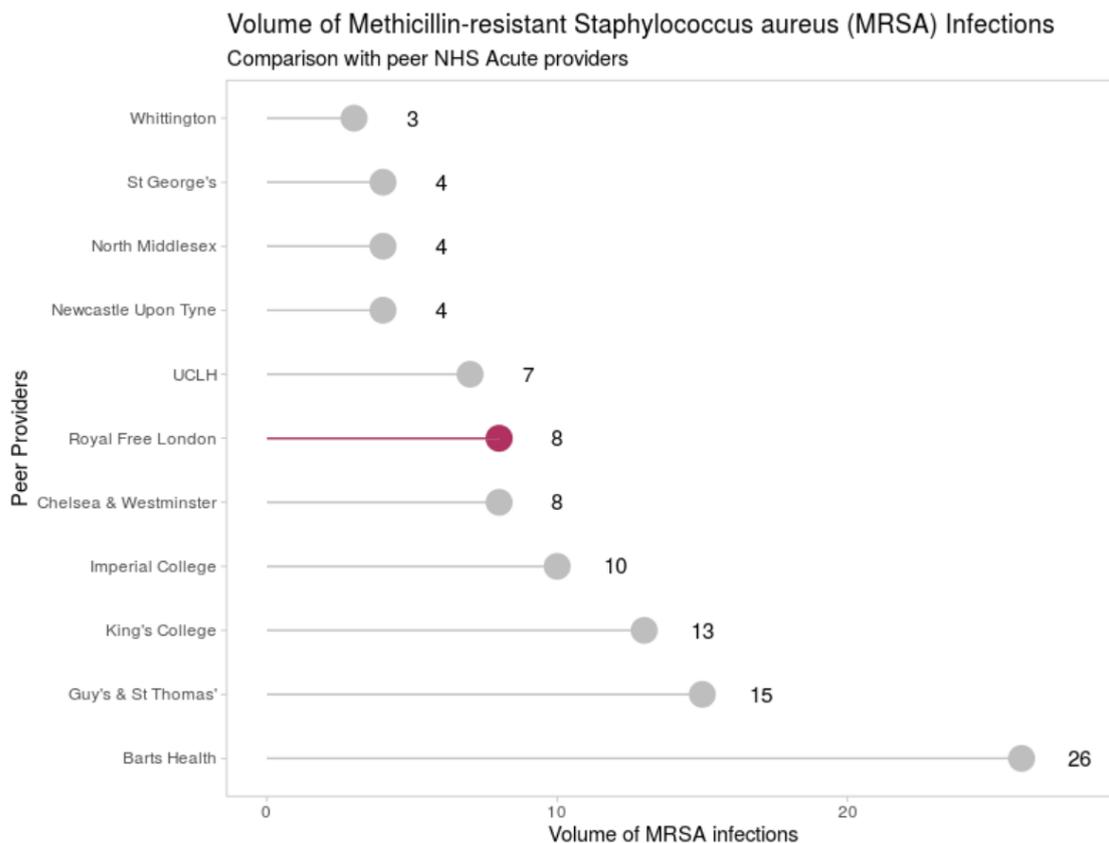
MRSA is an antibiotic resistant infection associated with admission to hospital. The infection can cause an acute illness, particularly when a patient's immune system may be compromised due to an underlying illness. Reducing the rate of MRSA infections is vital to ensure patient safety and is indicative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



Source: Royal Free London NHS FT 2015-2020

During 2019/20 the Royal Free reported 4 MRSA bacteraemias attributable to the Royal Free London. The chart below shows the number of MRSAs by the location at which they were detected. There were 8 cases detected at the Royal Free London, however only 4 remain attributable to the trust.

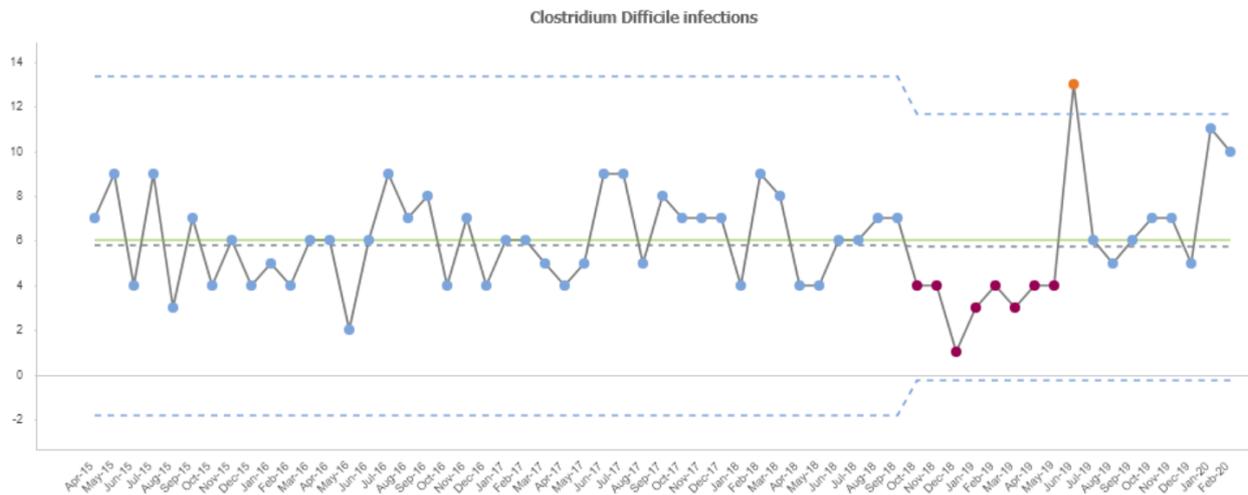
### Chart: Total volume of MRSA bacteraemias, February 2019 – February 2020



Source: gov.uk, 2020

## C. difficile

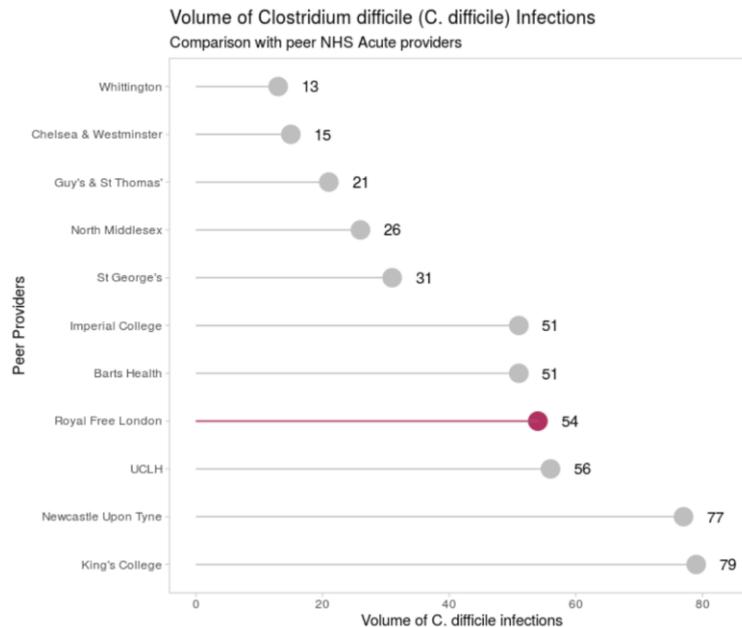
In relation to C. difficile the trust saw a positive shift in performance ending in April 2019, however since then numbers have been variable, with one negative outlier in June 2019.



Source: Royal Free London NHS FT 2015-2020

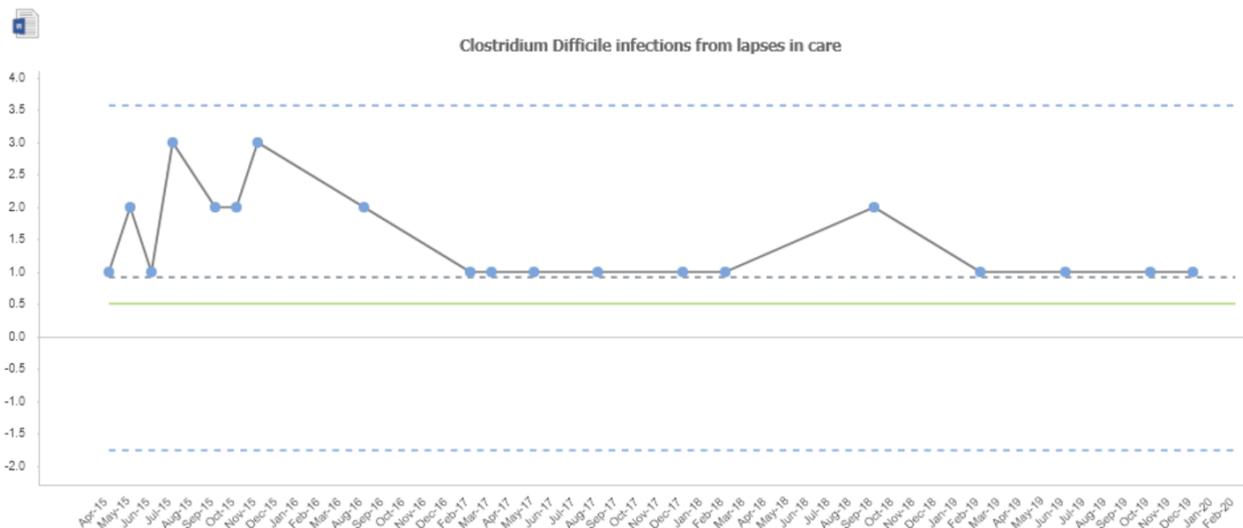
Benchmarking data is available only up to March 2019. Over this time period, the Royal Free London reported 54 infections, the 4<sup>th</sup> highest compared to the 10 benchmark providers.

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



Source: gov.uk, 2020

However, of the c.difficile volumes that can be attributed to “lapses in case” by the trust are significantly lower. Against this measure of performance the trust has seen 3 incidents in the 12 months prior to February 2020.



Source: Royal Free London NHS FT 2015-2020

## Section 2: Clinical Effectiveness

### Referral to treatment (RTT)

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

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

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

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

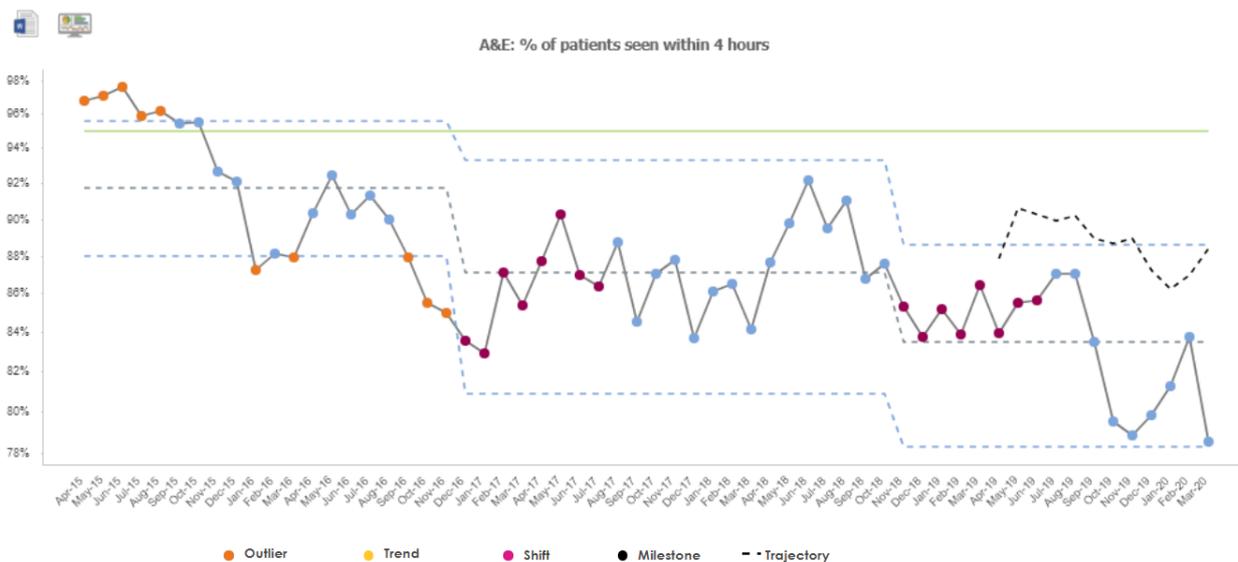
- Commissioning external support to carry out a large scale validation exercise of a stratified sample of the pathways from the Trust's historic data. This work is on track and due to be completed in April 2020.
- Validating and correcting a large number of more recent pathways with our internal validation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

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

## Accident and Emergency performance

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

During the period April 2019 to March 2020, the Royal Free London NHS FT achieved an average monthly performance of 82.9%. This is lower than 2018/19 which averaged at 87.4%.

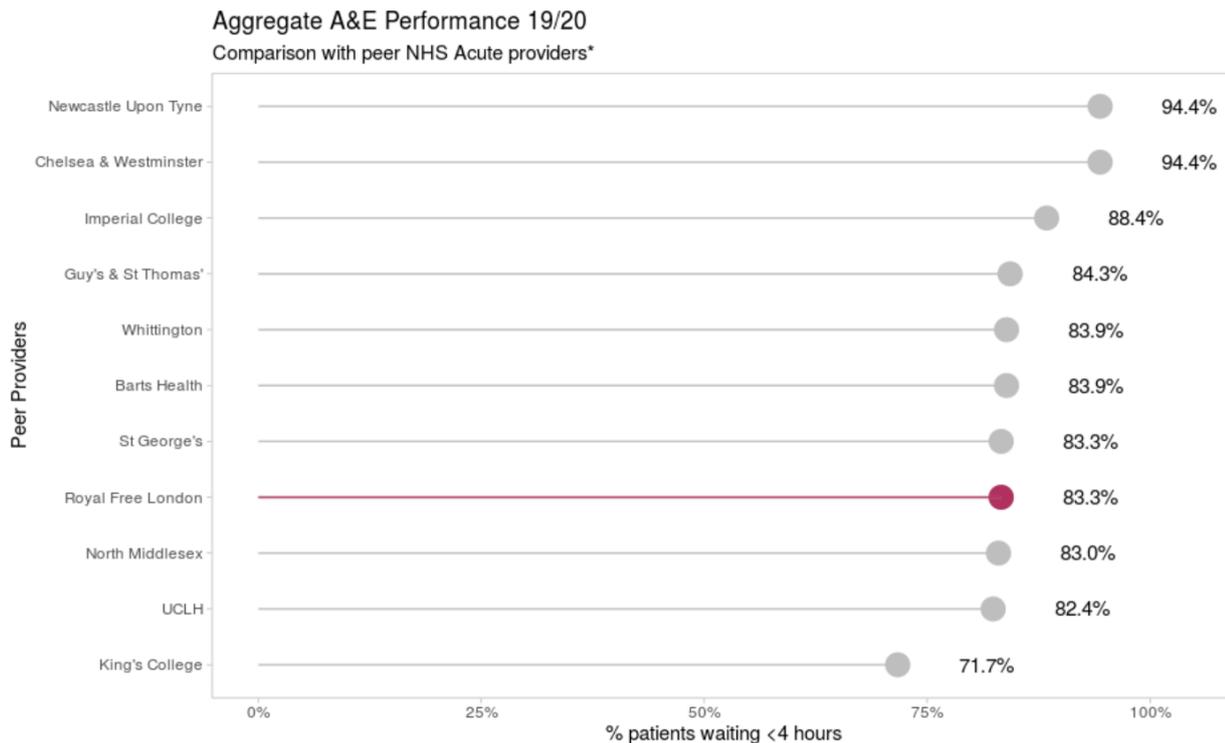


Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
86.5%	83.9%	85.5%	85.6%	87.1%	87.0%	83.5%	79.5%	78.8%	79.8%	81.3%	83.7%	78.5%

Source: Royal Free London NHS FT 2015-2020

The chart below shows the Royal Free London performance for April 2019 – January 2020 benchmarked against 10 peer providers. This shows that our performance was seventh out of 11 peer providers. However, two of the trusts, Imperial College and Chelsea & Westminster, ceased reporting in June 2019 which means their performance is based on the aggregate of April and May 2019 only.

## Chart: Mean performance against 4 hour A&E standard between April 2019 – January 2020<sup>3</sup>



Source: NHS Digital, 2020

## Cancer waits

The Cancer CPG was established in January 2019 with the aim of driving improvement in delivery of cancer services through a focus on experience, outcomes and waiting times. The Cancer CPG has been created to analyse the cross-sectional themes which underpin cancer pathways, such as cancer MDTs, radiology, histopathology and endoscopy, with a view to optimising processes, removing unwarranted variation and improving outcomes for patients.

The initial stages of the cancer CPG have involved a series of three workshops aimed at bringing together the clinical and operational teams who deliver cancer services across the trust.

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

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

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

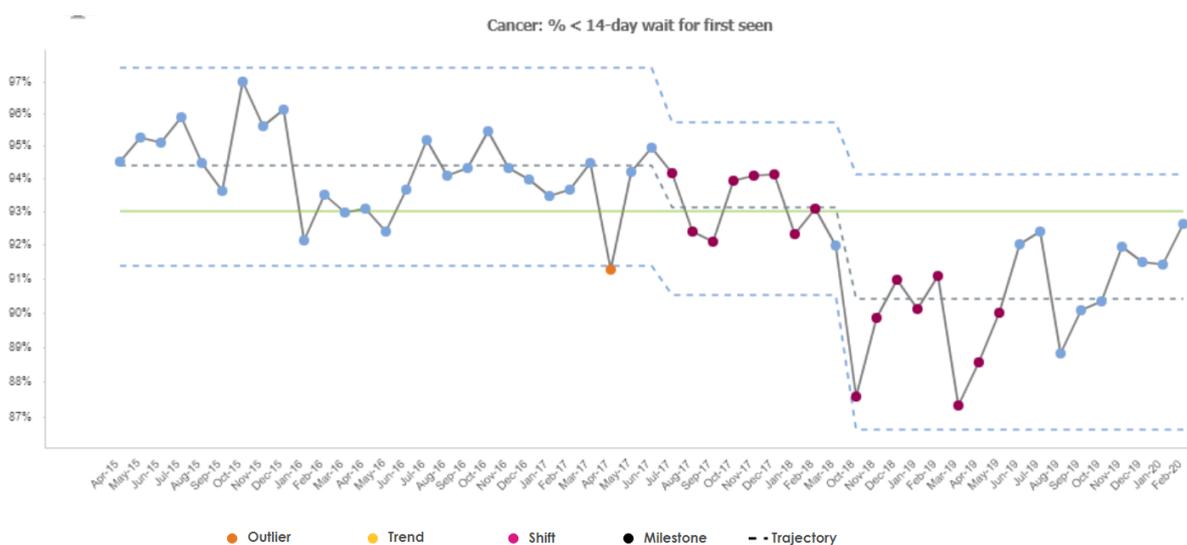
Cancer MDTMs (multi-disciplinary team meetings) form a key part of the cancer pathway that is common across tumour sites and utilise a high volume of clinician time. Alongside the context of national guidance from NHSI/E on MDT streamlining; the Cancer CPG are facilitating workshops which optimise MDT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

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

## All cancer 2 week waits

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

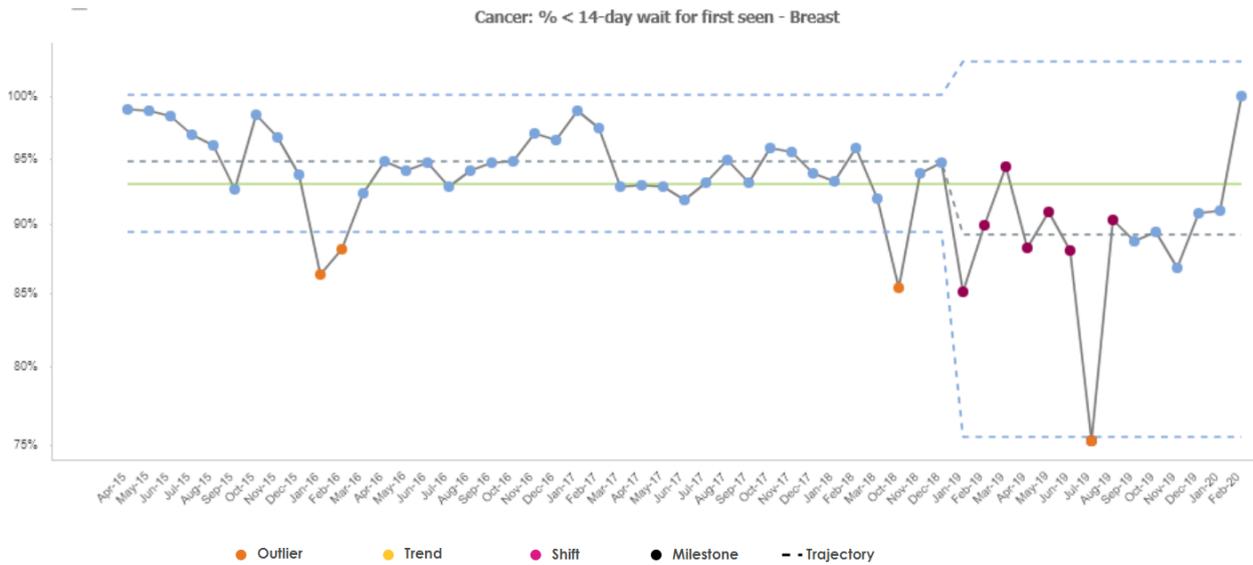
For 2019/20, the trust has failed to meet the standard to see at least 93% of patients within 2 weeks from GP referral, achieving an average performance of 90.9%.



Source: Royal Free London NHS FT 2015-2020

## Breast urgent referral 2 week waits

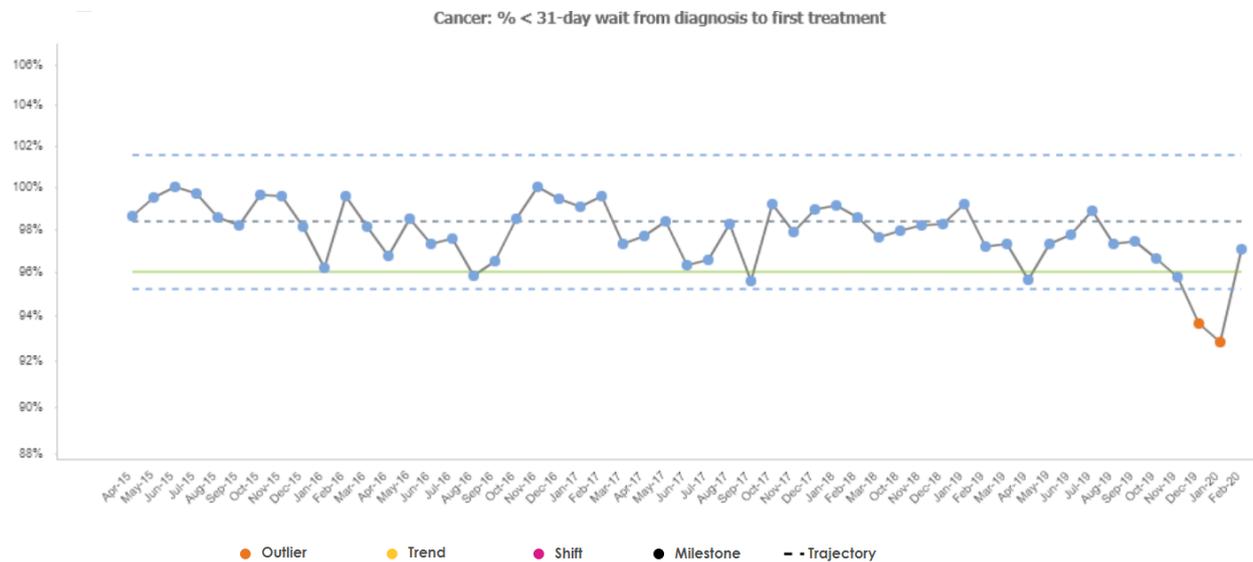
In 2019/20 up to February, the trust saw 89.0% of patients on an urgent (symptomatic) breast referral pathway within 2 weeks, below the national standard.



Source: Royal Free London NHS FT 2015-2020

## First definitive treatment within 31 days

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

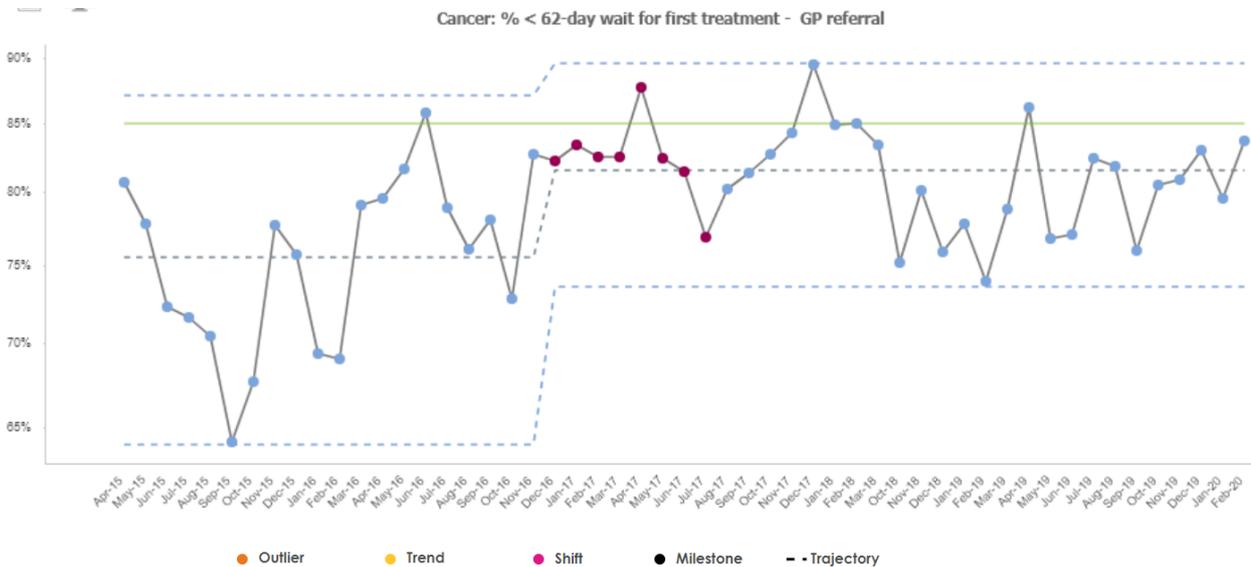


Source: Royal Free London NHS FT 2015-2020

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

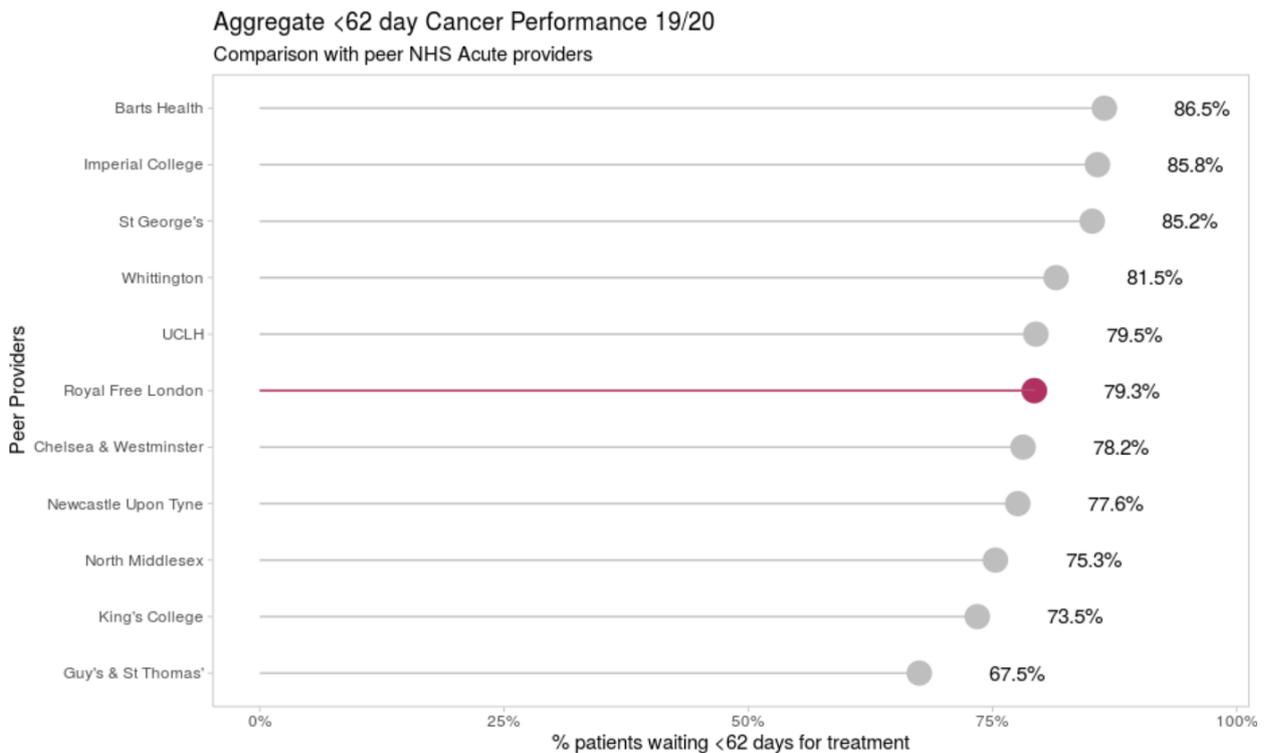
## First definitive treatment within 62 days of an urgent GP referral

The trust did not meet the 62 day standard in 2019/20, with 79.3% of patients receiving first treatment within 62 days of a GP referral. This is comparable with 2018/19 where 80% of patients were treated within the standard.



Source: Royal Free London NHS FT 2015-2020

## Chart: Mean performance against 62 day cancer standard between April 2019 – February 2020

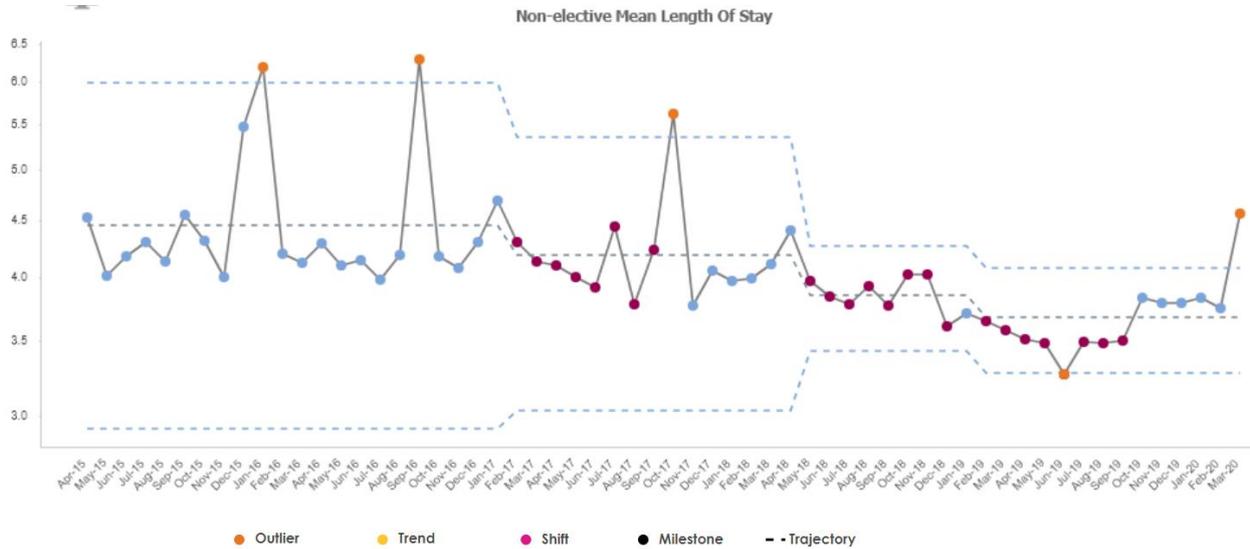


Source: NHS England, 2020

## Average length of stay:

### Non-elective mean length of stay

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

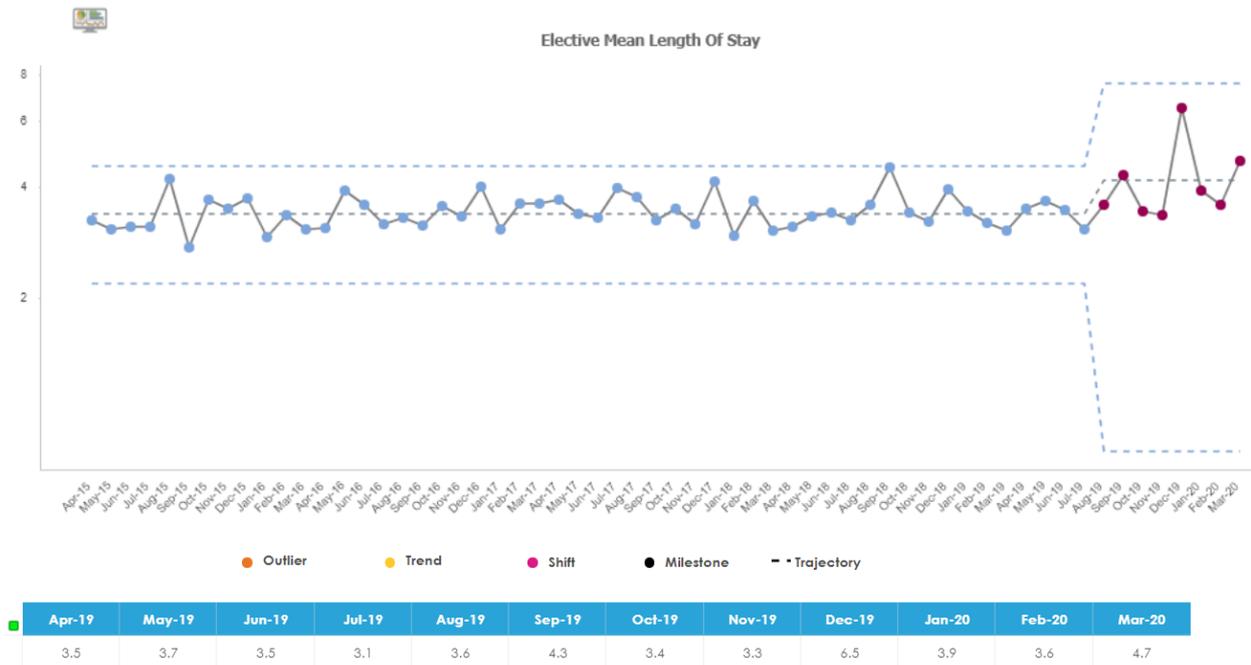


Source: Royal Free London NHS FT 2015-2020

Benchmark information is not available for this measure

## Elective mean length of stay

The trust average inpatient length of stay for patients admitted as elective to shows that the trust average length of stay in the period April 2019 to March 2020 was 4.0 days.



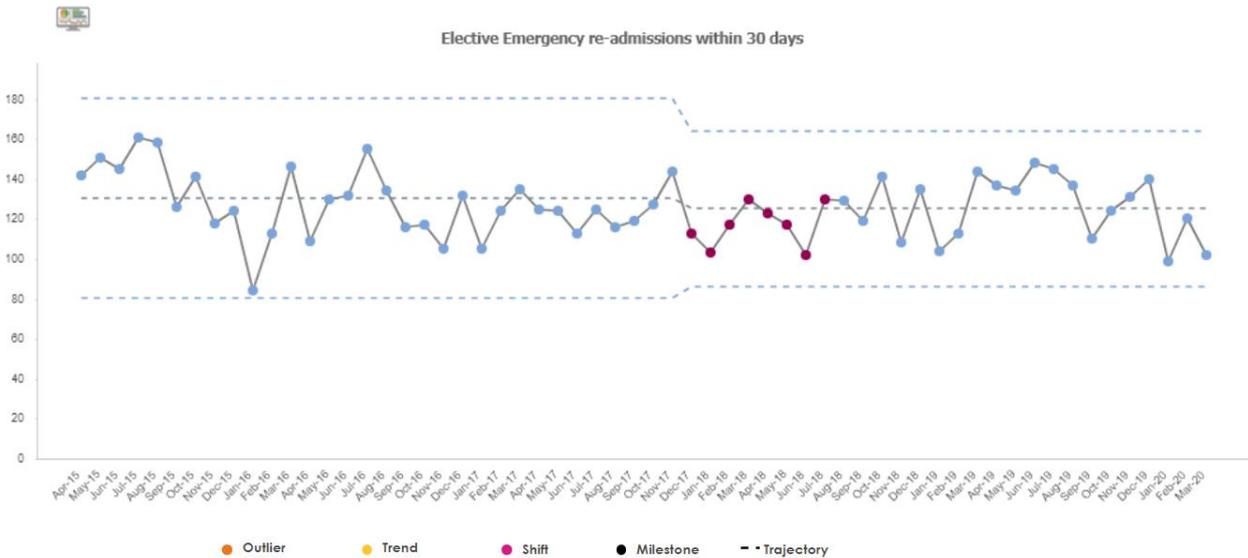
Source: Royal Free London NHS FT 2015-2020

Benchmark information is not available for this measure.

## Emergency re-admissions:

### 30 day emergency re-admissions following an elective admission

The chart below shows the proportion of patients re-admitted as an emergency following an elective admission in the previous 30 days between April 2015 and March 2020. The average for April 2019 to March 2020 was 128 and any variation has been within expected limits.



Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
144	137	134	148	145	137	110	124	131	140	99	120	102

Source: Royal Free London NHS FT 2015-2020

Benchmark information is not available for this measure.

## Section 3: Patient experience indicators

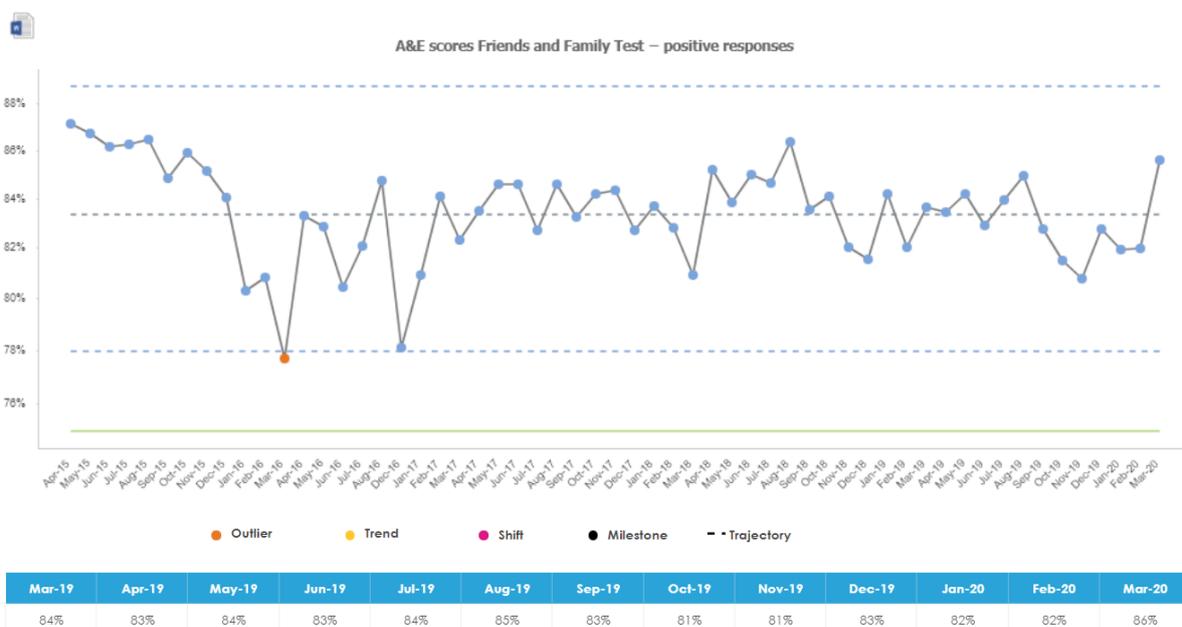
### Friends and family test (patients)

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

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

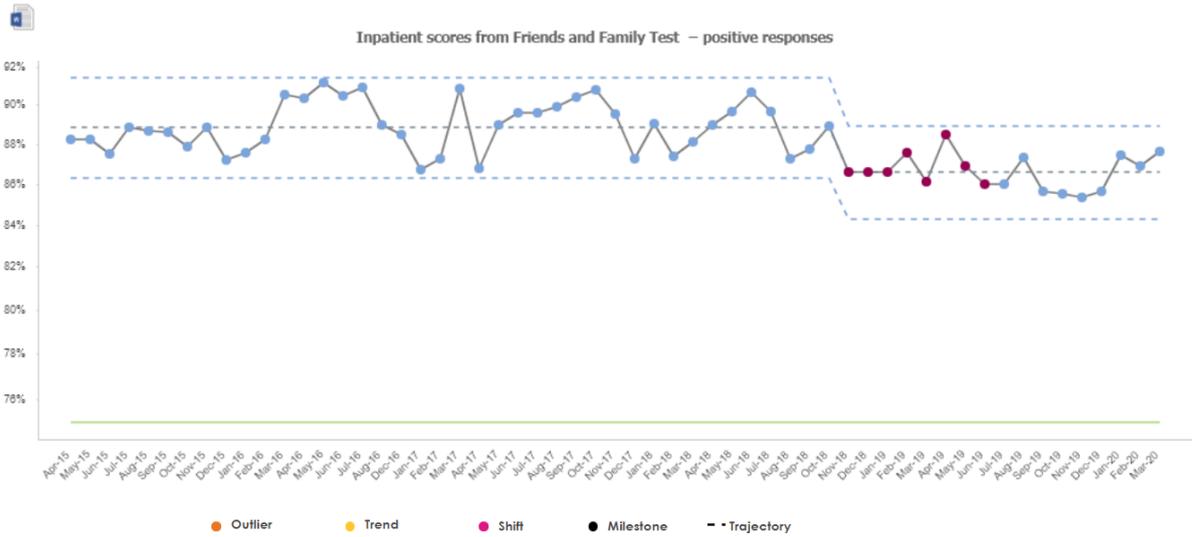
For all areas we have maintained performance over the last year. Whilst we previously did include benchmarking charts for these measures, NHSE recommends that benchmarking is not used to compare providers due to the flexibility of local data collection methods and variation in local population.

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



Source: Royal Free London NHS FT 2015-2020

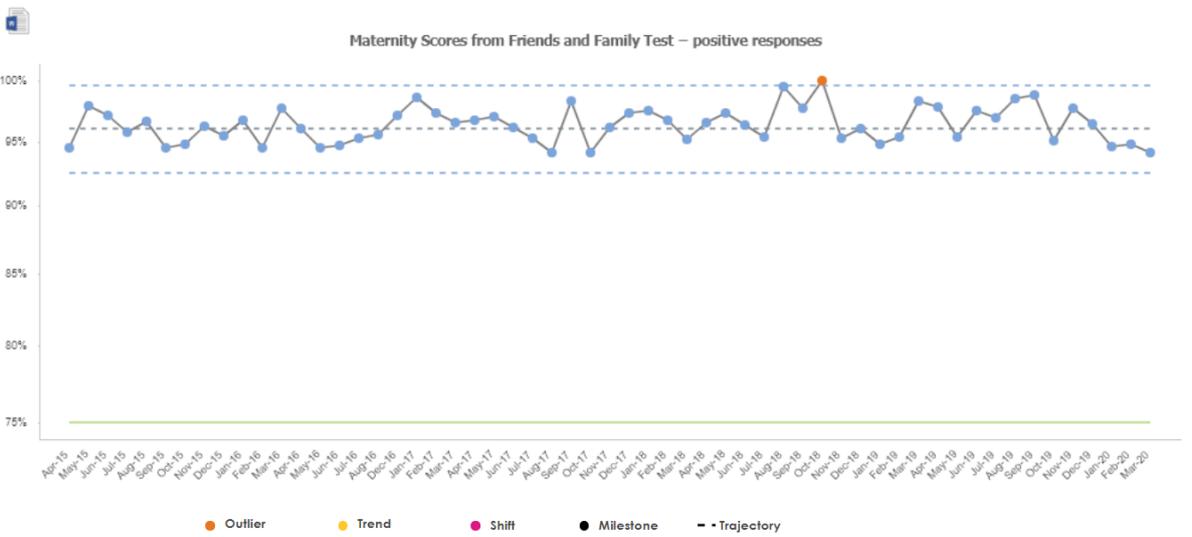
The FFT scores for inpatients have remained above target throughout 2019/20. There was a negative shift in performance starting in November 2018 but performance has remained well above compliance.



Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
86%	88%	87%	86%	86%	87%	86%	85%	85%	86%	87%	87%	88%

Source: Royal Free London NHS FT 2015-2020

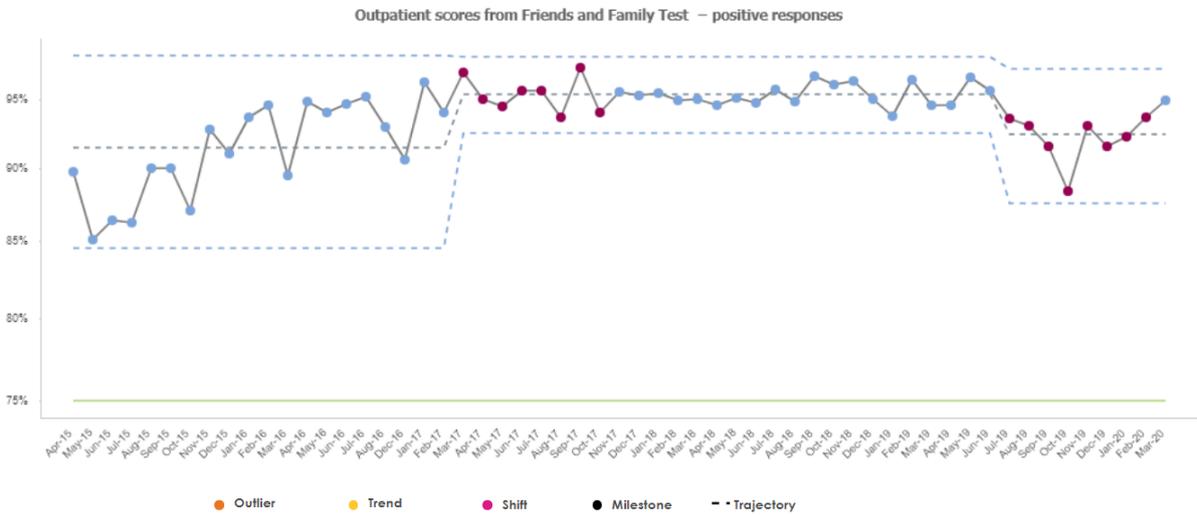
The FFT scores for maternity have remained stable above target throughout 2019/20. Any variation has been within expected limits.



Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
98%	98%	95%	98%	97%	99%	99%	95%	98%	96%	95%	95%	94%

Source: Royal Free London NHS FT 2015-2020

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

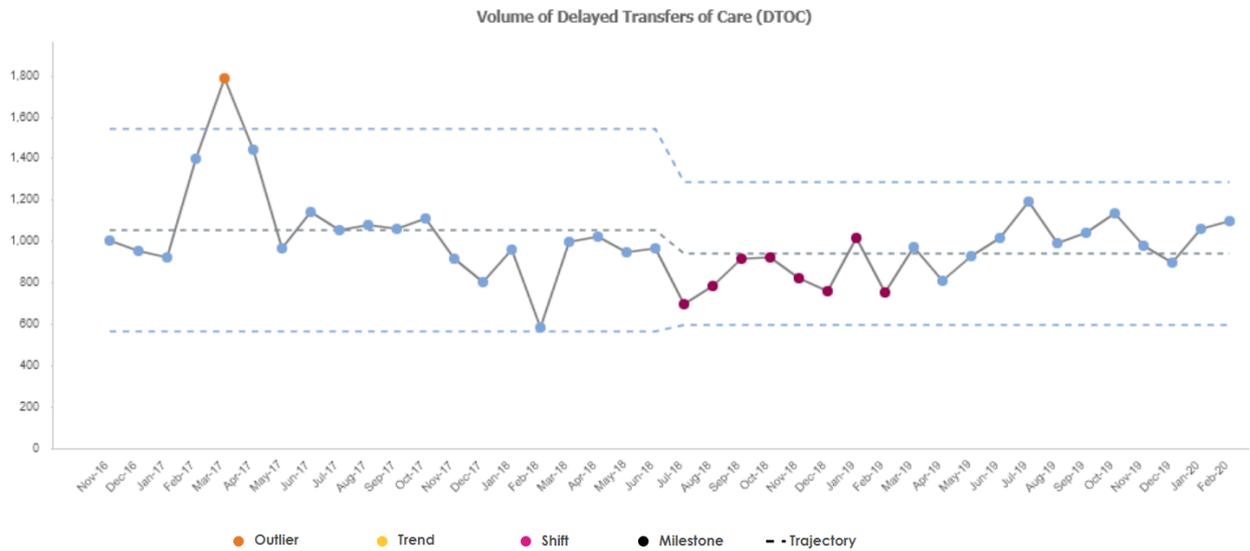


Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
95%	95%	97%	96%	94%	93%	92%	88%	93%	92%	92%	94%	95%

Source: Royal Free London NHS FT 2015-2020

## Volumes of delayed transfers of care

This is the number of bed days per month that the trust lost to patients who were waiting for a transfer to social or NHS community care. Over the course of 2019/2020 this has remained stable. We have been working closely with our local commissioners and social and community care providers to continue to reduce the number of delays.

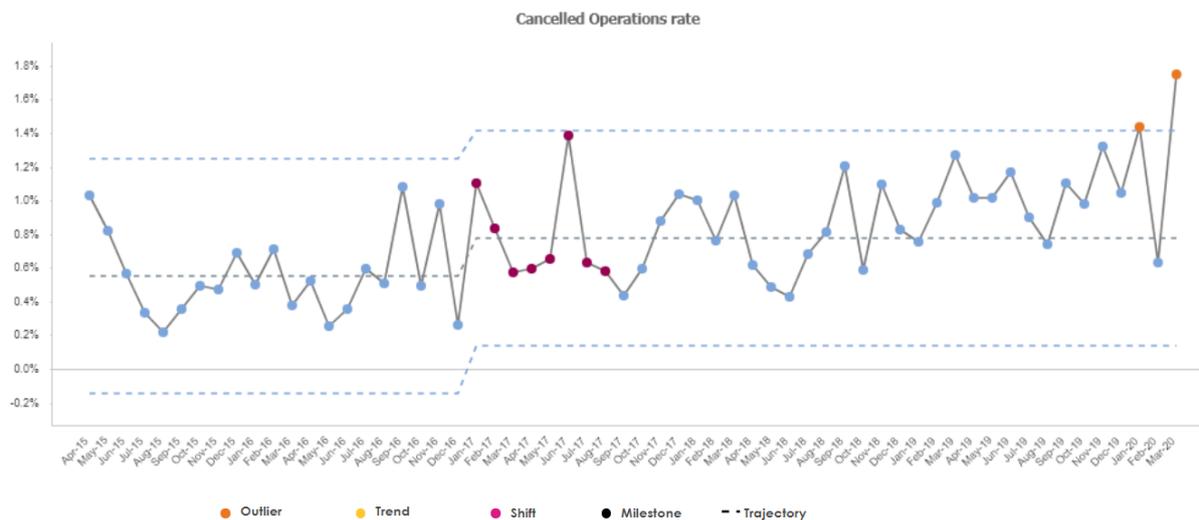


Source: Royal Free London NHS FT 2016-2020

Benchmark information is not available for this measure.

## Cancelled operations rate

This is the volume of last minute (on the day of surgery or following admission) cancellations for non-clinical reasons as a proportion of all elective inpatient and daycase operations. Over the course of 2019/20, this rate has remained within expected control limits with the exception of negative outliers in January and March 2020. The latter is due to coronavirus related cancellations.



Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	2%

Source: Royal Free London NHS FT 2015-2020

Benchmark information is not available for this measure.

## 3.2 Performance against key national indicators

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

### Operational Performance

Key Indicator	Target	Q1	Q2	Q3	Q4	19/20
A&E: <4 hour wait from arrival to admission/transfer/dischARGE	95%	85.0%	85.9%	79.4%	81.2%	82.9%
Diagnostics <6 week wait from request to diagnostic test	99%	93.9%	90.8%	93.3%	93.3%	92.8%
Cancer: <2 week wait from referral to date first seen (all)	93%	90.2%	90.4%	91.2%	-	90.6%
Cancer: <2 week wait from referral to date first seen for symptomatic breast patients	93%	89.0%	84.8%	89.0%	-	87.6%
Cancer: <31 day wait from diagnosis to first treatment	96%	96.9%	97.9%	95.4%	-	96.7%
Cancer: <31 day wait from diagnosis to subsequent treatment (surgery)	94%	93.1%	94.5%	93.5%	-	93.7%
Cancer: <31 day wait from diagnosis to subsequent treatment (chemotherapy)	98%	100.0%	99.2%	100.0%	-	99.7%
Cancer: <31 day wait from diagnosis to subsequent treatment (radiotherapy)	94%	100.0%	100.0%	100.0%	-	100.0%
Cancer: <62 day wait from referral to first treatment	85%	80.0%	80.0%	81.4%	-	80.5%
Cancer: <62 day wait from referral to first treatment for screening service referrals	90%	94.7%	87.1%	91.2%	-	91.0%

### Patient Safety

Key Indicator	Target	Q1	Q2	Q3	Q4	19/20
C difficile infections*	18	21	17	19	27	84
C difficile infections attributable to lapses in care	0	1	0	2	0	3
MRSA infections	0	0	1	0	3	4

## Patient Experience

Key Indicator	Target	Q1	Q2	Q3	Q4	19/20
Percentage of positive responses on A&E Friends and Family Test	75%	84%	84%	82%	-	83%
Percentage of positive responses on Inpatients Friends and Family Test	75%	87%	86%	85%	-	86%
Percentage of positive responses on Outpatients Friends and Family Test	75%	96%	93%	91%	-	93%
Percentage of positive responses on Maternity Friends and Family Test	75%	97%	98%	96%	94%	96%

## Other key indicators of performance

Key Indicator	Target	Q1	Q2	Q3	Q4	19/20
Non-elective mean length of stay (days)	-	3.4	3.5	3.8	4.0	3.7
Elective mean length of stay (days)	-	3.8	4.1	4.7	-	4.2
Number of emergency readmissions within 30 days following an elective admission	-	140.0	131.0	132.0	107.0	127.5

## 3.3 Our plans for improvement

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

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

### The Care Quality Commission

The trust final CQC report was published 10 May 2019. The trust is rated overall as 'requires improvement' as a provider and rated 'requires improvement' at two of our three sites; Barnet Hospital and the Royal Free Hospital. Chase Farm hospital was rated good.

The trust was rated requires improvement for the following domains:

- Safety at all three hospital sites
- Responsive at both Barnet and Royal Free Hospital

The inspection focused on the following core services:

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

As a provider the following regulatory requirements are required to be met as outlined in the inspection report:

- Regulation 11 HSCA (RA) Regulations 2014 Need for consent
- Regulation 12 HSCA (RA) Regulations 2014 Safe Care and Treatment
- Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance

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

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

<p><b>Barnet Hospital – Critical Care</b></p> <p><b>MUST</b> ensure all risks are accurately assessed and regularly monitored with timely mitigating actions taken to address issues, including the safe and secure storage of medicines and intravenous fluids</p> <p><i>The Trust undertook a review of the management of risks across the service and developed a standard operation procedure adapted from the Trust risk management policy.</i></p> <p><i>We also reviewed the governance arrangements across the service, implementing a critical care clinical governance meeting.</i></p> <p><i>We developed a critical care dashboard to cover critical care risks for on-going monitoring including medication audit compliance, delayed discharged and out of hours discharges.</i></p>	<p><b>Royal Free Hospital – Critical Care</b></p> <p><b>MUST</b> reinforce the use of an up to date risk register that includes all risks and comprehensive mitigations</p> <p><i>All ICU risks are reviewed at the monthly ICU governance &amp; performance meeting.</i></p> <p><i>New risks and risks for closure (from all clinical areas) are discussed at the surgery &amp; associated divisional board meetings.</i></p> <p><i>Risk around ICU private patients' priority and long stays - it has been agreed by chief executive, divisional directors and director of finance and private practice unit in March 2019, not to bring in long term overseas patients to ICU if we are outsourcing hepato-biliary surgery..</i></p>
<p><b>Chase Farm Hospital – Urgent &amp; Emergency Care</b></p> <p><b>MUST</b> ensure that staff follows the trust’s record management policies concerning safe storage and security of patient and staff records</p> <p><i>Documents referred to in the report were removed and placed in to a secure cupboard with swipe access for appropriate staff members only.</i></p> <p><i>A new secure cabinet has been placed in the management office in the urgent care centre for such documents to be stored in future.</i></p> <p><i>A process for collecting papers that require scanning and sending to medical records for scanning on a daily basis has been implemented in the department.</i></p>	
<p><b>Barnet Hospital – Critical Care</b></p> <p><b>MUST</b> ensure there is a sustainable plan and action is taken to improve the quality of service in relation to delayed discharges, and patient experience staying in an inappropriate environment and discharge transfers out of hours</p> <p><i>A critical care task and finish group was set up to develop a strategy for improving the quality of the service in relation to delayed discharges and out of hour transfers, with monthly oversight of the progress via the critical care clinical governance meeting and is monitored by the surgery &amp; associated services divisional board and Barnet Hospital clinical performance &amp; patient safety committee.</i></p> <p><i>Delayed discharges and out of hour transfers to be reviewed weekly by the ITU matron and the clinical director.</i></p>	<p><b>Trust-wide</b></p> <p><b>MUST</b> ensure that its restraint policy follows best practice guidance as set out in Positive and Proactive Care:</p> <p><i>The trust updated the restraint policy in January 2019 and this was ratified at the Trust integrated safeguarding committee on 17 January 2019.</i></p> <p><i>This has been disseminated to all staff and is available on the trust intranet system.</i></p>
<p><b>Chase Farm Hospital – Urgent &amp; Emergency Care</b></p> <p><b>MUST</b> act to ensure staff follow-up with patients that leave the Urgent care centre before being seen, particularly with vulnerable children and adults</p> <p><i>A process for reviewing did-not-attends and informing patient's GPs of any children or known vulnerable adults of the did-not-attend has been put in place.</i></p> <p><i>This will be included in the daily check in the urgent care centre to ensure compliance with the process.</i></p>	

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

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

One of the “should do” recommendations is no longer the responsibility of RFLNHS FT as the service has moved to a different provider. The CQC and the new provider were informed in May 2019. We have achieved a significant amount of these 55, and we will continue to ensure we complete all our intended actions on the remaining 45%.

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

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

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

### Completed CQC Should-do findings at Barnet Hospital:

#### SAFE - Critical Care

The trust should ensure staff have clear guidance and take appropriate action when temperature is outside optimal levels for medicine storage in drug fridges and storage rooms.

<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>Undertaken weekly pharmacy medication audits</i></li> <li>✓ <i>Shared medication audit findings with the ward sisters and matrons</i></li> <li>✓ <i>Introduced monthly oversight of the medication audits via the senior nurse meeting, surgery &amp; associated services divisional board and is overseen by Barnet Hospital clinical performance &amp; patient safety committee</i></li> </ul>
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The trust should ensure contents, including medicines, in transfer bags are regularly checked and records kept.

<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>Implemented a system whereby junior doctors check the transfer bag at each shift, document that this has been done and is embedded by monthly auditing</i></li> <li>✓ <i>Introduced new labelling to be attached to the transfer bag containing the date the earliest drug will expire</i></li> </ul>
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The trust should ensure critical care staff receives sufficient training to enable them to confidently use the new hospital EPR system as needed.

<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>Introduced a trust wide approach to 'electronic patient record' training for critical care</i></li> </ul>
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#### SAFE – Urgent & Emergency Care

The trust should ensure all staff have up to date adults and children's safeguarding training at all levels and ensure the trust's 85% target is met.

<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>Introduced compliance checks by matrons, clinical directors and service managers to ensure staff members are compliant in adult and children's safeguarding</i></li> <li>✓ <i>Cascaded training via clinical practice educators in each area</i></li> <li>✓ <i>Identified safeguarding link nurses</i></li> <li>✓ <i>Monthly monitoring of adult and children safeguarding training compliance by the medicine &amp; urgent care services divisional board and is overseen by Barnet Hospital clinical performance &amp; patient safety committee and the Barnet Hospital executive committee for monitoring of the medicine &amp; urgent care CQC action plan</i></li> </ul>
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The trust should ensure staff understand how and when to assess whether a patient with mental health needs has the capacity to make decisions about their physical care and treatment.

<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>Introduced compliance checks by matrons, clinical directors and service managers to ensure staff members are compliant with Mental Capacity Act training</i></li> <li>✓ <i>Weekly audit of patient notes to identify compliance with the policy to be undertaken for at least 3 months in order to achieve 100% compliance</i></li> <li>✓ <i>Monthly monitoring of Mental Capacity Act compliance by the medicine &amp; urgent care services divisional board and is overseen by Barnet Hospital clinical performance &amp; patient safety committee and the Barnet Hospital executive committee for monitoring of the medicine &amp; urgent care CQC action plan</i></li> </ul>
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#### SAFE – Medical Care

The trust should ensure appropriate checks are undertaken on patients wearing mittens.

<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>Reviewed the policy to ensure that there is clear guidance in place that outlines the training and education required to be competent in the assessment and management of patients with mittens in situ</i></li> <li>✓ <i>Trained staff in the appropriate checks required for patients wearing mittens</i></li> <li>✓ <i>Quarterly documentation audits of the checks required for patients wearing mittens three months after embedding the updated policy</i></li> </ul>
The trust should ensure they review processes for the management of medicines used in emergencies and the systems for the monitoring of temperatures of medicines storage areas.	
<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>Undertaken pharmacy monthly medication audits of the following areas: medication security, key storage, ambient temperature, fridge temperature, IV fluids storage to achieve 100% compliance with Trust guidance</i></li> <li>✓ <i>Shared medication audit findings with the ward sister and matron on a monthly basis</i></li> <li>✓ <i>Monthly oversight of the medication audits via the senior nurse meeting, medicine &amp; urgent care divisional board and is overseen by Barnet Hospital clinical performance &amp; patient safety committee</i></li> <li>✓ <i>Provided staff training on the appropriate storage of medication</i></li> </ul>
<b>SAFE – Medical Care</b>	
The trust should ensure hand hygiene compliance meets the trust targets across all the wards.	
<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>Held a hand hygiene campaign across the group in 2019. This will continue to be supported by the medicine &amp; urgent care matrons and clinical directors by monthly audits of hand hygiene via the Perfect Ward app</i></li> <li>✓ <i>Results monitored by the ward sister and consultant of the week on each ward and monitored at the monthly directorate service performance reviews and divisional board meetings</i></li> </ul>

<b>SAFE – Surgery</b>	
The trust should address the high turnover rate amongst nursing staff and ensure all of the shifts are covered at all times.	
<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>Developed an over-arching action plan to incorporate all strands of work involving nursing recruitment and retention in order to address the high nurse turnover rate</i></li> <li>✓ <i>Monthly monitoring of the nursing staff turnover rate via the surgery &amp; associated services divisional board and is overseen by Barnet Hospital clinical performance &amp; patient safety committee as part of the monitoring of the Surgery CQC action plan</i></li> </ul>
The trust should fill the vacancies for medical staff to ensure there is sufficient number of doctors available to provide patient's care and treatment.	
<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>Undertaken a recruitment drive to appoint to substantive vacant posts.</i></li> <li>✓ <i>Undertaken monthly reviews of safe medical staffing</i></li> <li>✓ <i>Continued to improve process of communicating with Health Education England to prevent last minute gaps in the rota</i></li> <li>✓ <i>Continued to follow escalation of short notice rota gaps</i></li> </ul>

<b>EFFECTIVE – Medical Care</b>	
The trust should ensure they reduce the average length of stay for medical non-elective patients, to meet the England average.	
<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>Continued to work through the urgent and emergency care improvement programme and progress monitored by the urgent and emergency care and the accident &amp; emergency delivery boards</i></li> </ul>

<b>CARING – Medical Care</b>	
The trust should ensure they focus on getting patients a bed on a ward for their speciality to reduce the number of patient moves at night.	

<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>An overview of the data to be presented at the medicine &amp; urgent care divisional board; this forms part of the multiple LLOS reviews each week</i></li> </ul>
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### RESPONSIVE – Critical Care

The trust should ensure patients are reviewed by a consultant within 12 hours of admission to critical care.

<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>Validated data, on a monthly basis, and compliance with the standard. This is monitored monthly at the consultants' meeting</i></li> <li>✓ <i>Compliance with the standard is monitored monthly by the surgery &amp; associated services divisional board and Barnet Hospital clinical performance &amp; patient safety committee as part of the monitoring of the critical care CQC action plan</i></li> <li>✓ <i>Changed the ITU electronic patient record system to be made to set a reminder to save the time of the review</i></li> </ul>
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The trust should ensure the data submitted to external bodies is accurate, particularly in relation to delayed discharges and mixed sex breaches.

<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>The Intensive Care National Audit and Research Centre (ICNARC) data validated on a monthly basis and the compliance with the standards is monitored monthly via the consultants' meeting</i></li> <li>✓ <i>Compliance with the standards for the ICNARC data, in relation to delayed discharges and out of hours discharges, is monitored monthly by the surgery &amp; associated services divisional board and is overseen by Barnet Hospital clinical performance &amp; patient safety committee as part of the monitoring of the critical care CQC action plan</i></li> </ul>
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### RESPONSIVE – Medical Care

The trust should ensure potential trip hazards in corridors are removed across all the wards.

<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>Instigated environmental audits, on a weekly basis, to identify and mitigate any actual or potential slip and trip hazards</i></li> </ul>
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The trust should ensure they follow best practice and not discharge patients at night. There was a high number of patients being discharged at night which did not reflect best practice.

<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>An overview of the data presented at the monthly medicine &amp; urgent care divisional board, this also forms part of the multiple LLOS reviews each week</i></li> </ul>
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### WELL LED – Medical Care

The trust should ensure that risks identified on the risk register are being dealt with in a timely way.

<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>Monitoring for the timeliness of risk reviews via the directorate and divisional board meetings by means of two key performance indicators: number of risks reviewed every three months and number of risks older than one year</i></li> <li>✓ <i>Monthly monitoring of the timeliness of risk reviews via Barnet Hospital clinical performance &amp; patient safety committee by means of two key performance indicators: number of risks reviewed every three months and number of risks older than one year</i></li> </ul>
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## Completed CQC Should-do findings at Chase Farm Hospital:

### SAFE – Surgery

The trust should ensure action is taken to prevent avoidable patient safety incidents from reoccurring.

<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>Ensured actions taken in response to serious incidents are presented back to serious incident review panels for scrutiny and oversight by the Chase Farm Hospital medical director and senior nurses</i></li> </ul>
The trust should ensure all five steps of the safer surgery checklist are appropriately completed and documented in line with national guidelines.	
<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>The team brief is now recorded on huddle forms. This form contains prompts to ensure consistent briefs are undertaken across all theatres</i></li> <li>✓ <i>A debrief form is used if there are any exceptions to report</i></li> <li>✓ <i>A question confirming that individual patients have been discussed in the team brief has been added to electronic patient record [completion of this section of the electronic patient record is mandatory]</i></li> </ul>
The trust should review processes to provide assurance that medicines are stored at the correct temperatures to remain effective.	
<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>Temperature monitoring in the operating theatre fluid store. The operating department practitioner checks the fluid store and the fluid warming cupboards, recording the check on a log</i></li> <li>✓ <i>There is a process in place for checking the temperature of medications and escalating when this is out of range. This process has been reiterated to the staff. The ward liaised with pharmacy to add the escalation process and added to the medication temperature check form</i></li> </ul>
The trust should review security of medicines storage areas.	
<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>Access control swipe lock is installed on to the intravenous fluid store room, to ensure appropriately controlled access</i></li> </ul>

#### SAFE – Urgent & Emergency Care

The trust should implement a formal process for reception staff to highlight issues in the waiting areas.

**We have:** ✓ *Written and distributed the process for reception staff to alert issues to the clinical teams*

The trust should improve the signage to the entrance to the Urgent Care Centre.

**We have:** ✓ *Additional signage has been added to the external entrance to the urgent care centre*

#### EFFECTIVE – Surgery

The trust should ensure the trust's consent policy is followed and that all stages of the consent process are appropriately documented.

**We have:** ✓ *Worked with the surgical teams to review the process and policy to ensure that process and policy match*

#### EFFECTIVE – Urgent & Emergency Care

The trust should ensure policies and guidelines available in hard copies are regularly reviewed and updated.

**We have:**

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

#### CARING – Urgent & Emergency Care

The trust should improve the reception area in the urgent care centre and paediatric outpatients to ensure patient confidentiality.

**We have:**

- ✓ Reviewed ways to improve confidentiality in the urgent care centre reception area.
- ✓ A new waiting area for urgent care centre paediatrics now in place, so there is no requirement to use the paediatric outpatient waiting area

### RESPONSIVE – Medical Care

The trust should continually review referral to treatment times to ensure it is in line with national standards.

**We have:**

- ✓ Undertaken a demand and capacity review
- ✓ A systematic plan to reduce the waiting list of for endoscopy with the use of increased resources both permanent and temporary has been devised
- ✓ Increased the number of permanent doctor sessions to ensure that the service is able to maintain the waiting list to meet referral to treatment targets

### RESPONSIVE – Urgent & Emergency Care

The trust should review the facilities and service provision on signage, leaflets and translation services so they meet the needs of the patients using them.

**We have:**

- ✓ The Trust uses a telephone translation service
- ✓ Details of how to access the translation service has been provided to all staff in the urgent care centre

The trust should review the facilities provided in the urgent care centre so they meet the needs of children and patients with visual and hearing impairments or complex needs.

**We have:**

- ✓ Worked with the local deaf society to provide deaf awareness training for key staff members

The trust should ensure service provision meet patients individual needs particularly those with complex needs and disabilities.

**We have:**

- ✓ Worked with the Trust learning disabilities team to create a discharge form which includes visual aids as well as written aids. A hospital passport has also been created for patients with learning difficulties and is now in use
- ✓ Worked with the local deaf society to provide deaf awareness training for key staff members

### WELL LED – Medical Care

The trust should ensure they engage with staff effectively.

**We have:**

- ✓ Listened to staff concerns and undertaken a full review of the endoscopy services across the group

The trust should review processes for risk management to ensure all risks are identified and dealt with appropriately.

**We have:**

- ✓ We implemented a new process for reviewing the risk register:
  - Each week one service's risk register is reviewed at the serious incident review panel meeting by:
    - Providing time to ensure risks are moving and are escalated as required
    - Ensure that key issues are present on the risk register

### WELL LED – Urgent & Emergency Care

The trust should improve the provision arrangement of children in the service and paediatric outpatient area to ensure there are adequate toys and children are safe while waiting in the paediatric outpatient waiting area especially during out of hours.

**We have:**

- ✓ A new dedicated urgent care centre paediatric waiting area is in place and in use
- ✓ Installed CCTV in the new paediatric urgent care centre waiting area
- ✓ The feed from this CCTV is monitored in the triage room to ensure that the urgent

	<i>care centre practitioners have oversight of patients in this area</i>
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## Completed CQC Should-do findings at Royal Free Hospital:

### SAFE – Critical Care

The trust should monitor medical staffing levels during the expansion of the unit to ensure they meet FICM standards.

<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>Recruited to all junior posts</i></li> <li>✓ <i>A fully staffed medical team</i></li> <li>✓ <i>Monthly trajectories for staffing</i></li> <li>✓ <i>Capacity on the specialist high dependency unit adjusted in line with staffing.</i></li> <li>✓ <i>The funded establishment matches Faculty of Intensive Care Medicine standards</i></li> <li>✓ <i>In addition we are:</i> <ul style="list-style-type: none"> <li>○ <i>Developing specialist roles in ICU to attract consultant staff</i></li> <li>○ <i>Developing a fellowship program to attract senior trainees, encouraging them to advance into consultant positions within the Trust</i></li> </ul> </li> </ul>
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### SAFE – Medical Care

The trust should ensure ward teams fully comply with the Control of Substances Hazardous to Health (COSHH) Regulations (2002) in reference to safe and secure storage of chemicals.

<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>New lockable domestic trolleys are on all wards</i></li> <li>✓ <i>Regular spot checks are undertaken to ensure drug rooms are locked at all times per policy by the ward managers and matrons.</i></li> <li>✓ <i>Staff have been made aware of hazardous substances in their working area and have read COSHH risk assessments</i></li> <li>✓ <i>Trained staff in correct practice</i></li> <li>✓ <i>Installed signage on storage room doors</i></li> <li>✓ <i>Monitoring in place using Perfect Ward audits</i></li> </ul>
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### SAFE – Surgery

The trust should ensure the review of Never Events and serious incidents are undertaken by senior clinical staff and robust actions should be documented and monitored.

<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>A designated lead investigator for all serious incidents declared within the Royal Free Hospital, who is at an appropriate senior level within the organisation. The lead investigator is supported by a member of the quality governance team and all investigation findings are presented to a panel of relevant senior staff, which is chaired by a member of the senior divisional leadership team (medical director, director of nursing/operations)</i></li> <li>✓ <i>Actions agreed by the clinical team, the panel, the safety incident review panel and the trust's commissioners</i></li> <li>✓ <i>All actions from serious incidents added to a serious incident action tracker that the governance team hold, and regular updates on progress are requested from the relevant clinical teams. The action is only closed as completed, once the relevant evidence has been provided</i></li> <li>✓ <i>To strengthen this process, the governance team send the submitted evidence to the action plan owner (usually the clinical lead) for additional assurances that the evidence provided appropriately confirms that the action has been completed</i></li> <li>✓ <i>The never events assurance plan is fully completed and shared with commissioners who are satisfied with the evidence</i></li> <li>✓ <i>Implemented 'Learning in Action' meetings have been following notification of a serious incident</i></li> </ul>
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The trust should ensure they continue to work with other external agencies to put systems in place to reduce the number of never events taking place.

<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>A continuous partnership programme with trust's commissioners in order to strengthen systems and processes</i></li> <li>✓ <i>An overarching never events assurance plan, created in conjunction with</i></li> </ul>
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	<p><i>commissioners</i></p> <ul style="list-style-type: none"> <li>✓ <i>Attendance and working in partnerships with other organisations as part of the UCLPartners LocSSIP network</i></li> <li>✓ <i>Implemented the never events risk assessment (shared by Barts Health NHS Trust) to assess clinical areas vulnerability of a never event</i></li> </ul>
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<b>SAFE – Surgery</b>	
The trust should review how medicines were stored and accessed in the operating theatres.	
<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>Swipe access into the pharmacy room</i></li> </ul>

<b>SAFE – Urgent &amp; Emergency Care</b>	
The trust should ensure that there is consistent record keeping for emergency department patients in the adult assessment unit.	
<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>Improved documentation in the acute admissions unit; this is monitored through Perfect ward and spot checks</i></li> <li>✓ <i>A program has started in acute admissions unit specifically focusing on admission paperwork and basic risk assessments being completed</i> <ul style="list-style-type: none"> <li>○ <i>The program is run by the clinical practice educator and ward manager. There is also a focus on NEWS 2 to ensure observations are completed in a timely manner and escalation completed. Spot checks are completed monthly</i></li> </ul> </li> </ul>

<b>EFFECTIVE – Urgent &amp; Emergency Care</b>	
The trust should ensure there is an action plan to address 2016/17 Royal College of Emergency Medicine (RCEM) moderate and acute severe asthma and consultant sign-off audit results.	
<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>Standardised the streaming process and improved competencies for the nursing team</i></li> <li>✓ <i>Established a ‘wheezy child pathway’ in collaboration with the paediatric team</i></li> <li>✓ <i>Assigned lead clinicians to sign off audit results</i></li> <li>✓ <i>Instigated an internal audit programme to assure correct sign off</i></li> </ul>

<b>RESPONSIVE – Surgery</b>	
The trust should continue to work towards a system which allows patients to arrive for their surgery in a timelier manner.	
<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>Reminded surgeons to stagger patients and ‘Golden Patient’ in board, theatre safety, theatre strategy and theatre productivity boards</i></li> <li>✓ <i>Written a standard operating procedure for staggering lists</i></li> <li>✓ <i>Reorganised design of the day surgery unit, with the ‘golden patient’ contacted the night before surgery</i></li> </ul>

<b>RESPONSIVE – Urgent &amp; Emergency Care</b>	
The trust should ensure there are clear lines of medical patient responsibility in the adult assessment unit.	
<b>We have:</b>	<ul style="list-style-type: none"> <li>✓ <i>Reviewed the acute assessment unit standard operating procedure; this will be reviewed every 3 months</i></li> <li>✓ <i>Employed 2 additional consultants to work exclusively in the acute assessment unit</i></li> <li>✓ <i>A working group has been set up to oversee development of the area, meeting every 14 days</i> <ul style="list-style-type: none"> <li>○ <i>Minutes will be kept of meetings</i></li> <li>○ <i>The acute medical team has overall responsibility for the running and governance of the unit</i></li> <li>○ <i>A consultant has been appointed to run the unit full time</i></li> </ul> </li> </ul>

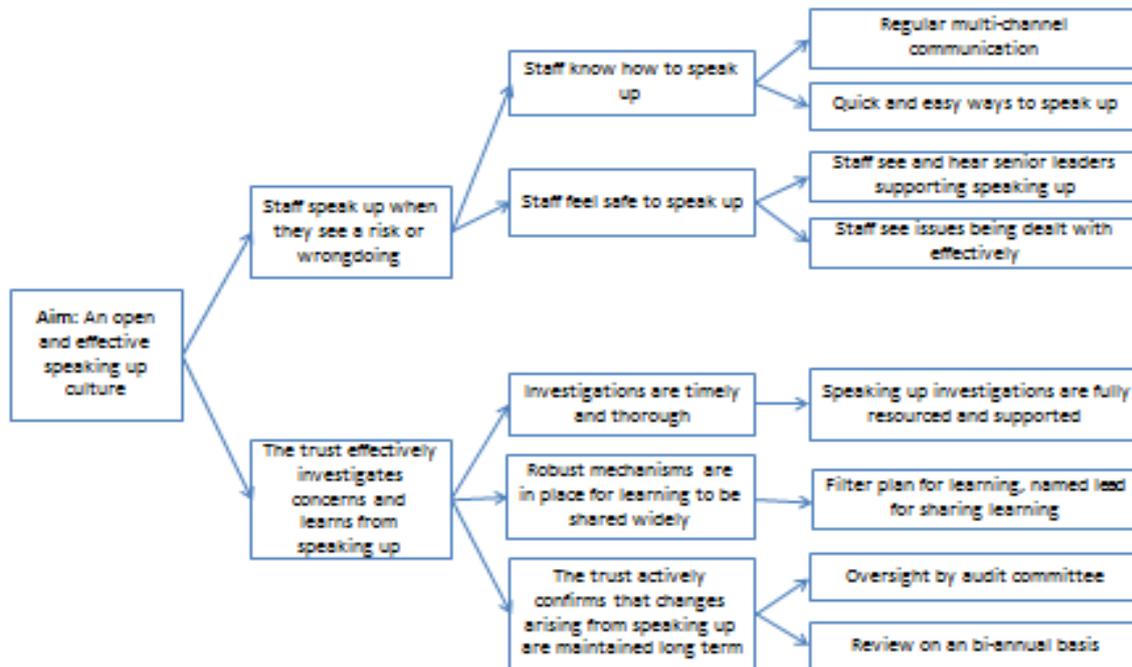
	<ul style="list-style-type: none"> <li>○ <i>The 'acute medical model' is being worked up, including the structure of acute assessment unit</i></li> </ul>
<p><b>The trust should ensure the needs of all patients who require additional support are met.</b></p>	
<p><b>We have:</b></p>	<ul style="list-style-type: none"> <li>✓ <i>Learning disability lead nurse has provided a resource box for patients with learning disabilities</i></li> <li>✓ <i>Flash cards have been provided for non-verbal patients</i></li> <li>✓ <i>The dementia lead and learning disability lead are working with the department to provide training guidance and support.</i></li> <li>✓ <i>Supplied an activity box and designated a room for patients who require less distraction or stimulation.</i></li> <li>✓ <i>Picture cards provided to staff from learning disability lead and a resource box in ATA multidisciplinary team</i></li> <li>✓ <i>Linking into 'Coordinate My Care' (CMC), which will allow for care plans to be shared</i></li> <li>✓ <i>Developed staff awareness around how to care for our patients with learning disabilities [this includes information and where to access learning aids and who to contact if needed]</i></li> <li>✓ <i>The acute assessment unit have begun a quality improvement working group regarding falls</i></li> </ul>

<p><b>WELL LED – Critical Care</b></p>	
<p><b>The trust should consider developing firm plans to realise the vision for the service.</b></p>	
<p><b>We have:</b></p>	<ul style="list-style-type: none"> <li>✓ <i>An ICU strategy has been developed and approved</i></li> <li>✓ <i>The strategy has been circulated to all critical care staff including consultants and is displayed on the notice board</i></li> </ul>

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

## Speaking up: It's safe to speak up

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



### The trust is committed to:

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



## Freedom to speak up champions

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

The role as a speaking up champion at the Royal Free London NHS Foundation Trust is to:

- Promote local speaking up processes and sources of support and guidance to staff
- Be available and accessible to staff who may have a concern
- Take immediate appropriate action when matters that people are speaking up about indicate that safety and quality may be compromised
- To ensure that any safety issues raised are addressed and feedback is given to the member of staff who raised it in line with confidentiality agreements
- Communicate with empathy and compassion with other staff about potentially emotive subjects
- Act as a buddy to newer champions to answer questions
- Good time management skills to balance the speaking up role with their existing role
- Work with the Board to create an open culture, by listening and learning and not blaming
- Develop ways to encourage staff to speak up
- Work entirely independently of the executive team
- Share learning with the wider Trust to develop the culture

- Review the governance and practice of raising concerns at the Trust
- Ability to turn 'speak up' scenarios into learning
- Be knowledgeable about FTSU matters and local issues, and able to advise staff appropriately about speaking up



## Implementing seven day services hospital services

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

The trust has been working to achieve all these standards, with a focus on four priority standards:

**Standard 2** - Time to first consultant review

**Standard 5** - Access to diagnostic services

**Standard 6** - Access to consultant-directed Interventions

**Standard 8** - On-going review by consultant twice daily if high dependency patients, daily for others

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

## **Standard 2: Time to first consultant review**

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

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

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

## **Standard 5: Access to diagnostic services**

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

## **Standard 6: Access to consultant-directed Interventions**

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

## **Standard 8: On going review by consultant twice daily if high dependency patients, daily for others**

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

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

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

## Annexes

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

#### Statements from Commissioners:



NHS North Central London (NCL) Clinical Commissioning Group (CCG) welcomes the opportunity to provide this statement on the Royal Free London NHS Foundation Trust's Quality Account. We would like to thank the Trust for preparing this quality account and recognising the importance of quality at a time when they are under additional operational pressures due to the Covid-19 pandemic.

NHS NCL CCG is responsible for the commissioning of health services from the Trust and all of its sites (Royal Free, Barnet and Chase Farm Hospitals), on behalf of the NCL population.

We confirm that we have reviewed the information contained within the draft Quality Account (provided to the CCG in April 2020) and that the document received complies with the required content as set out by the NHS England/Improvement or, where the information is not yet available, a placeholder has been inserted. We have reviewed this Quality Account and are pleased to note the continuing work that has been undertaken to make improvements across patient safety, clinical effectiveness and patient experience.

Throughout 2019/20, the CCG continued to meet with the Trust on a monthly basis at its Clinical Quality Review Group meetings. At this forum, the commissioners were provided with assurance regarding the quality of services provided by the Trust. The meeting received a range of reports covering patient safety, experience and clinical effectiveness from the Trust and there is robust discussion with the Trust and challenge regarding their quality objectives.

The Trust has undertaken a number of successful high level quality improvement projects such as the development of an Acute Kidney Injury (AKI) app to alert clinicians of AKI in real time by comparing patient blood samples. The Trust deserves commendation for this life saving app, which has also received an award from the Health Service Journal.

The "joy in work" initiative also was introduced to increase staff appreciation and involvement and, over the year, worked to increase the core training programme take-up. We welcome the improved staff retention, reduced sickness levels and direct benefit for patients. These improvements were highlighted by the Care Quality Commission (CQC), noting that staff

were proud to work for the organisation and dedicated to their jobs. This work is set to continue through 2020/21.

A further high level improvement project the Trust reported on was digitising twenty clinical pathways to improve patient flow and experience. The Electronic Patient Records (EPR) were introduced across Barnet and Chase Farm sites. The work is continuing into 2020/21 to further digitise pathways and introduce EPR at the Hampstead site to further enhance patient experience.

We also commend the Trust on the continuing improvements of their dementia training to staff and dementia friendly ward environments. We are pleased to note that this work is set to continue in 2020/21 building on the current achievements and involving staff, carers and patients.

However, the Trust did also experience quality challenges in 2019/20. It was disappointing that, following an announced inspection of the Trust at the end of 2018, the CQC reduced their overall rating from “good” to “requires improvement” in May 2019. Since then, the Trust has worked hard implementing the majority of actions to address the “must do” and “should do” recommendations, with the remaining “must do” on target for completion by mid-2020/21 and the “should do” actions by quarter 3 of 2021.

The work on Referral to Treatment (RTT) lists is continuing and commissioners are pleased to note that due to significant data accuracy issues and the suspension of RTT reporting in early 2019, return to reporting is due to take place at the end of 2020. The Trust has worked with commissioners to continue reporting the patient-tracking list informally, as well as associated harm reviews so that any associated impact is monitored and actioned.

The Trust did not manage to achieve their ‘reducing harm to zero’ target of having no Never Events (NE) in 2019/20. However, it is noted that the Trust had implemented an NE improvement plan and in 2019/20 there was a reduction on the previous year, with six NEs recorded in 2019/20 against nine recorded in 2018/19. Investigations into these incidents identified several cross cutting themes, including human factors and human behaviours which may have contributed to some of these particular events. It is essential that the Trust ensures their Patient Safety Strategy supports and drives further work essential to promoting understanding of Human Factors and reinforce shared learning.

There has been a small improvement across cancer targets but the Trust are still only meeting one of the three main targets across this area. It is encouraging that performance was improving towards the end of 2019/20 and we hope this will continue in 2020/21. The Trust has also worked to further improve performance against the cancer targets in 2019/20 by establishing a Clinical Practice Group (CPG) looking at improving patient pathways and patient experience. A number of workgroups were established to review pathways and implement action plans developed. This has seen some improvement in performance, however, much of the implemented CPG actions are not expected to influence performance until 2020/21.

A&E performance further deteriorated from 2018/19 to the period April 2019 – February 2020. As noted in the Quality Account, it was third lowest against peer Trusts and the CCG recognises that achievement of this standard has been a challenge nationally.

The Trust had two events that impacted significantly on quality and increased risk to patient safety in 2019/20 that commissioners would have liked to see referenced in the quality account and to understand what learning has been identified:

Firstly, there was an information technology (IT) incident that resulted in delays to over 26 thousand out-patient summary letters being sent out to GPs, patients and other health partners. The Trust are in the process of undertaking clinical harm reviews of all of the patients affected. The review of the letters is ongoing and, at the point of writing this statement at the beginning of May 2020, the Trust have not identified any cases of moderate or severe patient harm. We appreciate that there is still some work to do on this and look forward to the results of the harm reviews.

The second event that arose earlier in the year was in relation to issues with laboratory results and results not being sent to GPs. This was as a consequence of the Trust transferring to a new pathology laboratory and IT systems. These issues continued throughout the year but commissioners are pleased to note that these have now been resolved as a result of collaboration between colleagues from the Trust, the laboratory, commissioners and GPs.

We would like to thank the RFL for requesting input into the draft Quality Account and to give comment on the plans for the coming year. We look forward to working in partnership with the Royal Free London NHS FT and system partners, on building on success and further developing the quality of services in 2020/21.

Accountable Officer, NCL CCG

Clinical Chair, NCL CCG



Frances O'Callaghan

Dr Jo Sauvage

14 May 2020

## Statements from Healthwatch organisations



Healthwatch (HW) Enfield takes an active role in providing feedback to the Royal Free London Hospital (RFLH), is particularly interested in the Chase Farm sites located in Enfield and key service provider for Enfield residents. HW Enfield recognises and values the contribution of hospital staff at all times but especially during the Pandemic and we appreciate the support staff are receiving from many sources.

It is good to note the hospital's success with the liver transplants and kidney care work. In addition, the dementia friendly work at the Hampstead site is ground breaking and good to note it will be rolled out to Barnet and hopefully to Chase Farm.

Improving patient experience and involving patients is at the heart of HW activity and we note the progress that has been made in this area, particularly the commitment to co-production and co-design as an approach. At the same time, it is also useful to that hospital has recognised that 'too many of our patients still wait too long to be seen, especially in the Emergency Department'.

It is good to note patients are now part of the Experience Committee and are actively involved in the Clinical Pathways groups. We note the comment "Putting Clinicians in Charge of the Clinical pathways (page 15), but understood they always were! Co-produced pathways would be a good next step. We also note the establishment of a Patient's Council at Chase Farm and would be pleased to see what has been achieved in subsequent reports.

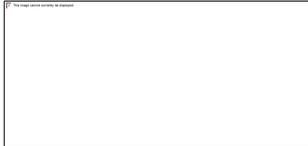
In terms of patient safety, we have raised concerns about 'never events' during the year. We, like you, are disappointed in the moderately high number of never events and hope to read in the next quality report that these have been reduced further. The work to improve Advanced Care plans is welcomed and we understand there has been some initial progress on this.

Looking forward, it is noted that the patient experience priorities will feed into the Trust Board but we hope that these WILL be a priority. We note on Page 22, section 4 that improving administrative support for patients is a 5 year target - we would like to see great strides in the first year. It would also be useful to see some ambitious targets for the activities listed under the patient experience priority. We hope that the focus on co-production and design will help in the development of a more patient-friendly quality report next year, although we do understand reporting constraints.

The pandemic has further highlighted the need for integration and whilst this does not form a formal part of the accounts, it would be good to see progress on this in next year's accounts. Finally, at this difficult time patients and residents are more aware of the essential role played by hospitals and we hope that some of the quality practice emerging during this challenging period informed by patient feedback is captured in next year's report.

01 May 2020

Healthwatch Hertfordshire values the relationship with the Royal Free London NHS Foundation Trust and supports the quality priorities outlined in this Quality Account to improve services for patients.



Steve Palmer, Chair Healthwatch Hertfordshire

09 April 2020

## Statements from Overview and Scrutiny Committees



Many thanks indeed for sending the draft quality accounts for the Royal Free London NHS FT covering 2019/20.

I would like to congratulate you all on this year's annual report. So much progress has been made since last year. This year's report is open, transparent, interesting, clear and well written. The report is long but it is well structured and logical.

My response, as Chair, and on behalf of NCL's Joint Health Overview Scrutiny Committee, will therefore be short. I am using the governance framework we agreed at JHOSC for all our work to assess the report.

1) Putting patients at the centre of all you do.

RFL's three strategic priorities in 2019/20 were to improve patient experience, improve clinical effectiveness and improve patient safety. The examples you provide of the work by the transplant and by the digital teams, for example, are uplifting.

Patient transport is not covered in the report. It remains a huge issue for local people. It won't go away. The Trust must work with others across London and nationally to achieve a solution. Some of our most disadvantaged residents suffer the most under the government's current framework. Unless it is resolved progress on many fronts will be slowed or be unachievable.

2) Focussing on a common purpose, setting objectives, planning.

The report describes clearly the seven priorities for 2019/20 - dementia care, patient involvement, building workforce capability, improving change-management, safer surgery, learning from deaths, and improving infection prevention. Explanations about progress made in 2019/20 and plans, where issues remain for 2020/21, are clear.

3) Working collaboratively.

The Trust provides a summary in the report how seriously it takes working with, listening to and learning from the wide range local residents and patients. In future reports it would be helpful to have more information on strategic priorities, areas of focus, what success should look like – and progress made.

The final section of the report 'It's safe to speak up' describes the Trust's pledge to use the commitment and passion of Trust colleagues in an open and transparent way to achieve what matters. The Trust is to be congratulated on its vision, on its commitment, and on its colleague champions.

The Trust is working increasingly positively with local, regional, national and international experts. This is work in progress. It would be helpful to understand what benefit this is bringing to patients, colleagues, the Trust and to North Central London residents and health organisations as a whole.

4) Acting in an open and transparent way

The Trust demonstrates clearly in this report its commitment to openness and transparency. For example the data provided against national standards are complex, but they show clearly where progress has been made, where things are improving and where progress is still needed.

I will finish by congratulating the Trust on its remarkable work during the current Covid-19 crisis – and for producing this report during the emergency. Trust colleagues are being super human working 12 hour, or longer, shifts. The leadership being shown by the Trust's top team under Caroline Clarke is awe inspiring. I know patients, their families and local residents are hugely appreciative.

My very best wishes

Cllr Alison Kelly  
Labour Councillor for Haverstock Ward, LB Camden  
Chair of Camden's Health and Adult Social Care Scrutiny Committee  
Chair of the Joint Health Overview Scrutiny Committee for Barnet, Camden, Enfield, Haringey and Islington

17 April 2020



The Hertfordshire Health Scrutiny Committee has had no engagement with the Trust over the last 12 months and is therefore unable to provide a meaningful response to the Trust's Quality Account.

Yours sincerely,  
Seamus Quilty  
Chairman Hertfordshire Health Scrutiny Committee

10 April 2020

Barnet Health Overview and Scrutiny Committee (HOSC) scrutinised the draft Royal Free London NHS Foundation Trust Quality Account 2019-20, and wish to put on record the following comments:

- The Committee was pleased to see positive outcomes and a lower mortality rate in Chronic Obstructive Pulmonary Disease in the Royal Free Hospital.
- The Committee commended the Trust on its specialist training courses on understanding the needs of patients with dementia and learning difficulties who have no mental capacity. The CQC has found improvements in urgent and emergency care for these patients across all three hospital sites. Understanding the needs of someone with no mental capacity, for example advanced dementia, is very difficult and challenging. Whilst it is pleasing that the Trust has Dementia-friendly Wards, it is important to ensure that staff are fully trained to understand how to care for patients with advanced dementia regardless of which Ward the patients are in, especially as it can also be difficult with staff changing shifts.
- The Committee was impressed that the Trust held an interactive workshop with the Chickenshed Theatre Company and over 100 members of staff had completed an innovative Study Day.
- The Committee was pleased to see the use of tele dermatology and high quality photographic work at the Trust, reducing the need to travel to larger hospitals and helping with capacity.
- The Committee congratulated the Liver Transplant Team at the Royal Free Hospital, which has one OrganOx machine, for their quick-thinking decision to ‘borrow’ a second machine from the University Hospitals Birmingham NHS Foundation Trust so that they could keep two livers ‘alive’ while performing two liver transplants in quick succession.
- The Committee thanked the Trust for the reduction in gaps in the data and the improved accessibility of the report. There are helpful explanations of the charts and the ‘lollipop’ chart presentation is much more accessible for people who are not used to viewing detailed data, making benchmarking much easier than in previous reports.
- The Committee noted the stabilisation in the C.Diff infection rate although there is some variability since April 2019. However, this is lower than benchmarked organisations. The Committee also noted the explanation that more C.Diff was being detected due to robust measures taken and a more sensitive test being used. The new ways of working in general are clearly demonstrated in this report and the Committee hoped the Trust will continue to develop the report in this way in future. It is helpful to understand the depth beneath some of the stories.
- The Committee congratulated the Patient and Risk and Resuscitation Team for winning a National Patient Safety Award for developing and pioneering a kidney care ‘Streams’ app in conjunction with Google Health.
- It was noted that ‘Joy in Work’ was launched in June 2019. This showed positive outcomes from 4 out of 15 teams showing 50% increase in the ‘good day’ measure. The link between staff satisfaction is directly linked to staff retention, less sickness/absence and improved patient experience.
- The Committee applauded the aim to have zero ‘never events’, zero trust-attributed MRSA cases and to remain below the mandated threshold for C.Diff as three of the priorities for improvement in 2020/21, as the Trust acknowledged that there is a continuing problem in this area.

- Members were pleased that the number of patients' valid NHS Numbers recorded in A&E were up from 95.7% in 2018/19 to 97.1% in 2019/20.
- The Committee noted that between Oct 2018 and Sept 2019, the risk of mortality was lower than expected for the case mix of the Royal Free and they were ranked 8<sup>th</sup> out of 129 non- specialist acute Trusts.

However:

- Concern was expressed that the Trust failed to achieve their aim of zero 'Never Events' by the end of March 2020 but unfortunately had had six.
- The Committee noted that the report mentions a review into the importance of quality data but there is no indication as to how that review is progressing or a completion date.
- The Committee noted that the number of reviews of 'Learning from Deaths' was down considerably from the previous year.
- The Committee was disappointed to note that SMART targets were discussed last year but these still haven't been taken up in relation to quality of data. The quality of data is most important, particularly in relation to research projects, and it is frustrating that this still hasn't been included despite it being requested.
- The Committee would like to know when Electronic Patient Records (EPR) would be available throughout the Trust as many patients are transferred between hospitals.
- With regard to Chronic Obstructive Pulmonary Disease, it was noted that the length of stay and re-admissions are higher than national figures.
- The Committee noted the reduction in the use of Agency staff and the continuing use of Bank staff whilst recognising that permanent recruitment is an ongoing national issue.
- The Committee requested that data be presented in a way that is easier to digest for the lay person. The Performance Indicator data was found to be illuminating and the graphics interesting but clarity was required relating to whether 'high' or 'low' was a positive indicator or not. The direction of historical trends needs to be clear and also exactly what the target is for.
- The Committee enquired why so many clinical pathways had been designed and yet still awaited digitisation.
- The Committee requested reassurance regarding infection control, especially given the current pandemic, but noted that all staff are adhering to the Trust's Infection Control policies.
- The Committee was disappointed to see there were 54 cases of C Diff in 2018/19 when the National average is 12 and that there are 84 cases this year, that is an increase again on the previous year.
- The national waiting time standard required Trusts to treat, admit or discharge 95% of patients within four hours. The Committee was disappointed that the Trust had substantially missed this target by only achieving an average of 83.2%, which was also worse than the 87.4% achieved the previous year.
- The Committee was disappointed that in 2019 the 'Friends and Family Test', as to whether staff would recommend the Trust as a provider of care for their family or friends, was down from 73% to 71% which continued the downward trend of the past three years.
- National targets require 93% of GP cancer referrals to be seen within two weeks. The Committee was disappointed that the Trust only achieved 90.9% of its targets for all cancers-and 89% for breast cancer. The Trust also did not meet the first definitive treatment within 62 days of an urgent GP referral, achieving only 80.7%.

- The Committee requested that all acronyms must be in the glossary and should be written in full the first time they are used in the report. The Quality Account is still not always written in easily accessible language.
- It was noted that the CQC had some criticism of written policies relating to care for patients with dementia which were not easy for staff to access.
- The Committee expressed great concern that out of the 11 'Must Do' Actions, which were part of the 93 recommendations in the CQC Report, only six had been done with five due to be achieved by mid 2020-2021 and that out of the remaining 82 recommendations, which were 'Should Do' Actions, only 44 had been done leaving 38 which the Trust anticipated would only be completed in full by the 3<sup>rd</sup> quarter of 2021.

11 May 2020

## Statement from the Council of Governors



Governors reviewed the draft quality account and provided detailed feedback and comments on the achievement of priorities in 2019/20 and confirmation of their part in the process for selecting priorities for 2020/21.

Information included in the report has been shared with the council of governors during the year by:

- Regular provision of information on the trust's performance
- Updates in the chief executive's briefing to the council of governors
- Briefings from non-executives on individual board committee work programmes
- A quality account consultation and stakeholders event could not be held, due to the Covid-19 pandemic in the spring of 2020; as an alternative governors participated in a survey to establish the priorities for the 2020/21 quality account.

### Council of Governors responsibilities

Governors are clear on their responsibility to hold non-executive directors to account, both collectively and individually, for the performance of the board. Governors focus their attention on ensuring high quality services are available both for the local population and for patients from further afield requiring specialist services.

To enable governors to carry out their statutory responsibilities, governors:

- attend council of governors' meetings and provide challenge to the trust
- attend board sub-committees and observe non-executive directors who either chair or attend these meetings
- comment on the robustness and timeliness of improvement plans to enhance both patient and staff experience
- sit on Local Members' Councils, which are chaired by non-executive directors, which look at how the individual hospitals in the group respond to the needs of the community they serve. This involves looking at performance data, friends and family test information and the number of serious incidents and complaints. In 2019/20 governors asked local health watch representatives to attend these meetings to gain stakeholder views on services provided.

Progress made on quality priorities in 2019/20:

Priority one: Improving patient experience: to further enhance and support dementia care and to improve involvement with patients and carers

In order to ensure progress is made in delivering on 2019/20 priorities, governors visited the refurbished dementia wards at the Royal Free Hospital and reviewed the programme of activities available to patients. Governors were impressed by the refurbishment and programme of activities available to dementia patients. Governors would support similar initiatives, particularly at Barnet Hospital, should funds be available. However, governors

would welcome mechanisms to measure how the experience of dementia patients has improved.

Governors welcome the Patient Council initiative at Chase Farm Hospital and would support its roll-out across all hospitals in the group. Governors consider that more could be done with carers and carers groups within each of the hospitals and hope that the Patient Council Initiative will also champion carers. Governors are aware of the proposals for the new Maggie's Centre which will support cancer patients and their carers and are supportive of it. This centre is expected to open in 2021.

Priority two: Improving clinical effectiveness: to build capability in the workforce and to develop superior change management capability putting clinicians in charge of clinical pathways

Governors agree that a stable workforce will enhance the capability of the organisation to deliver change; and have been informed of the QI training programme for staff. Quality improvement is regularly monitored by the Clinical Standards and Innovation Committee of which governors are members. Governors are presented with the annual staff satisfaction survey data comparative across London and have asked for regular updates on how bullying and harassment is being dealt with. Governors regard improving staff satisfaction ratings, particularly regarding reducing bullying and harassment, as being a priority for the board.

Governors are regularly informed on the progress of the whole Clinical Pathway (CPG) programme and a presentation was given to the Council of Governors on the emergency care pathway. Also a medicine for members' event was held at the Royal Free Hospital on the heart failure clinical pathway where more than 100 members of the Trust/public attended. Governors are confident that clinical pathways will deliver improved quality of service.

Priority three: Improving patient safety: improve safer surgery, improve learning from deaths and to improve infection control and prevention

Governors receive an overview on never events at each hospital Local Members' Council (LMC); where they can ask questions of the hospital executive. Governors sit on the Clinical Standards and Innovation Committee where serious incidents are monitored. Governors are assured that learning from never events is effectively undertaken and that the Safety Strategy 2020-2025 provides a framework to make change.

Governors also receive performance information for each Council of Governor meeting that includes the monitoring of Clostridium Difficile (C. Diff) and MRSA bacteraemia outbreaks.

Priorities for 2020/21

Governors were involved in the survey that selected the quality priorities for 2020/21 and agree with the priorities that have emerged from the consultation. Governors welcomed the ranking tool as a way of differentiating between priorities.

Judy Dewinter  
Lead Governor  
On behalf of the Council of Governors  
07 May 2020

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

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2019/20 and supporting guidance: detailed requirements for quality reports 2019/20;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2019 to May 2020
  - papers relating to quality reported to the board over the period April 2019 to May 2020
  - feedback from commissioners dated 14 May 2020
  - feedback from governors dated 07 May 2020
  - feedback from local Healthwatch organisations dated 09 April and 01 May 2020
  - feedback from Overview and Scrutiny Committees dated 10 April, 17 April and 11 May 2020
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated July 2019
  - the latest national patient survey dated June 2019
  - the latest national staff survey dated February 2020
  - the Head of Internal Audit's annual opinion over the trust's control environment (date to be confirmed)
  - CQC inspection report dated 10 May 2019
- the quality report presents a balanced picture of the RFL's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions and is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

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

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

## **Annex 3: Limited assurance statement from external auditors**

As a result of the COVID-19 pandemic, there was no requirement for foundation trusts to prepare a quality report and include this in its annual reporting for 2019/20.

There was therefore no requirement to commission external assurance on our quality report for 2019/20.

Based on this, the trust's external auditors were not required to test indicators, perform a consistency and completeness check or provide a limited assurance statement.

## Appendices

### Appendix A: Changes made to the quality report

The views of our stakeholders and partners are essential in developing our quality report. In addition to correcting the identified grammatical and formatting errors, our report has changed as follows, in response to comments received from the distribution of the draft quality account:

Comment	Update
<p>Patient transport is not covered in the report. It remains a huge issue for local people. It won't go away. The Trust must work with others across London and nationally to achieve a solution. Some of our most disadvantaged residents suffer the most under the government's current framework. Unless it is resolved progress on many fronts will be slowed or be unachievable</p>	<p>The trust is extremely sorry that patients have found the assessment process for transport eligibility frustrating, and sometimes experienced a poor outcome. We have included a comment about this in our reporting on improving our involvement with patients and carers. We endeavour to make patient transport an on going priority in order to improve our performance and patient experience</p>
<p>The use of acronyms is not always clear to a layperson. There is a list but it isn't very comprehensive</p>	<p>The quality account was reviewed for acronyms and 'Appendix B: Glossary of definitions and terms used in the report' was updated as appropriate</p>
<p>There is too little focus on the CQC report. The introduction is limited, and in the main report at the back end there is a section on the progress of implementing the CQC recommendations. It is almost completely factual, and feels as though it has been inserted into the report, but does not really relate to the rest of the report. What comes over is a view that the CQC report is an irrelevance, and that the Quality plans of the trust have not in any way been influenced by the CQC whose comments are trivially meaningless compared to the important work the Trust is doing. This may be true, but is this the impression you really want to give to the CQC</p>	<p>As a trust we are committed to delivering excellent care and the process of the CQC inspection contributes to informing where we may need to provide more and specific attention to support improvements. We have extended our CQC narrative throughout the relevant sections of the quality account and hope that it now reflects this message far clearer</p>

## Appendix B: Glossary of definitions and terms used in the report

Term	Explanation
Acute Kidney Injury (AKI)	A sudden episode of kidney failure or kidney damage that happens within a few hours or a few days
ASA	The ASA physical status classification system is a system for assessing the fitness of patients before surgery adopted by the American Society of Anesthesiologists (ASA) in 1963
Best Practice Tariff (BPT)	A BPT is a national price that is designed to incentivise quality and cost effective care. The first BPTs were introduced in 2010/11 following Lord Darzi's 2008 review. The aim is to reduce unexplained variation in clinical quality and spread best practice
Cardiotocography (CTG)	Cardiotocography (CTG) is a technical means of recording the <a href="#">fetal heartbeat</a> and the <a href="#">uterine contractions</a> during <a href="#">pregnancy</a> . The machine used to perform the monitoring is called a cardiotocograph
Care Quality Commission (CQC)	The main independent regulator of all health and social care services in England
Clostridium difficile (C-diff)	A type of bacterial infection that can affect the digestive system
Clinical Practice Group (CPG)	Permanent structures which the trust is developing to address unwarranted variation in care)
Commissioning for Quality and Innovation (CQUIN)	CQUIN is a payment framework that allows commissioners to agree payments to hospitals based on agreed improvement work
Continuous positive airway pressure (CPAP)	Continuous positive airway pressure (CPAP) is a form of <a href="#">positive airway pressure</a> ventilator, which applies mild air pressure on a continuous basis to keep the airways continuously open in people who are not able to breathe spontaneously on their own
Healthcare Information and Management Systems Society (HIMSS)	HIMSS are a not-for-profit organisation that is based in Chicago with additional offices in North America, Europe, United Kingdom and Asia. Their aim is to be leaders of health transformation through health information and technology with the expertise and capabilities to improve the quality, safety, and efficiency of health, healthcare and care outcomes. HIMSS drives innovative, forward thinking around best uses of information and technology in support of better connected care, improved population health and low cost of care
Hospital Episode Statistics (HES)	A database containing details of all admissions, A&E attendances and outpatient appointments at NHS hospitals
Infoflex	InfoFlex is an information management software tool dedicated to managing and improving patient pathways and treatment processes within the NHS. However, it does so differently. Instead of imposing a "system", InfoFlex is modelled to fit the needs of the clinicians, IT staff and management who will use it
Learning from Deaths (LfD)	National guidance for NHS trusts on how they should support, communicate and engage with bereaved families and carers following a death of someone in their care

Local Safety Standards for Invasive Procedures (LocSSIPs)	A set of National Safety Standards for Invasive Procedures modified for local use
Multi-disciplinary team (MDT)	A team consisting of staff from various professional groups i.e. nurses, therapist, doctors etc
NHS NCL	NHS north central London clinical network
Never event	Never events are extremely serious and largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place
National Institute of Clinical Excellence (NICE)	An independent organisation that produces clinical guidelines and quality standards on specific diseases and the recommended treatment for our patients. The guidelines are based on evidence and support our drive to provide effective care
National Institute for Healthcare Research (NIHR)	A central part of the UK research landscape, collaborating in national activities to improve research and supporting NHS research performance.
Patient at Risk and Resuscitation Team (PARRT)	The Patient at Risk & Resuscitation Team (PARRT) is a combined nursing service to provide 24/7 care to patients at risk, including attending medical emergency calls (2222) and reviewing all patients post discharge from intensive care. The team members provide education, training and support to manage life-threatening situations, including in-hospital resuscitation, care of the patient with a tracheostomy and CPAP
Paediatric early warning score (PEWS)	A scoring system allocated to a patient's (child's) physiological measurement. There are six simple physiological parameters: respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness
Patient Reported Outcome Measures (PROMs)	Measure of health gain in patients undergoing hip replacement, knee replacement (and up to September 2017, varicose vein and groin hernia surgery) based on responses to questionnaires before and after surgery
Situation, background, assessment, recommendation (SBAR)	SBAR is a structured method for communicating critical information that requires immediate attention and action contributing to effective escalation and increased patient safety. It can also be used to enhance handovers between shifts or between staff in the same or different clinical areas
Summary hospital level mortality indicator (SHMI)	The SHMI is an indicator which reports on mortality at trust level across the NHS in England using a defined methodology. It compares the expected mortality of patients against actual mortality
University College London Partners (ULCP)	UCLP is organised around a partnership approach. It develops solutions with a wide range of partners including universities, NHS trusts, community care organisations, commissioners, patient groups, industry and government ( <a href="http://www.uclpartners.com/">http://www.uclpartners.com/</a> ).
Urinary Tract Infection (UTI)	Infections that affect different parts of the urinary tract, including the bladder (cystitis), urethra (urethritis) or kidneys (kidney infection)
Venous thromboembolism (VTE)	A blood clot that occurs in the vein

