



NOTICE OF MEETING

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Contact: Dominic O'Brien, Principal
Scrutiny Officer

Friday 31st May 2024, 10:00 a.m.
Committee Room 5 & 6, Islington Town Hall,
Upper Street, N1 2UD

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Councillors: Rishikesh Chakraborty and Philip Cohen (Barnet Council), Lorraine Revah (**Vice-Chair**) and Kemi Atolagbe (Camden Council), Chris James and Andy Milne (Enfield Council), Pippa Connor (**Chair**) and Matt White (Haringey Council), Tricia Clarke (**Vice-Chair**) and Jilani Chowdhury (Islington Council).

Quorum: 4 (with 1 member from at least 4 of the 5 boroughs)

AGENDA

1. FILMING AT MEETINGS

Please note this meeting may be filmed or recorded by the Council or by anyone attending the meeting using any communication method. Members of the public participating in the meeting (e.g. making deputations, asking questions, making oral protests) should be aware that they are likely to be filmed, recorded or reported on. By entering the 'meeting room', you are consenting to being filmed and to the possible use of those images and sound recordings.

The Chair of the meeting has the discretion to terminate or suspend filming or recording, if in his or her opinion continuation of the filming, recording or reporting would disrupt or prejudice the proceedings, infringe the rights of any individual, or may lead to the breach of a legal obligation by the Council.

2. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

3. URGENT BUSINESS

The Chair will consider the admission of any late items of Urgent Business.

4. DECLARATIONS OF INTEREST

A member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting of the authority at which the matter is considered:

- (i) must disclose the interest at the start of the meeting or when the interest becomes apparent, and
- (ii) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in the Register of Members' Interests or the subject of a pending notification must notify the Monitoring Officer of the interest within 28 days of the disclosure.

Disclosable pecuniary interests, personal interests and prejudicial interests are defined at Paragraphs 5-7 and Appendix A of the Members' Code of Conduct

5. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

To consider any requests received in accordance with Part 4, Section B, paragraph 29 of the Council's constitution.

6. SCRUTINY OF NHS QUALITY ACCOUNTS (PAGES 1 - 194)

- Royal Free London NHS Foundation Trust
- Whittington Health NHS Trust
- North Middlesex University Hospital NHS Trust (quality accounts document to follow)

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Fiona Alderman
Head of Legal & Governance (Monitoring Officer)
George Meehan House, 294 High Road, Wood Green, N22 8HZ

Wednesday, 22 May 2024

Equality Matters

Quality Account 2023/24

Royal Free London NHS
Foundation Trust

Comprising of:

Barnet Hospital, Chase Farm Hospital, Royal Free Hospital

Quality Account 2023/24

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Part 1: Achievements in quality

1.1 Statement on quality from the chief executive

Welcome to our Quality Account for 2023/2024 in which we share our achievements over the past twelve months and set out our quality priorities for 2024/2025.

The past year has seen continued growth in demand for our services in the context of complex operational challenges. Against this backdrop, we recognise that the communities we serve are affected by health inequalities that mean some people are more likely than others to become ill or experience unfair difficulties in accessing treatment. For this reason, we have chosen Equality Matters as a theme for this year's quality account. We have been working hard over the past year to ensure that all of our patients, carers and their loved ones receive kind and compassionate, safe and effective care in the right place at the right time whenever they need our help. We have more work to do but I am pleased to introduce some highlights of the progress we have made over the past year and our plans for the future.

I would like to thank everyone who works at Royal Free London for their commitment and dedication over the past year. As well as providing safe patient care during periods of industrial action, our clinical and operational teams have maintained a relentless focus on reducing waiting times for treatment and making improvements in quality. I am immensely proud to work with such inspirational colleagues who are building the future of our services while continuing to do brilliant things each and every day.

We remain committed to providing high quality care for all and to learning from new challenges in areas where we need to make improvements. I hope you will see this reflected in the focus of this Quality Account.

2023-24 Achievements to highlight:

- The publication of our quality strategy was a milestone in 2023. The strategy provides the direction for how we will deliver safe and effective care for all while ensuring that patients have the best possible experience when they need the support of our services. Along with the clinical strategy, the quality strategy underpins the delivery of our Excellent Health Outcomes governing objective which guides our commitment to improving the health of the communities we serve by optimising the way we work together and transforming services for the future.
- The clinical practice group (CPG) programme continued to operate at scale to reduce unwarranted variation in clinical care across 64 clinical pathways. The improvements achieved by the Better Births, Virtual Hospital Care, Child and Adolescent Mental Health Services and Inpatient Diabetes pathways are described in detail in this Quality Account.
- We accomplished 100% participation and data submission for all National Confidential Enquires into Patient Outcome and death studies in the year.

- We continued to strengthen the Royal Free London Involvement Framework, a formalised infrastructure to support staff to involve patients and carers in designing and improving services. We successfully introduced the involvement register, which provides a standardised process for recruiting and supporting patients and carers in involvement activity across the group.
- There has been a significant improvement in the number of never events across the trust compared with 2022/23.
- The trust went live with the Patient Safety Incident Review Framework (PSIRF) on 4th March 2024. The trust patient safety incident response plan (PSIRP) sets out how we will learn from patient safety events reported by staff, patients, families and carers in order to continually improve the quality and safety of care.
- As part of the Ockendon Review, the Care Quality Commission (CQC) carried out a focused inspection of our maternity services at Edgware Community Hospital on 24 October 2023. The CQC rated the service as good for both the safe and well led domains.

Part 2 of this report summarises the quality priorities identified for 2024/25. These priorities have been aligned to our Excellent Health Outcomes governing objective and build on the progress achieved in 2023/2024.

Part 3 describes performance against key indicators and gives examples of improvement plans we have put in place over the past year.

I hope you enjoy reading this Quality Account, which I believe demonstrates our continuing commitment to providing high quality care. I confirm to the best of my knowledge the information provided in this Quality Account is accurate and reflects the quality of care delivered by the Royal Free London NHS Foundation Trust.

Peter Landstrom
Group Chief Executive
Royal Free London NHS Foundation Trust

1.2 Who we are and our values:

Royal Free London Who we are The Royal Free London is a large NHS foundation trust employing more than 11,000 staff and serving a population of more than 1.6 million people across 70 sites in north London and Hertfordshire. Our values positively  welcoming actively  respectful clearly  communicating visibly  reassuring Royal Free London Group The Royal Free London is made up of three main hospitals: • Royal Free Hospital • Barnet Hospital • Chase Farm Hospital We also operate satellite sites at other hospitals	Our services We attract patients from across the country and beyond to our specialist services in liver, kidney transplantation, haemophilia, renal, HIV, infectious diseases, plastic surgery, immunology, vascular surgery, Parkinson's disease, cardiology, amyloidosis and scleroderma. We are one of the largest cancer providers. Our group partnerships and host services We work in partnership with two wholly owned subsidiaries of the trust who offer expertise in their respective areas to both RFL and a wide range of other healthcare providers: • Royal Free London Property Services Limited • Royal Free London Dispensary Services Limited We host the following clinical and non-clinical services which provide support to the Royal Free London and other NHS trusts: Central and East London Breast Screening Service North London Partners Shared Services Transformation Partners in Health and Care Royal Free NHS Central Sterile Services Department
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1.3 Equality matters

Further to the Chief Executive's statement on quality in opening the 2023/24 quality account report, the examples below represent a selection of improvement work undertaken in the trust over the last year to demonstrate our commitment to equality, diversity and inclusion while delivering high-quality care.

Equality, diversity and inclusion

The Trust believes that promoting equality, diversity and inclusion is integral to achieving our governing objectives of delivering excellent health outcomes and outstanding experiences of care for all our patients and carers.

Our commitment to reducing health inequalities is a cross-cutting principle within our Quality and Clinical strategies. Our [Equality, Diversity and Inclusion Framework \(2021-2024\)](#) set out equality objectives that has helped the Trust progress in its journey to delivering these commitments.

We will continue building on this foundation by ensuring that equality, diversity and inclusion and a focus on health inequalities will be fundamental in our work within our Quality Strategy Delivery Group. We will use the equalities measures we have developed to monitor what changes we make to health inequalities and to improve the quality of our equality data. We will also continue to build partnership approaches to tackling health inequalities with our patients, carers, partners and local communities so we co-design solutions and ensure accountability on our equality performance.

During 2023-24, the Trust's work on equality, diversity and inclusion for patients has included:

- Working in partnership with West Hertfordshire Teaching Hospital, to develop a new electronic patient record field for recording and flagging patient reasonable adjustment requirements (including accessible communication needs). This work will continue next year with an initial focus on implementation within outpatient services alongside support for staff to ask, record and respond to patients' reasonable adjustment requirements.
- With Royal Free Charity support, the EDI team worked in partnership with the Asian Peoples Disability Alliance (ADPA) to complete an audit of disability accessibility of My RFL Care Patient Portal, Website and our three main hospital site estates and facilities. The audit's findings and recommendations have been used to inform developments (such as the 2023 PLACE surveys). ADPA's CEO shared positive feedback on the changes made to our website, highlighting 'it is much clearer and easier to navigate'. This evidence in the audit has also helped initiate discussion on future improvements with leads each of the three audited areas.
- The LGBTQ+ (lesbian, gay, bisexual, transgender, queer plus) Staff Network delivered a programme of Allyship Training to support staff across the Trust to improve their awareness and care for LGBTQ+ patients and colleagues. The network also initiated the development of additional electronic patient record fields for monitoring patient sexual orientation and gender identity. Once live, we will promote confidence and capability of using these for care-focused discussions about sexual orientation and gender identity and improving the demographic data available for measuring equity of access, experience and outcomes for LGBTQ+ patients and improving our accountability on this.



- Ongoing work to improve use of equality analysis to inform clinical policy reviews and service transformations such as programmes on Barnet Flow, outpatient improvement and theatre productivity.
- Building on our [Equitable Recovery Programme](#) by developing phase one of a new inequalities dashboard in partnership with North Middlesex University Hospital. This Power BI tool visualises age, ethnicity, gender and indices of multiple deprivation (IMD) data on a range of access indicators such as outpatient did not attend (DNA) rates, inpatient length of stay, referral to treatment and Diagnostic waiting time performance, 4 and 12 hour emergency department waits and cancer 28 day faster diagnosis performance. The new inequalities dashboard provides a valuable tool analysis and action on equity within these indicators. The dashboard has enabled us to show that the introduction of appointment SMS messaging to patients, in September 2023 as part of our Outpatient Improvement and Productivity Programme, reduced DNA rates for patients in all age group, ethnicity, gender and IMD categories. The dashboard shows us where unwarranted demographic variation remains in this and the other indicators. We are using the dashboard to inform relevant equality analysis, performance management and equitable access improvement activity across the Trust. Phase two of the dashboard's development will incorporate learning from phase 1 and additional demographics and indicators to further strengthen data-led approaches to reducing health inequalities.

A final equality objective progress report will be submitted to the Board alongside our annual 2023/24 equality information and new equality objectives in the new financial year. All this information will be published alongside our previous years' reports on the [equality and diversity documents](#) page of our website.

Maternity Equality, Diversity and Inclusion Working Group

The maternity equality, diversity and inclusion working group brings together staff, representatives from Maternity and Neonatal Voices Partnership (MNVP) and women and birthing people from diverse backgrounds. The group meets monthly to continue work to embed equality, diversity and inclusion (EDI) into maternity and neonatal patient experience.

In the past year, this EDI work has included:

- Continuing to promote race equality and inclusion in maternity care by delivering 14 rounds of tailored parent education classes for black women and birthing people. Around 65 birthing people and couples have participated in these classes with 100% of participants saying that they would recommend the classes. Feedback from participants included:

“So nice to meet other black mums and a black midwife. From this point I no longer feel isolated”.

“It was very informative and tailor made”.

“Wealth of knowledge, this is a safe space”.

“These classes are invaluable. They teach you how to advocate for yourself”.

- Translating patient information into the top ten languages within maternity, auditing language and interpretation and working with the MNVP to hold listening sessions in other languages.
- Trialling ‘Muslim Mama’ information cards to support staff awareness and care for Muslim service users.
- Introducing calm bags with items to support service users with sensory needs to Triage and MDU.
- Holding monthly meetings to improve maternity staff EDI awareness by listening and learning from the lived experience of diverse service users and external speakers on issues such as autism and neurodiversity, FGM, the needs of Orthodox Jewish women, South Asian women, LGBTQ+ service users and same sex couples in maternity services.
- Appointing an Equity and Equality Specialist Midwife and implementing the Capital Midwife Anti-racism framework. Work to achieve this has included:
 - Establishing the Anti-Racism Implementation Advisory (ARIA) Group
 - Analysing maternity workforce race equality data
 - ARIA-led anti-racism sessions
 - Coordinating with Trust Freedom from Racism Programme Lead and Group Head EDI (Patients and Carers).
- Sharing learning and engaging on EDI in maternity care and reducing inequalities with wider partners and stakeholders such as:
 - Delivering a presentation on the Royal Free London’s maternity EDI work to the BHBU Nursing and Midwifery Conference.
 - Developing a poster to share learning on the tailored parent education classes for black women and birthing people at the Black Health Inequalities Summit.
 - Streaming the Motherhood Group’s 2nd annual Black Maternal Health Conference UK to maternity staff to support efforts to bridging community members, healthcare providers, policymakers and mothers to address systemic racism in maternity care.

These are some of the highlights that we have achieved so far, and we continue on our journey of equality matters.

Part 2

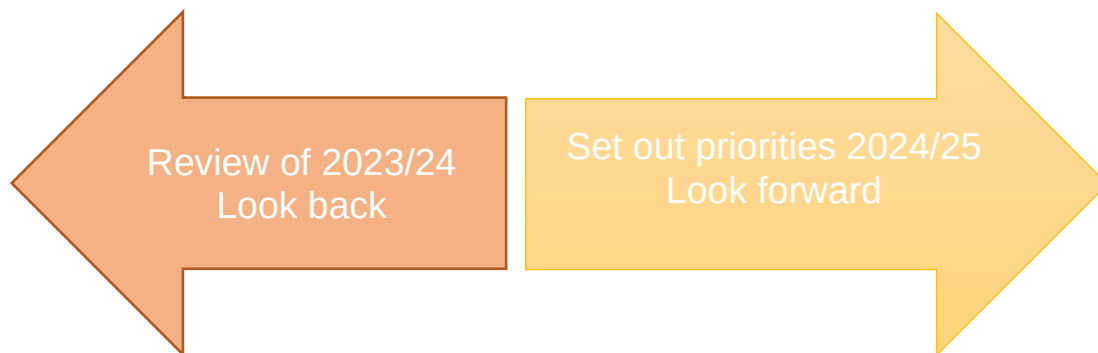
Priorities for improvement and statements of assurance from the board

2.1 Priorities for improvement

All NHS Trusts have to publish their annual accounts. Since 2009, as part of the drive across the NHS to be open and honest about the quality of services provided to the public, all NHS trusts must produce a quality account report for their stakeholders detailing the quality of their care provision and outlining their priorities for the year ahead.

The purpose of this Quality Account is to:

1. Summarise our performance and improvements against the quality priorities and objectives we set ourselves for 2023/24
2. Set out our quality priorities and objectives for 2024/25.



To begin with, we will give details of how we performed in 2023/24 against the quality priorities and objectives we set ourselves under the categories of:

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



QUALITY

What were our priorities for 2023/24 and how did we do?

The development of the priorities for improvement in 2023/24 remained within the three domains of quality: patient safety, clinical effectiveness and patient experience.

The trust developed these priorities through engagement with relevant stakeholders and committees. The engagement process included the trust quality group, trust quality committee, council of governors, group executive meeting, stakeholder consultation and events and the trust board.

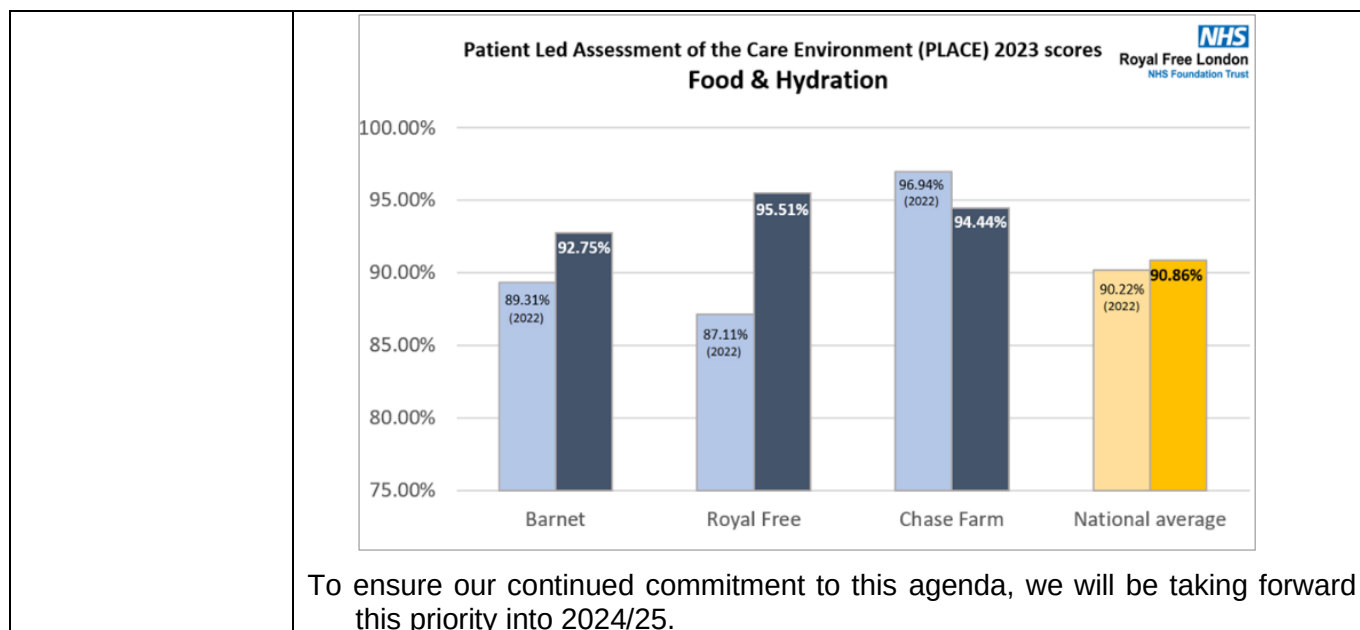
Priority 1: Patient experience - Improving patient experience – delivering excellent experiences.

Priority 1a	Embed shared principles for involving patients and carers in our services to better monitor their experiences and make relevant improvements. <i>This is a new priority for 2023/24</i>
What success looks like:	• We will build on the patient involvement framework to facilitate and embed high quality, diverse involvement work across the trust. • We will work collaboratively with patients to identify and act on areas for improvement and better understand health inequalities through changes in service utilisation. • We will develop clear processes to better understand the experience of patients with learning disabilities and work with patients and carers in the co-production and design of our services. • We will make every contact count by supporting the prevention of poor health across the North Central London patch.
Key performance indicators, goal milestones, deliverables and/or other metrics	• Patient involvement is included as part of our board assurance framework. • Business Units to continue to build on patient involvement. • QI projects require patient involvement to be a part of the process.
Our Progress:	The trust is committed to continually improving the care we provide and the experience that our patients have. To achieve this, we need the input and involvement of our patients and their loved ones to guide and influence changes that matter. Involving patients and the wider public is not a soft, optional activity. Expectations regarding patient involvement have grown considerably over the last decade. Today's patients are better informed, have greater choice and are less likely to accept being passive recipients of care in a system they have no influence over. This cultural shift is reflected in the proliferation of fora within which patients and the wider public are connecting with healthcare organisations. It is hard to capture within one summary all the activity that has been ongoing for patient involvement within the trust and below under the involvement register several examples are cited. However, it feels right and proper to mention the RFL clinical strategy and quality strategy that both have the patient voice threaded through them. There were slightly different approaches that were designed around the way the voice of patients was captured. The quality strategy pooled through hundreds of patient's feedback comments to find commonality, this was then triangulated with other sources of patient voices. The clinical strategy has chosen to hold patient voices meetings. Both are validated ways to recognise the voice with the key being any workstreams that fall from the strategies continue to evolve and strengthen the approach to involving patients. Key highlights and successes achieved for patients and cares in the last 12 months include:

	- In April 2023, the Royal Free London NHS Foundation Trust (RFL) launched the involvement register, which provides a standardised process for recruiting and supporting patients and carers in ad-hoc and regular involvement activity across the group, as well as documenting evidence of involvement. The involvement register is essentially a database of individuals that have indicated their interest in being informed about opportunities to get involved with the RFL group. The register is managed by the group patient experience teams. Staff submit their projects or activities to be advertised to members and then the patient experience teams facilitate connections between members and staff via the register. All involvement register documents and templates are available on RFL Freenet. Examples of opportunities that patients are/ have been involved in include, - Playing an active role on the deteriorating and resuscitation committee - Patient assessors as part of the 2023 PLACE audits across sites - Performing reviews of patient information leaflets - A steering group was established, the purpose of which is to provide governance and assurance on the patient involvement agenda within the trust to ensure a consistent group-wide approach to involvement that remains responsive to staff, services, patients, and carers. It is used to inform the development and embeddedness of patient involvement in service delivery and development, in teaching and research. - Working group established to develop an effective reasonable adjustment field on EPR (electronic patient records) (including LD-related communication and information needs). - The site-based Patient Voices groups continue to meet regularly to offer staff looking for face-to-face feedback on their projects an opportunity for this. To show continued commitment, currently a mapping exercise of involvement activity across the trust is underway and developing a business case development for easy read translation of patient information. We will be taking forward this priority into 2024/25.
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Priority 1b	Ensuring all adult inpatients and those having a procedure receive appropriate nutrition and hydration and where necessary support them to meet nutritional and hydration requirements. <i>This was a new priority for 2023/24</i>
What success looks like:	- We will ensure the red tray is used on the wards to help staff identify which patients need extra attention when eating or need foods that have a modified texture (such as mashed or pureed foods). - We will undertake a nutrition screening tool audit to establish a baseline. - We will establish a group-wide nutrition group; to include patients, speech and language therapist, dieticians and estates and facilities. - We will publish our 'patient led assessment care environment' report (PLACE).

	• We will co design and publish a food and drinks strategy.
Key performance indicators, goal milestones, deliverables and/or other metrics	• The purpose of this priority is to ensure embeddedness of the processes, requirements, roles, and responsibilities concerning nutrition and hydration care that ensure all patients and clients under the care of RFL. Considering the nature of the priority the activity was planned to be back loaded. • There is a Quality Improvement project at Barnet Hospital for nutrition and hydration.
Our Progress:	Nutrition and hydration are an essential part of a patients' treatment and recovery during a hospital admission and therefore we focus on providing quality food that gives the patients the nutrition they need for their stage of illness. Protected mealtimes are in place and designed to make sure patients are not unnecessarily interrupted during meal service. Key highlights: • Food and fluid record charts are essential for monitoring patients' however, completion rates and accuracy can be poor giving rise to opportunities for malnutrition and dehydration to be missed or poorly managed. Maintaining standards across all wards is key for patient safety and experience, with multidisciplinary teamwork at ward level essential to drive improvement and develop ownership. Implementation of the electronic health record system (EPR) includes the Malnutrition Universal Screening Tool (MUST). This allows a baseline to be established and inpatients have a MUST completed for each week they are in hospital. These MUST scores are reported to the Trust Nursing and Midwifery Committee. • Introduction of red trays across inpatient areas with potential consideration for red lids on water jugs. • Hospital sites have Nutrition and Hydration Steering Committees, they are multi-professional groups; RFH membership has a patient representative on the committee, that oversees the delivery of nutrition and hydration care to patients, staff, and visitors. It provides the over-arching leadership on all aspects of nutrition, including catering and food procurement. They are chaired by the Directors of Nursing. • Training programmes for staff have been implemented to ensure that all staff have the appropriate skills and competencies to enable clear identification of patient's nutritional needs. Catering provides training to healthcare assistants, nursing and all ward staff to ensure best practice. • The patient led assessment care environment (PLACE) 2023 results shows sustained improvement for the catering domain. Table below shows that RFL performed well above the national average at all three sites.



Priority 1c	We will improve how we communicate with patients regarding cancellation of clinic appointments and also on waiting times for outpatient clinics. This was a new priority for 2023/24
What success looks like:	- We will identify the best practice methods to keep patients informed and updated of any cancellations and delays and roll these out across the group. - We will monitor our progress using patient experience to collect patient and carer feedback.
Key performance indicators, goal milestones, deliverables and/or other metrics	- Reduction in DNA rates - (reduce the volume of missed appointments against the number of appointments attended) - Reduction in missed appointments (reduce volume) and - Increase attended appointments (increase volume) - Increase uptake use of patient portal to enable patients to better manage their health care. - Volume of patients contacted via the Patient Portal to validate whilst waiting - Volume of patient pathways closed as a result of validation via the Portal
Our Progress:	The RFL invested in a best practice SMS set up and implemented it across all outpatient sites and services and all planned imaging appointments. Put in place automated SMS cancellation notification for patients whose appointment is cancelled by the Trust (but temporarily left in a cancelled status) to ensure patients have up to date information about the status of their appointment. All these resulted in a DNA rate improved by 25% (11% reduced to 8.2%). The trust will continue to leverage the new ways of working around 2-way SMS and support patients to reschedule their appointments (reduce missed appointments and DNA rate further). To ensure our continued commitment to improve our communication with patients regarding cancellation of clinic appointments, we have updated this priority and will take it forward into 2024/25.

Priority 2: Clinical effectiveness- Improving clinical effectiveness: delivering excellent outcomes.

Priority 2a	To embed learning from our morbidity and mortality reviews we will develop a coordinated approach to ensure that learning is shared across the group. <i>This was a new priority for 2023/24</i>
What success looks like:	- Standardising the process to conduct morbidity and mortality reviews that is aligned with the learning from deaths process. - Developing improvement plans from the learning and ensure the improvement actions are delivered. - Share the learning identified across teams, divisions, hospital business units and trust wide.
Key performance indicators, goal milestones, deliverables and/or other metrics	- M&M process to be aligned with LfD Process - M&M process to be standardised in line with Royal College of Surgeons standards - All specialties to confirm they hold regular M&M meetings (feed into others where number of deaths are small) - All specialties to select the % of cases they will review through the M&M process each year and for this to be agreed by DQSB - Electronic platform to be designed as a central place to record M&M outputs
Our Progress:	The trust initiated a project on standardising the process to conduct morbidity and mortality reviews that is aligned with the learning from deaths process. During the year work was carried out to align morbidity and mortality process with Learning from Death process for the review of deaths. A gap analysis exercise confirmed that all specialties hold regular M&M meetings (or feed into others where number of deaths are small). An M&M handbook has been developed, including core principals of M&M process in a standardise way (in line with Ryal college of surgeons) and it is planned to be circulated to the specialities. All specialties are required to agree the % of cases they will review through the M&M process each year and for this to be agreed by DQSB by end of March 2024. There has been a limitation to identify a suitable platform to record M&M discussions electronically and the trust is exploring possible options for this. This priority has been carried forward to 2024/25 to ensure continued commitment for the system to be rolled out effectively.

Priority 2b	Over the next year the Clinical Practice Group (CPG) programme will continue to embed the 64 CPG pathways across all hospital sites to ensure we are involving patients in design and optimising patient outcomes. <i>This was an updated priority from 2022/23</i>
What success looks like:	- Through the digitised better birth CPG pathway, support delivery of the continuity of care model for women in the vulnerable groups and areas where there is deprivation decile score of 1-4. - Develop a virtual hospital so that patients can be cared for at home whilst under the care of hospital doctors and teams. - Improve the children and young person's experience through the emergency flow with particular focus on child and adolescent mental health services (CAMHS). - Develop a training package to increase knowledge, skills and capabilities across operational and clinical teams to monitor the safety and quality of the inpatient diabetes care through the roll out of the inpatient adult diabetes pathway.
Key performance indicators,	Better Births CPG Pathway - Aim: To ensure women from Black, Asian, and mixed ethnicity groups alongside women from areas of high deprivation (deciles 1-4) are prioritised for

goal milestones, deliverables and/or other metrics	continuity of care (CoC). Ensure all women are offered choice in relation to place of birth and information to facilitate informed decision making. • Ambulatory Emergency Care CPG: Virtual Hospital Care Improve patient flow and experience through the following. ○ Development of a virtual hospital care model to enable early supported discharge or admission avoidance for agreed pathways. ○ Optimise the utilisation of the virtual community ward across NCL. ○ Enable remote monitoring of patients in the virtual ward and contribute to the systemwide learning. ○ Develop a dashboard to monitor activity and length of stay. • CAMHS CPG ○ Aim: All children that present to ED in mental health crisis are treated with respect and dignity and cared for in a time appropriate manner achieved through the development of an integrated model of care with local crisis teams and boroughs. • Inpatient Diabetes CPG ○ Successful safe roll out of the inpatient digital diabetes pathway across all RFL sites to improve safety and clinical effectiveness
Our Progress:	(*In this section, the data shows the current position of the trust at the time of producing the draft report. The figures and tables might change as awaiting final data to be validated). The CPG programme in 2023-24 has continued to work across 64 clinical pathways, for the purpose of the quality accounts focussed on Better Births, Virtual Hospital Care, CAMHS and the Inpatient Diabetes CPG pathways. The clinical led multi professional teams have worked across all RFL business units with a focus on developing a robust internal infrastructure to be able to realise the aims of the four pathways. ○ to support delivery of the continuity of care model for women in the vulnerable groups and areas where there is deprivation decile score of 1-4. ○ to develop a virtual hospital so that patients can be cared for at home safely. ○ to improve the children and young person's experience when in crisis through the emergency flow by ensuring they get the right care in the right environment to supports their needs. ○ a safe roll out of the inpatient digital diabetes pathway across all RFL sites to improve safety and clinical effectiveness. This year has resulted in increasing knowledge, capability, enhancing the workforce and procuring the right equipment to realise the full benefits of the pathways. We have also ensured we have built the key metrics in our electronic patients record for regular monitoring. These developments will continue across all the pathways into the next financial year 2024-2025 so that the clinical teams can deliver better care to their patients and monitor their patient experience and clinical outcomes. Key metrics agreed for each CPG for regular monitoring across all sites are as follows: ○ Better Births:

- percentage of women booked onto a CoC model of care by 29 weeks.
- percentage of women booked onto a CoC model from Black, Asian, and mixed ethnicity groups.
- percentage of women booked onto a CoC from highly deprived geographical areas.
- Ambulatory Emergency Care CPG: Virtual Hospital Care
 - Virtual ward encounter developed to enable patients being cared for in the virtual ward.
 - Build of virtual wards for Barnet Hospital to pilot Heart Failure, Frail, Covid and Dementia and delirium patients
 - Activity report to monitor data commissioned.
- CAMHS CPG Pathway
 - Understand unwarranted variation in the current CAMHS RFL
 - The team have divided into sub-groups focusing on aligning the embedded improvements on the BH site with the RF site: Info leaflets, distraction tools and the mental health observational and action tool.
 - Designing the MH observational tool for use on the ward by the nursing staff. Standardising documentation for the CAMHS team in EPR, access to EPR for all the CAMHS team.
 - Making the MH observational tool mandatory for the nurses to complete in Triage.
 - Agreement across RFL to develop a crisis hub within the community and to optimise access for CAMHS assessment.
- Inpatient Diabetes CPG
 - Secured Group wide senior responsible owner – RFH chief nurse.
 - Set up a cross site core pathway team for RFL.
 - Engagement of all key stakeholders across RFL
 - Detail project plan and roll out plan
 - Training plan for all groups of clinicians
 - Business case for Nova meters for RFH to secure funding

2023/24 progress:

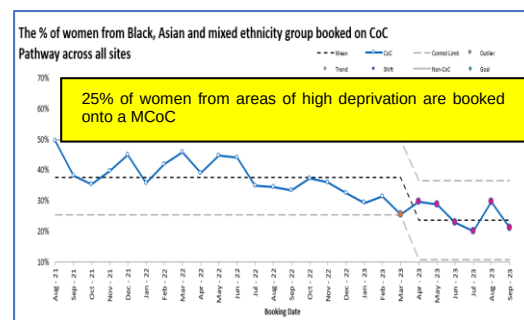
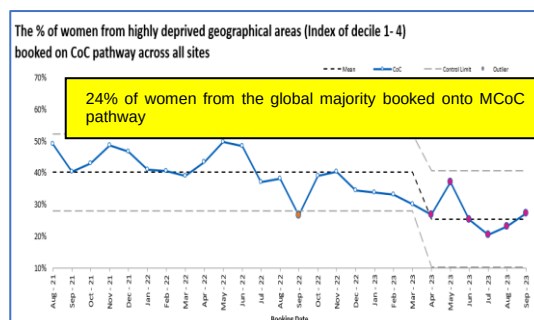
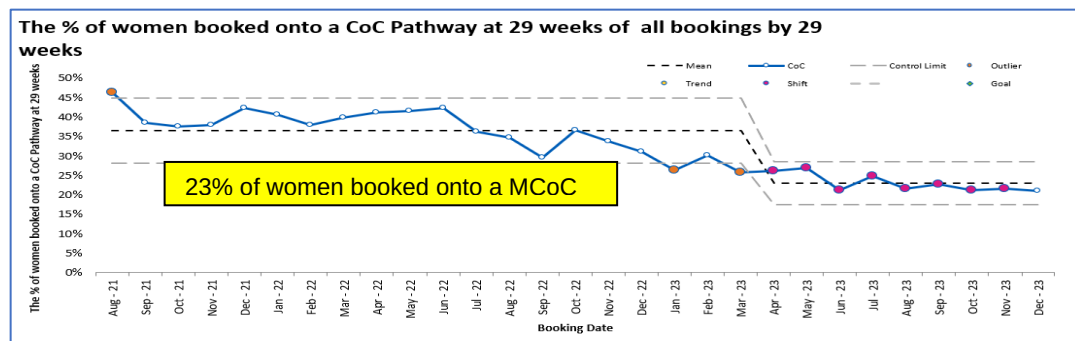
1.Better Births:

- In line with national guidance women and birthing people from the global majority and areas of high deprivation are prioritised for maternity continuity of carer (MCoC). As of end of year position, the team currently awaits for the national maternity continuity of care (MCoC) targets.
- An in-depth analysis will start to establish the:
- Total population of women from areas of high deprivation and from the global majority that book to have their baby at the trust.
- Total numbers that are not receiving MCoC and establish their geographical demographics, so that MCoC teams can be focussed in these areas.
- Further patient co-design is underway for the Vulnerable women`s team, Unity, and Fortune Green.
- Patient co-design for the Edgware team has revealed an overwhelming positive experience for those that have received MCoC. Women report that they built up a feeling of trust with their midwife, they didn't have to constantly repeat their story, and the midwife knew them very well. That they felt

comfortable to discuss mental health issues. A focus group for those women that booked care with the Edgware team is planned for 18th April, 24.

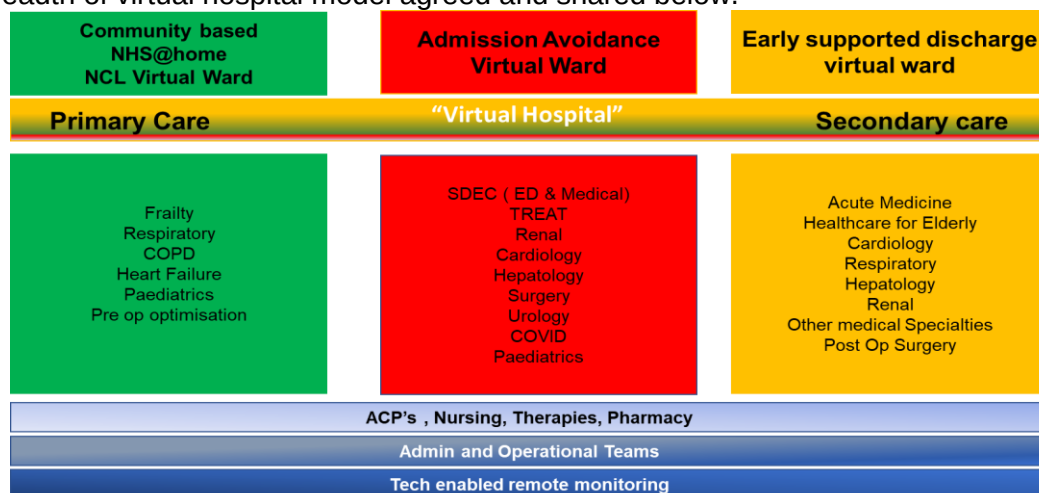
- Support required for the workforce as the Startwell consultation process continues.

Baselines are shown below (awaiting new continuity of care national guidance to set trajectories).



2. Ambulatory Emergency Care CPG: Virtual Hospital Care

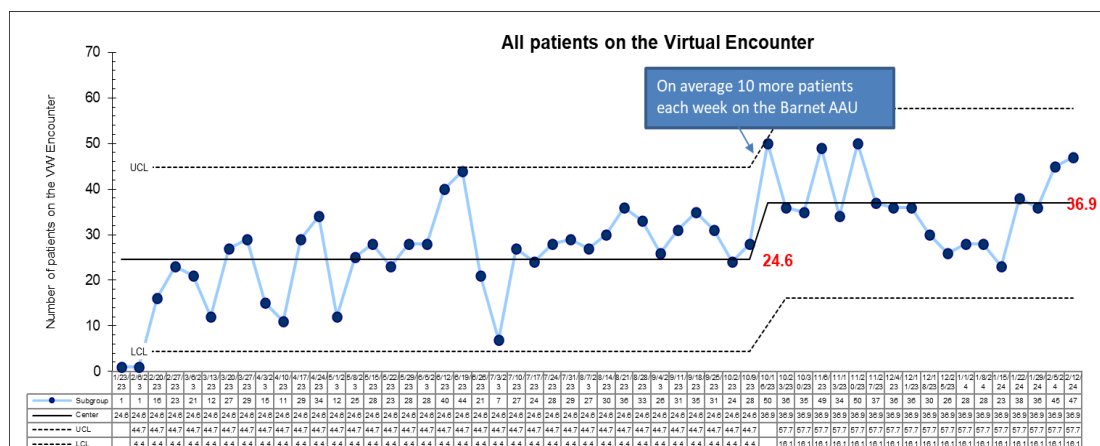
Breadth of virtual hospital model agreed and shared below.



2.1 Virtual Hospital Encounter

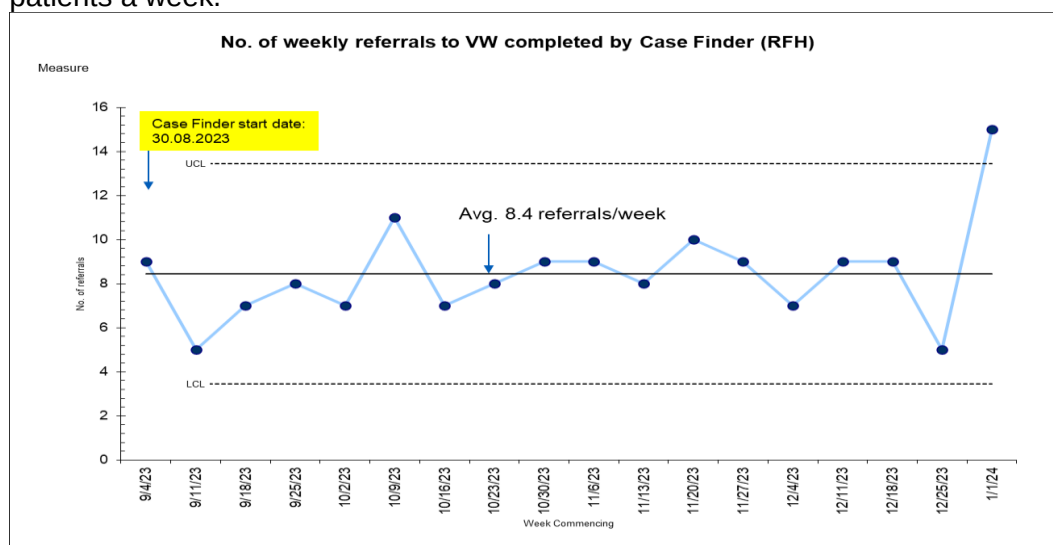
The virtual care CPG is making good progress. We continue to maintain activity and supporting North Central London (NCL) by sharing learning and supporting integrated care board (ICB) wide learning from the virtual care pathways and remote monitoring. RFL continue to work with central informatics to establish a dashboard. The dashboard will be developed in the next financial year with the roll out of the type 5 same day emergency care (SDEC) design in the RFL electronic patient record (EPR), diagram

below shows we continue to maintain the progress in virtual ward activity as we develop the infrastructure and pathways to support patients virtual and at home.



2.2 Hospital @ Home (Virtual Community Hospital)

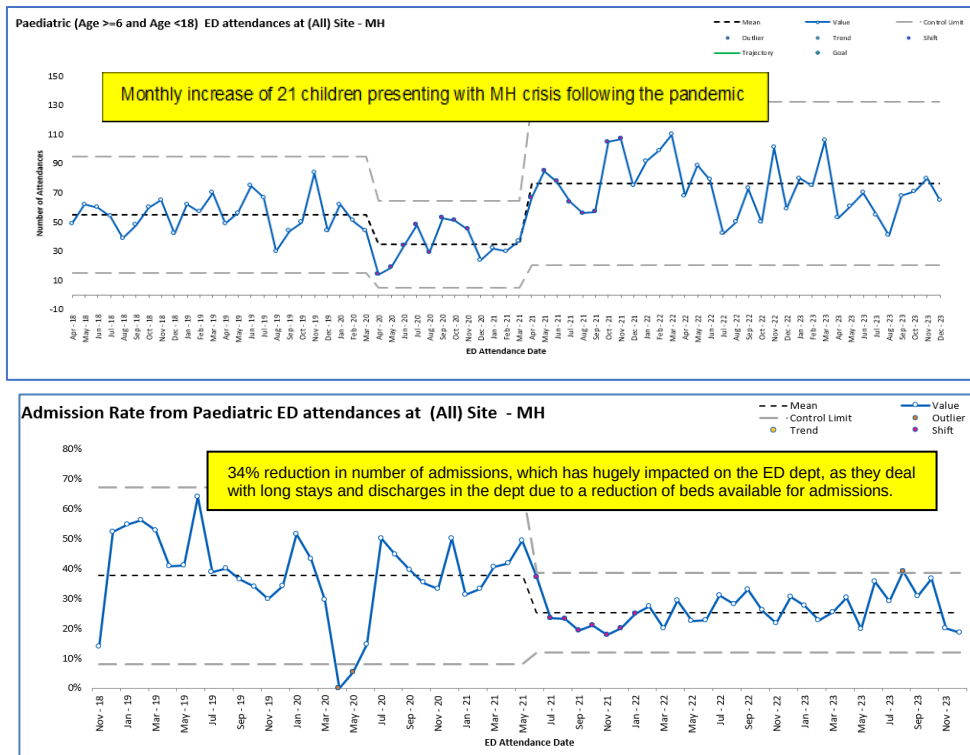
RFL continue to build a strong interface with the community virtual ward and have establish increase flow with support of the case finder role to enable more discharges into virtual ward as shown in the diagram below from on average 1 patient a week to 8 patients a week.



3. CAMHS CPG Pathway:

- All children and young people (CYP) will receive a standardised mental health assessment at triage and then 4 hourly while they remain in PEDs as this is now mandated in EPR.
- Embedded standardised mental health assessment once admitted to the ward and 4 hourly thereafter.
- Standardising documentation for the CAMHS team within EPR is in development.
- Time stamps: Referral to CAMHS, seen by CAMHS, is in development with the EPR team, to provide an audit trail of meeting the national target to be seen by the CAMHS team within one hour.
- SBAR tool for CAMHS CYP has been developed, currently assessing how to position it within EPR in relation to the interface with the adult Internal transfer policy.

- Patient led information leaflets designed and embedded with QR code.
- Patient co-design in progress
- System wide meeting planned for NCL boroughs on 12th March, 24 following two successful borough-based stakeholder events. This will aim to map all the MH services for CYP that are available within the NCL sector that present in mental health crisis. Aiming to develop a shared vision whereby we develop



optimal pathways to reduce the numbers of CYP that present to ED. It is known both locally and nationally that following the COVID pandemic there has been a notable increase in the number of CYP presenting with mental health crisis. It is anticipated that by working collaboratively within the NCL sector to design the optimal pathways, attendances and admissions will reduce.

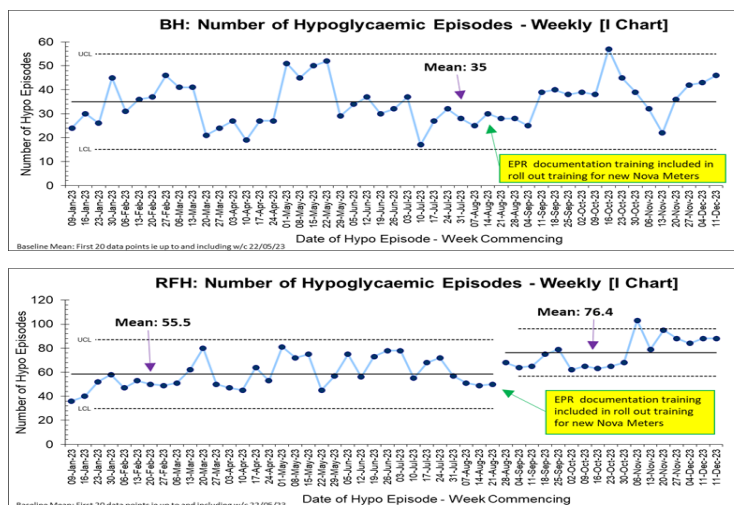
4. Inpatient Diabetes CPG pathway

RFL continue to make steady progress in building a robust infrastructure for hospital wide implementation of the inpatient diabetes pathway. The digital pathway progress made is as follows:

- Novameter POCT CBG/Ketone device roll out: deploy devices to Edgware, FMH, St Pancreas, Tottenham Hale, Hadley Wood.
- Submit D3 workforce business case – critical for progressing CPG workplan.
- Progress wider CPG workplan including education plan, local leadership, governance/assurance.
- Develop dashboards using data extract from specification.
- EPR changes in development: x3 including Referral to Diabetes Team – ESCALATE re pending EPR change freeze.
- CPG data analysis commenced [Dec 2023] baseline data outlined below

Baseline Data: Number of Hypoglycaemic Episodes

Episode of hypo: triggered by CBG ≤ 3.5 and resolved when CBG documented as < 4.0 mmol/L



NB: CPG data analysis recently commenced and will be refined during Q4

Priority 3: Patient safety - Improving Patient Safety: delivering safe care.

Priority 3a	Achieve zero trust attributed Methicillin-resistant Staphylococcus aureus bacteraemia (MRSA) case and reduce Gram negative bacteraemia in line with NHS Long Term Plan objective of 50% by 2024/25. This was an existing priority from 2021/22.
What success looks like:	- Implementing an education and training plan to improve (intravenous) line care practice. - Undertake post Infection Reviews carried out to identify and act on key areas of improvement.
Key performance indicators, goal milestones, deliverables and/or other metrics	- Implementation of a recognised Aseptic Non-Touch Technique Clinical Practice Framework® has been initiated using the Model for Improvement Quality Framework. - Annual cannula audits are carried out across the trust. Results based actions are implemented as part of an updated action plan. - There is an established education programme for care and insertion of invasive devices. - Multi-disciplinary post infection reviews are carried out where indicated. learning is shared with all relevant stakeholders in meetings at all levels of the organisation to drive improvement.
Our Progress:	(*In this section, the data shows the current position of the trust at the time of producing the draft report. The figures and tables might change as awaiting final data to be validated). From April 2023 to March 2024, the trust recorded 7 [Final data to be confirmed] attributable cases of MRSA bacteraemia, a reduction of two infection in comparison to the previous financial year.

MDT PIRs continue where indicated. Thematic analysis identified that 43% cases showed suboptimal compliance with MRSA decolonisation protocol, and 43% of cases identified VIP scoring and documentation was not completed as per policy. See table 1: MRSA BSIs from April 2023 to March 2024.

Ongoing line care workshops and training continue as part of zero preventable bloodstream infection Quality Improvement (QI) plan.

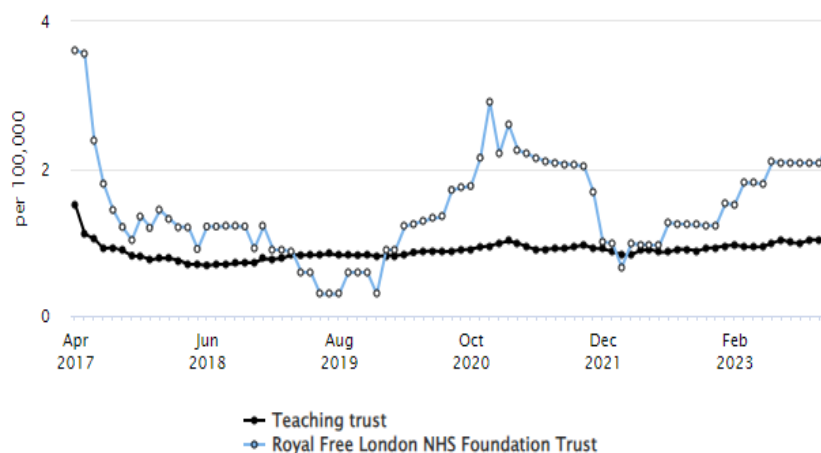
First Plan Do Study Act (PDSA) cycle initiated in pilot areas for ANTT Clinical Practice Framework® QI project.

IPCT are collaborating with Urology Specialist Nurses regarding urology study day for Clinical Practice Educators (CPEs). It is anticipated that increased knowledge will be rolled out to clinical colleagues to improve urinary catheter care and management, thus reducing the risks of urinary catheter associated GNBSIs.

Table 1: MRSA BSIs from April 2023 to March 2024

Month	Site	Speciality	Comment
Q1/2023	Royal Free Hospital	Nephrology	Suboptimal compliance with MRSA decolonisation protocol and lines/devices documentation
Q2/2023	Royal Free Hospital	Plastic and Breast	Screening was not followed, appears to be cannula related, incomplete documentation of cannula care. Ensure MRSA admission screening protocol is followed, and VIP score is recorded as per policy.
Q2/2023	Royal Free Hospital	Cardiology	No clear cause or sub-optimal care identified.
Q2/2023	Royal Free Hospital	Surgery	Known MRSA with a chronic leg wound: unavoidable
Q3/2023	Royal Free Hospital	Medicine	Delay in starting MRSA decolonisation protocol due to stock availability
Q3/2023	Barnet Hospital	Neonatal	Suboptimal compliance with MRSA decolonisation protocol and communication/documentation review required
Q4/2024	Barnet Hospital	Children	A clear community onset case, with no healthcare or device related contributing factors, and no learning identified

MRSA case count and 12-month rolling rates of hospital-onset for Royal Free NHS Foundation Trust



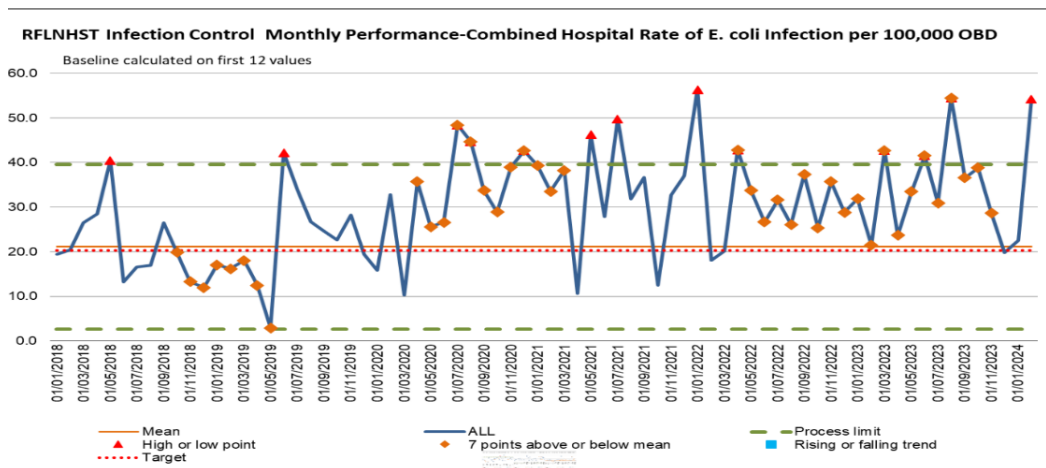
Source:

https://fingertips.phe.org.uk/profile/amr-local-indicators/data#page/4/qid/1938132910/pat/158/par/TE_trust/ati/118/are/RAL/iid/93361/age/1/sex/4/cat/-1/ctp/-1/yr/1/cid/1/tbm/1/page-options/tre-ao-0

All MRSA bacteraemia infections have been subject to a PIR. Outcome, learning, and action plans are shared at monthly site-based Infection Control Divisional Leads meetings and the quarterly Group Infection Prevention and Control Committee (IPCC) have oversight.

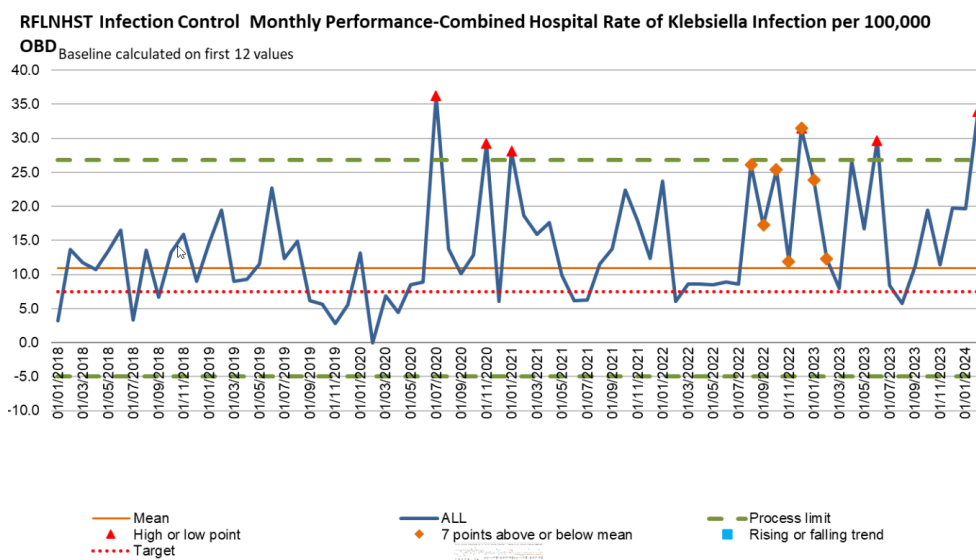
“A healthcare associated Gram-negative BSI will be a laboratory-confirmed positive blood culture for a Gram-negative pathogen in patients who had received healthcare in either the community or hospital in the previous 28 days. *E. coli*, *Pseudomonas aeruginosa* and *Klebsiella spp.* account for 72% of all Gram-negative BSIs. Public Health England’s data capture system is configured to automatically classify Gram-negative BSIs occurring at least 48 hours after admission to a healthcare institution as healthcare associated”.

(PHE 2017: https://www.england.nhs.uk/wp-content/uploads/2020/08/HCA_BSI_definitions_guidance.pdf)



Royal Free London Performance				National		
19/20	20/21	21/22	22/23	Average Performance	Highest Performing NHS Trust Performance	Highest Performing NHS Trust Performance
26.8	31.1	24.5	Awaiting information	Awaiting information	Awaiting information	Awaiting information

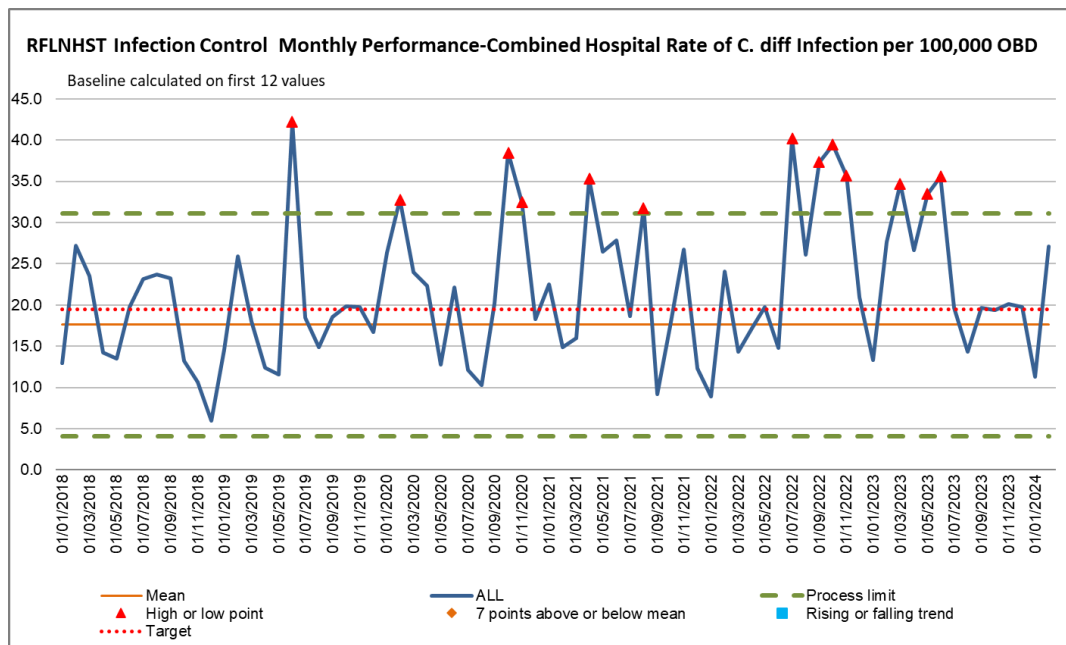
Source:NHS Digital



Royal Free London Performance				National		
19/20	20/21	21/22	22/23	Average Performance	Highest Performing NHS Trust Performance	Highest Performing NHS Trust Performance
11.9	17.6	13.4	Awaiting information	Awaiting information	Awaiting information	Awaiting information
Source: NHS digital						
RFLNHST Infection Control Monthly Performance-Combined Hospital Rate of Pseudomonas Infection per 100,000 OBD Baseline calculated on first 12 values Legend: Mean: Solid orange line High or low point: Red triangle Target: Red dotted line ALL: Blue line 7 points above or below mean: Blue diamond Process limit: Green dashed line Rising or falling trend: Blue square						
Royal Free London Performance				National		
19/20	20/21	21/22	22/23	Average Performance	Highest Performing NHS Trust Performance	Highest Performing NHS Trust Performance
5.8	15	8.5	Awaiting information	Awaiting information	Awaiting information	Awaiting information
Source: NHS Digital						

Priority 3b	Achieve zero trust attributable Clostridium difficile (C. diff) infection cases with a lapse in care. This was an existing priority from 2021/22.
What success looks like:	C. diff knowledge and practice audit amongst staff. - Audits of commodes, mattress and pillows. - Develop a robust and practical action plan with clinical team to reduce rates of C. diff infection. - Review of all cleaning audit reports at site divisional lead meetings. - Root cause analysis will be carried out in order to identify what changes would prevent reoccurrence.

	Revitalise the deep cleaning programme across all sites.
Key performance indicators, goal milestones, deliverables and/or other metrics	- Annual audit of staff C.diff knowledge and practice across the trust. Education events are delivered based on identified areas for learning. This includes, but is not limited to, infection prevention and control (IPC) summits, roadshows, and ward-based teaching sessions. - Audits of commodes, mattresses and pillows are carried out at least annually. Results are shared with stakeholders at all levels through written reports and presentations at meetings to facilitate targeted improvements. - Weekly cleaning audits are collaboratively carried out by domestic supervisors and area clinical staff. Results and rectifications are shared with all stakeholders; weekly reports to clinical managers and IPC teams and summary reports are shared at IPC Divisional Lead meetings. - Multi-disciplinary root cause analysis (RCA) reviews are carried out where indicated. learning is shared with all relevant stakeholders in meetings at all levels of the organisation to drive improvement. - Weekly multidisciplinary deep clean meetings are held to review progress with the planner and to agree next steps based on operational needs.
Our Progress:	(*In this section, the data shows the current position of the trust at the time of producing the draft report. The figures and tables might change as awaiting final data to be validated). The Trust reported 86 CDT cases [Final data to be confirmed] from April 2023 to March 2024, against a threshold of 85. This is reduction in 29 cases (25% decrease) [Final data to be confirmed] from 115 confirmed cases of CDT reported in 2022/23. The 86 cases [Final data to be confirmed] comprised of 67 hospital onset healthcare associated (HOHA), and 19 community onset healthcare associated infections (COHA). This is a 31% reduction in HOHA cases compared with financial year 2022/2023. <i>Note:</i> <i>Hospital-onset healthcare associated infection is where the positive specimen date is equal to or greater than 3 days after admission date (where day of admission is day 1).</i> <i>Community-onset healthcare associated infection is categorised as a hospital-onset healthcare associated infection and the patient was recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date).</i> All cases had an RCA, with learning fed back at the monthly site-based Infection Prevention and Control Divisional Leads meetings and the quarterly Group Infection Prevention and Control Committee (IPCC) have oversight.



What have we done to reduce *C. diff* infection?

- Audits of commodes, mattresses and pillows demonstrates an excellent of standard of cleaning and prompt replacement of equipment that is non-compliant. Mattress replacement programme in place for all areas.
- Feedback from staff was positive regarding the *C. diff* education programme. Comments included: very informative and interactive, significant increase in knowledge and awareness.
- Revitalised the deep cleaning programme across all sites. Rolling programme of monthly sluice and commode cleaning embedded across the trust.
- Review all cleaning audit reports at site-based IPC divisional lead meetings. Increased collaborative working between IPCT and Facilities to ensure effective and prompt implementation of enhanced and outbreak/Period of Increased Incidence (PII) cleaning where applicable.
- Ongoing MDT RCA reviews to identify an action strategies to prevent reoccurrence.
- Overarching robust and practical action plan to reduce rates of *C. diff* infection.

Priority 3c	Learning from incidents in the context of Patient Safety Incident Review Framework (PSIRF) and achieving zero never events. This was a new priority for 2023/24
What success looks like:	• A standard operating process in place on how to disseminate learning from safety incidents. • The introduction of a new learning methods as part of a patient safety event response that includes multi-disciplinary (MDT) review, after action review, swarm huddle, hot debriefs, learning in action meetings. • Produce a criteria for specific learning methods to be recommended for types of safety learning events.

	• Use of our QI methodology to test learning, to evaluate the effectiveness of the learning methods and dissemination.
Key performance indicators, goal milestones, deliverables and/or other metrics	• Standard operating procedure(SoP) in place • Established new learning methods • Criteria for specific learning methods in place • Number of QI projects in progress to evaluate effectiveness of key learning methods
Our Progress:	At the start of 2023/24, as part of PSIRF policy and plan development, we established new learning methods and agreed that all nationally mandated patient safety incidents (PSIs) will be investigated using system engineering investigation initiative for patient safety (SEIPS) method. Following review of our safety profile, we also identified that the following types of incidents will also be added to this PSI list: • Escalation • Deteriorating patient conditions • Failure to act on results • Cancer Patients Missed Diagnosis and dropping off Patient Tracking Lists • Patients adversely affected by being treated by multiple teams and no team taking ownership • Where patients care has been affected by being on an outlying ward • Any maternity/paediatric incident with significant learning outside of the National priorities. The PSIRF policy and plan also describe the proportionate use of multi-disciplinary (MDT) review, after action review, swarm huddle, hot debriefs, learning in action meetings. In the course of the development of the PSIRF plan and policy a collective decision was made not to be prescriptive about the choice of learning tools but this be guided by professional judgement. The trust went live with PSIRF on the 4th March 2024. The trust patient safety incident response plan (PSIRP) sets out how RFL will learn from patient safety events reported by staff and patients, their families and carers, as part of the trust work to continually improve the quality and safety of the care it provides. 4 cohorts of NHSE Framework Approved Provider training (3 day) delivered to date this financial year. Business case developed for 4 further cohorts this year. NEVER EVENTS: There have been 2 Never Events reported between April 2023 to the end of Jan 2024 one wrong site surgery and one ABO incompatible blood transfusion. This is a reduction from 9 NE's reported in the financial year 2022/23. The trust has always taken never events very seriously and ensures that thorough investigations are undertaken. We have a strong and solid commitment to learning from safety incidents and share the learning from incidents through a variety of methods; this includes information sharing such as reports, safety bulletins and emails as well as interactive methods such as learning in action meetings and simulation training. We are strengthening our processes for sharing and embedding learning across teams, divisions, and hospital business units and in 23/24 have developed a Standard

	Operating Procedure (SOP) to Share the Learning from Patient Safety Events. This SOP is being embedded within the daily management of patient safety events. There have been a number of additional actions that have taken place across the trust, to address and mitigate the risk of never events occurring. These include the implementation of PSIRF, embedding NatSSIPs 2 requirements and the Never event consultation, discussed further below. On the 07/02/2024 NHSE launched our <u>public consultation</u> seeking views on the future of the Never Events Framework. The last framework was published in January 2018, in which Never Events are defined as patient safety incidents that are 'wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Reports from the Care Quality Commission (CQC) and Hospital Safety Investigation Board (HSIB), as well as a series of NHSE focus groups with relevant experts, has highlighted that for several types and sub types of Never Events the barriers are not strong enough and called for the Never Event framework to be reviewed. The outcomes of these reports have been used to inform a national consultation, which will run for 12 weeks until 5 May 2024. The consultation focuses on the question 'on balance do you think the Never Events framework is an effective mechanism to support patient safety improvement?' The Deputy Director for Patient Safety and Risk (DDPSR) (as a Patient Safety Specialist) is sharing views via the consultation's <u>online survey</u>. The <u>consultation document</u> is being considered to inform responses. The DDPSR will also coordinate a response on behalf of RFL. The DDPSR is sitting on the NHSE Never Events Consultation Focus Group, due to commence on the 21/02/2024.
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Our priorities for improvement for 2024/25

The Trust aims to provide world-class clinical care, education and research that improves the health of the local community and of the wider populations that we serve. This ambition is reflected in our strategic objectives and is underpinned by our quality strategy and quality goals.

We have developed a set of quality priorities for 2024/25 and ensured that these are embedded across the Trust through our executive assurance committees.

How we chose our priorities

The quality priorities chosen for 2024/25 are drawn from the quality strategy, clinical strategy, healthcare digital strategy, NHs long term plan objectives, our governing objectives and feedback following consultation with key stakeholders. The stakeholder engagement included hosting engagement event and collating survey responses concerning the long list of priorities. The trust executive then further reviewed this to approve the set of priorities for the year ahead.

Progress in achieving these priorities will be monitored by our trust strategic committees and reported to the Trust Board.

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

Our commissioners receive regular progress updates via the Clinical Performance and Patient Safety Committees and the Trust Quality Committee.

Some of the priorities from 2023/24 have been carried over as proposed priorities for the new financial year 2024/25 as they form part of an extended plan or quality strategy within the trust. Some have been adapted and reworded to make them more current to the teams committing to the delivery of them.

In addition, all the quality priorities have been linked to the trust's governing objectives to align our quality performance aims with the overall strategic ambitions of the trust.

Priority 1: Our patient experience priorities - Improving patient experience – delivering excellent experiences.		
Our quality priorities and why we chose them:		
Priority 1a Source: Quality Strategy	Patient involvement Embed shared principles for involving patients and carers in our services to better monitor their experiences and make relevant improvements. <i>This is an existing priority from 2023/24.</i>	What success looks like: - We will build on the patient involvement framework to facilitate and embed high quality, diverse involvement work across the trust. - We will work collaboratively with patients to identify and act on areas for improvement and better understand health inequalities through changes in service utilisation. - We will develop clear processes to better understand the experience of patients with learning disabilities and work with patients and carers in the co-production and design of our services.
Priority 1b Source: Quality Strategy	Fundamentals of care: nutrition Ensuring all adult inpatients and those having a procedure receive appropriate nutrition and hydration and where necessary support them to meet nutritional and hydration requirements. <i>This is an existing priority from 2023/24.</i>	What success looks like: - We will establish a group-wide nutrition group; to include patients, speech and language therapist, dieticians and estates and facilities. - We will co design and publish a food and drinks strategy.
Priority 1c Source: Quality Strategy	How we communicate with patients (on cancellations) We will improve how we communicate with patients regarding cancellation of clinic appointments. <i>This is an update priority from 2023/24.</i>	What success looks like: - We will identify the best practice methods to keep patients informed and updated of any cancellations and delays and roll these out across the group. - We will monitor our progress using patient experience to collect patient and carer feedback.

Priority 1d Source: Quality Strategy	Compassion and Kindness To increase compassion and kindness within the care we deliver, we will deliver a civility and kindness project. <i>This is a new priority for 2024/25.</i>	What success looks like: • Deliver civility and kindness project. <i>* This is a three-year project. In 2024/25 our aim is to deliver the project and implement interventions successfully – our long-term success will include improvement in staff satisfaction rates with civility in the staff survey and improvement in the patients' responses on dignity and respect in the inpatient survey.</i>
Priority 1e Source: RFL Digital Healthcare Strategy & Trust Strategic Goal	Patient experience feedback To increase linked actions using digital technology to improve the number of patient survey actions delivered by the trust. <i>This is a new priority for 2024/25.</i>	What success looks like: • We will establish a baseline of services where surveys are undertaken and number of responses. • We will increase the number of services undertaking surveys across all sites. • We will work with services to improve the number of responses received. • We will launch action plans in response to survey results.

Priority 2: Our clinical effectiveness priorities: Improving clinical effectiveness: delivering excellent outcomes.

Our quality priorities and why we chose them:

Priority 2a Source: Quality Strategy	Learning from mortality reviews Standardised reporting format within all mortality and morbidity groups and standardised escalation reports from M&M groups to CPPSs. <i>This is an updated priority from 2023/24.</i>	What success looks like: • We will standardise reporting format within all Mortality and Morbidity groups and standardise escalation reports from Mortality and Morbidity groups to our hospitals Clinical Performance and Patient Safety meetings.
Priority 2b Source: Governing objectives	Research and development: Achieve 75% recruitment in-year to open research studies. <i>This is a new priority for 2024/25.</i>	What success looks like: • $\geq 75\%$ of studies open in year will show recruitment.

Priority 3: Our patient safety priorities: Improving Patient Safety: delivering safe care.

Our quality priorities and why we chose them:

Priority 3a Source: NHS long term plan objective	Infection Control: MRSA Achieve zero trust attributed Methicillin-resistant Staphylococcus aureus bacteraemia (MRSA) case and reduce Gram negative bacteraemia in line with	What success looks like: • Implementing an education and training plan to improve (intravenous) line care practice.
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	NHS Long Term Plan objective of 50% by 2024/25. <i>This is an existing priority from 2021/22.</i>	Undertake post Infection Reviews carried out to identify and act on key areas of improvement.
Priority 3b <i>Source: NHS long term plan objective</i>	Infection Control: C. diff Achieve zero trust attributable Clostridium difficile (C. diff) infection cases with a lapse in care. <i>This is an existing priority from 2021/22.</i>	What success looks like: C. diff knowledge and practice audit amongst staff. - Audits of commodes, mattress and pillows. - Develop a robust and practical action plan with clinical team to reduce rates of C. diff infection. - Review of all cleaning audit reports at site divisional lead meetings. - Root cause analysis will be carried out in order to identify what changes would prevent reoccurrence. - Revitalise the deep cleaning programme across all sites.
Priority 3c <i>Source: Quality Strategy</i>	Patients with deteriorating conditions Getting escalation for patients with deteriorating conditions always right, as reported in PSIs. <i>This is a new priority for 2024/25</i>	What success looks like: At the end of 2024/25 we aim for a reduction by 30% of patient safety event reports (PSIs) where these have been identified as contributing factors.
Priority 3d <i>Source: Quality Strategy</i>	Learning from safety incidents All ward areas and divisions have an established practice of reviewing shared learning and produce their own improvement plans. <i>This is a new priority for 2024/25.</i>	What success looks like: All ward areas have established practice of reviewing shared learning and produce own improvement plans. Improve Quality Walkabouts rating by 10% on the question that staff are aware of 3 top safety shared learnings as applicable to their clinical area and able to describe the improvement plans.

2.2 Statements of assurance from the board

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

1. Review of services

During 2023/24, the Royal Free London NHS Foundation Trust provided and/or subcontracted 42 relevant health services.

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

The income generated by the relevant health services reviewed in 2023/24 represents 100% of the total income generated from the provision of relevant health services by the Royal Free London NHS Foundation Trust for 2023/24.

2. Participation in clinical audits and national confidential enquiries

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

During 2023/24, 59 national clinical audits and 6 national confidential enquiries covered relevant health services that the Royal Free London NHS Foundation Trust provides.

During that period the Royal Free London NHS Foundation Trust participated in 96% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Royal Free London NHS Foundation Trust was eligible to participate in during 2023/24 are detailed in table 1 and 2 below.

The national clinical audits and national confidential enquiries the Royal Free London NHS Foundation Trust participated in during 2023/24 are detailed in table 1 and 2 below.

The national clinical audits and national confidential enquiries that the Royal Free London NHS Foundation Trust participated in, and for which data collection was completed during 2023/24, 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 are detailed in table 1 and 2 below.

The reports of TBC national clinical audits were reviewed by the provider in 2023/24 and the Royal Free London NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- We will continue to scrutinise and share learning from national audit reports at our corporate committees (clinical performance and patient safety committee and clinical standards and innovation committee).

- We will use outcomes from national clinical audits to help us prioritise pathway work in our Clinical Practice Groups across our group of hospitals.
- We will continue to make improvements to our clinical processes where national clinical audits suggest care could be improved.

In addition, the trust has undertaken specific actions to improve the quality of the national clinical audits set out in table 3.

The reports of 142 local clinical audits were reviewed by the provider in 2023/24 and the Royal Free London NHS Foundation Trust intends to take the following 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.

In addition, the trust has undertaken specific actions to improve the quality of the local clinical audits set out in table 4.

Explanatory notes:

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 all admissions, out-patient appointments and accident and emergency attendances at NHS hospitals in England.

Where 2023/24 data is not yet published, the previous year's reported participation and ascertainment rates are recorded as an indicator.

The national data opt-out service allows patients to opt out of their confidential patient information being used for research and planning. The national data opt-out was introduced on 25 May 2018, enabling patients to opt-out from using their data for research or planning purposes, in line with the recommendations of the National Data Guardian in the 'Review of Data Security, Consent and Opt-Outs'.

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

Table 1: National Clinical Audit; eligibility and participation

National Clinical Audit	Data collection completed in 2023/24	Trust eligibility to participate	Data reported at:	Data collection applicable for:	Data collection NOT applicable for:	Reporting period & case ascertainment
National Cancer Audit Collaborating Centre (NATCAN) National Bowel Cancer Audit (NBOCA)	Yes	Yes	Trust level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	2021/22: Royal Free London: n=156
National Gastro-Intestinal Cancer Audit Programme (GICAP): National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	Yes	Trust level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	2020/22: Royal Free London: n = 170
National Lung Cancer Audit (NLCA)	Yes	Yes	Trust level	Royal Free Hospital	Barnet Hospital Chase Farm Hospital	2023: Royal Free London: n = 379
National Prostate Cancer Audit (NPCA)	Yes	Yes	Trust level	Royal Free Hospital	Chase Farm Hospital Barnet Hospital	2020/21: Royal Free London: n = 465
National Respiratory Audit Programme (NRAP) COPD Secondary Care	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	2023/24: Barnet Hospital: n = 210 Royal Free Hospital: n = 58
National Respiratory Audit Programme (NRAP) Adult Asthma Secondary Care	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	2023/24: Barnet Hospital: n = 74 Royal Free Hospital: n = 81
National Respiratory Audit Programme (NRAP): Paediatric Asthma Secondary Care	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	Report not published yet.
National Adult Diabetes Audit (NDA): National Foot Care in Diabetes Audit (NFCA)	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	2022/23: Barnet Hospital: n= 80 Royal Free Hospital: n = 160
National Adult Diabetes Audit (NDA): National Diabetes Inpatient Safety Audit (NDISA)	Yes	Yes	Trust level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	2023/24 (up to 05/02/24): Royal Free London: n = 5 (low case ascertainment is positive)

National Clinical Audit	Data collection completed in 2023/24	Trust eligibility to participate	Data reported at:	Data collection applicable for:	Data collection NOT applicable for:	Reporting period & case ascertainment
National Adult Diabetes Audit (NDA): National Pregnancy in Diabetes audit (NPID)	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	Jan. 2021 to Dec. 2022: Barnet Hospital: n= 110 Royal Free Hospital: n = 55
National Adult Diabetes Audit (NDA): National Diabetes Core Audit	Yes	Yes	Trust level	Royal Free Hospital	Barnet Hospital Chase Farm Hospital	2021/22 Royal Free Hospital (Type I): n = 1455 Royal Free Hospital (Type II): n = 96
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	Site level	Barnet Hospital Chase Farm Hospital Royal Free Hospital	N/A	2022/23: Barnet Hospital: n = 129 Chase Farm Hospital: n = 67 Royal Free Hospital: n = 83
British Association of Urological Surgeons Nephrostomy Audit	Yes	Yes	Trust level	Royal Free Hospital	Barnet Hospital Chase Farm Hospital	Report not published yet.
Elective Surgery – National PROMs Programme	No	Yes	N/A	Barnet Hospital Chase Farm Hospital Royal Free Hospital	Not applicable	During 2023/24, no data was submitted for PROMs due to the change of survey supplier.
Falls and Fragility Fractures Audit Programme (FFFAP): Fracture Liaison Service Database (FL-SD)	Yes	Yes	Site level	Barnet Hospital	Chase Farm Hospital Royal Free Hospital	2023: Barent Hospital: n=618
Falls and Fragility Fractures Audit Programme (FFFAP): Inpatient Falls	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	2023/24 (up to 07/02/24 confirmed falls only): Barnet Hospital: n = 3 Royal Free Hospital: n = 4 (low case ascertainment is positive)
Falls and Fragility Fractures Audit Programme (FFFAP): Hip Fracture Database (NHFD)	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	2022/23: Barnet Hospital: 115.3% Royal Free Hospital: 220.8%
National Cardiac Audit Programme (NCAP): Cardiac Rhythm Management (CRM)	Yes	Yes	Site level	Barnet Hospital	Chase Farm Hospital Royal Free Hospital	2021/22: Barnet Hospital: n = 9 (software issues meant submissions were not made to NICOR.)

National Clinical Audit	Data collection completed in 2023/24	Trust eligibility to participate	Data reported at:	Data collection applicable for:	Data collection NOT applicable for:	Reporting period & case ascertainment
National Cardiac Audit Programme (NCAP): Myocardial Infarction National Audit Project (MINAP)	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	2021/22: Barnet Hospital: n = 146 (146/207 = 70.53%) Royal Free Hospital: n = 793 (793/812 = 97.66%)
National Cardiac Audit Programme (NCAP): National audit of percutaneous coronary interventions	Yes	Yes	Site level	Royal Free Hospital	Barnet Hospital Chase Farm Hospital	2021/22: Royal Free Hospital: n = 1083 (Minimum required is 400)
National Cardiac Audit Programme (NCAP): National Heart Failure Audit (NHFA)	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	2021/22: Barnet Hospital: n = 702 Royal Free Hospital: n = 382 (Overall Royal Free London ascertainment = 90.2%)
National Audit of Cardiac Rehabilitation (NACR)	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	2022: Barnet Hospital: 5/7 KPIs submitted Royal Free Hospital: 7/7 KPIs submitted
Intensive Care National Audit and Research Centre (ICNARC): Case Mix Programme (CMP)	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	22/23 Barnet Hospital: n = 750 Royal Free Hospital: n = 2385
Intensive Care National Audit and Research Centre (ICNARC): National Cardiac Arrest Audit (NCAA)	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	2022/23: Barnet Hospital: n = 67 Royal Free Hospital: n = 170
Improving Quality in Crohn's and Colitis (previously named IBD Audit)	No	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	No data has been submitted since 2021 due to Infoflex issues
National Audit of Dementia	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	14 Aug 23 -10 Sept 23: Barnet Hospital n=40 Royal Free Hospital: n=50

National Clinical Audit	Data collection completed in 2023/24	Trust eligibility to participate	Data reported at:	Data collection applicable for:	Data collection NOT applicable for:	Reporting period & case ascertainment
National Audit of Pulmonary Hypertension Audit (NAPH)	Yes	Yes	Trust level	Royal Free Hospital	Barnet Hospital Chase Farm Hospital	2022/23: Royal Free Hospital: n = 843 (Minimum required is 300)
National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy12)	Yes	Yes	Trust level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	2022: Royal Free London: n = 38 (38/42 = 90%)
National Clinical Audit of Care at the End of Life (NACEL)	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	2024 data collection underway
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	Site level	Barnet Hospital Chase Farm Hospital Royal Free Hospital	N/A	2022/23; Barnet Hospital: n = 51 Chase Farm Hospital: n = 64 Royal Free Hospital: n = 8
National Emergency Laparotomy Audit (NELA)	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	1 Feb 23 to 31 Jan 24 Barnet Hospital: n = 36 Royal Free Hospital: n = 97
National Joint Registry (NJR)	Yes	Yes	Site level	Barnet Hospital Chase Farm Hospital Royal Free Hospital	N/A	2022: Completed operations Barnet Hospital: n = 53 (NJR consent rate= 77%) Chase Farm Hospital: n = 937 (NJR consent rate=86%) Royal Free Hospital; n = 68 (NJR consent rate= 62%)
National Maternity and Perinatal Audit (NMPA)	Yes	Yes	Trust level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	Report not published yet.
National Neonatal Audit Programme (NNAP)	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	2022: Barnet Hospital: 100% Royal Free Hospital: 100%
National Vascular Registry (NVR)	Yes	Yes	Site level	Royal Free Hospital	Barnet Hospital Chase Farm Hospital	2022: Royal Free Hospital: Abdominal aortic aneurysm: n = 49 Carotid endarterectomy: n= 23

National Clinical Audit	Data collection completed in 2023/24	Trust eligibility to participate	Data reported at:	Data collection applicable for:	Data collection NOT applicable for:	Reporting period & case ascertainment
						Lower limb angioplasty/stent: n = 20 Lower limb bypass: n = 17 Lower limb amputation: n = 6
Emergency Medicine National Quality Improvement Programme Mental health self-harm	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	The data collection period is 3 Oct 2022 – 3 Oct 2024
Emergency Medicine National Quality Improvement Programme Care of Older People	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	The data collection period is 3 Oct 2022 – 3 Oct 2024
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	2022/23: Barnet Hospital: 90%+ Royal Free Hospital: 90%+
Trauma audit research network (TARN) – Major trauma audit	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	Report not published yet
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	Yes	Trust level	Barnet Hospital Chase Farm Hospital Royal Free Hospital	N/A	2022: Royal Free London: n = 47
National Comparative Audit of Blood Transfusion: a) 2023 Audit of Blood Transfusion against NICE QS 138	N/A	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	Report not published yet
National Comparative Audit of Blood Transfusion: b) 2023 Bedside Transfusion Audit	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	Delayed until March 2024-TBC
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	2023: Barnet Hospital: n = 53 Royal Free Hospital: n = 32
Chronic Kidney Disease registry	Yes	Yes	Trust level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	2021: Royal Free London: n = 283 (98 % completeness)

National Clinical Audit	Data collection completed in 2023/24	Trust eligibility to participate	Data reported at:	Data collection applicable for:	Data collection NOT applicable for:	Reporting period & case ascertainment
						KRT incidence data
Learning disability and autism programme Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	N/A	Yes	Site level	Barnet Hospital Chase Farm Hospital Royal Free Hospital	N/A	2023/24: No cases allocated for the trust to review
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal mortality and serious morbidity confidential enquiry	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	2023/24: Barnet Hospital: 100% Royal Free Hospital: 100%
Maternal, Newborn and Infant Clinical Outcome Review Programme Perinatal mortality surveillance	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	2023/24: Barnet Hospital: 100% Royal Free Hospital: 100%
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal mortality surveillance	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	2023/24: Barnet Hospital: 100% Royal Free Hospital: 100%
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal morbidity confidential enquiry - annual topic based serious maternal morbidity	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	2023/24: Barnet Hospital: 100% Royal Free Hospital: 100%
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal mortality confidential enquiries	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	2023/24: Barnet Hospital: 100% Royal Free Hospital: 100%
MBRRACE-UK: Perinatal Mortality Review Tool (PMRT)	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	2023/24: Barnet Hospital: 100% Royal Free Hospital: 100%
National Child Mortality Database (NCMD)	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	2023/24: Barnet Hospital: 100% Royal Free Hospital: 100%
National Ophthalmology Database (NOD) Adult Cataract Surgery	Yes	Yes	Trust level	Barnet Hospital Chase Farm Hospital Royal Free Hospital	N/A	2021/22: Royal Free London: 100%
Breast and Cosmetic Implant Registry	Yes	Yes	Site level	Royal Free Hospital	Barnet Hospital	April 22 to July 23:

National Clinical Audit	Data collection completed in 2023/24	Trust eligibility to participate	Data reported at:	Data collection applicable for:	Data collection NOT applicable for:	Reporting period & case ascertainment
					Chase Farm Hospital	Royal Free Hospital: 100%
Perioperative Quality Improvement Programme (PQIP)	Yes	Yes	Site level	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	July 21 – Mar 23: Royal Free Hospital: n=30 Barnet Hospital: n=6
Adult Respiratory Support Audit	Yes	Yes	Site level	Royal Free Hospital Barnet Hospital	Chase Farm Hospital	Feb 23- Mar 23: Royal Free Hospital: n = 17 Barnet Hospital n = 13
UK Parkinson's Audit	N/A	Yes	Site level	Royal Free Hospital	Barnet Hospital Chase Farm Hospital	Not running this year – next cycle is 2025
National Cancer Audit Collaborating Centre (NATCAN) National Audit of Primary Breast Cancer	Yes	Yes	Trust level	Royal Free Hospital	Barnet Hospital Chase Farm Hospital	First report due Sept 24
National Cancer Audit Collaborating Centre (NATCAN) National Audit of Metastatic Breast Cancer	Yes	Yes	Trust level	Royal Free Hospital	Barnet Hospital Chase Farm Hospital	First report due Sept 24

Table 2: National Confidential Enquires; participation and case ascertainment

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Data collection completed in 2023/24	Trust eligibility to participate	Data collection applicable for:	Data collection NOT applicable for:	Reporting period & case ascertainment
Community Acquired Pneumonia	Yes	Yes	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	Clinical questionnaire: 6/6 Case notes: 6/6 Organisational questionnaire: 2/2
Testicular Torsion	Yes	Yes	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	Clinical questionnaire: 3/3 Case notes: 3/3 Organisational questionnaire: 2/2
Endometriosis	Yes	Yes	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	Clinical questionnaire: 14/14 Case notes: 14/14 Organisational questionnaire: 2/2
End of Life Care	Yes	Yes	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	Clinical questionnaire: 8/10 Case notes: 10/10 Organisational questionnaire: Not available
Juvenile idiopathic arthritis	Yes	Yes	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	Clinical questionnaire: 2/2 Case notes: 2/2 Organisational questionnaire: 1/1
Rehabilitation following critical illness	Not started	Yes	Barnet Hospital Royal Free Hospital	Chase Farm Hospital	Enquiry in process

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

Table 3: National Clinical Audits; actions for improvement.

National clinical audit	Actions to improve quality
National Early Inflammatory Arthritis (NEIAA)	Royal Free Hospital • The main challenges to maintaining patient recruitment were clearing waiting lists and nursing team support These areas have now been addressed and will be monitored • The appointment of a locum consultant has helped RFH to improve on EIA referrals seen within 3 weeks where the trust were previously identified as an outlier. • GIRFT have recommended that the trust strive for a 80% target for both QS 2 and QS 3, and work to meet this target is ongoing
National Audit of Cardiac Rehabilitation (NACR)	Royal Free Hospital • Acquire NCL bid for 0.4 admin support recruitment • Locate venue for exercise sessions • Obtain quote and approval for heart rate monitors • Increase exercise capacity tests
Pulmonary Hypertension	Royal Free Hospital • Expediting the processes (including coordinating investigations in the new rare diseases hub') to improve referral to treatment time with newly appointed CNS and band 5 administrator, • To reduce the number of non- group 1 and 4 PH patients wrongly incorporated, we will rationalise our PH database with a parallel system for non group 1 and 4 PH patients in the service. In the long-term, a divisional strategy for a new rare diseases database which will include mitigation for the data storage problem is being worked on

National clinical audit	Actions to improve quality
National Gastrointestinal Cancer Programme: National Oesophago-gastric Cancer Audit (NOGCA)	Royal Free London Audit why patients did not complete palliative chemotherapy and radiotherapy treatments to establish if changes can be made to increase the completion ratse of these treatments in line with national averages.
National Prostate Cancer Audit (NPCA)	Royal Free London - Work with the NCRAS and the Trust's Informatics team to develop a 'missing reports' function in the Cancer app on Power BI, which will enable the Trust's cancer management teams to check individual patient submissions to the COSD, SACT and Radiotherapy data streams before they are finalised - In addition, the MDTC's and cancer management team now have protected time to solely concentrate on capturing these items and general data quality. These changes will reflect in the 22/23 reporting
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Royal Free London - Complete EPMA build for blood prescriptions and link with the vein-to-vein project - Create EpR forms for pre prescription blood transfusion risk assessment - Pilot vein-to-vein business project, which delivers electronic bedside safety checks for administration to prevent NHSE never events - OnDemand sample labelling, instead of handwritten and paperless pathways for traceability.
National Diabetes Audit Core report 1: care processes and treatment targets	Royal Free Hospital - The Renal MDT which commenced in 2022 should show an improvement in ACR and creatinine levels being captured by the next data collection period. - HbA1c in T1 will continue to improve as more patients are onboarded in CGM devices and the EPR CPG pathways once fully enabled, will assist data transfer and collection - Currently in review stages for the acute foot pathway at RFH for coordinating pathways with front door and acute medicine. Improving education and training for HCPs across the sites. The CPG has included the foot assessment in the patient pathway.

National clinical audit	Actions to improve quality
NICOR National Audit of Percutaneous Coronary Intervention & Myocardial Infarction	Royal Free London • Several actions were already implemented after the 2020/21 data release in June 2022 and these changes will reflect in the next reporting period (2022/23) • Internal, unpublished, data shows a significant improvement in the angiography within 72 hours for patients presenting with a NSTEMI and further improvement is expected with the imminent introduction of a Low-Risk Virtual NSTEMI ward
NICOR National Heart Failure Audit	Royal Free Hospital • Development of a virtual ward for heart failure patients • Ongoing education in the use of Sodium-glucose co-transporter-2 inhibitors to increase appropriate prescriptions. • During this time period most of the cardiac rehab programmes were not yet up and running. The team are now running programmes that include heart failure patients and Reach heart failure trial which is a remote run cardiac rehab programme. The current pathway does not allow for direct referrals as inpatients. The service to liaise with the cardiac rehab team regarding this pathway • Development of a heart failure dashboard which will be used to aid inpatient reviews by the heart failure team
National Cardiac Arrest Audit (NCAA)	Royal Free Hospital • Feeding back on cardiac arrest rate to whole site and specific teams • Deeper data dive to understand reasons for futile resuscitation attempts. • Trial of predictive model as part of suite of decision-making tools • Liaison with key stakeholders including PALS, palliative care, educational and clinical teams. • Improved information for public re DNACPR decisions and links to NHSE resources
Case Mix Programme (ICNARC) CMP	Royal Free Hospital • The unit continues to maintain a high level of performance, scoring green for most key domains. This indicates that the current practise of the unit is largely safe and robust. • There is an ongoing piece of work looking at readmission to ICU following discharge. • Initial results indicates that approximately 65 % of readmissions occur with patients who are discharged from the EPIC unit. • Further granular data will be available to give further insight into this domain.

National clinical audit	Actions to improve quality
Falls and Fragility Fractures Audit programme: Inpatient falls	Royal Free London • Walking aid audit • Continue assessment of need for falls practitioners • Education on high quality MFRA requirement and EPR clarity • Ward managers to ensure there is adequate written falls information on wards
National Vascular Registry (NVR)	Royal Free London • We plan to appoint a governance lead to aid in data capture on the NVR • We plan to build a second theatre which will allow daytime operations for amputations. • The second theatre will also increase carotid surgery turnover on the RFH site
Adult Respiratory Support Audit	Royal Free Hospital • Refining acute NIV pathway and ED education • Deep dive into patients with consolidation
NCEPOD: Crohn's Disease: Making the Cut	Royal Free Hospital • All patients with Crohn's disease planned for elective surgery are seen and counselled in the OP clinic by one of our IBD consultant colorectal surgeons, and all undergo local pre-assessment as well as referral to our consultant led complex surgical patient anaesthetic MDT. • All patients with Crohn's disease requiring surgery are discussed at the IBD MDT, which is attended by our IBD colorectal surgical team. Patients requiring surgery are offered the next available date for surgery, and wherever possible, and based on operating theatre schedules, these patients are offered surgery within 1 month of the decision to operate. We will perform a prospective audit to check our compliance with this recommendation. • Patients with a confirmed diagnosis of Crohn's disease awaiting elective surgical input are managed in an efficient way by our dedicated IBD Surgical team. • Patients undergoing surgery for confirmed or suspected Crohn's disease are all discussed pre- and post-operatively in our dedicated IBD MDT, which runs on Wednesday mornings. In attendance are IBD radiologists, IBD gastroenterologists, IBD nurses and IBD colorectal surgeons. Follow up requirements and plans are set out at this meeting, • Provided stoma closure is not contraindicated for other clinical reasons, all patients have their stoma closure undertaken within 12 months at our organisation.

National clinical audit	Actions to improve quality
NCEPOD: Testicular Torsion Twist and Shout	Royal Free Hospital The RFH Urology team was instrumental in putting together a robust and safe pathway in conjunction with NCL. The RFH Urology team are fully compliant with the Hospital related recommendations regarding management of these children.
National Paediatric Diabetes Audit (NPDA)	Royal Free London HbA1c - To increase the amount of young people using technology, particularly insulin pumps across all sites. This will reduce the HbA1c figure/ bring it into range. - To increase the amount of young people using closed loop pumps to help further reduce the rate of HbA1c. - To increase staffing at Chase Farm Hospital to help lower the rate of HbA1c. Percentage receiving all six annual key health checks - To improve on data collection for Chase Farm Hospital. This has been discussed at cross site meetings. The department have met with IT and there are discussions around changing from TWINKLE system to Diamond. - To make sure EPR and TWINKLE or Diamond are connected to eliminate human error in data collection. - To continue offering Healthy Futures Preconception Advice for Teens as a motivational tool to educate young people around the effects of having type 1 diabetes on conception for both girls and boys.
National Asthma and COPD Audit Programme (NACAP) - Drawing Breath CYP National Audit Report	Royal Free London - To work with EPR lead to include the wheeze discharge proforma in the discharge letter for children with asthma, the wheeze discharge proforma has the areas (inhaler technique, smoking etc) and to make this a mandatory field to complete before discharge. - To ensure training is provided to staff so that data is recorded correctly on EPR.
National Emergency Laparotomy Audit (NELA)	Barnet Hospital Ongoing education for anaesthetic and surgical teams to enter relevant patient data, both quantity and quality.

National clinical audit	Actions to improve quality
	• Ongoing discussion stemming from recent Anaesthetic governance meeting regarding involvement of ITU consultants for higher risk patients and improving the documentation on EPR of these discussions, as it is dependent on the clinical judgement and governance structure of the critical care consultants. • Development and implementation of an acute abdomen CPG will help to improve clinical care as well as documentation.
Chronic Obstructive Pulmonary Disease	Barnet Hospital • Electronic recording of spirometry results to be included in regular primary care teaching as IT issues and poor documentation on the primary care Health Information Exchange means that even if performed the result is still not always fully available. The availability of spirometry results will improve as access to services post COVID-19 are reinstated. • Patients who are admitted and discharged without being seen by the CNS or respiratory team may not be getting referred for early follow up by the community team, which may impact elements of the discharge bundle provided metric. Liaison with acute medicine colleagues to highlight all COPD exacerbations to allow completion of the discharge bundle.
Adult Asthma	Barnet Hospital • Respiratory review within 24 hours will improve with recruitment of second respiratory CNS role which has recently been appointed to. • Ongoing education with emergency department teams to improve on the swift administration of steroids and in peak expiratory flow measurement
TARN	Barnet Hospital • Missing data mainly regarding date and time of injury and name and role of clinician.is impacting data accreditation. Communication has been shared with ED doctors to ensure better record keeping and additional admin to support the TARN coordinator will improve data submission rates. • Trauma patients with an injury severity score over 15 are largely over the age of 65 and present following a fall from standing, and therefore do not trigger major trauma criteria. Communication has been shared with all ED consultants to ensure their presence at trauma call/involvement in management of trauma patients is clearly documented.

National clinical audit	Actions to improve quality
Heart Failure	Barnet Hospital • Heart failure fellow appointed and 2.5 WTE nurse prescribers in the team from 1 WTE. • Development of a virtual ward for heart failure patients with a WTE band 6 short term post funded by NCL
Acute Respiratory Support	Barnet Hospital • Support ongoing CPG work to improve non-invasive ventilation (NIV) care within the trust • New online training modules developed for staff training • Application in process for NIV advanced care practitioner to support optimised NIV pathways
Diabetes Footcare Audit	Barnet Hospital • The additional member of staff in 2023 has allowed for personal and professional development of other staff to continue ensuring we are providing the standard of care expected and no patient has a delay in this care.
Neonatal Audit	Royal Free Hospital • Training for nursing staff and junior doctors on how to enter the data correctly. Encourage consultants to use Well Organised Wards (WOW) modules on ward rounds to check daily summary entries from the day before. • Encourage clinical staff to use ROP calculator to calculate correct window for screening. • Temperature on admission - introduce trans-warmer mattresses for extreme preterm deliveries. • Delayed cord clamping - launch the guideline for extreme preterm at the RFH site. Barnet Hospital • Continue to verify data for all our positive blood cultures and for necrotising enterocolitis (NEC) babies. • Seek support for more time resources to be able to verify data on intraventricular haemorrhage over the coming year.

Table 4: Local Clinical Audit; actions for improvement

Local clinical audit	Actions to improve quality
Outcomes Following Free Flap Breast Reconstruction – A Single Centre Re-audit	• Discuss changes to current free flap protocol with CNS and the Anaesthetic Team regarding analgesia used, with the aim to reduce post-operative opioid use • Produce patient leaflet which gives a realistic overview of whole treatment pathway
Blood Glucose monitoring & IV Insulin Administration on ICU	• Specific focus on insulin prescribing during doctors' induction and insulin administration and monitoring during nurses induction • Increasing number of blood glucose machines to enable appropriate monitoring. • Review of protocol, monitoring, and administration plan with bedside nurses by pharmacist during ward rounds. • Create a guide for how to handle VRII and monitoring when the patient leaves the ward to theatres or for scans • Revisit design of prescribing plan on EPR • Future potential for continuous glucose monitoring using Dexcom 6 straight into EPR
Sepsis Compliance Audit (ongoing)	• Review new EPR sepsis workflow with aim to capture more elements of sepsis bundle • Regular snapshot once workflow live • Improve appropriateness of monitoring by discussion at senior nurses meeting
The RFH HIV Two-tier Screening Pathway	• Develop stringent evidence-based criteria for the use of the reference laboratory. • Decrease the interval between the first and the second samples to reduce TAT • Advise patients on the prevention of transmission of HIV when they are under investigation for indeterminate HIV status • To reduce misinterpretation of false Roche reactivity by service users, change the word "indeterminate" in the result field to "See Comment"
CDC Ophthalmology Finchley Memorial Hospital & Woodgreen CDC: Time taken to outcome the patients attending the virtual clinics	• Maximum utilization of available readers • Reassess effectiveness of regular weekly lists • Incorporate virtual clinics in the job plan • Provision of Doctors/AHP bank shifts to be done by readers • Reaudit to assess if changes and recommendations were implemented and target for reviewing is achieved

Local clinical audit	Actions to improve quality
Follow up of DNA patients at the vascular clinic	- Follow the original check out scheme presented - DNA patients to have clear documentation and pathway as to where and when they need to be seen again - Using discharge summary in EPR and sending emails to the corresponding admin to allow better tracking for all patients who attend the clinic
Open vs endovascular treatment of popliteal artery aneurysms; a 5-year single centre retrospective study	- Appropriate preoperative planning is mandatory to have satisfactory outcomes as patent distal runoff is associated with maintaining patency and decrease reintervention rates - Patient selection prior to treatment - Both endovascular and open repair are acceptable for popliteal artery aneurysm treatment with pre-operative good planning
VTE audit - Cycle 2	- Remind team to use a ward round proforma that includes VTE. - Circulate findings to Plastics team. - Proposed VTE prompt in Pathpoint when adding to inpatient list, and when writing an operation note
Dental Management & Compliance According to WFH Guidelines	- Patient education - Good and accurate record keeping - Reiteration that surgical extractions are high risk procedures and special care needs to be taken. - Use of Extended half-life on non-severe haemophilia
Secondary Scleral Sutureless Fixated IOL using the Yamane technique	- To ensure that samples are collected and delivered to the Barnet Hospital reception promptly after collection, ideally with a collection time noted and to add collection time to the clinical details to allow accurate auditing. - The process of sample transport and processing seem to indicate a delay especially with recent change in courier protocol, which will be addressed in an MDT framework. - Suggestion of potential change would be to have on site microscopy to reduce this delay.
Re-Audit BCC/SCC excision rates	- Close attention to ensuring compliance with margins standards, especially H&N and deep margins. - State margins in all operation notes, and also useful in the histology request under "History". - If there is a reason that margins are not achievable due to anatomical site, then this is required to be ensured to documented. - Operation notes to state if the sample has been biopsy proven for evidence of margins chosen

Local clinical audit	Actions to improve quality
Devising explicit instructions for Dedicated Abscess Pathway (2nd cycle)	• Post instructions should be explicit, clear and patient friendly. Copy and paste from EPR template during busy CEPOD and on call where there is a chance of missing post instructions. • Patient centred education in wound management to improve outcomes and adherence and empowering patients. • Simplifying discharge instructions by consistent and standardised template for post op instructions (which can be integrated in EPR). Daily dressings as required till healing by the GP practice or district nurse. • First pack removal after 24 or 36 hours. Healing by secondary intention (from within upwards) can take a few weeks according to the size and depth of the wound, depends on individual wound healing rate. • Analgesia is codeine based, which can cause constipation, therefore laxatives to be prescribed for used as required
Timing of surgical intervention for NOFs	• Prioritise NOF patients on trauma lists with future audit to identify how many times NOF fractures are first. • Early identification of patients who may need specialist input and early identification of patients on anticoagulation and reversal if required
Histological Reporting of Testicular Neoplasms in Radical Orchidectomy Specimens	• Discussion of main contributing factors to delays in order to establish a strategy, which will require liaison with the laboratory management. • To introduce an easily accessible reporting proforma to include all dataset items, including LVI tumour type involvement for mixed GCTs. • Discussion of turnaround times for supra-regional reports and establish a way to reduce these
Interventional radiology objective image quality audit	• Refine the measurement techniques developed and produce accurate image quality metrics for large datasets to be used in protocol optimisation in the future. • Audit of clinical image quality to be carried out using a larger sample size to determine the overall spread of image quality more accurately between patients.
Appropriateness of MRI IAM referrals for investigation of tinnitus	• Train clinical teams in the appropriate radiological pathways for pulsatile and non-pulsatile tinnitus and reiterate how to order the most appropriate test

Local clinical audit	Actions to improve quality
Audit of Inpatient Missed Doses	• Highlight to pharmacy ward staff the importance of checking that patients have sufficient supply of their prescribed medications. • Ensure staff are endorsing medication on the drug chart to illustrate when it has been ordered, what medications are ward stock and where patients have PODs. • Further education of ward staff on the importance of documenting rationale for delayed doses, how to obtain medication out of hours, and pharmacy cut-off times and the importance of putting through medication requests with adequate time for pharmacists to respond, therefore allowing evening/night nursing staff better equipped to give patients their due medications during pharmacy non-working hours. • Ensuring medications are kept in the appropriate secure location, such as non-controlled drug medications dispensed for patients being locked away in their POD locker to ensure they do not go missing. • Alternate lunch times to avoid omitted doses and review of staffing numbers around lunch time. • 8 Prescribers or Pharmacists to review dose timing of medications on drug charts and group as many at the same times as possible to make medication schedules more convenient and easier to manage
Brain FDG PET Audit	• Reminder to align external auditory meatus and lateral canthus of eye. • Update FDG protocol to clarify which recons we use and which to transfer
Myocardial Perfusion Scanning – MPS	• Request for more slots from cardiology for Rapiscan and Treadmill • Proper screening/assessment as to whether patient can really exercise using treadmill. • Patients not prepped for Stress or converted to Rapiscan, can have the Rest scan first instead. • Shift all to Pharmacologic stress test and follow up patients, prior the appointment, to confirm that they are attending and followed the preparation for the test.
An audit of clinical referrals, correct patient and body part with clinical info given	• Clinicians to provide more detailed clinical information for each examination and refrain from writing “as above” as a clinical indication. • Radiographers to make sure to document on CRIS whenever they had to change the body part being x-rayed to another after discussion with the patient or in the case of A&E if they had to contact the referrer for additional x-ray. • Improve general awareness of referral guidelines by RCR royal college of radiologist guidelines
Neuroendocrine Tumour Service Re Audit: Reporting patterns	• Continue the use of format/proforma in reporting the NEN resections. • Use both mitotic count and Ki67 index to assess proliferation rate. • Discussion with the HSL laboratory on improving the H&E and IHC processing times.

Local clinical audit	Actions to improve quality
	• Discussion with the MDT coordinators on emphasizing importance of unstained slides/paraffin blocks to external senders to improve turnaround times
Lu177-PSMA Radionuclide Therapy Audit	• Timeliness of bloods to be co-ordinated with oncology team and GP • Admissions to be co-ordination with admissions team and 11E for therapy schedule for the following week. • Delayed clerking to be co-ordinated with admissions and oncology team. • Delayed TTAs to be checked on EPR and coordinated with oncology team
Ga-68 DOTATATE in PET CT with MEN 1	• In patients with MEN1, with known or suspected neuroendocrine tumours, 68-Ga DOTATATE PET CT should be an essential component in the staging process
CT Contrast Audit	• NM consultants to check/request valid eGFR <3 months and potentially to be made compulsory for referrer on EPR/CRIS • Ideally use pink (20 gauge) cannulation and check patency before injection • Reassure patients with explanation and information on contrast administration & expected reaction
Audit on out of hours CT head/C-spine/facial bones reporting outsourced to Everlight	• Improving integration of RFL PACS with Everlight PACS for more seamless image, clinical data and report transfer • Automating transfer of number of slices in full scan to Everlight • Automating upload of radiologist report from Everlight to RFL PACS • Targeting busier hours/days through better resource and staffing management and additional staffing at busier hours • Sharing our data with Everlight • Examining the reasons behind the positive skew in the data, more detailed analysis to find patterns in outlier data and comparison with in-house reporting

3. Participating in clinical research

The number of patients receiving NHS services provided or sub-contracted by Royal Free London NHS Foundation Trust in 2023/24 that were recruited during that period to participate in research approved by a research ethics committee was 11,222. (*The data shows the current position of the trust at the time of producing the draft report. The figures will change as awaiting final data to be validated).

4. CQUIN payment framework

A proportion of Royal Free London NHS Foundation Trust income in 2023/24 was conditional on achieving quality improvement and innovation goals agreed between 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.

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 upon. In 2023/24, CQUIN was worth 1.25% of the fixed element of the annual contract value; hence a significant amount of the trust's income was conditional upon achieving quality improvement and innovation goals.

Our CQUIN payment framework was agreed upon with NHS North-East London Commissioning Support Unit and NHS England as follows:

CQUIN scheme priorities 2023/24	Objective rationale
Staff Flu Vaccinations	Staff flu vaccinations are a crucial lever for reducing the spread of flu during winter months, where it can significantly impact the health of patients, staff, their families and the overall safe running of NHS services.
Supporting patients to drink, eat & mobilise after surgery	Ensuring that patients drink, eat and mobilise as soon as possible after surgery is a key element of the NHS's enhanced recovery programme, helping to prevent post-operative blood clots and respiratory complications resulting in an average 37.5% reduction in length of stay for patients who dream in the first 24 hours after surgery.
Compliance with timed diagnostic pathways for cancer services	Faster diagnosis is proven to improve clinical outcomes: patients are more likely to receive successful treatment when diagnosed earlier. This indicator sets out key elements of the timed pathways for colorectal, lung, oesophago-gastric, prostate, head & neck and gynaecological cancers, which have been identified by a clinical expert group as crucial to achieving faster diagnosis targets.
Prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria	There are significant benefits to IVOS interventions demonstrated in research literature including: increasing hospital bed capacity to support recovery from the COVID-19 pandemic; reducing exposure to broad-spectrum antibiotics; increasing nursing workforce capacity; reducing drug expenditure; reducing carbon footprint of medicines; and reducing healthcare-associated bloodstream infections.

Identification & response to frailty in emergency departments	There are well-evidenced links between frailty and adverse health outcomes including deconditioning, malnutrition and irreversible cognitive decline which may all lead to increased health and care requirements. Early identification of frailty can mitigate some of these risks.
Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service	NICE NG5 recommends that medicines-related communication systems should be in place when patients move from one care setting to another and the act of reconciling medicines should happen within one week of the patient being discharged.
Recording of and appropriate response to NEWS2 score for unplanned critical care admissions	The NEWS2 protocol is the RCP and NHS-endorsed best practice for spotting the signs of deterioration and ensuring a timely response, the importance of which has been emphasised during the pandemic. This measure incentivises adherence to evidence-based steps in the identification, recording and timely response to deterioration, which will reduce the rate of preventable deaths and ICU admissions in England.
Achievement of revascularisation standards for lower limb Ischaemia	Following guidance published by the Vascular Society to reduce the delays in assessment, investigation, and revascularisation in patients with chronic limb threatening ischaemia and in turn reduce length of stay, in-hospital mortality rates, readmissions and amputation rates. Estimated annual savings are £12 million.
Achieving progress towards Hepatitis C elimination within lead Hepatitis C centres	In support of the NHS England public commitment to achieve hepatitis C elimination ahead of the WHO target of 2030 and be the first country in the world to do so.
Radical treatment for patients with Stage I – II Non Small Cell Lung Cancer	Patients given radical (aka curative intent) treatment have a markedly improved survival and reduced mortality compared to no treatment or palliative treatment.
Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery	Achieving high quality shared decision making conversations to support patients to make informed decisions based on available evidence and their personal values and preferences and knowledge of the risks, benefits and consequences of the options available to them about both their clinical condition and the consequences of the current pandemic.
Assessment & documentation of pressure ulcer risk	NICE clinical guideline CG179 sets out clear best practice for assessing the risk of pressure ulcer development and acting upon any risks identified. It is fully aligned with the recently republished NPIAP (National pressure injury advisory panel) international clinical practice guidelines.
Enabling the Core20plus5 programme through targeted population cohorts to reduce health inequalities.	This local CQUIN will support the North Central London Integrated Care System in its delivery of the Population Health Strategy and agenda. Whilst also informing and enabling the Core20plus5 programme through targeted population cohorts and interventions to reduce healthcare inequalities experienced by Black, Asian and minority ethnic communities and the most deprived groups living in North Central London.

5. Registration with the Care Quality Commission (CQC)

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

The Care Quality Commission has not taken enforcement action against Royal Free London NHS Foundation Trust during 2023/24 reporting period.

The Royal Free London NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during 2023/24.

CQC inspection

The RFL NHS FT was subject to a CQC announced (Ockendon Review) inspection of our maternity services at Edgware Community Hospital on 24 October 2023, with the final inspection report published in February 2024. The inspection of the maternity service at Edgware Birth Centre was part of the national maternity inspection programme.

The programme aims to give an up-to-date view of hospital maternity care across the country by understanding what is working well to support learning and improvement at a local and national level. The CQC carried out a short notice announced focused inspection of the maternity service, looking only at the safe and well led. The CQC rated the service as good for both safe and well led. The inspection key areas for improvement found that the trust was required to make improvements in three areas:

Regulation 17: Good governance

- The service should ensure references to policies and guidelines were up to date and in line with national guidelines.
- The service should ensure appropriate checks and oversight was maintained on safety and specialist equipment including resuscitaire and resuscitation trolley.
- The service should ensure internet connectivity at the birth centre improves to maintain safe management of medicines and records.

Barnet Hospital local executive committee, who have delegated board oversight of the improvement actions performance and completion, receives a monthly update on the progress of the improvement actions from maternity services as part of the Women's and Children divisional senior management team.

6. Information on the quality of data

The Royal Free London NHS Foundation Trust submitted records during 2023/24 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Good quality information ensures the effective delivery of patient care and is essential for quality improvements. Improving information on the quality of our data, including 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 percentage of records in the published data for 2023/24:

Which included the patient's valid NHS number was:

The percentage of records in the published data which included patient's NHS number for 2023/24 is as follows:

NHS Number	2023/24
For admitted patient care	99.38%
For outpatient care	99.72%
For accident and emergency care	98.58%

Explanatory note:

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.

Which included the patients valid General Medical Practice Code:

The percentage of records in the published data which included the patient's valid General Medical Practice Code for 2023/24 was:

General Medical Practice Code	2023/24
For admitted patient care	100.00%
For outpatient care	100.00%
For accident and emergency care	100.00%

7. Royal Free London NHS Foundation Trust Information Governance Assessment Report:

The Data Security and Protection Toolkit (DSPT) is an online annual self-assessment that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. It is a statutory requirement to comply with the DSPT as it is an information standard published under section **250** of the Health and Social Care Act 2012. All organisations that have access to NHS patient data and systems must use the DSPT to provide assurance that they are practising good data security and that personal information is handled correctly. The requirements of Cyber Essential Plus align to DSPT standards. As data security standards evolve, the requirements of the Toolkit are reviewed and updated to ensure they are aligned with current best practices. The trust commissions an independent audit of its DSPT submission for assurance purposes. The trust currently has a status of 'standards met'.

The Royal Free London NHS Foundation Trust has a detailed assurance programme in place and is working towards the 2023/24 DSPT submission deadline of June 2024. The trust is expected to reach a status of 'standards met'.

8. Payment by results

The Royal Free London NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2023/24 by the Audit Commission.

9. Action taken by Royal Free London NHS Foundation Trust to improve data quality

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

1. The Data Quality team will continue the work programme to ensure agreed KPIs are being met and issues will be escalated to divisional management with corresponding action plans.
2. Audits to ensure data is being captured correctly are being undertaken in each area (IP, ED, OP) on a quarterly basis, as well as ad hoc audits as and when required
3. The data quality dashboard is in development. This will be monitored and updated to ensure ongoing due diligence of internal and external submissions.
4. More data quality awareness sessions will be carried out to raise issues caused by incorrect usage of the electronic patient record (EPR) system
5. Audits on the EPR system configuration will take place in conjunction with the back-office teams and services to ensure that systems are optimised for accurate reporting.
6. The data quality manager plays an active role in the monthly PAS user group, to ensure data quality issues are highlighted trust wide and to promote good practice.

10. Learning from deaths

(*In this section, the data shows the current position of the trust at the time of producing the draft report. The figures and tables might change as awaiting final data to be validated).

During 2023/24 [Final data to be confirmed], 1410 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: 481 in the first quarter; 435 in the second quarter; 494 in the third quarter; [Final data to be confirmed] in the fourth quarter.

By 31/12/2023, 36 case record reviews and 4 investigations have been carried out in relation to 1410 of the deaths included above.

In 4 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 2 in the first quarter; 1 in the second quarter; 1 in the third quarter; [Final data to be confirmed] in the fourth quarter.

0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of 0 representing 0% for the first quarter; 0 representing 0% for the second quarter; 0 representing 0% for the third quarter; 0 representing 0% for the fourth quarter. [Final data to be confirmed]

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

The Royal Free London NHS Foundation Trust provides care and treatment to thousands of patients each year. Most patients receive treatment, get better and can return home or be transferred to other care settings. Sadly, and inevitably, some patients will die in the hospital; this is approximately 1% of all admissions.

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

Likert avoidability Scale:

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

Table 5: Summary of learning from death reviews

Reporting period		Number of deaths	Number of reviews completed	Number of serious incident investigations	Number of patient deaths considered to be avoidable	Percentage of patient deaths considered to be avoidable
Q1	April 2023 to June 2023	481	22	2	0	0%
Q2	July 2023 to September 2023	435	11	1	0	0%
Q3	October 2023 to December 2023	494	3	1	0	0%
Q4	January 2024 to March 2024	Awaiting information	Awaiting information	Awaiting information	Awaiting information	Awaiting information
Year	2023-24 (Q1-Q3)	1410	36	4	0	0%

Summary of lessons learnt:

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

Good practice	Areas for improvement
- Patients' treatment ('best interest') led to excellent care being provided quickly. - Advanced care planning and discussions with patients and their families about DNA CPR is fully documented.	- Earlier recognition of dying in some cases – impacting on care planning and management and communication with patients and their families. - Improved documentation required, including outcomes from Morbidity and

• Compassionate care and discussions with families noted. • Quick palliative care team involvement. • Clear documentation, including care plans, and addressing patients' nutrition and hydration needs. • Clear communication and involvement of patients and their families in decision-making. • There has been a reduction in the backlog of learning from deaths to review.	Mortality (M&M) meetings and risk assessments. • Earlier referral to required Nursing teams when a patient with a learning disability is admitted is needed.
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The 4 incidents below relate to those patient deaths which were considered likely to be avoidable and/or where opportunities for learning were identified, and therefore reported as serious incidents:

Incident	Financial Year	Quarter	Likert Avoidability
2023/8558	2023/24	Q1	3 Probably avoidable, more than 50/50
2023/7470	2023/24	Q1	3 Probably avoidable, more than 50/50
2023/17027	2023/24	Q2	4 Possibly avoidable, but not very likely, less than 50:50
2023/19080	2023/24	Q3	5 Slight evidence of avoidability

Following the investigation, each serious incident report contains a detailed action plan agreed upon with our commissioners and shared with the deceased patient's relatives. The trust reviews the action log to ensure the actions are implemented and completed.

These actions are logged in our risk management system (Datix) and are monitored by our hospital clinical performance and patient safety committees and clinical standards and innovations committee to ensure completion and compliance.

In addition, our commissioners review some action to provide external assurance of our processes. External review by our commissioners has been completed to their satisfaction.

11. Seven-day hospital services

The seven-day services programme is designed to ensure patients that are admitted as an emergency receive high quality consistent care no matter which day, they enter hospital.

Providers have been working to achieve all these standards, with a focus on four priority standards:

Standard 2 – time to first consultant review

Standard 5 – access to diagnostic services

Standard 6 – Access to consultant-led interventions

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

The Royal Free London is compliant with standards 6 and 8.

Standard 2 requires that all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the

time of admission to hospital. In 2023-24 Royal Free London developed a focused approach to develop reporting systems to collect data from the electronic patient records to identify areas where we are not meeting this standard. In August 2023, the team built a "Consultant Post Take Ward Round (PTWR) " note type to improve EPR workflow adoption to facilitate extractable data quality to measure time to first consultant review. Following this adaptation, all surgical and medical teams have been asked to use PTWR note type for recoding the post take ward round. RFL will continue to improve compliance with ongoing monitoring of this via operational teams.

For standard 5, RFL meets this standard for all diagnostic services for weekdays and for most over the weekends. The gap in meeting standard 5 continues to be the lack of provision of out of hours MRI in less than one hour for indeterminate probability of a cerebrovascular accident.

12. Speaking up (including whistle-blowers) declaration

The trust has a comprehensive speaking up policy (<https://www.royalfree.nhs.uk/about-us/patient-safety/speaking-up-policy/>) and associated pathways, jointly designed and agreed with staff side partners, as per our recognition agreement and the trust's Freedom to Speak Up Guardian. The policy outlines how colleagues can safely raise any concerns relating to malpractice or wrongdoing, including; quality of care, patient safety, sub-optimal culture (eg bullying and/or harassment) or alleged criminal activity for further investigation (eg fraud). The policy is supplemented by a repository-based local intranet page which is accessible from handheld and potable devices as well as fixed workstations. This provides further detail regarding the pathways, avenues of support and details of our 100 strong speaking-up champions network, overseen by the trust's 'Freedom to Speak Up Guardian'. Our long-established speaking up pathway is promoted at corporate induction on a weekly basis and through a cycle of on-site promotional events. The pathway is also available on the speaking up pages on our intranet and on cards, leaflets and posters regularly distributed to departments alongside the visible presence of our FTSU champions across our hospital sites and satellite units.

We compile bi-monthly assurance reports for the trust's sub-board level audit committee to provide updates on speaking up activity, cases, themes and learning outcomes for the organisation. Assurance as to the delivery of the rolling 24-month action plan is also provided to this forum. The Freedom to Speak Up Guardian and Executive lead compile an annual 'Freedom to Speak Up' report which highlights an overview of internal and benchmarked case activity and key system and/or process improvements made in the reporting period and a view of the numbers of colleagues who report that they have been subjected to detriment having spoken up.

In year, our trust Board has also been through the first of a series of reflection exercises on its individually-led and collective role and accountability throughout the speaking up pathway with a view to shaping its corresponding objectives into the coming year.

2.3 Reporting against core indicators

This section of the report presents our performance against eight 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:

- Summary hospital-level mortality (SHMI)
- Patient reported outcome measures scores (PROMS)
- Emergency readmissions within 30 days
- Responsiveness to the personal needs of our patients
- Staff recommendation to friends and family
- Venous thromboembolism (VTE)
- C difficile
- 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.

A) Summary of hospital-level mortality indicator (SHMI)

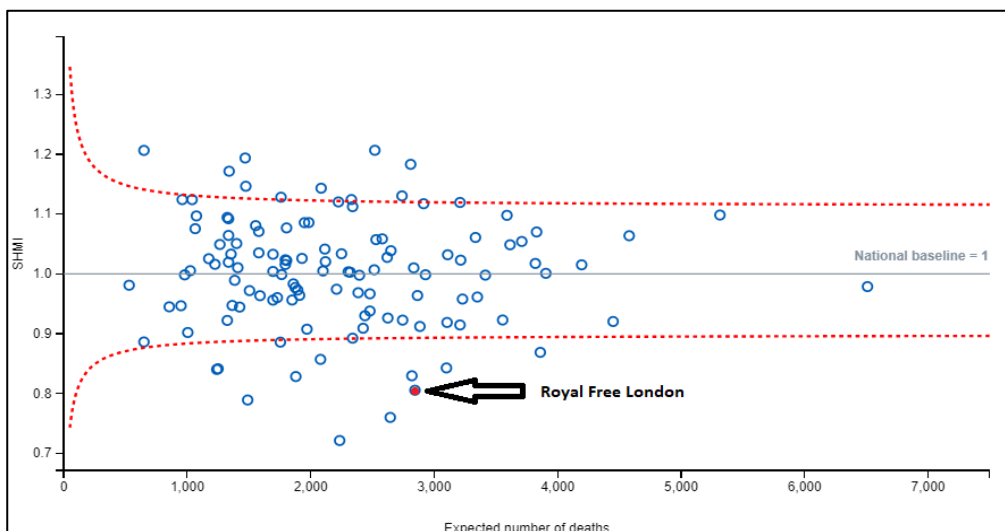
The value and banding of the summary hospital-level mortality indicator (SHMI) for the Trust for the reporting period

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

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

The Royal Free London NHS Foundation Trust participates in the HSCIC NHS Choices/Clinical Indicator sign-off programme, whereby data quality is reviewed and assessed monthly and quarterly. The trust has identified no significant variance between the data held within the trust systems and data submitted externally.

The latest available data covers the 12 months from November 2022 to October 2023. During this period, the Royal Free London had a mortality risk score of 0.8055, representing a risk of mortality lower than expected for our case mix. The score represents a mortality risk statistically significantly below (better than) expected, with the Royal Free London is ranked 4 out of 119 non-specialist acute trusts, an improvement of three places compared to last year.



Royal Free London Performance					National		
2018/19	2019/20	2020/21	2021/22	2022/23	Average Performance	Highest Performing NHS Trust Performance	Lowest Performing NHS Trust Performance
0.8207	0.8501	0.8192	0.8367	0.8055	1.0021	0.7215	1.2065
Lower than expected.	Lower than expected.	Lower than expected.	Lower than expected.	Lower than expected.	As expected.	Lower than expected.	Higher than expected.

Note:

The data reporting period for this metric is November to October.

The percentage of deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period

We have included the percentage of patient deaths with palliative care coded at either diagnosis or speciality level as a contextual indicator to the SHMI indicator; this is because other methods of calculating the relative mortality risk make allowances for palliative care, whereas the SHMI does not consider palliative care.

Royal Free London Performance					National		
2018/19	2019/20	2020/21	2021/22	2022/23	Average Performance	Highest Performing NHS Trust Performance	Lowest Performing NHS Trust Performance
35%	37%	40%	37%	36%	43%	16%	66%

Note:

The data reporting period for this metric is November to October.

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

B) Patient reported outcome measures (PROMs)

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

PROMS measures health gains in patients undergoing hip replacement or knee replacement and, up to September 2017, varicose vein and groin hernia surgery in England, based on responses to questionnaires.

Clinicians must review the service's scores regularly and the trust level to ensure that what we learn from patient feedback is incorporated into our quality improvement programmes.

During 2022 and 2023, the trust did not submit PROMS data due to the inability to procure a new PROMS provider.

In 2023/2024, the trust undertook procurement to align our PROMS supplier with that of the North Middlesex Hospital. The PROMS procurement for Trauma and Orthopaedic elective knee and arthroplasty surgery is currently awaiting information governance approval to ensure due diligence.

The trust anticipates implementation and data collection six months following procurement.

C) Emergency readmission within 30 days

Internally, the trust reviews its 30-day emergency readmission rates for elective patients as part of the board's key performance indicators. 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 readmission rate at Royal Free London NHS Foundation Trust increased for adult patients and reduced for paediatric cohorts; however, remains below national averages for both cohorts in 2022/23. The trust also undertakes detailed enquiries into patients classified as readmissions with our public health doctors, working with GP's and identifying the underlying causes of readmissions.

Note:

The emergency rate is the percentage of patients readmitted to a hospital within 30 days of being discharged from a hospital.

Royal Free London Performance					National		
2018/19	2019/20	2020/21	2021/22	2022/23	Average Performance	Highest Performing NHS Trust Performance	Lowest Performing NHS Trust Performance
Patients aged 0 to 15 years old							
9.4%	9.1%	9.2%	8.7%	8.5%	14.1%	3.7%	37.7%
Patients aged 16 years old or over							
13.2%	13.9%	13.3%	11.0%	11.7%	12.6%	2.5%	27.5%

Note:

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

D) Responsiveness to the personal needs of our patients

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

Royal Free London Performance					National		
2018/19	2019/20	2020/21	2021/22	2022/23	Average Performance (2019/20)	Highest Performing NHS Trust Performance (2019/20)	Lowest Performing NHS Trust Performance (2019/20)
64.0	66.7	No data	No data	No data	67.1	84.2	59.5

Note:

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

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.

E) Staff recommendation to friends and family

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

Royal Free London Performance					National		
2019	2020	2021	2022	2023	Average Performance	Highest Performing NHS Trust Performance	Lowest Performing NHS Trust Performance
71%	77%	71%	66.1%	69.0%	63.4%	88.8%	44.3%

Note:

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

Each year the NHS surveys its staff and one of the questions looks at whether staff would be happy with the standard of care provided by their organisation if they had a relative or friend who needed treatment. Trust performance is above the national average for acute trust providers. The Royal Free London NHS Foundation Trust improved in 2023 from 2022 and remains above the national average of all other acute NHS providers.

F) Venous thromboembolism (VTE)

The percentage of patients admitted to the 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 London Performance					National		
2019	2020	2021	2022	2023	Average Performance	Highest Performing NHS Trust Performance	Lowest Performing NHS Trust Performance
96.9%	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Note:

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

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

G) Clostridium difficile

Clostridium difficile (C. diff) is an infection which can cause severe diarrhoea and vomiting and has been known to spread within hospitals, particularly during the winter months. Reducing the rate of C. diff infections is a key government target. Royal Free London NHS Foundation Trust performance increased in 2022/23 and higher than the national average.

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

Royal Free London Performance					National		
2018/19	2019/20	2020/21	2021/22	2022/23	Average Performance	Highest Performing NHS Trust Performance	Lowest Performing NHS Trust Performance
16	14.6	16.1	16.0	25.0	19.1	4.5	73.3

Note:

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

H) Patient safety incidents

In line with national requirements, in March 2024 the trust implemented the Patient Safety Incident Response Framework (PSIRF), having also launched the Learning from Patient Safety Events (LFPSE) reporting portal, in October 2023. Both these national patient safety initiatives support the trust to improve learning from our patient safety events, to help make the care that we deliver safer.

Following the implementation of PSIRF all safety learning events meeting both local and national criteria below are discussed by the Patient Safety Event Response Panel (PSERP) who review the safety events against the local and national frameworks and agree a planned approach for each safety event. The PSERP panel at each business unit meets weekly to discuss and agree the planned approach for these safety events, engaging the most appropriate and proportionate learning response to the safety events discussed.

The table below displays the number of patient safety events reported which affected an NHS or Private Patient, during April 2023 to March 2024. This data is subject to change as safety events are discussed at PSERP.

The number of patient safety events reported by the trust during the reporting period	Royal Free London
Number	21,516

The number and percentage of such patient safety events that resulted in severe harm or death.	Royal Free London
Number	78 (57+21)
Percentage	0.4% (0.3+0.1)

Part 3: Overview of the quality of care in 2023/24

3.1 Performance against nationally selected indicators

This section of the quality report presents an overview of the quality of care offered by the trust based on performance in 2023/24 against indicators and national priorities selected by the board in consultation with our stakeholders.

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

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

Relevant quality domain	Quality performance indicators
Section 1: Patient safety	• Methicillin-resistant staphylococcus aureus (MRSA) • C. difficile Infections
Section 2: Clinical effectiveness	• Referral to treatment (RTT) • A&E performance • Cancer waits • Average length of stay (elective and non-elective) • 30-day emergency readmission rates for elective patients • Maximum 6-week wait for diagnostic procedures
Section 3: Patient experience	• National surveys • Friends and Family Test • Volume of cancelled operations

Section 1 PATIENT SAFETY

Methicillin-resistant staphylococcus aureus (MRSA)

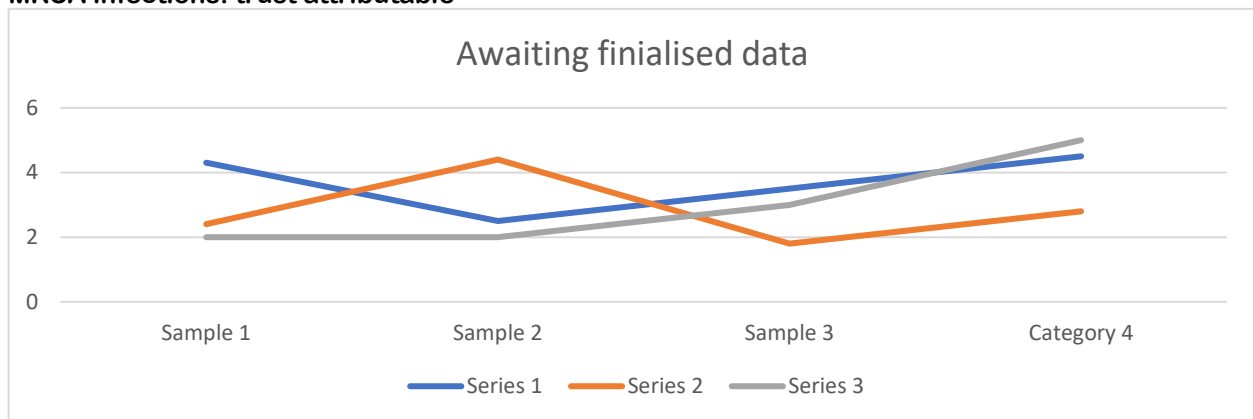
(*In this section, the data shows the current position of the trust at the time of producing the draft report. The data and narrative will be updated for end of year position as awaiting final data to be validated).

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.

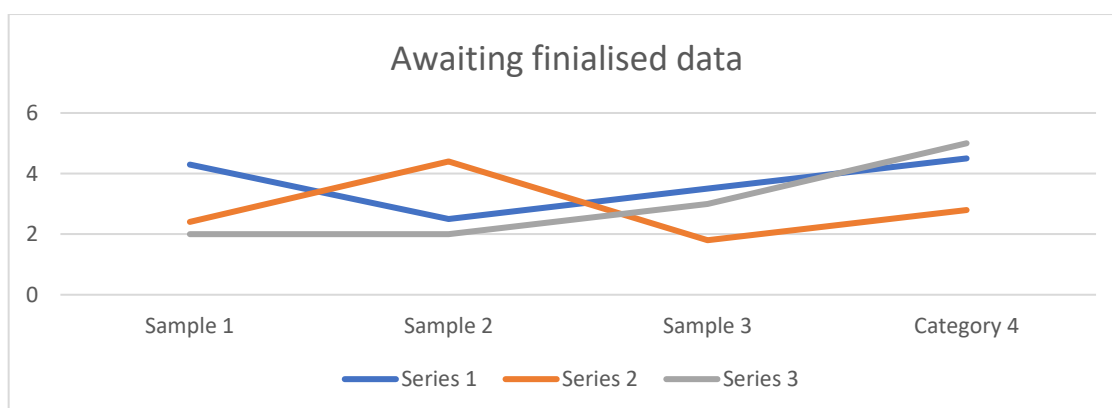
During 2023/24, the trust recorded 7 [Final data to be confirmed] MRSA trust attributable infections, which is down from nine recorded in 2022/23.

MRSA infections: trust attributable



Source: Royal Free London W2B PBI 2023/24

Benchmarking Chart: total volume of MRSA bacteraemia, April 2023 – March 2024



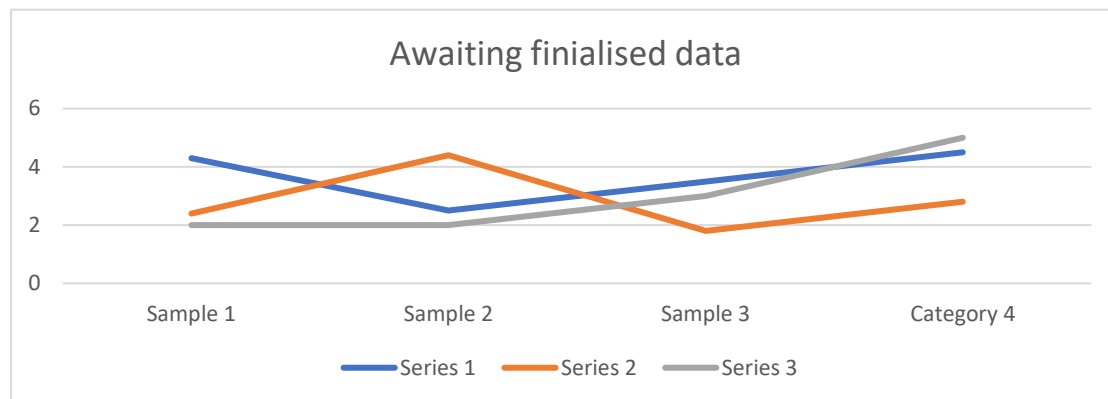
Source:

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

C. difficile Infections

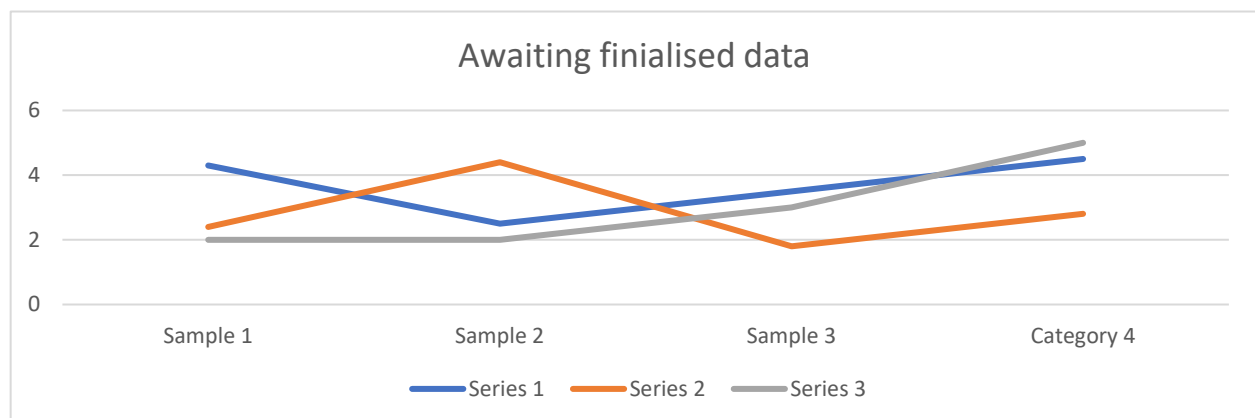
(*In this section, the data shows the current position of the trust at the time of producing the draft report. The data and narrative will be updated for end of year position as awaiting final data to be validated).

In relation to C. diff the trust saw a downward trajectory against our threshold for 2023/24. Over this period, the Royal Free London reported 86 infections [Final data to be confirmed] compared to 115 in 2022/23.



Source: Royal Free London IBR PBI 2023/24

Benchmarking Chart: Total volume of C. diff infections, April 2023 – March 2024



Source: Royal Free London W2B PBI 2023/24

Section 2 CLINICAL EFFECTIVENESS

Referral to treatment (RTT)

18-week waiting times

(*In this section, the data shows the current position of the trust at the time of producing the draft report. The data and narrative will be updated for end of year position as awaiting final data to be validated).

The trust is one of the largest providers of elective care (including specialist tertiary care) nationally. It has the largest waiting list in north central London, with the fifth largest waiting list in London and thirteenth largest nationally.

In line with the NHS priorities, the Trust focus has been on continuing to reduce the number of our longest waiting patients, and we finished the year with no one waiting more than 104 weeks and have significantly reduced the number of patients waiting over 78 weeks to 35 at March month end.

The Industrial Action (IA) seen across the NHS has had a significant impact on the overall size of the RTT PTL and the number of patients waiting over a year for treatment, which has been seen across the NHS this year. We now have 102,000 patients on the waiting list, up from 92,000 at the start of the year, and 5,000 of these patients have waited more than a year, up from 3,000 a year ago.

Key improvements the trust has undertaken include:

- Continued delivery on reducing the longest waiting patients throughout 2023/24. This included:
- Maintaining 0 104+ week waits throughout 2023/24 (excluding September where the trust reported 5 104-week breaches).
- Delivering a significant reduction to the volume of patients waiting over 78+ weeks. In April 2023 the trust submitted 177 patients waiting longer than 78 weeks. This increased to a peak of 234 in December as a direct result of the ongoing Industrial Action (IA). By March 24 month end the trust had reduced the volume of 78 week waits to 37 (still under review and subject to change) **[Final data to be confirmed]**
- Finishing 2023/24 ahead of the trust revised trajectory on 65+ week waits. There has been an increase through 2023/24 in the volume of 65+ week waits from 609 in April to a peak of 1608 in December. This is as a direct result of IA. The trust has however started to see a reduction in 65 week waits and March 2024 will close ahead of trajectory which was set at 1,593. March month end starting position is 1,264 which will reduce through to submission which will be made on Thursday 18th April 24. **[Final data to be confirmed]**
- As a result of IA the trust has seen an increase in the volume of 52+ week waits. In April the trust submitted 3,304 breaches and in February 24 (latest submitted position) **[Final data to be confirmed]** the trust submitted 5,132. It is likely this will increase further through March.
- The trust entered quartile 2 for RTT performance in April 2023 having remained in quartile 3 since returning to national reporting, and has maintained Q2 status throughout 2023/24. It

is important to note that although this is an improvement, the national average is moving frequently and this could tip the organisation back into quartile 3.

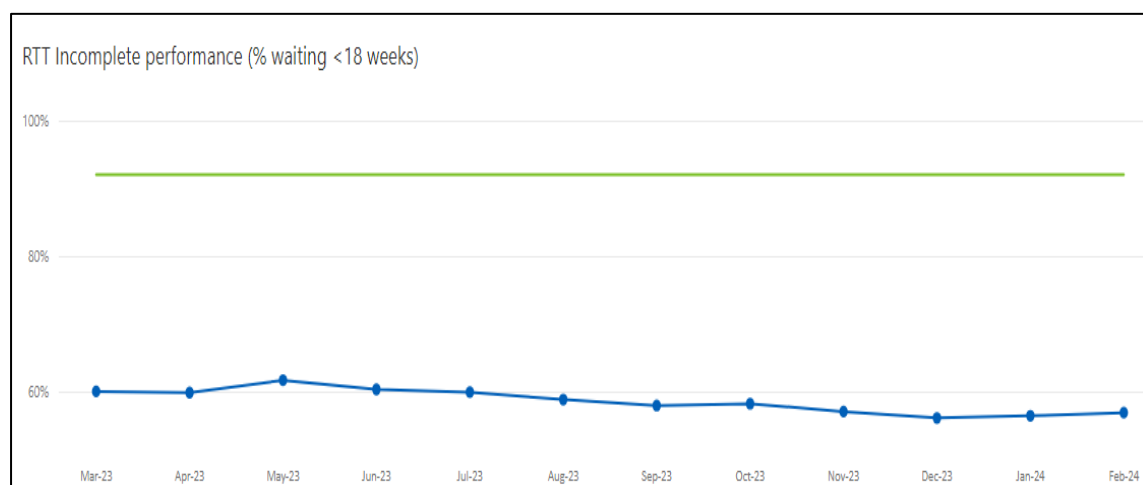
Looking ahead:

The trust focus for 2024/25 is to ensure that we can continue to deliver progress in reducing the time patients wait to receive treatment. The Royal Free London group model developments will be core to providing this, as they enable increased flexibility, productivity, and activity through the Chase Farm Hospital elective site, supporting Barnet Hospital and the Royal Free Hospital as well as capacity for the wider North Central London health and social care system. In addition, shared improvement activities are being led through the group-wide elective programme, supporting local hospital teams with the additional capacity to redesign and transform pathways and ensure maximising the Royal Free London group's combined resources to support reducing waiting times and improve patient experience and outcomes.

Our key access priorities are to ensure we:

- have no patient waiting more than 65+ weeks for treatment by September 2024.
- Continue to reduce the number of patients waiting 52 weeks.
- Continue to make improvements in data quality building on the improvements delivered and audited in 2023/24.

RTT incomplete performance (percentage patients waiting <18 weeks)



Source:

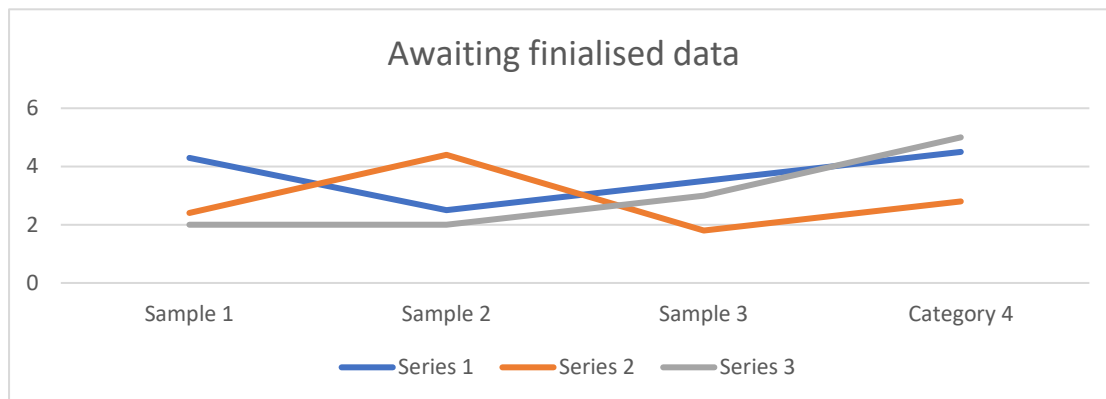
Royal Free London W2B PBI 2023/24

The chart below shows the Royal Free London performance January 2024 benchmarked against all national acute Trusts and peer providers for 18 weeks performance. **[Final data to be confirmed]**

The Royal Free London remains in the lower third quartile with 56.4% of patients waiting within 18 weeks of referral. **[Final data to be confirmed]**

The Royal Free London is ranked 63 out of 120 Trusts and is ranked 10 out of 20 peer trusts. **[Final data to be confirmed]**

Benchmarking chart: percentage of patients waiting within 18 weeks of referral

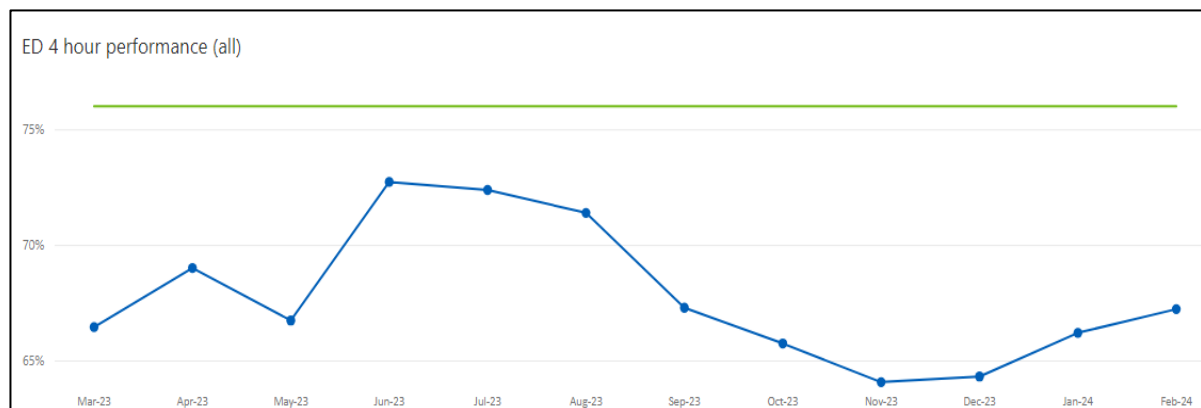


Accident and Emergency performance

(*In this section, the data shows the current position of the trust at the time of producing the draft report. The data and narrative will be updated for end of year position as awaiting final data to be validated).

Accident and emergency departments are often the patient's point of arrival. The graph below summarises Royal Free London's performance concerning meeting the 4-hour maximum wait time standard set against the performance of accident and emergency departments. The national waiting time standard requires trusts to treat, transfer, admit or discharge 95% of patients within four hours of arrival.

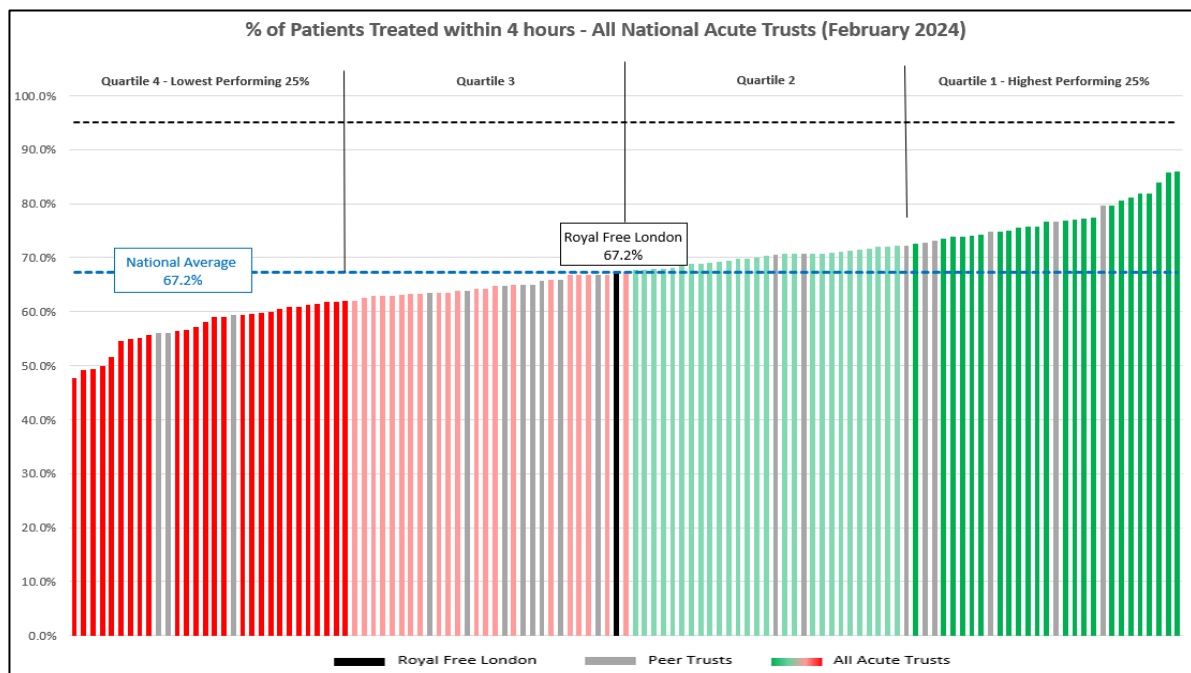
During the period April 2023 to February 2024, the Royal Free London NHS Foundation Trust achieved an average monthly performance of 67.9%, higher than in 2022/23 which averaged at 64.9%. [Final data to be confirmed]



Source:
Royal Free London W2B PBI 2023/24

The chart below shows the Royal Free London performance for February 2024, benchmarked against all national acute trusts and peer providers for four-hour emergency department performance. The Royal Free London is ranked 61 out of 119 trusts and is ranked 9 from 20 peer trusts. [Final data to be confirmed]

Benchmarking chart: percentage of patients treated within 4 hours



Source: NHS Digital, 2023/24

Cancer waiting times

(*In this section, the data shows the current position of the trust at the time of producing the draft report. The data and narrative will be updated for end of year position as awaiting final data to be validated).

Cancer waits

This year, our focus has been to ensure the continuity of cancer care and cancer treatment activity during a year of unprecedented industrial action. We have worked with clinical teams to improve cancer pathways leading to diagnoses being communicated to patients earlier and then commencing treatments for those patients with confirmed cancers.

NHS England set three key performance indicators for cancer:

- Reducing the backlog of patients waiting more than 62 days for cancer treatment following a GP urgent referral for suspected cancer.
- The achievement of 75% of patients to be given either a diagnosis of cancer or the ruling out of cancer within 28 days of referral.

Royal Free London received the largest volume of urgent suspected cancer referrals of any London provider and commenced the second largest number of first treatments for patients with confirmed cancer in London.

This year, the trust has focused on the robust management of patients in the backlog to reduce the number of patients waiting longer than 62 days for treatment. The changes implemented include improving communication and transfer of care for shared patients with other NCL providers, and A robust tracking approach with clinical input to ensure patients are moved through the pathway in a timely way to avoid any potential clinical harm. The other focus this year has been on the delivery of best practice timed pathways, using CPG designed tumour site-specific digital pathways to diagnose and communicate the diagnosis to patients much earlier in their pathway.

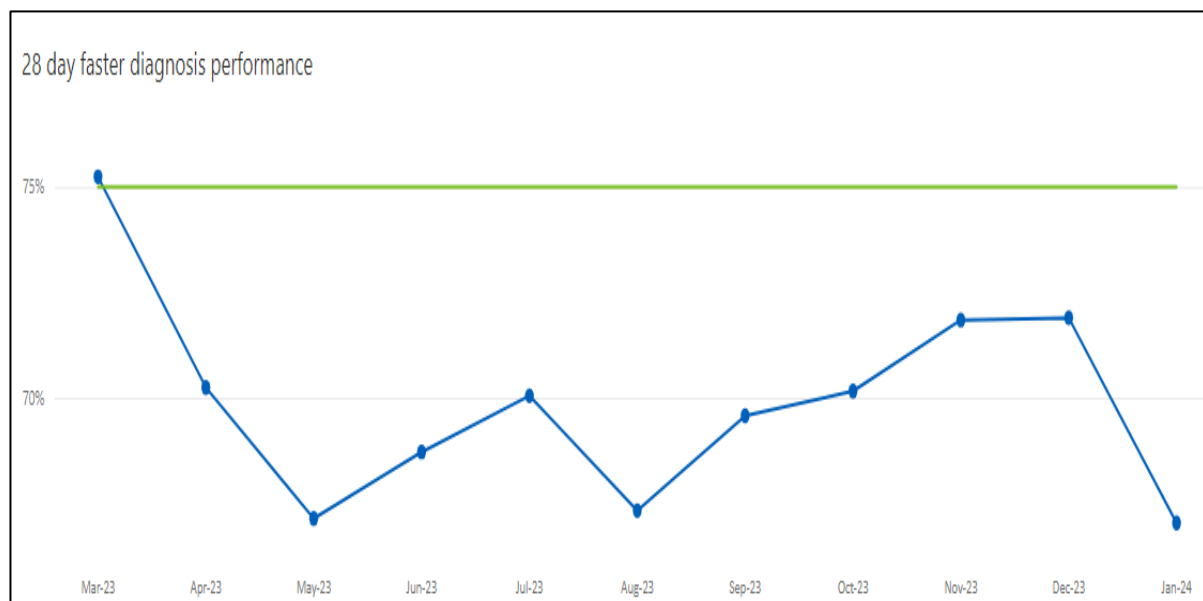
In 2023/24 the trust received 14.3% [Final data to be confirmed] more urgent suspected cancer referrals than in 2019/20, approximately 6,000 [Final data to be confirmed] more cancer referrals than the trust received before the COVID-19 pandemic and 2.3% [Final data to be confirmed] more referrals than 22/23.

The trust has successfully restored 31-day treatment volumes not just to pre-pandemic levels but 459 [Final data to be confirmed] treatments more than in 2022/23. Delivering this target has been challenging due to the complex capacity challenges faced when reducing an RTT backlog.

The 28-day faster diagnosis standard (75%) that was introduced in 2021/22 has been a challenging standard to deliver, particularly around months where industrial action has taken place. The trust had consistently performed at higher than 70% each month before industrial action. To mitigate some of the capacity lost the trust has put on additional capacity for endoscopy, prostate biopsies, hysteroscopies and one-stop clinics for breast patients. Additionally the trust has endeavoured to focus on the transformation of certain pathways, including implementing a FIT<10 pathway. The trust has also led NCL in its ambition to have a breast pain pathway and a tele-derm pathway for urgent suspect skin cancer patients.

Diagnosis communicated to the patient within 28 days

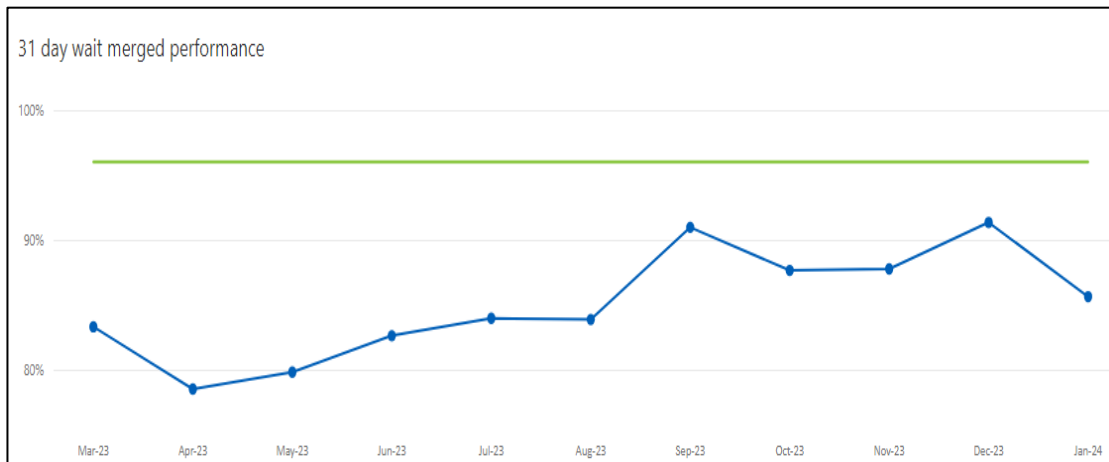
In 2023/24, the trust was below the standard to communicate a diagnosis of cancer or ruling out cancer to 75% of patients by day 28, the underperformance has been significantly impacted industrial action. The trust's average performance is 68.7% [Final data to be confirmed]



Source:
Royal Free London W2B PBI 2023/24

First and subsequent treatment within 31 days

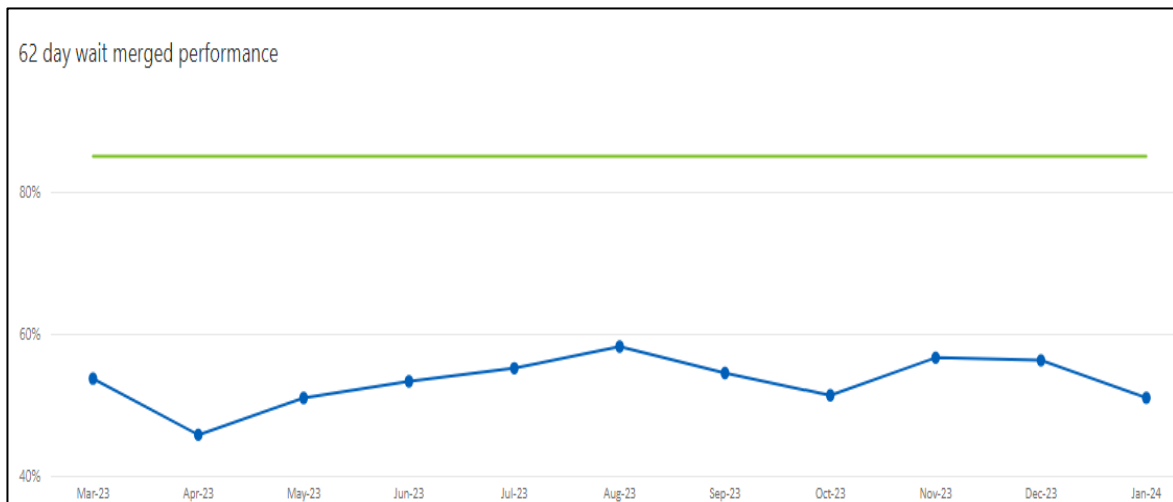
In 2023/24, the trust was below the standard to treat 96% of patients within 31 days of a decision to treat cancer, with an average of 85.8% [Final data to be confirmed]



Source:
Royal Free London W2B PBI 2023/24

First definitive treatment within 62 days of a urgent GP referral, screening referral or a consultant upgrade

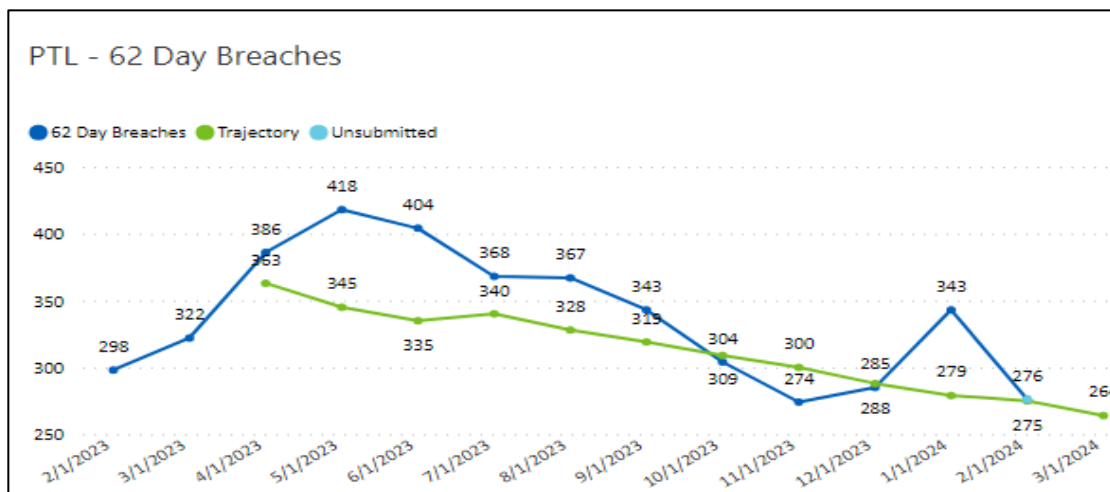
The trust did not meet the 62-day standard in 2023/24, with an average of 52.8% [Final data to be confirmed] patients receiving first treatment within 62 days of a GP referral, screening referral or consultant upgrade. The 62-day performance has been challenged due to the trusts focus on working through the significant backlog of patients waiting longer than 62 days.



Source:
Royal Free London W2B PBI 2023/24

Patients waiting over 62 days for treatment following an urgent suspected cancer referral from a GP

The backlog is reviewed twice per week, and patients are being booked on clinical priority and highest risk basis. The trust has reduced the backlog down to 274 [Final data to be confirmed] patients which is better than trajectory and better than NHSE fair share of 304.



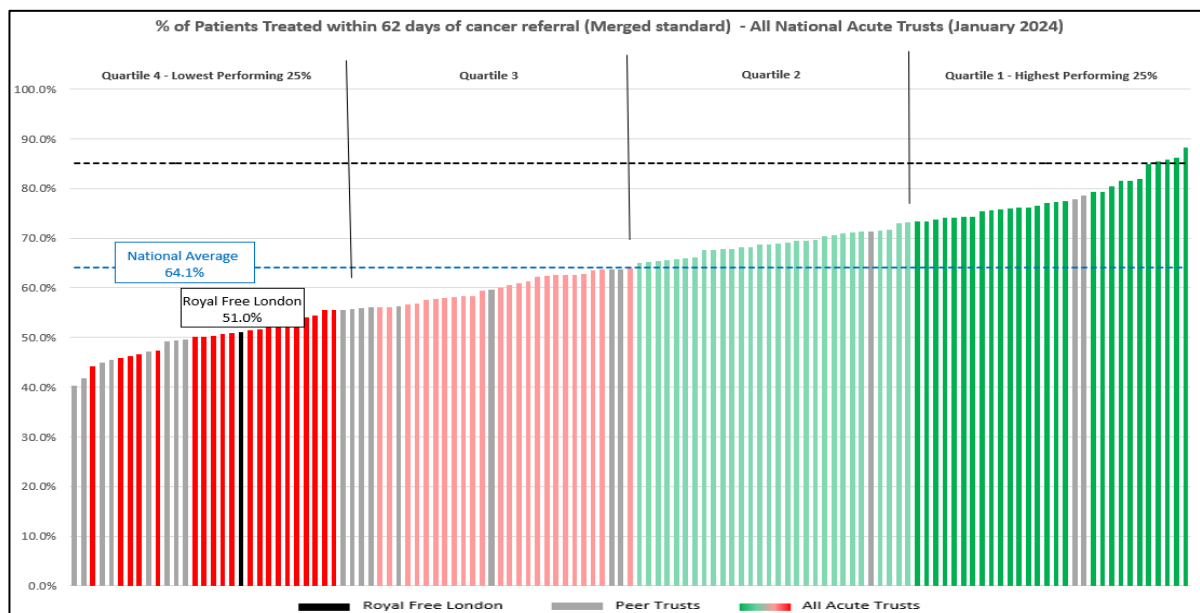
Source: RFL weekly cancer PTL 2023/24

The chart below shows the Royal Free London performance for January 2024, benchmarked against all national acute Trusts and peer providers for 62 day waits for treatment.

The Royal Free London is in Quartile 4 with 51.0% [Final data to be confirmed] of cancer patients treated within 62 days of referral).

The Royal Free London is ranked 103 [Final data to be confirmed] out of 121 Trusts and is ranked 11 [Final data to be confirmed] from 20 peer Trusts.

Percentage of patients treated within 62 days of cancer referral

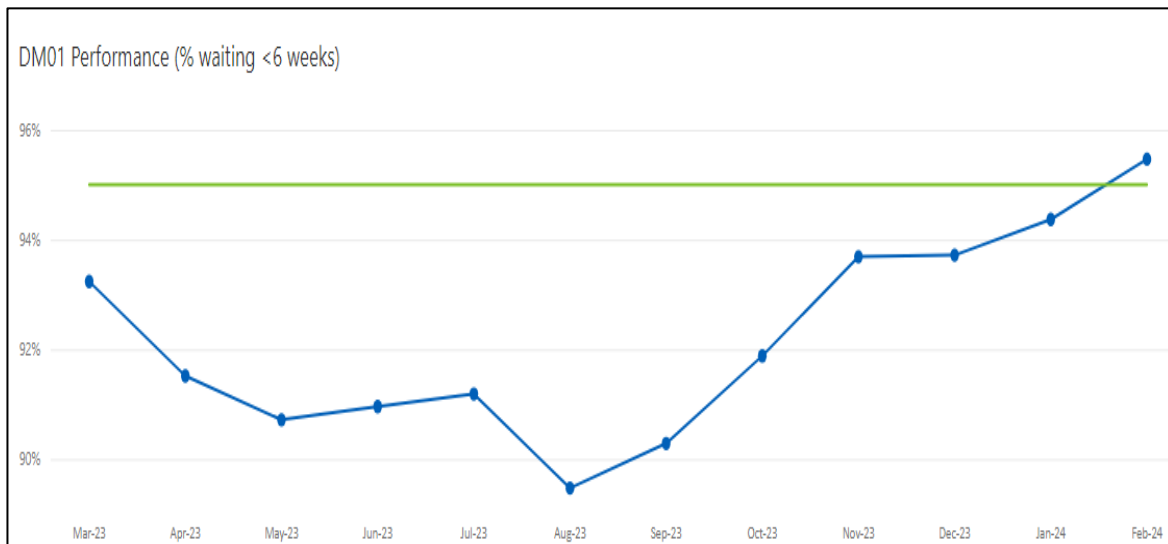


Source: NHS Digital, 2023-24

Diagnostics waiting times

(*In this section, the data shows the current position of the trust at the time of producing the draft report. The data and narrative will be updated for end of year position as awaiting final data to be validated).

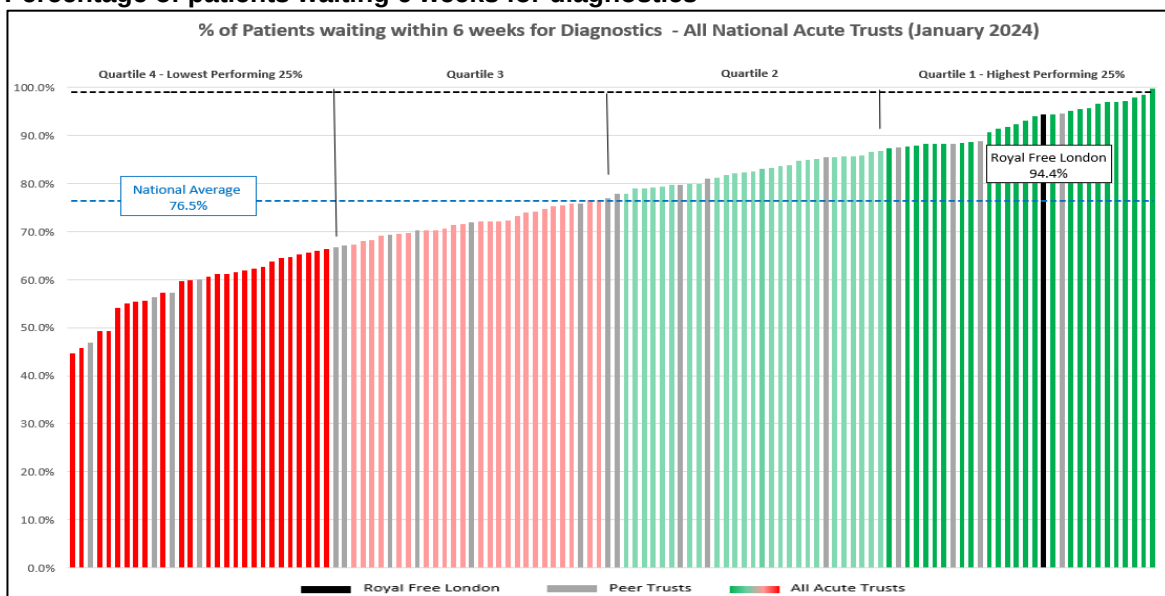
The trust continues to perform well in relation to Diagnostic performance (DM01) and Patients waiting less than six weeks for a Diagnosis. February month end reported 95.5% [Final data to be confirmed] against a 95% target, a 6th consecutive month of performance improvement and the first time of achieving compliance. The performance increase is being driven by improvement in Endoscopy access compliance.



The Chart below shows RFL diagnostics 6 weeks performance compared to other national trusts.

In January RFL 6-weeks diagnostics waits performance remains strong and improved to 94.4% [Final data to be confirmed] in the 1st Quartile. RFL ranked 13th highest [Final data to be confirmed] from 120 Trusts and 2nd highest amongst the 20 peer Trusts Group. Peer group average is 74.8% and London provider average is 83.1%.

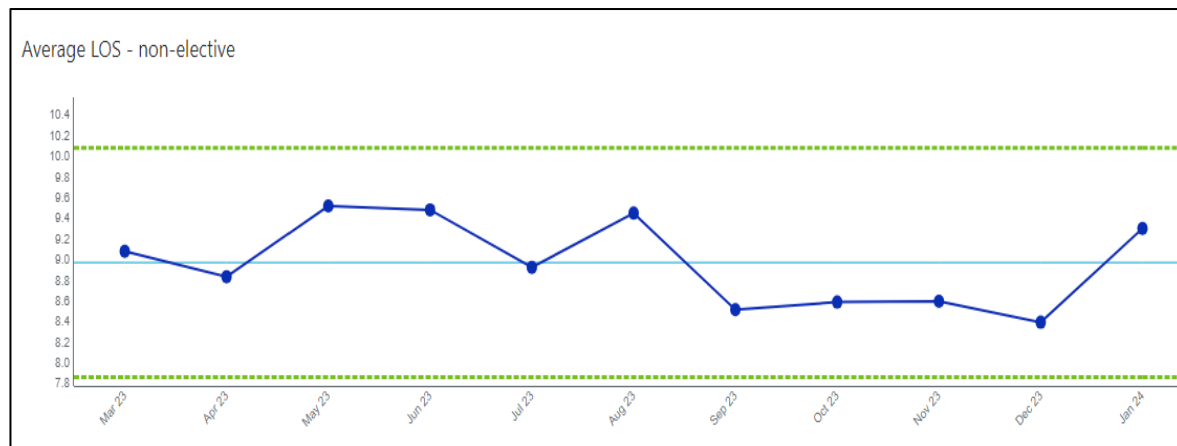
Percentage of patients waiting 6 weeks for diagnostics



Source: NHS Digital 23/24

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 2023 to January 2024 shows that the trust average length of stay was 8.9 [Final data to be confirmed] days per month, which is an improvement of 9.1 in 2022/23. Variation has been much less than previous years where the previous case-mix of COVID-19 patients mixed with the usual emergency cases has decreased substantially.

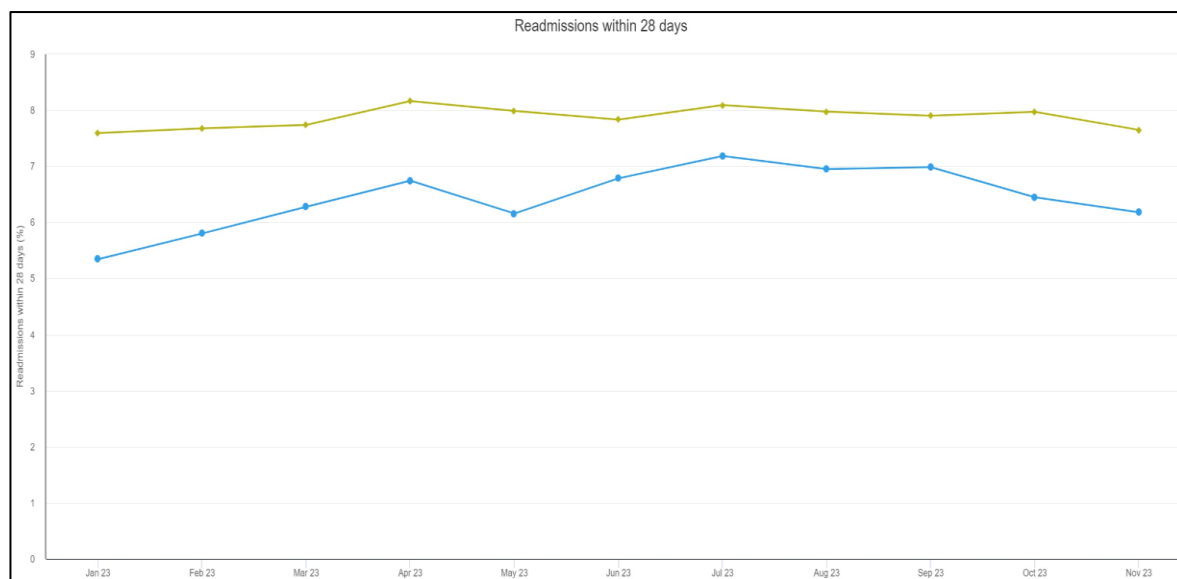


Source: Royal Free London W2B PBI 2023-24

28 Days readmissions following inpatient admissions

The chart below shows the proportion of patients re-admitted as an emergency following an elective admission in the previous 28 days between January 2023 and December 2023.

Readmissions performance from January 2023 – December 2023 shows that RFL has a lower re-admissions rate overall (6.5%) [Final data to be confirmed] than the peer group average (7.6%) over that period.



Source: CHKS Benchmarking 23/24

Section 3

PATIENT EXPERIENCE

Patient experience

National patient survey programme

In 2023/24, the results of three national surveys were published:

Urgent and emergency care 2022 – July 2023

In-patient 2022 – September 2023

Maternity 2023 – February 2024

The results of these surveys are standardised by the Care Quality Commission (CQC) and benchmarked reports are produced.

These reports inform trusts, patients and other stakeholders whether each trust is performing 'better than', 'worse than' or 'about the same' as expected. You can download these reports from the CQC website (www.cqc.org.uk)

Each question in these surveys is given an 'expected range' (within which a trust can score without significantly differing from the average). Questions where the trust falls within this range are described as 'about the same'. Questions where the scores are outside of this desired range are referred to as 'worse than' or 'better than' expected.

The seven different bandings a question can score can be seen below:

Much worse	Worse	Somewhat worse	About the same	Somewhat better	Better	Much better
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Urgent and emergency care survey

Two sets of results are published for the urgent and emergency care survey:

- Type 1 – major A&E departments which are consultant led, have full resuscitation facilities and operate 24 hours a day, seven days a week.
- Type 3 departments – urgent treatment centres which can be doctor or nurse led, treat at least minor injuries and illnesses and can be routinely accessed without an appointment.

Type 1 results

In total, 170 responses were received to the type 1 survey, giving a response rate of 18% compared to the national response rate of 23%. When the survey was last undertaken in 2020, the trust response rate was 28% and the national response rate was 30% so a significant decrease has been seen across the country.

All sections in the survey scored 'about the same' as expected with only one question performing differently:

Question	RFL score	Average score	Range of scores
Worse than expected			
18 Did doctors and nurses talk to each other about you as if you weren't there?	8.2	8.9	7.7 – 9.5

Ten questions in the type 1 survey saw a statistically significant decrease when compared to the 2020 survey and these can be seen in the table below:

Question	2020 score	2022 score
Q7 – how long did you wait before you first spoke to a nurse or doctor?	6.3	4.6
Q8 – from the time you arrived how long did you wait before being examined by a doctor or nurse?	6.5	4.8
Q12 – overall, how long did your visit to A&E last?	7.1	4.9
Q13 – did you have enough time to discuss your condition with the doctor or nurse?	8.7	7.8
Q14 – while you were in A&E, did a doctor or nurse explain you condition and treatment in a way you could understand?	8.5	7.8
Q18 – did doctors or nurses talk to each other about you as if you weren't there?	9.0	8.2
Q24 – if you needed attention, were you able to get a member of medical or nursing staff to help you?	7.7	6.6
Q41 – did staff give you enough information to help you care for your condition at home?	7.6	6.5
Q44 – after leaving A&E, was the care and support you expected available when you needed it?	8.1	6.4
Q47 – overall experience (from 0 – 10)	8.2	7.5

Type 3 results

117 patients completed the type 3 survey, giving a response rate of 20% compared to the national response rate of 22%. In 2020, the trust response rate was 30% and the national was 31%. Again, a decrease in response rate has been seen across the board.

All sections and all questions in the survey scored 'about the same' as expected, however 16 questions scored significantly worse in 2022 when compared to 2020.

Question	2020 score	2022 score
Q8 – how long did you wait before you first spoke with a health professional?	8.3	6.0
Q9 – from the time you arrived, how long did you wait before being examined ?	6.9	4.6
Q12 – overall, how long did you visit to the Urgent Treatment Centre last?	8.6	5.9
Q13 – did you have enough time to discuss your condition with the health professional?	9.6	8.9
Q14 – while you were in the Urgent Treatment Centre, did a health professional explain your condition and treatment in a way you could understand?	9.3	8.5
Q16 – If you had any anxieties or fears about your condition or treatment, did a health professional discuss them with you?	8.4	6.9
Q17 – did you have confidence and trust in the health professional examining or treating you?	9.4	8.7
Q18 – did health professionals talk to each other about you as if you weren't there?	9.8	9.2

Q22 – while you were at the Urgent Treatment Centre, how much information about your condition or treatment was given to you?	9.5	8.7
Q28 – do you think the staff did everything they could to help control your pain?	8.3	7.0
Q29 – in your opinion, how clean was the Urgent Treatment Centre?	9.6	8.8
Q33 – did a member of staff tell you about what symptoms to watch for regarding your illness or treatment after you went home?	8.6	6.8
Q35 – did staff give you enough information to care for your condition at home?	9.0	7.9
Q38 – after leaving the Urgent Treatment Centre, was the care and support you expected available when you needed it?	9.4	7.9
Q40 – overall, did you feel you were treated with respect and dignity while you were in the Urgent Treatment Centre?	9.7	9.2
Q41 – overall experience (from 0 – 10)	9.1	8.2

Children and young people's experience survey:

The Care Quality Commission did not undertake this bi-annual survey in 2023.

Maternity survey

A total of 34% of women completed the 2023 maternity survey (down from 42% in 2022), compared to an average response rate of 41%.

Of the eight sections in the maternity survey, the trust scored somewhat worse than expected in one (feeding). Six questions scored worse than expected and one scored better than expected.

The maternity division has developed an action plan that focuses on the areas identified as requiring improvement in this survey, in triangulation with other feedback mechanisms. Oversight for this action plan will be via the Barnet Joint Patient and Staff Experience Committee (PSEC).

The results can be seen in the table below:

Question		RFL score	Average score	Range of scores
Better than expected:				
D6	Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?	9.1	5.8	2.4 – 10.0
Somewhat worse than expected:				
B10	During your antenatal check-ups, did your midwives ask you about your mental health?	7.7	8.5	7.0 – 9.6
D2	On the day you left hospital, was your discharge delayed for any reason?	5.3	6.2	4.2 – 8.0
F15	In the six weeks after the birth of your baby, did you receive help and advice from a midwife or health visitor about feeding your baby?	6.6	7.4	6.1 – 8.5
Worse than expected:				
E2	Were your decisions about how you wanted to feed your baby respected by midwives?	8.5	9.0	8.2 – 9.7
F12	Were you given information about any changes you might experience to your mental health after having your baby?	6.8	7.4	6.2 – 8.3
F17	In the six weeks after the birth of your baby, did you receive help and advice from health professionals about your baby's health and progress?	7.2	8.0	6.7 – 8.9

The trust saw a statistically significant increase (p) in the scores of six questions and a decrease (q) in one when compared to the 2022 survey:

Question		2022 score	2023 score	
B7	During your antenatal check-ups, did your midwives or doctors appear to be aware of your medical history?	6.5	7.6	p
B8	During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?	8.3	9.2	p
B10	During your antenatal check-ups, did your midwives ask you about your mental health?	7.0	7.7	p
D6	Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?	2.0	9.1	p
F2	If you contacted a midwifery or health visiting team, were you given the help you needed?	7.4	8.2	p
F6	Did the midwife or midwifery team that you saw or spoke to appear to be aware of the medical history of you and your baby?	6.9	8.2	p
D2	On the day you left hospital, was your discharge delayed for any reason?	6.5	5.3	q

National cancer patient experience survey

Although not part of the official national survey programme, the 2022 national cancer patient experience survey results were published in July 2023. The trust response rate was 44% compared to the national response rate of 53%.

The table below shows how Royal Free London scored across key themes through the cancer pathway compared to the national average.

Theme and question	RFL score	Average score
Support from your GP practice Q.3 Referral for diagnosis was explained in a way the patient could completely understand.	63%	65%
Diagnostic tests Q.9 Enough privacy was always given to the patient when receiving diagnostic test results.	93%	95%
Finding out that you had cancer Q.12 Patient was told they could have a family member, carer or friend with them when told the diagnosis.	69%	76%
Support from a main contact person Q.17 Patient had a main point of contact within the care team.	92%	91%
Deciding on the best treatment Q.21 Patient felt they were definitely involved as much as they wanted to be in decisions about their treatment.	74%	79%
Care planning Q.24 Patient was definitely able to have a discussion about their needs or concerns prior to treatment	68%	71%
Support from hospital staff Q.27 Staff provided the patient with relevant information about available support or self-help groups, events, and resources	88%	90%
Hospital care Q.31 Patient had confidence and trust in all of the team looking after them during their inpatient stay.	73%	79%
Treatment Q.43 Patient felt the length of waiting time at clinic and at the day unit for cancer treatment was about right.	73%	78%
Immediate and long-term side effects Q.47 Patient felt possible long-term side effects were definitely explained in a way they could understand in advance of their treatment	50%	59%
Support while at home Q.49 Care team gave family, or someone else close, all the information needed to help care for the patient at home.	54%	58%
Care from your GP practice Q.51 Patient definitely received the right amount of support from their GP practice during treatment	39%	45%
Living with and beyond cancer Q.55 Patient was given enough information about the possibility and signs of cancer coming back or spreading.	57%	62%
Cancer research and clinical trials Q.58 Cancer research opportunities were discussed with patient	45%	43%

Friends and family test (FFT)

The FFT is a nationally mandated question, which asks patients to rate their overall experience on a scale of 'very good' to 'very poor'. In most areas the FFT question forms part of a longer questionnaire which patients can use to provide feedback on their hospital experience.

Patient experience feedback is collected using a combination of feedback kiosks, tablets and QR codes linked to online surveys for in-patients, out-patients and in maternity settings. Patients discharged from our emergency departments receive an SMS inviting them to respond to the FFT.

Inpatient FFT:

Inpatient survey FFT	Percentage patients reporting a good/very good experience	Number of responses
April 2023	91%	1,117
May 2023	86%	1,291
June 2023	88%	1,205
July 2023	89%	1,361
August 2023	89%	1,359
September 2023	88%	1,423
October 2023	89%	1,728
November 2023	89%	1,424
December 2023	88%	1,105
January 2024	87%	1,338
February 2024	87%	1,645
March 2024	89%	1,623

Outpatient FFT:

Outpatient survey FFT	Percentage patients reporting a good/very good experience	Number of responses
April 2023	87%	1,036
May 2023	89%	1,309
June 2023	88%	1,601
July 2023	89%	1,890
August 2023	91%	2,032
September 2023	88%	2,070
October 2023	90%	1,909
November 2023	90%	2,180
December 2023	88%	1,530
January 2024	90%	2,138
February 2024	90%	2,591
March 2024	89%	2,342

Maternity survey:

Maternity survey	Q1 – antenatal care		Q2 – labour and birth		Q3 – postnatal hospital care		Q4 – postnatal community	
	Percentage good or very good	Number of responses	Percentage good or very good	Number of responses	Percentage good or very good	Number of responses	Percentage good or very good	Number of responses
April 2023	56%	68	91%	176	95%	338	67%	3
May 2023	56%	71	95%	160	98%	555	86%	7
June 2023	44%	70	96%	174	97%	667	100%	1
July 2023	44%	48	98%	165	99%	927	100%	2
August 2023	44%	27	92%	143	90%	200	-	0
September 2023	60%	10	94%	140	95%	283	100%	1
October 2023	55%	11	95%	112	89%	162	100%	5
November 2023	64%	14	94%	140	91%	159	71%	7
December 2023	50%	4	94%	111	92%	133	100%	7
January 2024	98%	213	94%	150	92%	251	100%	62
February 2024	96%	109	94%	200	94%	444	92%	50
March 2024	95%	64	95%	155	96%	217	94%	53

Emergency Department survey:

Emergency Department survey	Percentage patients reporting a good/very good experience	Number of responses
April 2023	84%	2,251
May 2023	81%	3,026
June 2023	83%	2,826
July 2023	87%	2,967
August 2023	86%	2,822
September 2023	81%	2,825
October 2023	83%	2,931
November 2023	80%	2,452
December 2023	83%	2,385
January 2024	82%	3,126
February 2024	80%	3,018
March 2024	81%	3,098

Caring for patients with learning disabilities

It is recognised that patients with learning disabilities experience inequalities in their access to healthcare, which results in them having poorer health outcomes and dying at a younger age than the general population. There are multiple barriers to accessing healthcare for people with learning disabilities and autism. They often have difficulties communicating their needs and find hospitals an unfamiliar and overwhelming environment. These patients can be hyper or hypo sensitive to sensory stimuli, such as loud noises, unfamiliar touch, strong smells and tastes, and visual cues such as bright or flashing lights or busy areas, which can result in sensory overload. To provide support for these patients, a grant from the Royal Free Charity has enabled us to purchase sensory bags which contain calming items, such as ear defenders, stress balls and fidget toys to help reduce stress and anxiety in the emergency department and for use in any required admission.

The sensory care bags were launched across the emergency departments at Barnet and Royal Free Hospitals in October 2023. The aim is to improve the patient experience and support with sensory overload which can cause distress and be a barrier to accessing the healthcare they require. We are collecting feedback from patients to enable evaluation of the bags.

The Trust continues to take part in the **NHSE Learning Disability Standards benchmarking project**. As a result of the benchmarking:

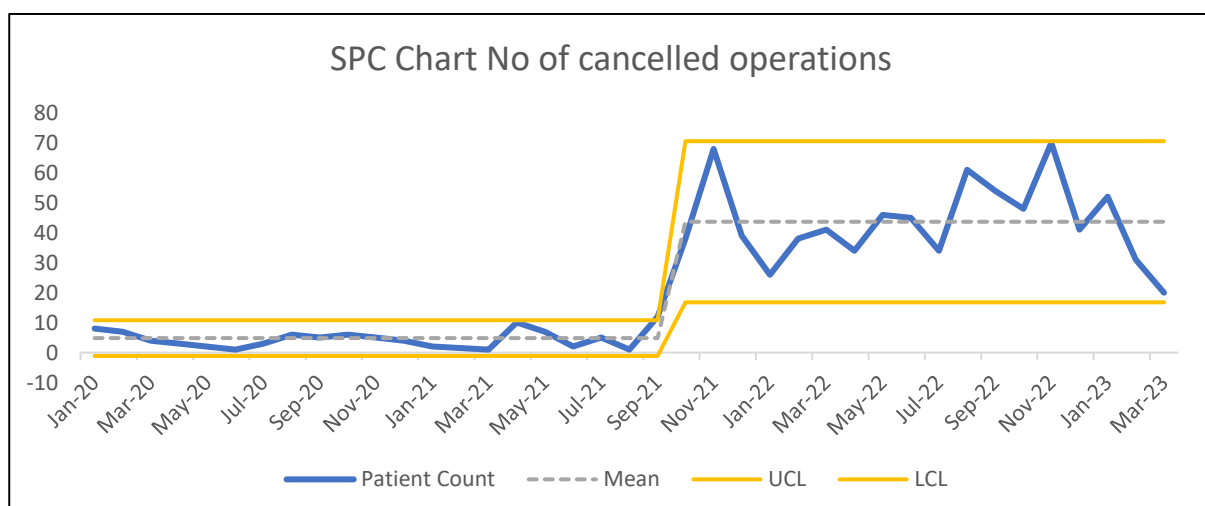
Work is on-going within the Accessibility Steering Group regarding how information including letters can be made more accessible. A business case was presented to GEMM for an accessible information post to be developed, we are working collaboratively with the Accessibility Steering Group led by the Group Head of Equality, Diversity and Inclusion for Patients and Carers. Members of the executive team have met with people with learning disabilities and autistic people to hear their experience of using Trust services. This work will continue to develop over 2024/2025.

Priorities 2024/2025

- Improving the identification of people with a learning disability
- improving how we communicate with people with a learning disability.
- training of our workforce
- supporting people with a learning disability and their families /carers

Number of cancelled operations on the day

(*In this section, the data shows the current position of the trust at the time of producing the draft report. The data and narrative will be updated for end of year position as awaiting final data to be validated).



3.2 Performance against key national indicator summary

(*In this section, the data shows the current position of the trust at the time of producing the draft report. The data and narrative will be updated for end of year position as awaiting final data to be validated).

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

Operational performance

Domain	Metric	Target	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Responsive	62 day wait merged performance	85%	53.7%	45.8%	51.0%	53.3%	55.1%	58.2%	54.5%	51.3%	56.6%	56.3%	51.0%	
	31 day wait merged performance	96%	83.3%	78.5%	79.8%	82.6%	84.0%	83.9%	91.0%	87.7%	87.8%	91.4%	85.6%	
	28 day faster diagnosis performance	75%	74.5%	69.6%	66.5%	68.0%	69.4%	66.7%	68.9%	69.5%	71.1%	71.2%	66.4%	
	>62 day wait for treatment (patients)		322	386	418	404	368	367	343	304	274	285	343	
	>104 day wait for treatment (patients)		149	141	136	170	152	127	121	148	136	136	140	
	62 day PTL size (GP urgent referrals)		4,484	4,616	4,639	4,599	4,615	4,464	4,654	4,617	4,104	3,791	4,159	
	Total new cancer referrals		4,575	3,628	4,008	4,389	4,080	3,911	4,286	4,470	4,386	3,302	3,723	
	ED 4 hour performance (all)	76%	66.4%	69.0%	66.7%	72.7%	72.4%	71.4%	67.3%	65.7%	64.1%	64.3%	66.2%	67.2%
	ED 4 hour performance (type 1)	76%	51.4%	55.2%	51.8%	60.3%	60.0%	56.3%	52.5%	49.0%	51.2%	49.5%	51.7%	54.1%
	ED 4 hour performance (UTC)		95.4%	95.6%	95.6%	95.4%	91.2%	93.8%	89.3%	90.3%	90.4%	88.0%	93.6%	96.9%
	ED 12 hour wait from decision to admit	0	540	473	685	501	218	599	692	767	688	724	1,038	749
	ED 30 mins Ambulance handover performance	80%	64.6%	69.3%	68.4%	71.7%	78.8%	75.6%	68.9%	68.3%	70.7%	63.0%	61.6%	65.0%
	ED 30 min ambulance handover delay	0	1,199	859	1,106	947	737	934	1,058	1,280	942	1,240	1,175	1,290
	ED attendance (all types)		25,724	23,475	25,420	25,266	24,968	23,433	25,353	25,745	26,273	26,373	26,515	25,686
	Admissions from ED		3,775	3,915	4,043	4,087	4,556	4,024	4,115	4,168	4,240	4,354	4,183	3,749
	Long LOS - >21 Days (incidences)*		206	243	236	239	214	223	224	236	211	177	219	215
	Average LOS - non-elective		9.1	8.8	9.5	9.5	8.9	9.4	8.5	8.6	8.6	8.4	9.3	
	Average LOS - elective (excluding daycases)		2.8	3.5	3.2	3.4	3.5	3.6	3.4	3.7	3.2	3.7	3.0	
	Medically optimised patients		209	204	205	217	218	224	228	209	228	222	211	223
	RTT Incomplete performance (% waiting <18 weeks)	92%	60.0%	59.8%	61.7%	60.3%	59.9%	58.8%	57.9%	58.2%	57.0%	56.1%	56.4%	56.9%
	RTT Total waiting list size		92,125	93,733	93,770	97,508	98,240	98,502	100,615	99,620	97,504	98,257	99,157	102,461
	RTT Over 104 week breaches	0	0	0	0	0	0	0	5	0	0	0	0	0
	RTT Over 78 week breaches	0	109	110	73	35	33	64	119	137	178	233	228	161
	RTT Over 65 week breaches		564	609	637	727	851	1,072	1,253	1,325	1,301	1,608	1,601	1,471
	RTT Over 52 week breaches		2,941	3,308	3,512	3,695	4,187	4,154	4,502	4,851	5,100	5,051	4,974	5,121
	DM01 Performance (% waiting <6 weeks)	95%	93.2%	91.5%	90.7%	91.0%	91.2%	89.5%	90.3%	91.9%	93.7%	93.7%	94.4%	95.5%
	DM01 Over 6 week breaches		1,018	1,318	1,580	1,559	1,529	1,777	1,700	1,425	1,077	1,009	995	842
	DM01 Total waiters		15,052	15,537	17,022	17,241	17,350	16,879	17,501	17,554	17,064	16,061	17,674	18,571
Safe	C.diff infections (trust attributable)		13	8	12	12	7	5	7	7	7	7	4	8
	C diff due to lapses in care	0	1	2	3	1	1	1	1	1	0	3	1	1
	MRSA infections (trust attributable)	0	2	0	0	1	1	1	1	1	0	1	0	0
	MSSA infections (trust attributable)		3	7	7	5	6	6	2	7	6	3	7	7
	E.coli infections (trust attributable)		16	8	12	14	11	19	13	14	10	7	8	16

3.3 Actioning our plans for improvement

3.3.1 The Care Quality Commission

As reported in our 2022/23 Royal Free London Quality Accounts, the trust has undertaken significant improvement work towards completing the improvement actions arising from previous CQC inspections.

Surgery inspection, Royal Free Hospital, January 2023.

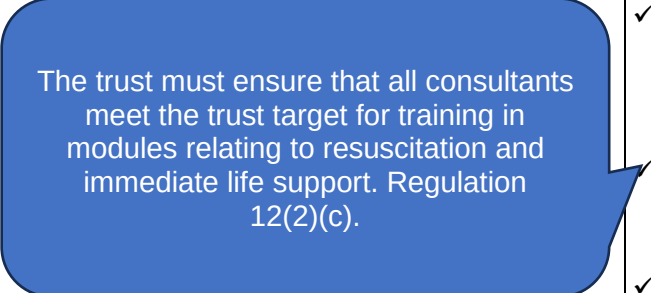
The Royal Free London NHS Foundation Trust was subject to a CQC announced, focussed surgery core-service inspection at the Royal Free Hospital on 10th January 2023. The inspection followed several Never Events that had occurred at the trust, focusing on the safety and leadership of the surgery service at the Royal Free Hospital. The CQC did not:

- Rate the service at this inspection; therefore, the previous rating of requires improvement remains.
- Inspect other locations or core services provided by the trust, as this was a risk-based inspection.

However, the CQC will continue monitoring all services as part of our ongoing engagement and re-inspect when appropriate.

The CQC published the inspection report on 19th May 2023, after the writing of the 2022/23 Royal Free London Quality Accounts. The CQC identified four must-do and one should-do findings. The actions undertaken by the business unit.

Royal Free Hospital's local executive committee, which has delegated board oversight of the improvement actions' performance and completion, receives a monthly update on the progress of the improvement actions from the surgical service.

The CQC said:	We have:
 The trust must ensure that all consultants meet the trust target for training in modules relating to resuscitation and immediate life support. Regulation 12(2)(c).	✓ Offered Resus level 1 - 'Basic life support E-learning', and Resus level 2 - 'Basic life support level 2', which is both e-learning and practical assessment of competence. The Medical Director sharing individual names of non-compliant with Divisional Clinical Directors. ✓ Divisional Clinical Directors communicated to individuals' that compliance is required by 30th November 2023. ✓ List of timings and links to register for training were provided. ✓ Divisional Clinical Directors monitor compliance within the division. ➤ <i>These actions are closed with compliance being monitored.</i>

The trust must ensure that all paediatric resuscitation trolleys have consistent regular checks. Regulation 12(2)(e).	✓ Resuscitation trolleys are checked and results are recorded on the Tendable app: ✓ daily as part of the Daily Checklist ✓ monthly as part of the Quality Walkaround Theatre leadership team present audit results for the resuscitation trolley checks in monthly divisional meetings. ✓ Feedback is given at the time of the monthly quality walkarounds, to the matron. ✓ Quality Walkaround results reported at divisional quality and safety boards, business unit clinical performance and patient safety committee and at Group executive management meetings. ➤ <i>These actions are closed with compliance being monitored.</i>
The trust must ensure that there is regular audit of compliance of staff with processes for managing sepsis. Regulation 17(2)(a).	✓ We undertook a manual audit using data extracted from the electronic patient record covering the Sepsis 6 (including, blood pressure, lactate, temperature, microbiology, confirmation of presence and diagnosis of sepsis, and confirmation of receipt of antibiotics and timing of antibiotics). ✓ We also undertook a snapshot audit using NEWS of 5 or above as a trigger across the Royal Free Hospital tower block. A record review was completed for every case scoring 5 and above on NEWS, to identify if it was sepsis, and assess if they received the appropriate treatment. ✓ The audit of compliance of the sepsis pathway recommenced in June 2023, and will continue to be undertaken on a regular basis. ✓ We are exploring how the electronic patient record can be used to undertake regular snapshot audits to reduce clinical time collating audit information. ➤ <i>These actions are closed with compliance being monitored.</i>

The trust must ensure that the risk register entry relating to the purchase of new ketone machines, covers the clinical risk and mitigations around the shortage of the machines. Regulation 17(2)(b).	✓ A business case was prepared and approved by the Group executive committee in June 2023. ✓ Training has been delivered using a 'train-the-trainer' model. Training has been cascaded from super-users to their clinical teams. ✓ There was a launch of the blood glucose/ketone devices in November 2023. ➤ <i>These actions are closed with compliance being monitored.</i>
The trust should ensure that as many staff as possible are aware of the learning from incidents.	✓ Shared learning currently occurs via the clinical performance & patient safety committee, divisional quality & safety boards, specialty/governance meetings, safety incident review panels, CLIPS report, safety bulletins, senior nurse/matrons meeting. The expectation is that those in attendance at the above meetings disseminate the learning amongst their teams. ✓ To further support dissemination of shared learning from incidents to frontline staff, the Royal Free business unit has implemented 'Monday Messages', a 1 page poster with the top 5 quality and safety messages for the week. ✓ Implemented the 'In Two Minds' process. ✓ The Quality Governance team visit clinical areas once a week, using this as an opportunity to ensure learning has been shared. ✓ The Patient Safety Incident Response Framework (PSIRF) was implemented and launched in March 2024. ➤ <i>These actions are closed with compliance being monitored.</i>

Maternity inspection, Edgware Community Hospital, October 2023.

The Royal Free London NHS Foundation Trust received a CQC announced (Ockendon Review) inspection of our maternity services at Edgware Community Hospital on 24th October 2023. The CQC published the final inspection report in February 2024.

The inspection of the maternity service at Edgware Birth Centre was part of the national maternity inspection programme. The national maternity inspection programme aims to give an up-to-date view of hospital maternity care across the country by understanding what works well to support learning and improvement locally and nationally.

The CQC carried out a short notice announced focused inspection of the maternity service, looking only at the safe and well-led. The CQC rated the service as 'good' for both safe and well led.

Barnet Hospital's local executive committee, which has delegated board oversight of the improvement actions' performance and completion, receives a monthly update on the progress of the improvement actions from maternity services as part of the Women's and Children divisional senior management team.

The CQC said:	We have:
The service should ensure references to policies and guidelines were up to date and in line with national guidelines.	✓ Reviewed the Edgware Birth Centre related guidelines to ensure references and content are up to date. ➤ <i>These actions are closed with compliance being monitored.</i>
The service should ensure appropriate checks and oversight was maintained on safety and specialist equipment including resuscitaire and resuscitation trolley.	✓ Learning has been shared with staff via the department's risk newsletter. ✓ Compliance for the completion of safety checks is monitored daily using the Tendable app. ➤ <i>These actions are closed with compliance being monitored.</i>
The service should ensure internet connectivity at the birth centre improves to maintain safe management of medicines and records.	○ A business case for funding to install Wi-Fi connectivity at Edgware Birth Centre is in progress. ➤ <i>This action is currently in progress with monitoring at a divisional and business unit level.</i>

3.3.2 Quality Improvement actions

The Quality Improvement (QI) team continue to work towards the vision of 'an RFL where what matters most to our staff, patients and population is continuously improved'.

The mission of the QI team is 'to inspire and empower staff and patients, to use quality improvement philosophy and tools, to improve their experiences and outcomes'.

The report is divided in the four 'buckets', which describe the different sets of activities we undertake to deliver our mission.

- Engage & Inspire
- Capability & Capacity

- Support Improvement
- Lead Improvement

Between April 2023 and March 2024, which is the period this report covers, the team have led, supported and enabled work that has helped improve patient experience, staff experience, clinical outcomes and service efficiency: selected highlights of that work are listed below.

Engage & Inspire Staff, Patients and Population

The QI team regard the engagement of our staff, patients, and population as being critical in generating enthusiasm for, and involvement in, improvement work. Some examples of the ways in which we create this engagement are described below.

Staff Induction – introducing new joiners to QI every week

The first opportunity to introduce QI to new RFL staff is at Corporate Induction. Each week, a member of the QI team delivers a 15-minute introduction to QI, which covers:

- the meaning of QI;
- the Model for Improvement, which is the method we use at RFL;
- how QI activity relates to research, audit and service evaluation;
- the support and training available from the QI team.

Feedback from attendees at Corporate Induction has consistently rated the QI component very highly.

Patient Voices – helping patients, carers and our local population shape services

Each of our hospitals has a Patient Voices group. In this report, we give details of the work that has taken place at the Royal Free Hospital (RFH), where the QI team have led on patient involvement, alongside colleagues from the RFH Therapy Team.

The RFH Patient Voices group, now in its sixth year, holds a monthly virtual meeting where patients and carers give invaluable feedback on projects and programmes happening across the organisation. They act as the 'Patient Voice' for two projects per month (approximately 20 projects per year) and each team that has attended the Patient Voices group has:

- reported that they will make changes as a result of the input received from lived experience experts; and
- recommended the Patients Voices group to other colleagues in the organisation.

The QI team have recently co-presented their work with a Patient Voices representative at an international health improvement network (Health Improvement Alliance Europe) – and are due to co-present the work at other regional and international forums during 2024.

The quotes below provide a flavour of the value of the Patient Voices forum – and are drawn from recent feedback provided by participants.

“The group is united in its goal of improving patient care on every level. It is stimulating to be a participant, with everyone feeling free to both reflect on past negative experiences, but to also suggest innovative ideas to improve present systems in the hospital.”

“I have found this group welcoming, insightful and inspiring. We are all able to be honest and it is so refreshing to have our insights taken on board and acted on. Thank you for this wonderful opportunity.”

“I enjoy the safe space that has been created. Everyone is able to express their views freely and we are united in our shared goal of improving patient care.”

QI Lunch Club – sharing QI learning and successes across the group

QI Lunch Club is a monthly event, open to all staff across the trust, where QI project teams present the work that they have done. When presenting, colleagues describe the problem they set out to address, what their aim and measures were, and how they went about testing their change ideas.

Teams have shared not only their successes, but also the learning from running their QI projects – both of which have been helpful for others to apply to their own improvement work. Showcasing improvement work in this way has also served as a catalyst to scale and spread improvement initiatives across the group.

Build Capability for Improvement

We know that change can be challenging – and that teams stand the best possible chance of success when they are supported to use a structured approach. As such, it is essential to have individuals across the organisation who are skilled in improvement methods. The QI team have designed and are delivering a training programme that is building staff capability to undertake and lead QI projects in their areas of work.

QI Practitioner – building our capability and capacity to lead improvement projects

During 2023/2024, the QI team have welcomed 4 cohorts of colleagues onto the QI Practitioner training course. QI Practitioners are individuals who can create, motivate, and sustain QI project teams, using the Model for Improvement. This training was originally developed as part of a wider programme focused on improvement priorities; however, due to strong demand from staff, we now offer it as a standalone course.



There are clear and practical steps I can take from today to move forward with my project.

Excellent presentations and informative, interactive sessions.

Training delivered just at the right pace and the group discussions were great

The training was really good and comprehensive. I enjoyed the simulation and hands-on approach

QI Snapshot – bringing QI content to clinicians’ learning and development

QI training plays a crucial role in clinicians’ professional development, for newly qualified nurses and doctors, as well as those seeking career development opportunities.

QI Snapshot is now a part of structured programmes for nurses, such as Preceptorship and Supporting Progression and Career Excellence (SPaCE). Through these sessions, nurses learn about the essential elements of quality, quality improvement and how we approach them at RFL.

For our newly qualified medical staff, typically FY1s and FY2s, we offer bespoke group sessions focused on how to be a part of successful QI projects. These sessions are usually part of a wider cycle of their structured training – and are now delivered in person at Barnet Hospital and Royal Free Hospital sites. These sessions have had strong participant feedback – and we look forward to extending them to a wider set of clinical and non-clinical staff.

PSIRF – working with hospital governance teams to shape PSIRF implementation

As the trust prepared for the launch of the new Patient Safety Incident Response Framework (PSIRF) during 2023, the QI team supported the governance teams across the trust and the future Learning Response Leads to determine the optimal approach for building the QI mindset, methods and tools into our overall implementation of PSIRF.

As a QI team, we:

- facilitated a discussion on the second day of the [framework-approved] System Learning Day, which was aimed at all new 'Learning Response Leads' and 'Compassionate Leads'.
- co-designed and facilitated workshops with the governance teams from the three hospitals.

Both of the above focused on the practical aspects of applying the Model for Improvement to the investigation of Patient Safety Events (PSEs) – and the development of meaningful actions in response.

Feedback, excerpts of which are shown below, from workshop participants was positive – so we have agreed there will be follow-up workshops, later in 2024, to reflect on PSIRF implementation and explore what further actions are needed to embed the new approaches.

Understanding more about QI and it's importance for positive change in healthcare.

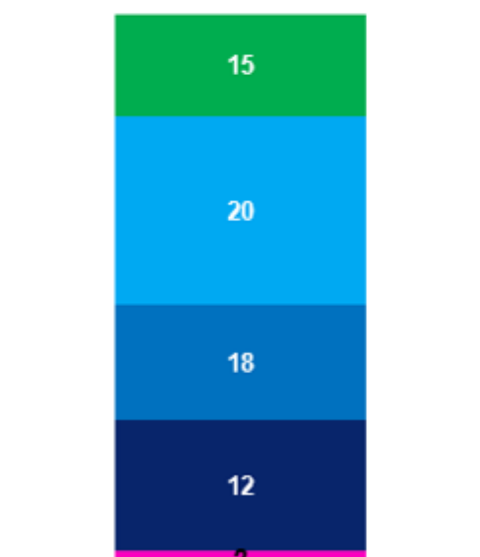
Feedback from QI experts really useful and needed for future investigations so that we can shape actions.

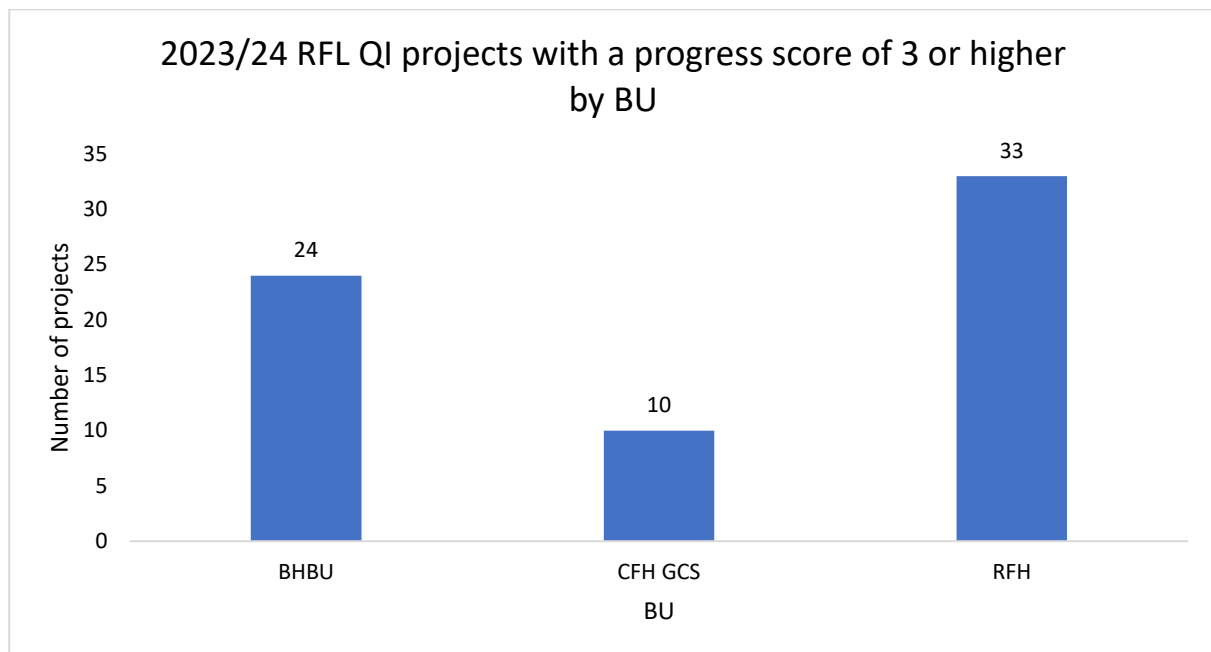
Support Improvement Activities

The QI team are an essential source of coaching and advice for colleagues who are undertaking improvement activities in the organisation. Data below shows details for numbers of projects that have reached a progress score of 3 or higher in the last 12 months.

Progress score	
3	Modest Improvement
3.5	Improvement
4	Significant Improvement
4.5	Sustainable Improvement
5	Outstanding Sustainable Results

RFL QI Projects that achieved a progress score of 3 or higher in 2023/24





Improvement work across our sites:

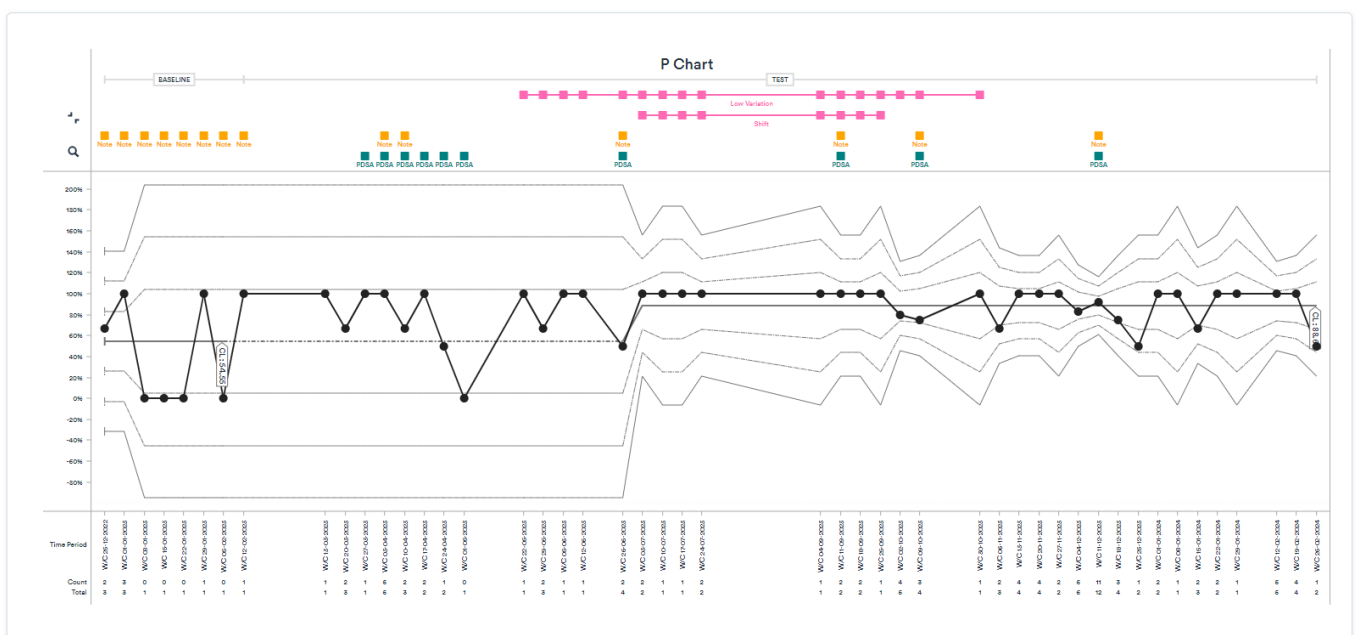
Barnet Hospital

The REACT team:

The REACT (rapid emergency and acute care therapy) team support the emergency department and assessment units to help prevent avoidable admissions. Patients under the care of the REACT team, have access to services in the community that support rapid discharges. However, once the patient transfers to the ward they have fewer rapid options for safe discharge back to the community. This can lead to delayed discharges for medically optimised patients – whose needs can't be met quickly on the ward, due to reduced access to these services in the community.

The REACT team started a QI project to expand their pathway and increase the proportion of REACT-eligible medical patients, per week, that are discharged from Barnet hospital within 5 days from 50% to 75% by 31st March 2024. They are testing this approach for patients from Barnet and West Herts boroughs and have exceeded their aim, with 88.6% of eligible patients being discharged within 5 days.

The REACT team recently won the Barnet and group Oscar (RFL staff award) for Clinical Team of the year for their work to continuously improve their service.



[Draft Note – this chart will be updated, so that the axes are easily legible]

Chase Farm Hospital and Group Clinical Services

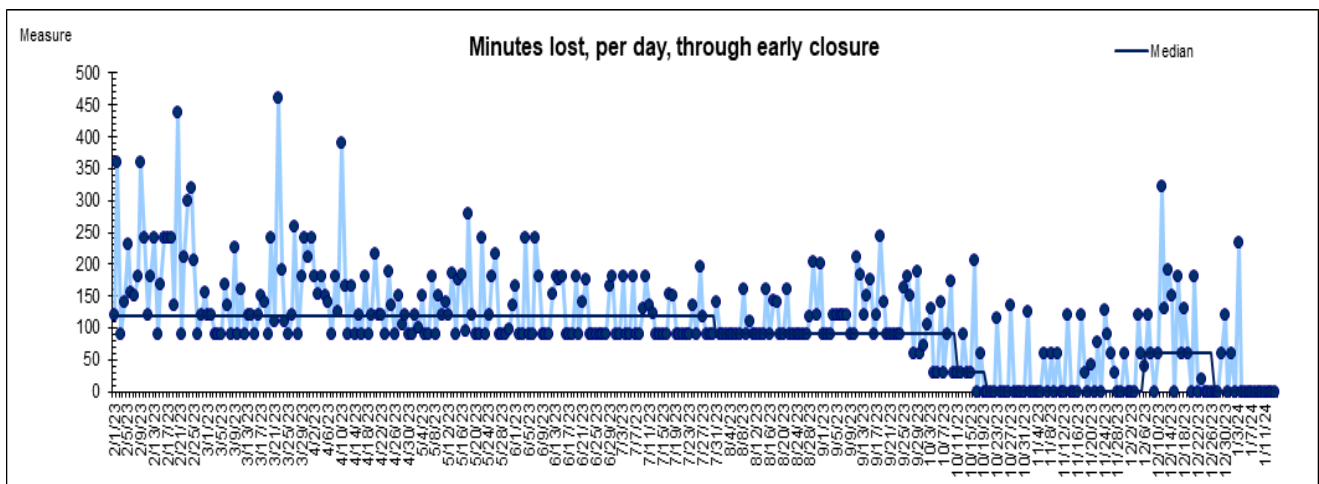
Urgent Treatment Centre

The team in the Chase Farm Hospital (CFH) Urgent Treatment Centre (UTC) discovered multiple issues leading to closing the service early, which impacted patient safety and patient and staff experience. The aim of the project was to reduce time lost through early closures to treatment – from a mean of 144 minutes per day, to 90 minutes per day by end January 2024.

Using the Model for Improvement, this team were able to test multiple change ideas to reduce the amount of time lost, per day, through early closures. Below, are listed some of the changes they implemented:

- Real time discharge documentation to avoid backlog;
- Substantive patient navigator;
- Moving to OPEL scoring and new situation report (SITREP);
- PGD's for all triage nurses;
- Reorganising the treatment rooms to save clinician time.
- Remove the RAT-ing process to free-up a GP and triage Nurse.
- Fixed rostering of GP's.

The data below show a reduction in the amount of time lost, per day, through early closure. The team recognise the outliers and are working on their next improvement project focussing on reducing time to triage, to ensure patients are seen quickly which in turn, promotes patient safety, despite higher attendances.



[Draft Note – this chart will be redrawn, so that the axes are easily legible]

Royal Free Hospital

Medication Scanning – Improving compliance to patient wristband and medication barcode scanning across site

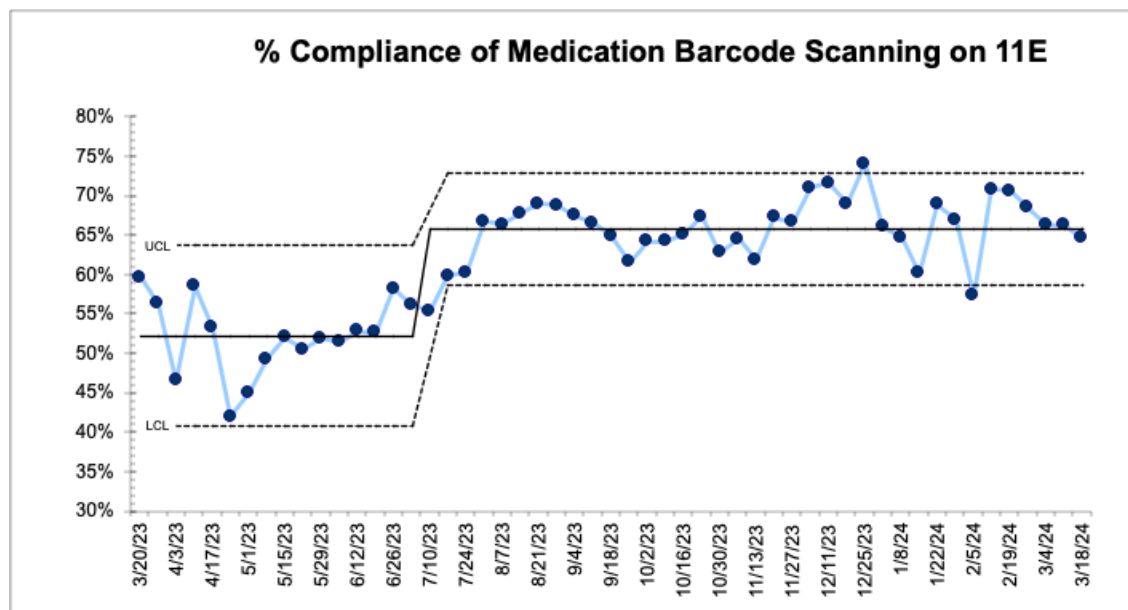
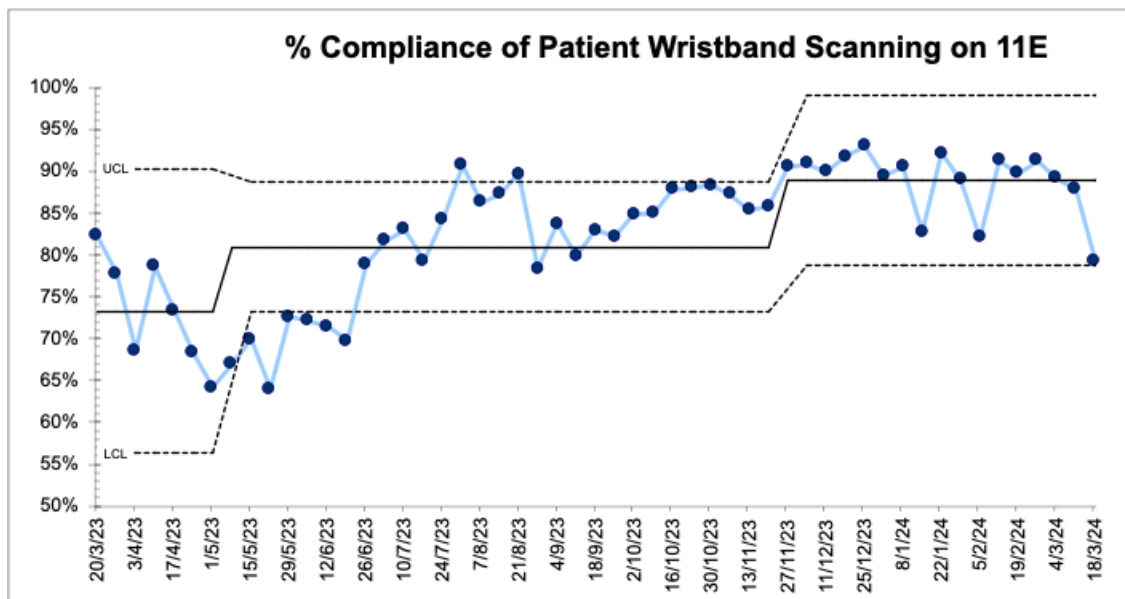
There has been a site-wide focus at the Royal Free Hospital (RFH) on improving compliance with medication barcode and patient wristband scanning to ensure patient safety.

Due to low scanning compliance on Ward 11 East (11E), in April 2023 a QI project was started to improve this. At the time of starting the project, the average compliance to patient wristband scanning was at 59% and medication barcode scanning was at 50%.

To improve this, 11E tested and implemented several change ideas, including: creating leaderboards highlighting individual staff compliance; working with pharmacy to manage stock; putting in processes for escalating IT tickets for drug carts; and identifying and procuring necessary equipment.

These changes led to significant improvements – so, by end November 2023, 11E had achieved sustained improvement with an average of 67% scanning compliance for medication barcodes and 88% [scanning compliance] for patient wristband.

The improvement in scanning compliance for 11E can be seen in the two charts below.



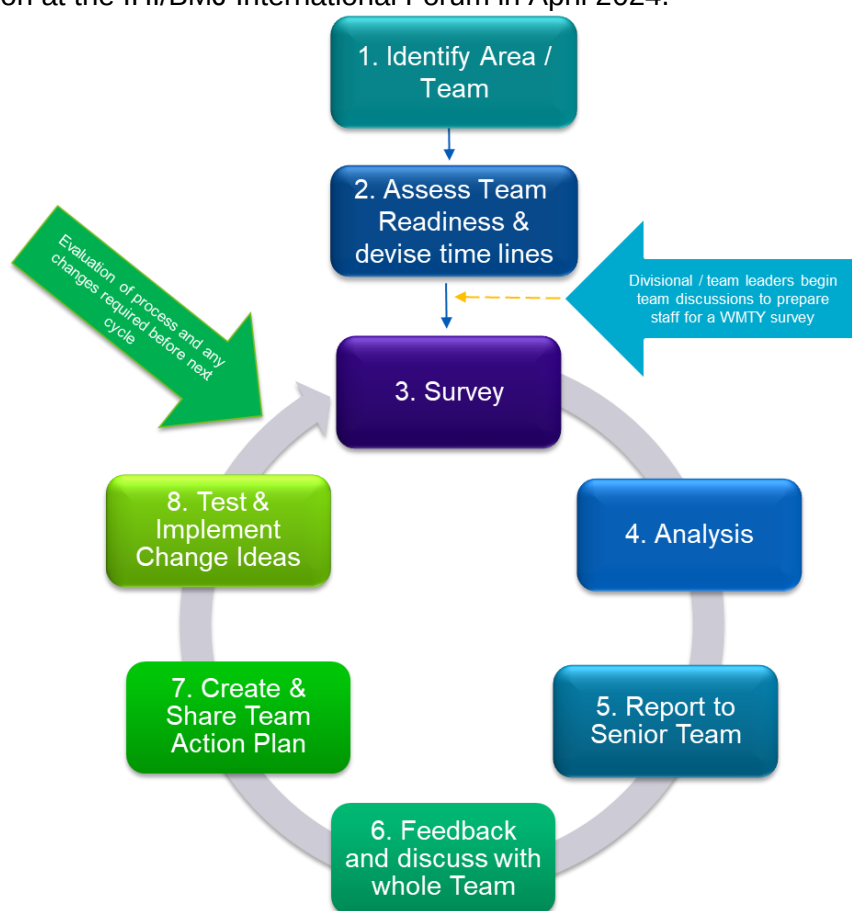
[Draft Note – this chart will be redrawn, so that the x axes date formats are consistent]

Encouraged by these improvements, as well as the occurrence of a never-event in another ward, five other wards have now begun working on a joint QI project to improve their compliance to medication barcode and patient wristband scanning. They are taking forward the change ideas that have worked on 11E and building on them.

Lead Improvement Activities of Strategic Importance

What Matters to Staff – Improving the Things that Matter to Our People

Royal Free Hospital have designed and led a programme that seeks to improve workforce wellbeing using the 'what matters to you' (WMTY) concept. In January 2022, the programme was launched and enrolled its first two teams and it has since spread, organically, to over 90 teams across the Royal Free Hospital. By end of March 2024, it had involved over 3,000 staff – and it is now well-established and embedded within divisional and governance structures. It is currently being spread to other hospitals across the group and the learning is being shared internationally, including a presentation at the IHI/BMJ International Forum in April 2024.



The schematic below shows the approach that is used for the WMTS programme.

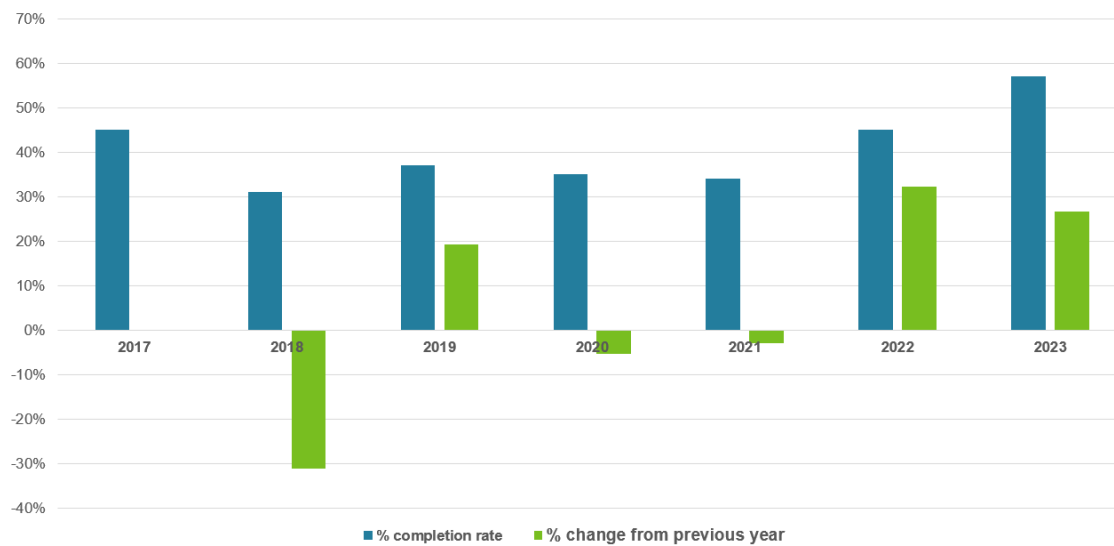
Barnet Hospital is currently piloting the WMTS approach developed at RFH. This is being led by the QI team in collaboration with the Staff Experience Working Group (sub-committee of Patient and Staff Experience Committee). Currently, five teams have started the improvement cycle and are being supported to improve what matters to staff in their areas

The aims, measures and outcomes of the programme at RFH, so far, are highlighted in the table below.

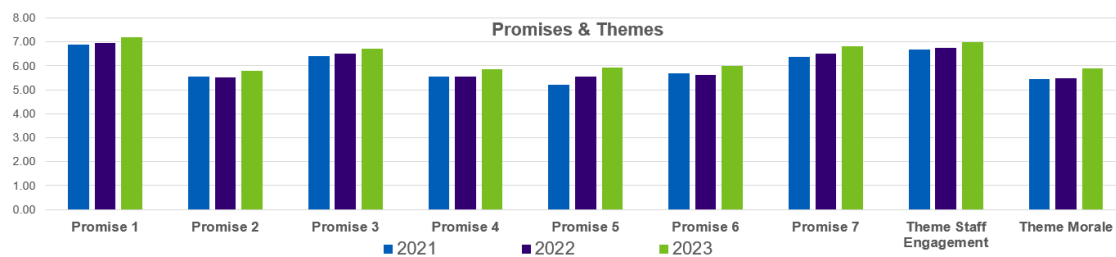
Measure Description	Aim for 2022/23	Progress to date	Aim for 2024/25
Percentage of staff reporting a positive change between their WMTS Survey	>70%	76%	Maintain >70%

Percentage of staff at Royal Free Business Unit who complete the Annual Staff Survey. (graph 1)	Increase from 35% in 2021 to >40% in 2022	57% in 2023	>60% in 2024
Percentage of questions on Annual NHS Staff Survey that show an improvement year on year. (graph 2)	Increase % of questions that show year on year improvement since start of programme	2018: 66% 2019: 40% 2020: 58% [First year of programme] 2021: Not available 2022: 76% 2023: 100%	Maintain year on year improvement of 90%
The number of 'Promises' and themes on NHS Annual Staff Survey that score >3% lower than national average (Graph 3)	Reduce from 9 to 5	2022: 8 2023: 3	No Promises or Themes scoring >3% lower than national average.
Percentage of teams at Royal Free Business Unit participating in programme.	70% of 100 teams by June 2023	85%	90% of enrolled teams to complete minimum one cycle each year

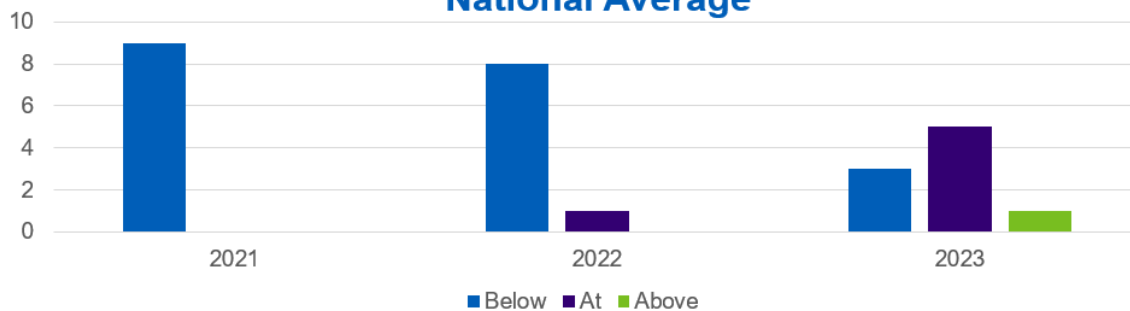
National Staff Survey % completion and % change (year on year)



National Staff Survey 2021-2023 new Promises and Themes



Number of Promises / Themes in relation to National Average



Team members as well as leaders have articulated the impact they have seen because of the WMTS programme – locally, within their teams and also the changes they have observed across the organisation.

Leaders also report how helpful the programme has been for them personally in their day-to-day roles as well as for their leadership development. Leaders are more aware of what matters to their team, have clear data summarising main issues and are supported to make specific and meaningful changes.

Anonymous survey feedback received about the programme confirms this anecdotal evidence and the key themes that have emerged from this qualitative data are that the programme gives staff a voice, empowers teams to facilitate change and is a supportive experience in-of-itself.

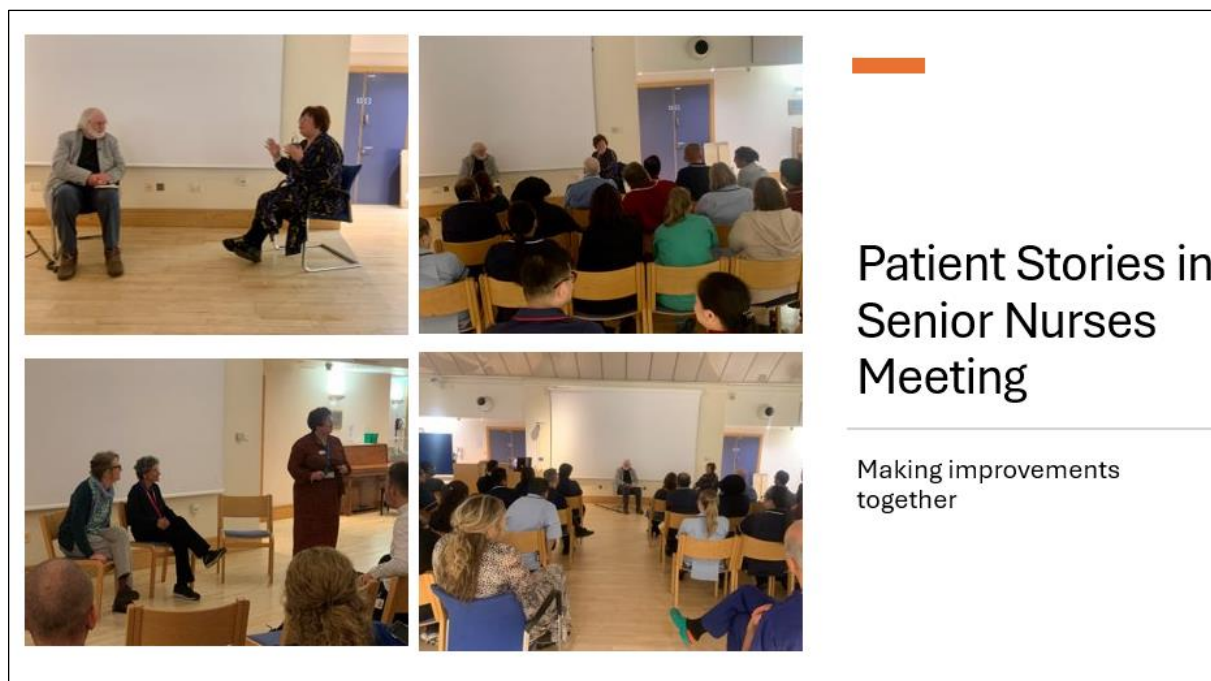
Royal Free Hospital improvement stories 2023/24

Patient Involvement:

The Royal Free Business Unit has been looking at ways to increase patient involvement and coproduction of improvement work.

We are delighted that Jeffrey Goodwin, who has been a patient at the Royal Free for over 40 years, and is part of the Royal Free Patient Voices Group and the Patient Representative for the Endoscopy Programme, has agreed to co-chair the What Matters to Patient's committee.

We have also started '*Patient Story*' sessions in the Senior Nurses meeting, where patients come and share experiences of care at the Royal Free, and ideas for improvements are discussed together:



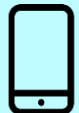
The first Patient Story session at the Senior Nurses meeting highlighted an issue about noise on the wards - not from staff or machines as expected, but from visitors and other patients not being considerate. This led to a co-designed noise poster which wards are now using:


 Royal Free London
 NHS Foundation Trust

[]

What matters to us is creating a calm and quiet environment for everyone on the ward.

Let's work together to do this by:

	Speaking quietly		Keeping mobile phones on silent
	Using mobile phones respectfully		Using headphones to listen to music or watch TV

Thank you for your co -operation.

[]

8N Safe Space Launch:

8N safe space is a bespoke, designated safe space for patients with mental health and medical needs. Designed by the local team and inspired by ED, the grand opening is 4 March 2024:

8 North safe space Feb 24

CCTV

Ligature free

Two way opening door

Lockable door

Concealed emergency equipment

Calm environment

Reinforced furniture

Viewing panel



world class expertise  local care

Royal Free London 
NHS Foundation Trust

AAU Digital Windows:

Designed as part of AAU's falls prevention and frailty work, digital windows have been installed, helping to reduce distress and associated behaviour for patients with dementia or delirium:

AAU digital window

AS RFH AAU has no windows and natural light, the team have campaigned for digital windows which have now been installed.

This will support our frailty patients particularly in relation to time and place orientation and sun downing

The image is controlled by the staff and depicts day and night in the image, helping the reduction of distressed behaviour for patients with delirium or dementia.

This was part of AAU's Falls prevention/Frailty workflow.



Annex 1: Statements from local Healthwatch organisations, health and care scrutiny committees, integrated care boards and council of governors

To follow in final report

Annex 2: Statement of director's responsibilities for the quality report

To follow in final report

Annex3: Changes made to the quality report

To follow in the final report

Meeting title	Department of Health and Social Care Meeting	Date: 31 st May 2024
Report title	Whittington Health NHS Trust Draft Quality Account Review	Agenda item:
Executive director lead	Sarah Wilding (SW), Chief Nurse and Director of Allied Health Professionals	
Report authors	Kat Nolan-Cullen (KNC), Compliance and Quality Improvement Manager	
Executive summary	1. The Committee is asked to approve the draft document and proposed priorities. 2. Patients and their families want to know they are receiving the very best quality of care from Whittington Health. NHS Providers are required to publish a Quality Account annually. 3. The reporting of Quality account requirements have been set by NHSE/I for 2024/25 and are as follows: - Organisations are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce Quality Accounts if they deliver services under an NHS Standard Contract, employ over 50 staff and an NHS income greater than £130k per annum. As a provider above this threshold, the trust is required to publish a Quality Account for the financial period 2023-24 by 30 June 2024. - There have been some minor changes to the process and terminology used in producing the quality account, these are detailed below: There is no national requirement for NHS trusts to obtain external auditor assurance on the Quality Account or quality report, with the latter no longer prepared. Any NHS trust or NHS foundation trust may choose to locally commission assurance over the quality account; this is a matter for local discussion between the Trust (or governors for an NHS trust) and its auditor. For quality accounts approval from within the Trust's own governance procedures is sufficient. The publication process has been amended for this year, as noted below. Integrated Care Boards (ICBs) will assume Clinical Commissioning Group (CCG) responsibilities for the review and scrutiny of Quality Accounts (subject to the Health and Care Bill receiving Royal Assent). Where this function has not transferred from CCGs to ICBs, CCGs must continue to undertake it for the 2023-24 reporting cycle. ICBs/ CCGs must clarify with providers	

	where they are expected to send their Quality Account. • When producing the Quality Account, reference will be made to the relevant NHS Operational Planning and Contracting Guidance for 2023-24. • Organisations are also reminded that schedule 6, paragraph 11b of the <i>Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016</i> requires “a consolidated annual report on rota gaps and the plan for improvement to reduce these gaps shall be included in a statement in the Trust’s Quality Account”. The quality priorities for improvement from 2024 onwards are below. They are aligned to the Trust’s commitment to helping local people live longer, healthier lives and build on factors such as quality performance, clinical or public proposals and our ‘Learn innovate and improve ambition, to continually improve and provide even better care. These include: • Ensuring patients are seen by the right person in the right place at the right time. • Access and attendance. • Reducing health inequalities in our local population. • Improving the Trust Environment to Improve Patient Experience.
Purpose:	Approval
Recommendation(s)	The committee is asked to: I. Provide approval on the draft Quality Account and agree the proposed priorities for 2024-2025.
Risk Register or Board Assurance Framework	BAF Quality Entry 1 - Failure to provide care which is ‘outstanding’ in being consistently safe, caring, responsive, effective or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation.
Report history	QGC 25/04/2024, QAC 08/05/2024, TMG 13/05/2024, TMG 20/05/2024
Appendices	Appendix 1 – Draft Quality account 2023/2024

Quality Account 2023/24

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Part 1: Statement on Quality from the Chief Executive

Comms to provide

Part 1: Trust information and What is a Quality Account?

About the Trust

Whittington Health is one of London's leading integrated care organisations – helping local people to live longer, healthier lives.

We provide hospital and community care services to over half a million people living in Islington and Haringey as well as those living in Barnet, Enfield, Camden and Hackney. Whittington Health provided over 40 acute and 60 community health services in 2023/24. In addition, we provide dental services in 10 London boroughs. Every day, we aim to provide high quality and safe healthcare to people either in our hospital, in their homes or in nearby clinics. We are here to support our patients throughout their healthcare journey – this is what makes us an integrated care organisation.

Our services and our approach are driven by our vision.

We have an excellent reputation for being innovative, responsive, and flexible to the changing clinical needs of the local population. We are treating more patients than ever before and are dedicated to improving services to deliver the best care for our patients, with a clear focus on integrating care for women, children, and the adult frail.

Our vision is: Helping local people live longer, healthier lives.

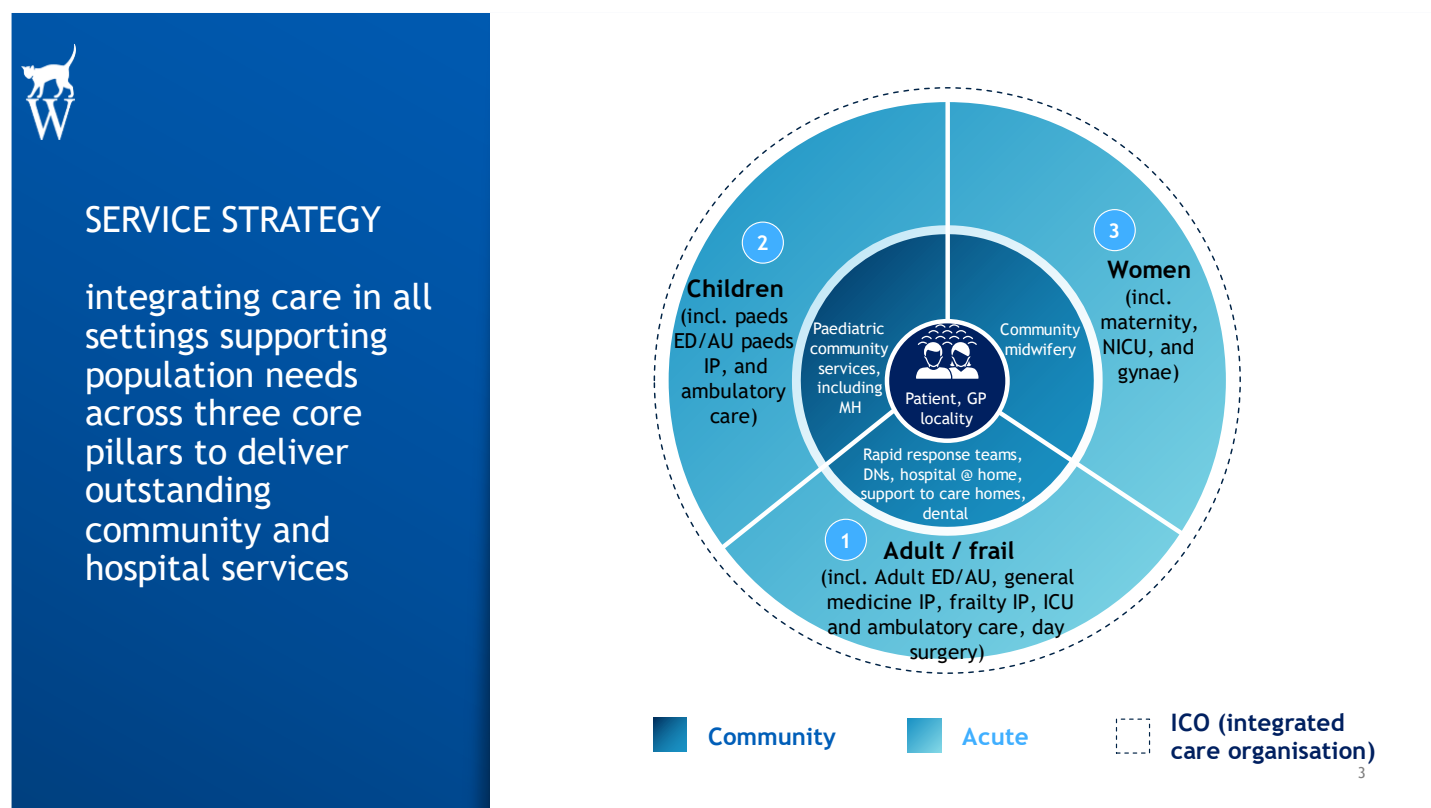
The Trust's strategic objectives for 2024 onwards are:



What we do: Deliver outstanding safe and compassionate care in partnership with patients



Our clinical service strategy is:



What is a Quality Account?

Quality Accounts are annual reports to the public from providers of NHS healthcare that detail information about the quality of services they deliver. They are designed to assure patients, service users, carers, the public and commissioners (purchasers of healthcare), that healthcare providers are regularly scrutinising each and every one of the services they provide to local communities and are concentrating on those areas that require the most improvement or attention.

Quality Accounts are both retrospective and forward looking. They look back on the previous year's information regarding quality of service, explaining where an organisation is doing well and where improvement is needed. They also look forward, explaining the areas that have been identified as priorities for improvement over the coming financial year.

The requirement for external review and assurance by an external auditor, has been removed again for this year by NHS England / Improvement.

Part 2: Priorities for Improvement and Statements of Assurance from the Board

This section of the Quality Account describes the priorities identified for quality improvement in 2024/25. It also sets out a series of statements of assurance from the Board on key quality activities and provides details of the Trust's performance against core indicators.

The progress made against priority areas for improvement in the quality of health services identified in the 2023/24 Quality Account can be found in 'Part 3: Review of Quality Performance' which starts on page 46.

2.1 Priorities for improvement 2024 onwards

Whittington Health recognises that to achieve sustainable improvement, projects need to be long-term and effectively monitored. Quality priorities for 2024 onwards have been developed following a range of engagement events with the public and our stakeholders. We have aligned our priorities for 2024 onwards to the Patient Safety Incident Response Framework (PSIRF) priorities which are:

- Patient falls.
- Medication safety.
- Deteriorating patients.
- Pressure damage.
- Delayed treatment.
- Unsafe discharge.

They priorities were also aligned to the Trust's Corporate Objectives to "Deliver outstanding safe and compassionate care in partnership with patients".

- Ensuring patients are seen by the right person in the right place at the right time.
- Access and attendance
- Reducing health inequalities in our local population
- Improving the Trust Environment to Improve Patient Experience.

The other area of focus for the organisation is linking value to quality through our value improvement priorities around access, elective and flow. We will be setting up an "improvement faculty" to bring these different pieces of work together to ensure they are aligned.

Our consultation process.

Whittington Health recognises that to achieve sustainable improvement, projects need to be long-term and effectively monitored.

To this end, the Trust has held several engagement events across the Trust and community sites to gather feedback from people who use our services and staff. This feedback was combined with intelligence from a range of data and information, such as learning from serious incidents, reviews of mortality and harm, complaints, claims, clinical audits, patient and staff experience surveys, and best practice guidance from sources such as the National Institute for Health and Care Excellence (NICE) and national audit data to help establish ongoing priorities and any new priorities to be added in 2024/25..

The specific objectives, to achieve the priorities set for 2024/25 have been refined and agreed by clinicians and managers who will have direct ownership and approved at the relevant Trust committees. The quality account, including the 2024/25 objectives, have been shared with our commissioners, whose comments can be seen within the appendices.

Monitoring of progress against priorities

We have developed a robust system to monitor and report on progress against the quality priorities. Each priority has a project work stream (which focus on the key objectives for the year) which is aligned to one of the three pillars of patient safety, patient experience or clinical effectiveness, and reports regularly to the relevant governance group (Patient Safety Group, Patient Experience Group and Clinical Effectiveness Group). The Quality Governance Committee reviews progress on a quarterly basis and any concerns are escalated to the Quality Assurance Committee, a committee of the Trust Board. Within each priority, key milestones and targets are identified to monitor progress which are reviewed in the context of the wider Quality Account priority ambition.

The key milestones and targets highlighted below, and in the table that follows we have provided a rationale for selecting this area for focus, details of the improvement plans, and detail on the monitoring data and progress indicators.

- Ensuring patients are seen by the right person in the right place at the right time.
- Access and attendance.
- Reducing health inequalities in our local population.
- Improving the Trust Environment to Improve Patient Experience.

(One Asterix * indicates alignment to the value improvement priorities, and two ** indicates a PSIRF priority)

Quality Account Priority	Why are we focusing on this as an area for improvement?	What are we doing to improve?	Goals for 24/25
Ensuring patients are seen by the right person in the right place at the right time.	The NHS Long Term Plan pledges radical change for people needing planned care.	The ensuring patients are seen by the right person in the right place at the right time will improve patient flow* and patient experience by:	
	Too often people are travelling for hours to a hospital appointment that lasts a few minutes when they could be saved time, cost and stress by the NHS doing things in a different way.	Reduce long waiting times for ASD/ADHD assessments, CAMHS and SLT services (** delayed treatment)	Reduce waiting times for 1st appointments across CAMHS, OT and SLT services by at least 20% by the end of March 2025.
	Sometimes people are waiting months to be treated at their local hospital when they could be seen faster elsewhere if they knew where to look.	Reducing harm from community and hospital acquired pressure ulcers (** pressure damage).	50% reduction in category 4 pressure ulcers in the community based on 2023/2024 data. 25% reduction from 2023/24 reported incidents, of ALL full thickness pressure damage incidents in line with the new national reporting

	The Elective Care Improvement Programme* is leading transformative change on these and other areas to make sure patients needing planned care see the right person, in the right place, first and every time, and get the best possible outcomes, delivered in the most efficient way. This also aligns with our Trust objective to deliver outstanding safe and compassionate care in partnership with patients.		requirements on pressure damage. (All previous unstageable and deep tissue injury incidents will now be categorised at stage 3 pressure ulcers)
		Preventing unnecessary hospital admissions through supporting patients to stay well in their home environments.	To utilise up to 48 Virtual Ward beds 28 acute and 20 community (With remote monitoring support where needed). Meet Virtual ward and rapid response urgent response 2hr/4hr/24hour targets to ensure timely patient care and admission avoidance for 60% of the year (At least six months) Ensure 75% of patients are streamed to an appropriate care pathway to improve flow and overcrowding in the ED, subsequently reducing patient admissions and LOS by end March 2025.
		Reducing harm from Hospital Falls (** falls)	20% reduction of moderate and over harm in trust wide falls, which will reduce hospital bed days. Increase falls training compliance among all staff groups by 20% by March 2024
Reducing health inequalities in our local population	The NHS Long Term Plan outlined an urgent need to prevent and manage ill health in groups that experience health inequalities. This includes population groups less able or likely to access health services available. This also aligns with our Trust objective to deliver outstanding safe and compassionate care in	Improving the care, we provide to those with Sickle Cell disease.	Lead, develop and deliver a new co- designed NCL Community Red Cell (sickle cell) Service with partners and patients in NMUH and UCLH to deliver NHSE targets, reduce LOS and admissions. Implement the NHSE 'Sickle Cell Card' for at least 75% of Sickle Cell patients attending ED by March 2025
		Improving the care, we provide to those with Cancer or suspected Cancer, that have been	To expand on the previous success of Prostate cancer events, holding up to 40 cancer events by the end of

	partnership with patients.	identified as having health inequalities.	March 2025, with a focus on those that disproportionately affecting patients with health inequalities.
		Understand our population so we can target services such Continuity of carer to tackle health inequalities and improve outcomes for women and their families.	Implement 'Attend Anywhere' in Maternity by the end of March 2025. Fully implement Birmingham Symptom Specific Obstetric Triage System (BSOTS) in Maternity Triage by end of March 2025.
		Improving the care, we provide to those with Learning Disabilities	Further develop the intranet page for people with autism and learning difficulties to access and ensure a range of accessible information is provided to this cohort of patients ensuring we are treating and supporting those with Autism and LD effectively. Success in the project will be measured by implementation of package, uptake of training and reviewing patient experience within these populations to determine whether the new information and training delivered shows a positive impact on patient experience and care. Deliver Oliver McGowan training to 80% of staff by March 2025.
		The appointment work stream focuses on improving communication, access, and attendance by:	
Improving access and attendance for appointments	We have received feedback from patient representatives that information around appointments can be confusing and access challenging.	Improving clarity within patient letters* and signposting around our sites	All outpatient letters to be reviewed and updated to ensure clinic and ward locations correctly matches hospital signage to improve wayfinding for patients. Implement a wayfinding strategy for patients and

Improving communication with patients	This includes comments around wayfinding on hospital sites; as well as poor communication being highlighted as a contributory factor in PALS contact, complaints, and incidents. Communication with patients / relatives in relation to care and treatment, responsiveness and attitude through patient feedback, surveys, PALS FFT. This also aligns with our Trust objective to deliver outstanding safe and compassionate care in partnership with patients.		carers to improve patient experience. Accessible information for those with Learning Disabilities (in the form of leaflets and videos) is currently in development for the following areas: • Outpatients (generic) • Outpatient check in stations • Going to Emergency Department • Going to Theatres • Having an operation • Having an anaesthetic • Going Home from Hospital • Compliments and Complaints • Appointment letters By the end of March 2025, this accessible information will be fully implemented, and accessible information will be further rolled out to other areas & topics as required. Success will be measured via audits of how many information leaflets have been distributed, how often videos have been used, as well as reviewing patient experience feedback to determine the impact on their care and treatment. Ensure a 10% reduction in complaints from patients relating to 'communication' across all ICSUs by the end of March 2025.
		Offering increased options to be able to attend more local sites for outpatient appointments*.	To offer Paediatric Blood Tests at Wood Green CDC by the end of March 2025.

Improving the Trust Environment to Improve Patient Experience.	We have received feedback from patients and their representatives, as well as national reports such as the Patient-led assessment of the care environment (PLACE) report and intelligence from the CQC and stakeholders that the hospital environment is not conducive to a high-quality patient experience. This also aligns with our Trust objective to deliver outstanding safe and compassionate care in partnership with patients.	We aim to make improvements to the hospital environment to ensure that we improve patient experience and feedback in this regard.	Work with estates team to identify opportunities to Transform ED Front of House to make the best possible use out of the space available to deliver: • An appropriately sized and comfortable waiting area for patients. • Effective triage and streaming cubicles. • A suitably sized rapid assessment area. • Review space available for patients with mental health needs to ensure it is of a high and appropriate standard. Improve the Cleanliness and condition / appearance and maintenance scores in the 2024 PLACE report to over 90% (PLACE assessment takes place in October 2024 and final report is released in February / March 2025)
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2.2 Statements of Assurance from the Board

The Trust provides statements of assurance to the Trust Board in relation to:

- Modern slavery
- Safeguarding children and young people
- Mixed gender hospital accommodation

Mixed sex/gender accommodation declaration

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. The Trust are committed to providing every patient with same gender accommodation to help safeguard their privacy and dignity when they are often at their most vulnerable.

Patients who are admitted to hospital or come in for a planned day case will only share the room or ward bay where they sleep, with members of the same gender, and same gender toilets and bathrooms will be close to their bed area.

There are some exceptions to this. Sharing with people of the opposite gender may sometimes be necessary. In addition to clinical need other reasons for exceptions would be in a major incident or to maintain infection prevention and control isolation. This will only happen by exception and will be based on clinical need in areas such as intensive/critical care units, emergency care areas and some high observation bays. In these instances, every effort will be made to rectify the situation as soon as

is reasonably practicable and staff will take extra care to ensure that the privacy and dignity of patients and service users is maintained.

Modern Slavery Act

It is our aim to provide care and services that are appropriate and sensitive to all. We always ensure that our services promote equality of opportunity, equality of access, and are non-discriminatory. We are proud of our place in the local community and are keen to embrace the many cultures and traditions that make it so diverse. The diversity of this community is reflected in the ethnic and cultural mix of our staff. By mirroring the diversity that surrounds us, our staff are better placed to understand and provide for the cultural and spiritual needs of patients. In accordance with the Modern Slavery Act 2015, the Trust has made a statement on its website regarding the steps taken to ensure that slavery and human trafficking are not taking place in any part of its own business or any of its supply chains.

Safeguarding Adults and Children Declaration 2023/24

Whittington Health NHS Trust (WH) is committed to achieving and maintaining compliance with national safeguarding children standards and guidance to ensure that children and young people are cared for in a safe, secure and caring environment.

The Chief Nurse holds the position as Executive Lead for safeguarding children and adults and the two Heads of Safeguarding (adult and child) report directly to the Chief Nurse.

A Safeguarding Bi-Annual Report is produced which is reviewed by the Trust Board (covers both children and vulnerable adults).

Whittington Health is an active member of two local safeguarding children's partnerships in Haringey and Islington. The Section 11 audits into safeguarding compliance across the Trust are completed as required.

The Trust is a member of the local safeguarding adults' partnerships in Haringey and Islington and the Safeguarding Adults Partnership Assessment Tool is completed annually for both.

The WH Joint Safeguarding Committee meets quarterly to discuss all matters pertaining to safeguarding, and monitors serious case review and Safeguarding Adult Reviews Recommendations. The committee reviews the Trust's responsibility across children and vulnerable adults.

Subcontracted Services

Whittington Health provided services across acute and community service in 2023/24. The Trust has reviewed all data available to them on the quality of care in these relevant health services through the quarterly performance review of the integrated clinical service unit and contract management processes. The income generated by the relevant health services reviewed in 2023-24 represents 100% of the total income generated from the provision of relevant health services that Whittington Health provides.

A breakdown of the individual subcontracted services can be found in Appendix 2

During 2023/2024, 60 national clinical audits including 8 national confidential enquiries covered relevant health services that Whittington Health provides.

During that period, Whittington Health participated in 98% national clinical audits and 100% of national confidential enquiries of those it was eligible to participate in.

The single national audit to which the Trust did not participate in was the Society for Acute Medicine Benchmarking Audit (SAMBA). This decision was taken at senior clinician level with the following rationale:

“We are awaiting any result from anticipated changes in the GIM rota which should impact in time to consultant review, but this will not occur before this year’s audit window. As no change in performance is currently expected, the time and effort (approximately 2 full days’ time of reg/consultant time) required to complete the audit is not justified.”

The Trust is further awaiting an updated benchmarking tool from SAMBA which is less time consuming.”

The national clinical audits and national confidential enquiries that Whittington Health was eligible to participate in, and participated in, during 2023/2024 are detailed in **(Appendix 1)**. This includes 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.

Additionally listed are the 20 non-mandatory national audits, in which the Trust also participated during 2023/2024 **(Appendix 1)**.

Whittington Health intends to continue to improve the processes for monitoring the recommendations of National Audits and Confidential Enquiries in 2024/2025 by ensuring:

- National audit and national confidential enquiries will remain the key feature of our Integrated Clinical Service Unit (ICSU) clinical audit and effectiveness programmes.
- Learning from excellence will continue to form an intrinsic part of our work, and innovative ways of promoting and celebrating successes will be considered and shared.
- Patient and carer representation in national clinical audit will continue to be developed and effectiveness monitored.
- Multidisciplinary quality governance sessions will continue to include reflective learning on national clinical audit findings and associated quality improvement.
- The Clinical Effectiveness group will continue to ensure actions from national audit reports are scrutinised and monitored at the highest level in order to provide additional organisational assurance.
- Continued collaboration with our Quality Improvement lead(s) will identify appropriate project follow up subsequent to national audit report publication.

The reports of 25 national clinical audits/national confidential enquiries were reviewed by the provider in 2023/2024.

Examples of results and actions being taken for a national clinical audit:

National Prostate Cancer Audit (NPCA)

The aim of the NPCA is to assess the process of care and its outcomes in men diagnosed with prostate cancer in England and Wales. The audit determines whether prostate cancer care is consistent with current recommended practice.

The review of the report provided excellent levels of assurance when compared to national performance.

The overall assurance from this report is **Green**

The action plan identified two areas with excellence levels of assurance:

	Action to be Taken
Review the NPCA completeness of data provided by the Trust	Ensure the documentation in Somerset Cancer register during the MDT is completed at the recommended level of detail, with clear documentation of the TNM staging, PSA, and performance score. Awareness of this will be raised to all MDT participants and MDT coordinators in the local governance meetings.
Review use of enzalutamide with ADT instead of Docetaxel	Liaison with the oncology MDT team to review usage.

Additional actions for improvement identified, as below:

	Action to be Taken
Family history of prostate, breast, and ovarian cancer. Genetic counselling	Ensure all members of the team and CNS explore family history on diagnosis and know who is responsible for genetic counselling in order to facilitate referral. Awareness will be raised to all MDT participants in the local governance meetings.
Specialist Gastroenterology service for bowel related SE of radiotherapy	Review the pathway for the referral of patients with gastroenterology SE after radiotherapy and see if there are any areas for improvement, with the increased alertness of the urology team members on appropriate pathways. Appropriate liaison with the oncology team to provide clinical input on the service available for these patients.
Initiation of hospital level PROMS to identify SE and	We need to integrate PROM questionnaires to patients followed up by our service after treatment. To quantify SE and support benchmarking for providers.

success of radical treatment	To raise this at our Audit meeting with the view to recruit team members to generate a Quality improvement project.
Investigate if any men with high-risk disease in the trust are not offered radical treatment	We need to review the number of these men and the reason not offered radical treatment in order to document this and prevent any lapses in our service. Will raise this matter in the governance meetings and promote an associated local audit.
Ensure patients are given standardised SMDT approved PIS regarding support for psychological and mental SE of PCa treatment	Ensure all members of the team and CNS explore family history on diagnosis to facilitate referral. Awareness of this will be further raised to all MDT participants in the local governance meetings.

National Neonatal Audit Programme: Your Baby's Care - Summary Report on 2022 data

The National Neonatal Audit Programme helps neonatal units give better care to babies who need specialist treatment. The programme assesses the following:

- Whether babies receive consistent, high-quality care.
- Whether babies have had the health checks recommended to reduce the risk of complications.
- How well babies are doing following this care.

The overall assurance from this report is **Green/Amber**.

Green Assurance

For 10 of the 12 NNAP (National Neonatal Audit Programme) measures included in the 2022 results, the Whittington performed at a higher standard than the national average, and for some of the measures the performance was considerably better.

Amber Assurance

For 2 of the 12 measures, the Whittington's Neonatal Unit performed at a lower standard than the national average. These included deferred cord clamping (although no longer a negative outlier) and temperature on admission.

Actions to be taken:

Temperature on admission: This is still slightly below national average although improving in 2023 NNAP data year to September. This is also the subject of a Trust QI project.

Deferred cord clamping: The Concord resuscitation trolley, to enable resuscitation with cord intact has been purchased. Results demonstrate a significant improvement from previous years. There is an ongoing QI project, and a request was submitted for inclusion on the CYP risk register.

National Lung Cancer Audit

The purpose of the National Lung Cancer Audit is to evaluate the patterns of care and outcomes for patients with lung cancer in England and Wales, and to support services to improve the quality of care for these patients.

The overall assurance from this report was **Amber**.

To improve patient care as a result of this report, the following has been actioned:

- To improve data completeness a permanent Lung cancer Coordinator is now in place.

To improve patient care as a result of this report, the following actions are to be taken forward:

- The pathway is to be reviewed to give better access to PET and CT reporting.
- In order for 90% of patients seen by CNS on diagnosis, the nurses cover each other's duties, and it has been suggested to retain the Macmillan support worker to further support the CNS.
- Resource the MDT according to commissioning guidance. The recommended staffing levels are 10 consultant PAs per 100 new patients.

Local Clinical Audits:

Whittington Health intends to continue to improve the processes for monitoring the recommendations of local clinical audits in 2024/2025 by ensuring:

- Reactive local audits, vital to patient safety, will remain of intrinsic value to clinical audit and effectiveness programmes with further emphasis upon collaborative working across clinical effectiveness, patient experience, quality improvement and patient safety domains.
- Project proposals will continue to be subject to a centralised and multidisciplinary quality review to prevent duplication and to ensure alignment to speciality priorities.
- Bespoke clinical audit training packages will continue alongside pre-existing workshops. These sessions will be open to staff of all designations and grades.
- Speciality performance in relation to local clinical audit will continue to be monitored on an ongoing basis, with regular reporting via the ICSU Board meetings.

The reports of 78 local audits were reviewed by the provider in 2023/2024.

Example of results and actions being taken for a local clinical audit:

Audit on Optimal Cord Management

In August 2022, we were notified of negative outlier status for the National Neonatal Audit Programme NNAP 2021 measures.

The outlier status referred to the audit standard for **Deferred cord clamping**, and for which we were a number of standard deviations from the expected measure.

From January to July 2022, the deferred cord clamping standard improved from 3.8% to 33% and the Trust instituted additional measures to further improve compliance, to include intensive training of obstetric and neonatal staff including a presentation at a perinatal meeting, and simulation exercises.

A local audit was undertaken to ascertain progress.

Whilst the results did not meet the standard of 80%, there was a continuous improvement noted, as demonstrated below:

- 46% of babies <34 weeks gestation had DCC in period Jan – March 2023
- 59% of babies <34 weeks gestation had DCC in period Apr – Jun 2023

Actions to be taken:

- Continuous education programme to raise awareness especially with the new trainees arriving in September.
- Concord resuscitation trolley acquisition*
- A pre-term checklist for Neonatologists.
- Establishment of pre-term champions.

*On 12 March 2024, Whittington Health confirmed the acquisition of the Concord Birth Trolley, its first use in the UK (see below article from Trust Intranet).

Home > News and Events



Innovation boosts survival rates for pre-term babies at Whittington Health



12 Mar 2024

Babies now benefiting from delaying the clamping of the umbilical cord

| Full story

Recent evidence has shown that, when babies are born, they benefit from a delay in the clamping of the umbilical cord. This enables the baby's blood in the placenta to circulate back into their body, rather than being lost, helping increase their iron levels and reducing the risk of anaemia. In preterm babies, this also reduces the chances of bowel problems, bleeding in the brain and the need for blood transfusions.

The challenge clinicians face is that, while preterm babies benefit from delayed cord clamping, some of them also need resuscitation when they are born. With the baby is at its most vulnerable, the pressure is on for doctors to act quickly by clamping the cord so that they can give the baby any treatment they require. Not only does it feel counter-intuitive to delay clamping the cord, it goes against previously established practice. Chandrima Biswas, consultant obstetrician at Whittington Health NHS Trust, worked with the Trust's neonatologists to adopt this new way of working.

Parents were also unaware of these benefits, so Whittington Health is currently introducing a perinatal passport, to empower them to ask for their baby to have delayed cord clamping at birth.

Within a year, more than two thirds of preterm babies are benefitting from this delay in clamping their umbilical cords, and parental satisfaction ratings for perinatal care had increased significantly.

More recently, Whittington Health has invested in a new piece of equipment, the Concord Birth Trolley, its first use in the UK. As it can be positioned closer to the baby, the resuscitation team and equipment at birth, it makes it easier for the birthing team to leave the cord intact and safely pause the clamping while monitoring and attending to the baby.

Chandrima Biswas said: "A recent review of 47 studies in the *Lancet* shows that deaths of pre-term babies can be prevented by delaying clamping the umbilical cord, even by a couple of minutes. The evidence shows that this new approach will help to reduce this risk for local people."

Sharon D'Souza, consultant paediatrician at Whittington Health, added: "Delayed cord clamping has been associated with significant neonatal benefits in preterm infants - this includes a reduction in significant complications such as intraventricular haemorrhage and necrotising enterocolitis - with improvement in both survival and neurodevelopmental outcomes secondary to this. We are very pleased to be part of this initiative, working collaboratively with our obstetric colleagues."

Chandrima has also been working with colleagues across the other trusts in North Central London to make sure that Whittington babies are not the only ones to benefit locally.

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Major haemorrhage (MH) protocol audit: The collection of emergency blood

The provision of blood during major haemorrhage (MH) calls in some areas within the hospital was unreliable and did not ensure the delivery of emergency blood in a consistent manner. The porter collection and delivery procedures were standardised to ensure all MH calls receive the same amount of stat blood in a timely manner, in all areas of the hospital. The major haemorrhage guideline and protocol documents the new procedure for collecting and returning emergency blood.

This clinical audit was required to ensure adherence with the new guideline and protocol following their implementation.

Criteria and Standards:

- 100% adherence with the protocol to collect and deliver 2 units upon the activation of a MH.

- 100% of RBC units are returned to the laboratory within 30min if not needed.

The results showed that the automatic collection of 2 units happened on 3/7 MH calls representing 43% compliance with the protocol.

The returning of RBC units within 30 minutes if not needed demonstrated 67% compliance with the protocol.

Action Taken:

The Transfusion Practitioner and Porter Facilities Manager met with the Portering staff to implement the following actions:

- Porter Management must ensure only porters trained in blood collection are allocated to MH calls.
- Transfusion practitioner to discuss any barriers with the Porter Management Team to training and devise an action plan to capture untrained staff.
- Porter Management must monitor training compliance to ensure staff have access to training, and track compliance to ensure staff are up to date with training.

A re-audit was subsequently undertaken demonstrating 87.5% of total adherence to the protocol.

Assessing the appropriateness of antibiotic prescribing for UTI in adults age 16+

The UK has launched a 20-year vision regarding antimicrobial resistance where the optimal use of antimicrobials and good antimicrobial stewardship across sectors is being promoted. A five-year UK Antimicrobial Resistance national action plan outlined concerns about an observed increase in gram-negative bloodstream infections, including *E. Coli* bloodstream infections. Targeting and improving the diagnosing and treatment of UTIs would help reduce avoidable infection rates, improve patient safety, reduce length of hospital stay, and in turn, release bed capacity.

Aim: Assess current clinical practice and compliance to NICE guidance regarding the diagnosis and treatment of UTI's in patients (16+ years) at Whittington Health NHS Trust.

Standards: A minimum of 40% compliance was expected for the following:

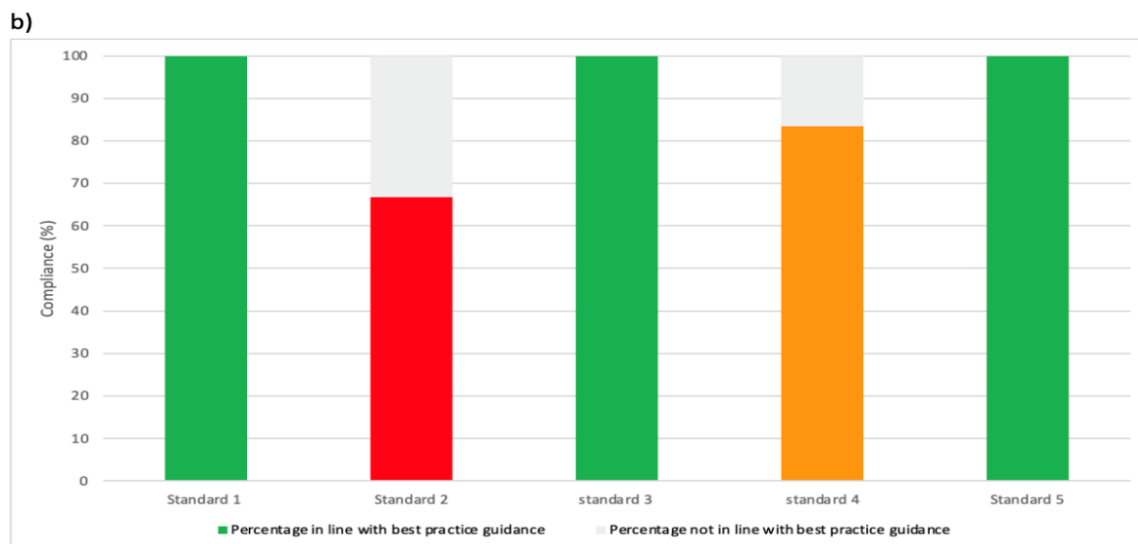
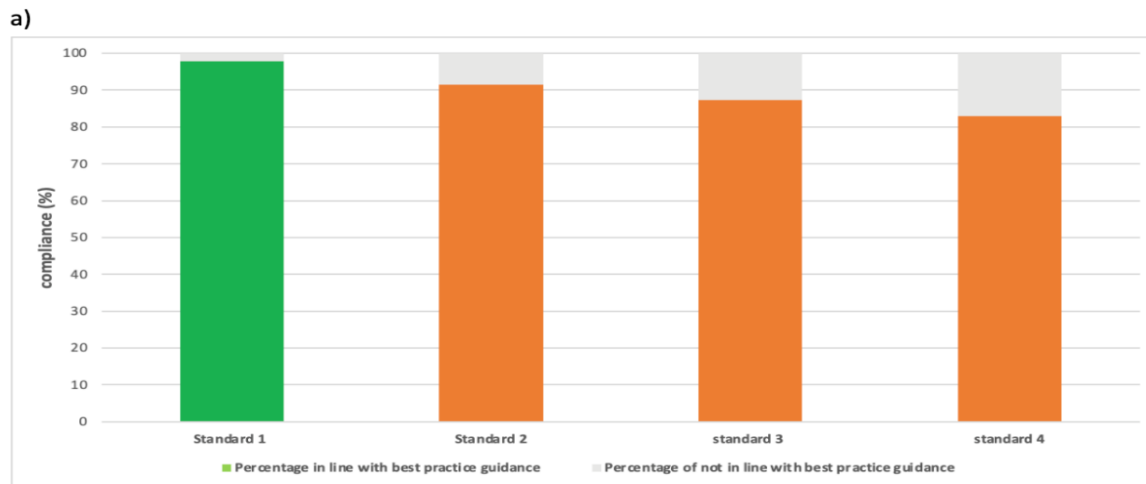
- (1) diagnosis of UTI based on clinical signs/symptoms.
- (2) diagnosis excluding urine dipstick in people aged 65+ years and in CAUTI.
- (3) empirical antibiotic regimen prescribed following national/local guidance.
- (4) urine sample sent to microbiology.
- (5) documented review of urinary catheter made in CAUTI diagnosis, in order to meet the CQUIN CCG2 target [3].

Methodology

A retrospective audit of 100 patient records of ages 16+ issued antibiotic prescriptions after a primary/secondary diagnosis of UTI in A&E, and in-patients from August to September 2022, were identified. Compliance to CQUIN standards were measured by accessing patient clinical records and cross-referencing documented clinical signs/symptoms/urinalysis and antibiotic regimen against national and local UTI diagnosing and treatment guidance.

Results and discussion

70% of the antibiotic prescriptions complied with all 5 standards, meeting the CQUIN CCG2 compliance target of 40% minimum. Lower and upper UTI antibiotic prescriptions showed good compliance to standard 1, and acceptable compliance to standards 2, 3 and 4 (see figure 1.a). This indicated satisfactory use of antimicrobials; however, further work could be done to increase compliance to national guidance.



CAUTI antibiotic prescriptions showed good compliance to standards 1, 3 and 5, acceptable compliance to standard 4, but poor compliance to standard 2, which can increase the rate of UTI diagnosis in cases of benign bacteriuria. National guidelines do not recommend dipstick testing to diagnose UTIs in adults with indwelling urinary catheters, therefore, interventions must be implemented to increase compliance to standard 2 (see Figure 1.b)

Conclusion

Results demonstrate that 70% of antibiotic prescriptions for UTIs at Whittington Health NHS Trust complied with all 5 standards set out by the CQUIN CCG2 target. However, interventions should be made to further increase and maintain compliance, whilst action must be taken to improve compliance to standard 2 in CAUTI diagnoses.

Recommendations and action plan

- Raising awareness for when it is appropriate to take urinalysis and appropriate antibiotic prescribing by implementing ward-based training sessions.
- Including a 'further details' parameter in the data collection toolkit, allowing inclusion of information about inappropriate antibiotic prescriptions.
- To present findings to the pharmacy and microbiology teams. Conduct a re-audit once recommendations have been implemented.

Participating in Clinical Research

The last year has seen progress in return to a 'business as usual' research landscape as delivery of COVID-19 research become an additional area for research activity rather than a primary focus. However, 2023-2024 still saw pressures and changes in service delivery that have prevented a 'new stable baseline' to be reached:

- (i) The Covid era generated residual systemic impacts on 'research process' for all providers (e.g. commercial trial focus; 'research resets' across portfolios; and patient appetite for engagement).
- (ii) Significant changes to the national infrastructure of the National Institute for Health and Care Research (NIHR) began and continue into 2024/25. These have required dynamic development of strategic partnerships and fiscal planning.
- (iii) Whittington Health (WH) in-sourced the R&D office function during the year, having outsourced this for circa 8 years. The newly formed 'Research Support Service' provides a robust yet responsive service to ensure study set-up is proportionate and works with the Trust's developing priorities in an efficient and cost-effective way. A further benefit of insourcing the service has been the ability of the Trust to act as sponsor for research developed by our own staff with far greater success than previously seen.

Staffing and Staff Engagement

WH currently have 16.9 WTE research staff- an increase from 12.7 WTE the previous year of which we are proud. Of these WTEs, two support the in-sourced R&D office function, while two specialty specific research delivery roles (paediatrics and oncology) were also created. The remaining 0.2 increased the hours for an existing post.

The Trust already has established medical research fellow posts and consultant posts that incorporate research in job planning. However, these have been expanded: have facilitating protected time for research has been created in 3 clinical services (ED, CAMHS and The Michael Palin Centre), demonstrating an organisational commitment to furthering research capacity and capability.

We have made great efforts to increase links with UCL and are proud that the Joint-Director for Research and Innovation Mr Chetan Parmar has been appointed as Honorary Associate Professor at University College London.

Whether or not engaged directly through the Trust's Research Department, many other Trust clinicians remain research active. This is demonstrated by research publication records. A PubMed search for 'Whittington Health' OR 'Whittington NHS' reveals a steady rise in publications year on year, with more than 113 such papers published in the 12 months to March 2023.

The Trust currently holds 1 research grant; Professor Ibrahim Abubakar's £2.5 million NIHR Programme Grant for Applied Research: Research to Improve the Detection and Treatment of Latent Tuberculosis Infection (RID-TB) which has had a 'no-cost extension' in response to delays in meeting milestones, predominantly due to the COVID Pandemic and import changes in response to Brexit.

There has been a significant advancement in finding academic partnerships via London Metropolitan University which has supported clinical teams to begin developing their own research ideas. Currently physiotherapy, CAMHS, dietetics and haemoglobinopathy partnerships are underway.

At the time of writing (February 2024), 832 patients had been recruited into 53 NIHR portfolio studies during 2023/24 with further recruitment to follow. This figure is a positive return to previous levels of recruitment following a (Covid-recovery period) lower than usual figure in 22/23 (see table) and substantial increase in open studies. This return to previous levels of recruitment is facilitated by in sourcing the R&D office function therefore seeing a significant rise in the number of studies open to recruitment as well as the increase in staffing levels supporting study delivery. The insourced R&D office have demonstrated a dynamic process with study set-up timelines taking on average 60 days to confirm Capacity & Capability (C&C) with the outlying studies that cause that to be the average having significant sponsor generated delays. In addition, the first sponsored study under the new service was approved by the HRA within 48 hours and positive feedback has been received from colleagues that the process is simpler to navigate and more responsive. This is a significant step and a success of which we are proud.

	NIHR Portfolio		Non-Portfolio
	Patients recruited	Number of recruiting studies	Number of recruiting studies
Year			
2018-19	1077	49	7
2019-20	848	29	5
2020-21	1241	20	4
2021-22	921	27	5
2022-23	689	30	4
2023-24	832	53	5

Completed Trials and Outcomes

Publication of a selection of trials (performed at or recruiting at Whittington Health) in the last year are described below:

The 'heROIC' trial: Does the use of a robotic rehabilitation trainer change quality of life, range of movement and function in children with cerebral palsy? - Grodon - Child: Care, Health and Development Wiley Online Library.

'Demonstrating the learning and impact of embedding participant involvement in a pandemic research study: the experience of the SARS-CoV-2 immunity and reinfection evaluation (SIREN) study UK, 2020-2023' BMC Part of Springer Nature

GWAS and meta-analysis identifies 49 genetic variants underlying critical COVID-19. Nature.

Empagliflozin in patients admitted to hospital with COVID-19 (RECOVERY): a randomised, controlled, open-label, platform trial. The Lancet – Diabetes and Endocrinology.

Children presenting with diabetes and diabetic ketoacidosis to Emergency Departments during the COVID-19 pandemic in the UK and Ireland: an international retrospective observational study. Archives of Disease in Childhood.

686 The Mental Health Interventions for children with epilepsy (MICE) trial: 6 month outcomes. Archives of Disease in Childhood.

The benefits of continuing patient and public involvement as part of a randomised controlled trial during the Covid-19 global pandemic. Research for All.

Evaluation of a quality improvement intervention to reduce anastomotic leak following right colectomy (EAGLE): pragmatic, batched stepped-wedge, cluster-randomized trial in 64 countries. Br J Surg.

CQUIN Payment Framework

A proportion of Whittington Health's income is conditional on achieving quality improvement and innovation goals between Whittington Health and NCL ICB through the Commissioning for Quality and Innovation payment framework.

Trust CQUINs for 2023/24 are:

- CQUIN01 - Flu vaccinations for frontline healthcare workers (Target)
- CQUIN02 - Supporting patients to drink, eat and mobilise (DrEaM) after surgery (Target)
- CQUIN03 - Prompt switching of intravenous to oral antibiotic (Target)
- CQUIN05 - Identification and response to frailty in emergency departments (Reporting only)
- CQUIN06 - Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service (Reporting only)
- CQUIN07 - Recording of and response to NEWS2 score for unplanned critical care admissions (Target)
- Local CQUIN: Core20plus5 (Target)

For 2023/24 the Trust is required to undertake 7 CQUIN Indicators (6 National and 1 Local). However, only 5 Indicators are included in the CQUIN payment scheme for 2023/24.

These CQUINs were set because they represent areas where improvements result in significant benefits to patient safety and experience.

Further details of the agreed goals for 2023/24 are available electronically at:

<https://www.england.nhs.uk/publication/cquin-scheme-for-2023-24-annex-indicator-specifications/>

CQUIN progress information for 2023/2024 can be found in **Appendix 7**.

2024/25 CQUIN Update

NHS England has paused the CQUIN scheme for 2024/25.

Registration with the Care Quality Commission (CQC)

Whittington Heath is registered with the Care Quality Commission (CQC) without any conditions. The CQC did not inspect the trust from April 2023 – March 2024.

There was a CQC Executive visit conducted in July 2023, this was an opportunity for CQC Executives to meet with the Trust Executive team, and the CQC Executives visited the following areas: Same day emergency care (SDEC), virtual ward, maternity, and the nursing recruitment teams. The visit was well received and the CQC Executives were very positive about the areas that they visited on the day.

There were three CQC relationship meetings held in 2023/2024, these focussed on Simmons House and medicines management. Simmons House was a focus due to a patient safety incident that occurred in October 2023. The unit has been temporary closed to admissions since December 2023. The medicines management engagement meeting happens yearly with the CQC pharmacy team and the Trust pharmacy team, this was a positive meeting. The meeting focussed on the Trusts electronic prescribing and medicines administration system (EPMA) and insulin management. The CQC raised no issues following the meeting and were assured regarding the processes for electronic prescribing and medicines management at the Trust.

The table below provides the rating summary table for the CQC's final report published in March 2020 following its previous inspection in December 2019 of four core services (surgery, urgent and emergency care services, our critical care, community health services for children and young people and families and specialist community mental health services for children and young people). The Trust's current CQC overall rating from that assessment is 'Good' for Whittington Heath, with 'Outstanding' ratings for our community health services and performance against the CQC's '*Caring*' domain. The overall rating of the Trust has not changed following the CQC inspection of maternity services in 2023 and remains 'Good' overall.

	Safe	Effective	Caring		Responsive	Well-led	Overall
Acute	Requires Improvement	Good	Good		Good	Good	Good
Community	Good	Good	Outstanding		Good	Outstanding	Outstanding
Children's mental health services	Requires Improvement	Good	Outstanding		Good	Good	Good
Overall trust	Requires Improvement	Good	Outstanding		Good	Good	Good

The CQC action plan remains a focus for improvement; the closed actions were reviewed with the responsible Integrated Clinical Service Units (ICSU) in 2024 to ensure that they are still relevant, and reflective of the current Trust position and they are monitored at the ICSU Quality meetings and via the Learn, Innovate, and Improve programme.

The CQC have been implementing their new single assessment framework from November 2023 – March 2024, although there are still some delays to the rollout Trusts have been notified. The new assessment framework has been developed to have a greater focus on care across local areas and systems, to make the CQC regulations less complex and more efficient, which will enable the CQC to regulate services in a smarter way and work better with health and social care sectors as they change and recover post COVID-19. Its aim is to use their new regulatory powers effectively to improve people's care. The domains from the old framework will remain and how the ratings are achieved. But the evidence gathered will be in the form of 'Quality statements'.

The CQC are moving away from multiple assessment frameworks to a single assessment framework, using a constant ongoing assessment of quality and risk, gathering evidence at multiple points in time rather than the previous single point in time.

Quality statements will underpin the assessments rather than the previous key lines of enquiry (KLOEs); however, the quality statements are still named after the previous KLOEs.

The new quality statements represent the commitments that providers, commissioners, and system leaders should live up to. Expressed as 'we statements', they show what is needed to deliver high-quality, person-centred care. They directly relate to the CQC regulations already in place. When the CQC refer to 'people' they mean people who use services, their families, friends, and unpaid carers. This includes:

- people with protected equality characteristics
- those most likely to have a poorer experience of care or experience health inequalities.

To develop the quality statements, the CQC have used aspects of the Making It Real framework [Making it Real - Think Local Act Personal](#).

This was co-produced by Think Local Act Personal (TLAP). They worked with a range of partners and people with lived experience of using health and care services. The Making it Real framework:

- support personalised care for people who use services.
- support people working in health, care and housing.
- contains a jargon-free set of personalised principles that focus on what matters to people.

The CQC have linked 'I statements' from Making it Real to each of the new 'quality statements'. These will be used to:

- help people understand what a good experience of care looks and feels like.
- support the CQC in gathering and assessing evidence under the 'people's experience' evidence category.

Secondary Uses Service

Whittington Health submitted records during 2021 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episodes Statistics. The percentage of records in the published data which included the patient's valid NHS number, and which included the patient's valid General Medical Practice Code were as follows:

2021/22		Percentage of records which included the patient's valid NHS number (%)	Percentage of records which included the patient's valid General Medical Practice Code (%)
	Inpatient care	99.45%	99.91%
	Outpatient care	99.62%	99.96%
	Emergency care	84.58%	100.00%

Data Item Score Average - April 2021 - December 2021

Information Governance (IG) Assessment Report

Information governance (IG) is to do with the way organisations process or handle information. The Trust takes its requirements to protect confidential data seriously and over the last 5 years have made significant improvements in many areas of information governance, including data quality, subject access requests, freedom of information and records management.

The Data Security and Protection (DSP) Toolkit is a policy delivery vehicle produced by the Department of Health; hosted and maintained by NHS England. It combines the legal framework including the UK General Data Protection Regulations (UK GDPR) and the Data Protection Act 2018, and central government guidance including the NHS Code of Practice on Confidentiality and the NHS Records Management Code of Practice. The framework ensures the Trust manages the confidential data it holds safely and within statutory requirements.

During the year the Trust implemented an improvement plan to achieve DSP Toolkit compliance and to improve compliance against other standards. As a result, the Trust hopes to meet the majority of the mandatory assertions with an improvement plan in place for the areas of IG training and supplier assurance. The Trust's DSP Toolkit submission and former IG Toolkit submissions can be viewed online at www.dsptoolkit.nhs.uk and www.igt.hscic.gov.uk.

Regarding IG training, all staff are required to this annually. The Trust ended 2023/24 with 88% of staff being IG training compliant. Compliance rates are regularly monitored by the IG committee, including methods of increasing compliance. The IG department continues to promote requirements to train and targets staff with individual emails includes news features in the weekly electronic staff Noticeboard and manage classroom-based sessions at induction.

Regarding supplier assurance, a project is currently underway to obtain evidence of appropriate certification and contract clauses from the Trust's IT suppliers.

Information Governance Reportable Incidents

IG reportable incidents are reported to the Department of Health and Information Commissioner's

Office (ICO). Reportable incidents are investigated and reported to the Trust's SIEAG Panel, relevant executive directorate or ICSU and the Caldicott Guardian and the Senior Information Risk Owner (SIRO). The IG committee is chaired by the SIRO who maintains a review of all IG reportable incidents and pro-actively monitors the action plans. The Trust declared two reportable incidents in 2023/24.

Data Quality

The Trust continued monitor all national data submissions data quality at the point of submission and respond to any issues raised by NHS Digital with any remedial action required. Where system limitations have existed, the Trust continues to work with system suppliers to include fixes in the scheduled system upgrades as part of the supplier contracts. A regular review of the Data Quality Maturity Index (DQMI) scores published by NHS Digital Monthly was done at the Data Quality Group as well as the RIO User Group to highlight specific data quality issues requiring attention and to update on progress on data quality improvement initiatives.

In order to improve data quality in 2023-24 the trust has established a Data Quality and Business Intelligence Group (DQBIG) where regular reviews of the data quality within clinical systems and reporting processes is regularly reviewed. This group includes key stakeholders covering Clinical Informatics, Operations, and Information Technology. The trust will continue to embed the following actions:

- Use of data quality dashboards for services to individually monitor their own data quality as required. Work is underway to develop a new Power BI dashboard that will include additional data quality metrics as well as bring internal as well as external data quality monitoring in one place.
- Issuing of regular data quality reports to specific services identified as requiring improvements.
- Continue monitoring data quality for each of the Integrated Clinical Service Units (ICSUs) through the Data Quality and Business Intelligence Group
- Undertake to complete any data quality related actions as stipulated in the Data Quality Improvement Plan (DQIP) requirements of Schedule 6 of the NHS Standard Contract
- Undertake regular internal clinical coding audits. The trust has purchased an audit tool to help with this.
- Systematic use of benchmarking of data where available.
- Running a programme of audits and actions plans
- Actively engage in any national or NCL-wide data quality improvement initiatives such as meeting the Emergency Care Data Set (ECDS) Conformance Indicators, matching of local and NCL community reports improving the Community dataset (CSDS)

Clinical Coding audit data is available in **Appendix 6**

End of life care

Adult Specialist Palliative Care Service

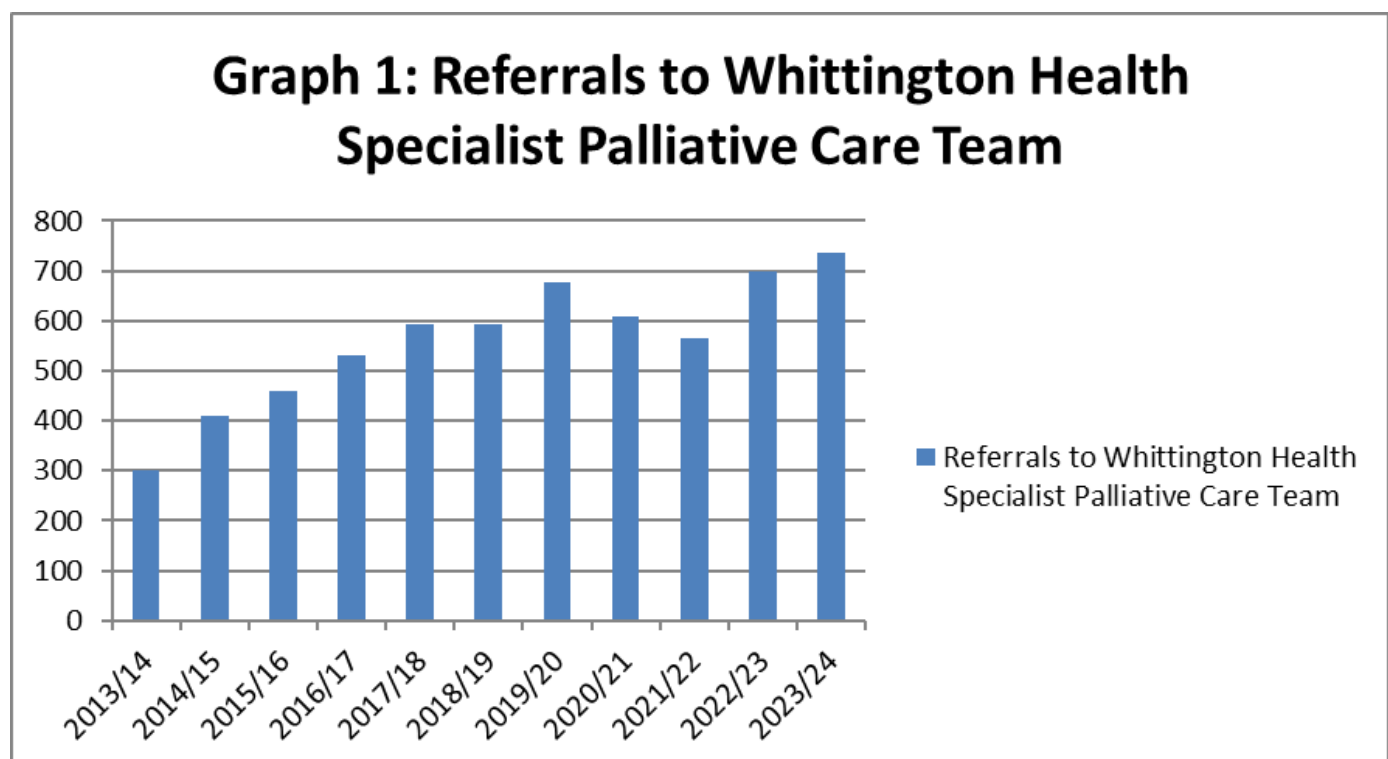
The Whittington Hospital Specialist Palliative Care team (SPCT) is a liaison service providing advice and guidance to the acute hospital teams caring for patients with palliative care needs. We manage

physical symptoms, provide psychological support to patients and families, and engage in advance care planning to ensure that patients are discharged to their preferred place of care and die in their preferred place of death. We also provide education for non-specialist clinicians delivering palliative and end of life care.

The team has a visible presence across all hospital adult wards, including ambulatory care and ED. We have robust relationships and maintain regular contact with the Haringey (North London Hospice) and Islington (CNWL) community palliative care teams in order to facilitate joined up care across settings for patients and families.

Activity

At Whittington Health we cared for 453 adult patients who died during an acute admission in 2023. The SPCT saw well over half of these patients. Our referrals for March 2023 to March 2024 were 736 which is an increase on last year.



As well as increasing numbers of referrals, the complexity of our caseload has increased, particularly the amount of complex family support required. 66% of patients referred to SPCT in 2023/24 were in an unstable or deteriorating phase of their illness, only 10% were in a stable phase of illness.

The SPCT proactively supports advance care planning discussions, including recording a patient's preferred place of care and death and whether this is achieved. Where appropriate, this is uploaded into the Pan-London Universal Care Plan (UCP), so it is visible to all urgent and emergency care staff. In 2023/24, 332 palliative care patients had a UCP of which 109 were created or updated by the SPCT.

Quality and Performance Indicators

The Whittington did not take part in the National Audit of Care at the End of Life (NACEL) in 2022/23

due to such a quick turn round time to realistically implement the findings from the preceding years audit. In 2023 there was no national audit. We focused on education which had been highlighted in the 2021-2022 audit. This included running study days for RGNs and NAs on palliative care and communication skills training, participating in nursing and medical induction training sessions, teaching of student midwives and health care support workers and presenting at the hospital's grand round on our work in the emergency department.

The hospital is currently undergoing the NACEL 2024 audit which is now a larger audit completed across the year rather than just one snapshot period. The audit this year consists of case note reviews of at least 20 deceased patients each quarter, quality surveys to bereaved carers, staff reported measures and an overview of the hospital looking at workforce, training, numbers of inpatient beds and other data.

Learning from Deaths

During 2023/2024 there were 460 inpatient deaths at the Trust (this figure excludes patients who have died in the Emergency Department) with the following distribution across the year:

- 108 In the first quarter
- 123 In the second quarter
- 118 In the third quarter
- 111 In the fourth quarter.

Oversight

The Trust has an embedded process to screen, review and investigate inpatient deaths. Each Clinical Directorate has a mortality review process to undertake reviews on any appropriate deaths and to identify learning. The Mortality Review Group (MRG) provides scrutiny of mortality surveillance to ensure the Trust is driving quality improvement by using a systematic approach to mortality review and learning from death. The MRG reports to the Quality Governance Committee, cascading upwards to the Quality Assurance Committee and the Trust Board, via a Quarterly Learning from Deaths report, authored by the Associate Medical Director for Learning from Deaths and the Project Lead for Mortality.

Reviews

51/460 deaths for the year were identified as meeting the criteria for a structured judgement review. Of the 51 identified deaths, 38 case record reviews had been completed by the end of the financial year with others from more recent deaths in progress.

The table below shows the number of case record reviews by quarter and the number of deaths judged more than likely than not to have been due to problems in care:

	Quarter 1 2023/24	Quarter 2 2023/24	Quarter 3 2023/24	Quarter 4 2023/24
Number of structured judgement reviews	11	10	21	9
Number of deaths judged probably avoidable (more than 50:50)	0	0	0	0

	Quarter 1 2023/24	Quarter 2 2023/24	Quarter 3 2023/24	Quarter 4 2023/24

In Q2 there was one SJR where the death avoidability score was judged to be 3 (Probably avoidable (more than 50:50)). This is not included in the above table, as the death occurred in another hospital after transfer.

Summary of themes, learning and actions from Case Record Reviews

From the deaths reviewed in 2023/24 the main themes, learning and actions were:

Ongoing importance of recognition of impending death and good communication to patients and families by clinicians. There were many comments in reports regarding thorough multispecialty reviews of patients with complex problems and high risk of death, and regular senior reviews of patients.

Multidisciplinary and multispecialty discussions were frequently commented on.

Learning from end-of-life care and treatment escalation planning and DNACPR decisions was that early opportunities to have sensitive conversations during admissions, prior to actual end of life phase, could be helpful and that near end-of-life anticipatory medicines should be actively considered to avoid any delays in relief of patients' symptoms and prioritisation of their comfort. The importance of ensuring that staff review treatment escalation plans prior to starting new treatments was also noted. Additionally ensuring good communication with actively dying patients including the use of a translator where necessary.

There was evidence of excellent communication with mental health teams for patients with serious mental health problems.

Reviews of patients with learning disabilities highlighted the importance of multi-team advanced planning for complex patients with hospital passports being reviewed. Learning Disability specialist nurse referrals were made promptly, unrestricted access to carers/ support workers and family visiting and referral to palliative care were commented on.

Second opinions are helpful to some families coming to terms with a relative at end of life alongside pastoral and palliative care support.

Scoring system use is important and now regularly used, but also important to reflect that scoring systems may not encompass all risks such as frailty.

Evidence of appropriate referrals to the Specialist Nurse for Organ Donation (SNOD) and timely identification of Brain Stem Death.

Other themes were:

- Ensuring long stay surgical patients with multiple medical comorbidities are referred to the liaison care of the elderly team.
- Ensuring samples are collected and sent as promptly as possible for analysis.
- Ensuring patients are aware of the risks of discharge/ leaving ward areas.

- Recognising that all patients readmitted to hospital need reassessment including observations.
- Teams must have in place recommendations when to call a consultant.
- Clarity about assigned responsible consultant for all patients is required.
- The importance of using the MicroGuide app to access antibiotic guidance and seeking advice from the Microbiology team.
- Documenting safety netting for patients being discharged from hospital.
- Ensuring that there is clear documentation regarding all patient reviews.
- Ensuring that referrals are received.

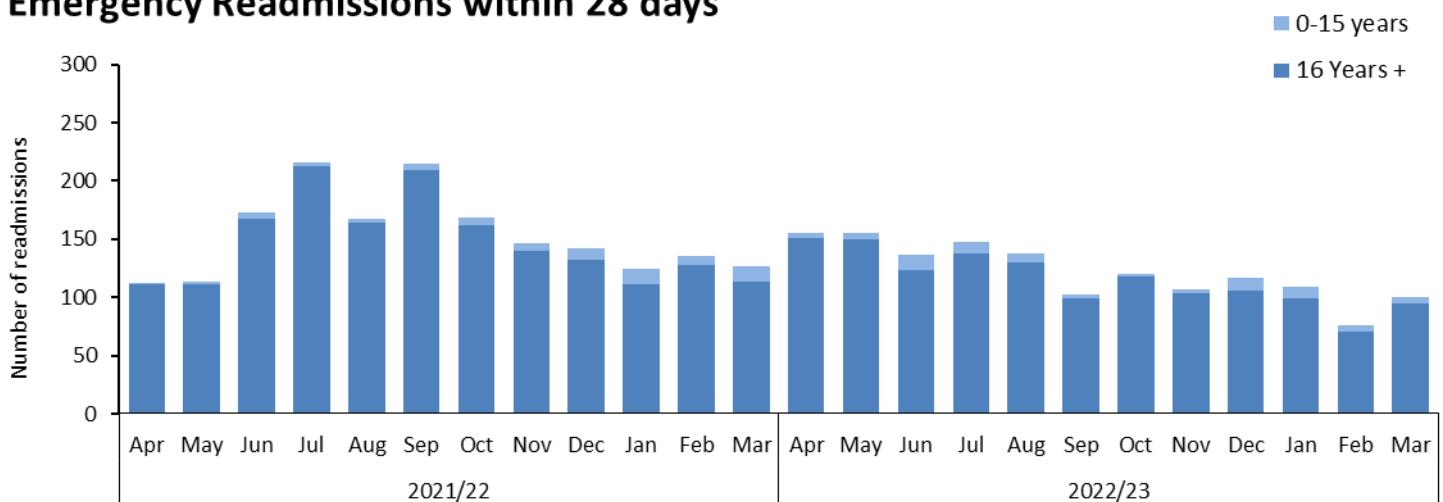
There were also many comments in reviews on excellent medical care delivered including management of acute medical problems, good perioperative care, and good adherence to resuscitation guidelines.

Medical Examiners Service

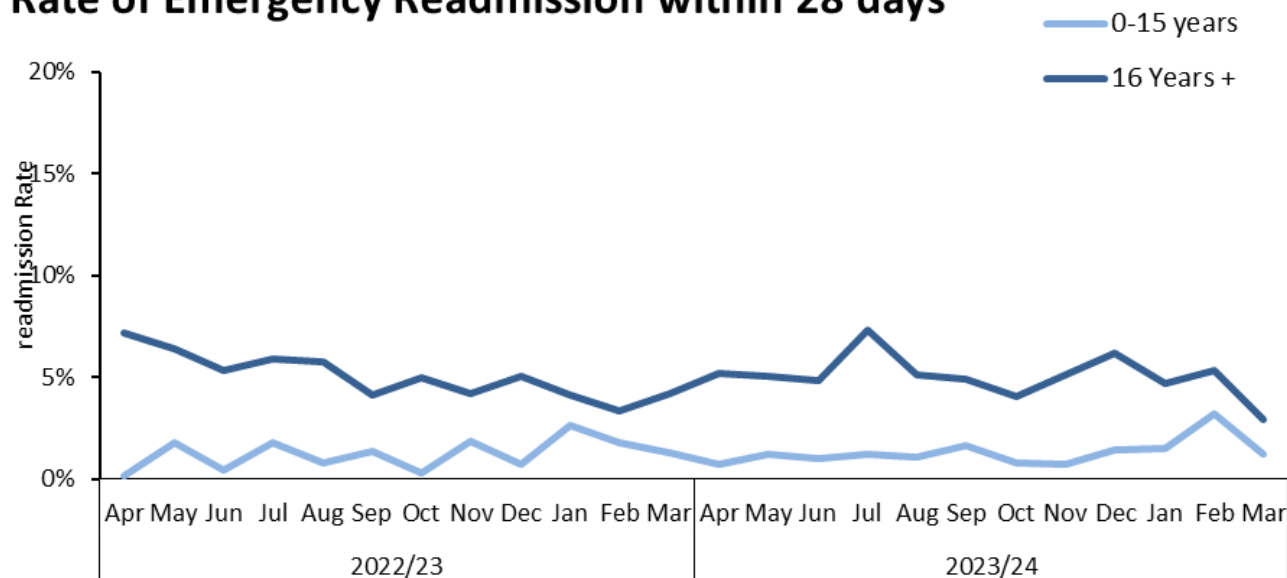
The Medical Examiners department is now well established and fully staffed and ready for the statutory changes coming in 2024 around the death certification process. This department provides reviews of case notes, discussions with members of clinical teams, supportive discussions with bereaved families and ensures accurate completed of the medical certificate of cause of death.

Percentage of patients 0-15 and 16+ readmitted within 28 days of discharge

Emergency Readmissions within 28 days



Rate of Emergency Readmission within 28 days



The Trust reports within stated requirements, the readmission data is reviewed thoroughly and compared closely to the metric that is used for routine board and departmental monitoring of readmissions.

*Data is reported against the month of discharge of the emergency readmission

*Data excludes patients between 0 and 4 years at time of admission or re-admission. Cancer and Maternity admissions and readmissions are excluded. Patients who discharged themselves are also excluded.

National data has not been published beyond 2011/12. Consequently, national comparison is not available, and this information is generated locally by the trust.

During 2023 / 2024 New streaming pathways have been implemented in the Emergency Department to try and reduce admissions and reduce waits against the 4 hour target, improving patient experience.

Our 'Multi Agency Discharge Event's' (MADEs) are now part of business as usual. They have regular input from Social Care, Clinicians, District Nursing and GPs to ensure patients are discharged to the most appropriate place for their care in a timely manner. However operational pressures have been experienced nationally which has affected discharge times. The data table that supports the graphs below can be found in **Appendix 3**.

The trust's Responsiveness to the Personal Needs of its Patients

Learning from National Patient Surveys

The Trust received the results for four national patient experience surveys during 2023/24. These were:

- 2022 Adult Inpatient Survey (published September 2022)

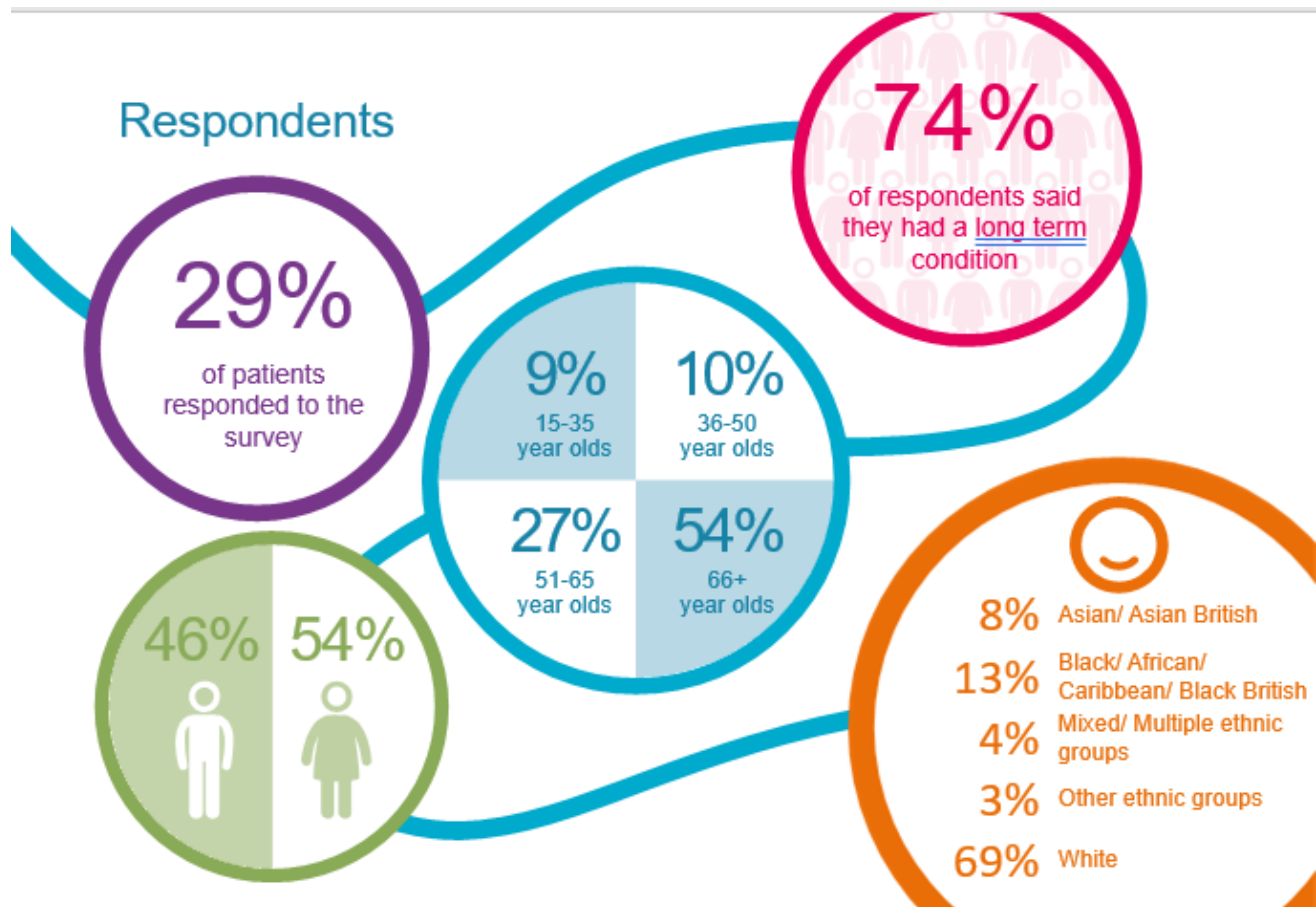
- 2022 Urgent & Emergency Care (UEC) (published July 2023)
- 2022 Cancer Patient Experience Survey (published July 2023)
- 2023 Maternity Survey (published February 2024)

Adult Inpatient Survey 2022

The adult national inpatient survey is held every year, patient cohort for the 2022 survey is those who spent one or more nights in hospital during November 2022, and fieldwork took place from January to April 2023. The findings were published nationally on 12 September 2023.

1250 people were invited to take part in the survey. 29% of people responded, a reduction of 1% response rate in comparison to our previous survey conducted in 2021. This percentage sits below the average response rate for similar organisations of 40%.

The survey, carried out by the Picker Institute on behalf of the Trust, used a mixed-mode data collection of both online and paper-based surveys, in addition to using a range of contact for invitation and reminders for completion, via letter and SMS format. The survey was made available in a range of accessible formats, including Braille, Easy Read, British Sign Language, non-English languages, telephone assisted completes and a screen-reader compatible online questionnaire. In addition to this, a freephone language line service was available to provide translation services. The representation of our respondents was as follows:



In comparison to the previous year, the following changes were noted within the demographics of respondents:

- A decreased percentage response from those who were white from 70% to 69%
- An increase of 5% of women in comparison to 2024 survey (49%)
- 74% said they had a long-term condition, an increase of 1% from the 2021 survey.
- An increase of 1% (74%) of those reported having a long-term condition.

Focus on Inpatient views	
73 %	Rated overall experience as 7/10
96%	Treated with respect and dignity overall
99%	Had confidence and trust in the doctors

The key improvements and issues to address are summarised below:

Most Improved Scores			
	Question	2022	2021
⬆	Q12. Food was very good or fairly good	62%	52%
⬆	Q13. Got enough help from staff to eat meals	85%	76%
⬆	Q11. Offered food that met dietary requirements	94%	85%
⬆	Q41. Told who to contact if worried after discharge	72%	64%
⬆	Q7. Staff explained reasons for changing wards at night	84%	76%

Top 5 Scores Against Picker Average			
	Question	2022	Picker Avg
⬆	Q11. Offered food that met dietary requirements	94%	90%
⬆	Q47. Asked to give views on quality of care during stay	16%	13%

	Q7. Staff explained reasons for changing wards at night	84%	81%
	Q13. Got enough help from staff to eat meals	85%	82%
	Q10. Able to take own medication when needed to	89%	87%

99%
Had confidence & trust in the doctors

Bottom 5 scores vs the Picker Average

	60%	Able to get meals outside of mealtime
	55%	Did not mind waiting as long as did for admission
	46%	Not prevented from sleeping at night
	38%	Staff did not contradict each other about care and treatment
	55%	Rated overall experience as 7/10 or more

Key successes include people being offered food that met their dietary requirements (Q11), increasing from 85% in 2021 to 94% (above the picker average of 90%). Other successes were doctors included patients in conversation (Q18) at 97%, 1% above the Picker average and an increase of 3% on our

2021 results of 94% and (Q41) told who to contact if worried after discharge, at 72%, 8% increase on our 2021 results.

99% of respondents have confidence and trust in the doctors (Q17), and 96% of our patients were treated with dignity and respect (Q45). These positive results are testament to the hard work and care of our clinical staff, and we aim to improve on these scores and on the experience of our patients.

You said, we did.....

- Patient Experience and Volunteering team are currently supporting a number of areas to increase the feedback we receive, and this area will be a focus for the teams.
- Implemented Inpatient Ward Leaflets – at the side of each inpatient which provides information on how to obtain food outside of mealtimes, help with sleeping at night, carers charter and who to speak to if you are worried.
- Welcome to the Ward Boards rolled out - which comprises of a suite of three boards detailing information on compliments, complaints and FFT data, alongside you said we did, as result of our patients' feedback.
- You said, we did – intranet and internet page to provide transparency and learning – updated quarterly.
Proactively recruiting volunteers to support obtaining feedback and ward befrienders.
- Re-introduced sleep well packs and sleep well postcards, with tips and tricks on how to have a restful night's sleep.

The patient experience team have developed a survey page for staff, to raise awareness of national survey programmes and survey results.

2024 National Survey Programme

- Children and young people: fieldwork July - October 2024, publications March 2025
- Urgent and emergency care: fieldwork April - July 2024, publication October 2024
- Maternity: fieldwork April - June 2024, publication December 2024
- Adult inpatient: fieldwork January - April 2025, publication August 2025

Staff Friends and Family Tests

Listening to Our Staff

This is the thirteenth year in which Whittington Health as an Integrated Care Organisation (ICO) has conducted the national staff survey and the sixth year in which the Trust opted to invite all eligible staff to complete it. It is the third year Whittington Health has opted to run the survey online only, which meant everyone received an online questionnaire via a personal link sent by email. This paper summarises the results of the survey, draws out key comparative data and provides details of the proposed steps for updating staff and developing action plans.

The 2023 NHS England-commissioned survey was sent to all staff in 122 NHS organisations. In 2023, 477, 643 staff nationally responded with a median response rate of 45%.

The findings from this NHS survey will be considered alongside the progress made on the five Trust-wide improvement areas from the 2022 Staff Survey. The analysis of these results will be discussed with the Trust Management Group (TMG) to agree priorities and the overall approach to the development of a staff survey action plan.

The Trust commissions the Picker Institute to run its survey, as do a further 62 other Acute and Acute & Community Trusts. In addition to the national comparisons, we have access to reports at ICSU,

directorates and individual service levels for a more detailed and local analysis. Nationally, Whittington Health was benchmarked against a total 122 similar Trusts.

This is the third year the survey results are aligned to the People Promise. There are seven People Promise elements. A total of 118 questions were asked in the 2023 survey, of these, 113 can be compared to 2022 and 100 can be positively scored. The results include every question where Whittington Health received at least ten responses, which is the minimum required.

This year, the data under the People Promise of 'We are safe and healthy', needs to be treated with caution as there was a national issue with the data quality. Results for questions 13a-d are absent. These questions ask about the experience of physical violence at work. This is currently under investigation by the Survey Coordination Centre and NHS England, and they will produce results at an organisational and aggregated level at the earliest opportunity. For Whittington Health, Picker estimates that approximately 129 respondents (6% of our total) may not have provided an answer to Q13a-d, because of this issue.

The 2023 survey asked three new questions which included the following themes: experience of unwanted sexual behaviour, availability of nutritious and affordable food, and frequency of home working. The COVID19 questions were removed from the 2023 staff survey.

A total of 2123 staff out of Whittington Health's (WH) 4865 eligible staff completed the survey. This equals a response rate of 44%, this is 2% below the Picker average of 46% for Acute and Acute & Community trusts. Despite an additional 104 staff completing the survey in 2023 compared to 2022, the actual response rate was down by 1% due to the increased number of eligible staff.

Staff Engagement Indicator

Whittington Health's staff engagement score is 6.94, which is slightly higher than the Picker average of 6.91. This has also been an improvement since the previous two years, which was 6.89 in 2021 and 6.81 in 2022.

The three key findings that make up the Engagement score are:

Advocacy: Staff recommendation of the trust as a place to work or receive treatment

Motivation: Staff motivation at work

Involvement: Staff ability to contribute towards improvements at work

Staff Morale Indicator

Whittington Health's score for staff morale is 5.74, slightly below the Picker average of 5.91. However, this result is an improvement from the morale score of the last two years, which was 5.56 in 2021 and 5.52 in 2022.

The key findings that make up the morale score are:

Staff retention/turnover – thinking about leaving the organisation

Work pressures

Stressors

Whittington Health – 2023 overall results – Themes

In 2023 Whittington Health is not ranked as 'worst' or 'best' in any of the themes. The Trust is slightly above average for the themes of: We are recognised and rewarded, We each have a voice that counts, We are always learning, We are a team and Staff Engagement. The Trust is average for one theme: We are compassionate and inclusive. The Trust has scored slightly below average for the themes of: We are safe and healthy, We work flexibly, and Morale. Due to a technical issue affecting questions under the We are safe and healthy theme nationally, accurate rankings are not available at the time of writing.



Most improved scores

The table below shows the top five most improved scores for 2023 in comparison to 2022. We have seen improvements since 2022 in q4c satisfied with level of pay and q3h have adequate materials, supplies and equipment to do my work, which both featured in the most declined scores for 2022. In addition, we have seen improvements in q10c don't work any additional unpaid hours per week for the organisation, over and above contracted hours, which featured in the bottom 5 scores for 2022. Q10c and Q3h were part of the Trust-wide five improvement areas for 2022.

People Promise element or theme	Question	Org 2023	Org 2022
We are safe and healthy	q3i. Enough staff at organisation to do my job properly	31%	23%
We are recognised and rewarded	q4c. Satisfied with level of pay	27%	21%
Not themed	q10c. Don't work any additional unpaid hours per week for the organisation, over and above contracted hours	41%	35%
We are safe and healthy	q3h. Have adequate materials, supplies and equipment to do my work	51%	46%
We are safe and healthy	Q11c. In last 12 months, have not felt unwell due to work related stress	58%	53%

Most declined scores

The below table indicates the most declined areas in comparison to the 2022 staff survey results. Q11a also featured in the most declined scores for the 2022 results. We are better than the NHS average in q9c and q9d, as well as average for q20a, although they are our most declined scores.

People Promise Element or theme	Question	Org 2023	Org 2022
We are safe and healthy	Q11a. Organisation takes positive action on health and well-being	50%	51%
We are a team	Q9c. Immediate manager asks for my opinion before making decisions that affect my work	63%	64%
We each have a voice that counts	Q20a. Would feel secure raising concerns about unsafe clinical practice	70%	71%
We are a team	Q9d. Immediate manager takes a positive interest in my health & well-being	70%	71%
Staff Engagement	Q2c. Time often/always passes quickly when I am working	73%	74%

Highest and lowest ranking scores

The below table shows the top 5 scores for Whittington Health in comparison to the NHS average scores for NHS organisations, similar to Whittington Health. Q10b and q5c also featured in the top 5 scores for 2022 and both have improved by another 2%.

People Promise element or theme	Question	Org	Picker average
Not themed	Q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	74%	63%
Morale	Q5c. Relationships at work are unstrained	53%	47%
We are compassionate and inclusive	Q25b. Organisation acts on concerns raised by patients/service users	74%	69%
We are a team	Q7b. Team members often meet to discuss team's effectiveness	66%	61%
Not themed	Q19d. Feedback given on changes made following errors/near misses/incidents	64%	60%

The table below shows the bottom five scores for Whittington Health in comparison to the NHS average. We can see that there has been slight improvement in q31b on Disability: organisation made reasonable adjustment(s) to enable me to carry out work by 2% since 2022, which was one of the focus areas for Trust last year.

People Promise element or theme	Question	2023	Picker Average
Not themed	Q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	66%	74%
Not themed	Q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	41%	48%
Morale	Q26b. I am unlikely to look for a job at a new organisation in the next 12 months	45%	52%
We are safe and healthy	Q11a. Organisation takes positive action on health and well-being	50%	57%
Morale	Q26c. I am planning on leaving this organisation	51%	58%

Current Developments and Future Plans

Last year, the Organisational Development team hosted five listening events alongside the Executive team focusing on the five Trust-wide improvement areas which included two of the People Promise themes: 'we are safe and healthy'; and 'we are compassionate and inclusive'. After each listening event, an action plan was created by key stakeholders, executive leads, and subject matter experts, to help implement changes across the Trust.

As a result of these listening events, we have seen improvements in the 2023 results in the following four areas: having adequate materials; don't work any additional unpaid hours; career progression: reasonable adjustments. However, this year we have seen a slight decline in staff feeling that the organisation takes positive action on health and wellbeing.

Five Trust-Wide Improvement Area	People Promise theme	Staff Survey 2022 Results	Staff Survey Results 2023
1. Fairness in career progression	We are compassionate and inclusive	49% of staff believe our organisation acts fairly on career progression.	50% of staff believe our organisation acts fairly on career progression 
2. Working additional unpaid hours	Not themed	65% of staff are working additional unpaid hours.	57% of staff are working additional unpaid hours. 

3. Improving wellness at work	We are safe and healthy	51% of staff felt that the organisation takes a positive action on health and wellbeing.	49% of staff felt that the organisation takes positive action on health and wellbeing. ↓
4. Making reasonable adjustments for staff	Not themed	65% of staff felt that the organisation made reasonable adjustment(s) to enable them to carry out work with their disability.	66% of staff felt that the organisation made reasonable adjustment(s) to enable them to carry out work with their disability. ↑
5. Having adequate materials and supplies to do the job properly	We are safe and healthy	46% of staff felt that they had adequate materials, supplies and equipment to do their work properly.	52% of staff felt that they had adequate materials, supplies and equipment to do their work properly. ↑

The directorate/ICSU results for Whittington Health and score matrix can be found in **Appendix 4**.

Equalities Indicators from the Staff Survey

In its sixth year, Workforce Disability Equality Standards (WDES) breakdowns are based on the responses to questions *Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?* The questions related to WDES results remain historically comparable since 2019, but the WDES labels have been updated to better reflect the new wording of the question, for example the word ‘*disability*’ has now been replaced by ‘*long-term condition (LTC) or illness*’.

WDES (Workforce Disability Equality Standards) indicators reported in the Staff Survey for Whittington Health

The WDES table can be seen in Appendix 5 shows **improvement in five out of the nine WDES indicators**, this includes: a decrease in staff with a long-term condition (LTC) or illness, who experience bullying or abuse from patients, managers or colleagues; staff with LTC or illness saying that they have felt pressure from their managers to come to work, despite feeling unwell; staff with LTC or illness feeling satisfied with the extent to which their organisation values their work; staff with LTC or illness saying that their employer has made adequate reasonable adjustments for them; and an increase in the staff engagement score of 0.1.

Significant effort from the Inclusion team has gone into improving reasonable adjustments for staff since the staff survey results of 2022, such as the holding of a Trust-wide listening event dedicated to this improvement area, the improvement of reasonable adjustment training, and further guidance to managers on how to carry out reasonable adjustments for staff.

However, two out of the nine WDES indicators have shown a decline since last year, these include the reporting of harassment, bullying or abuse at work of a staff with LTC or illness (by self or colleague), and staff with LTC or illness believing that their organisation provides equal opportunities for career progression or promotion.

Patient Feedback: Friends and Family Tests

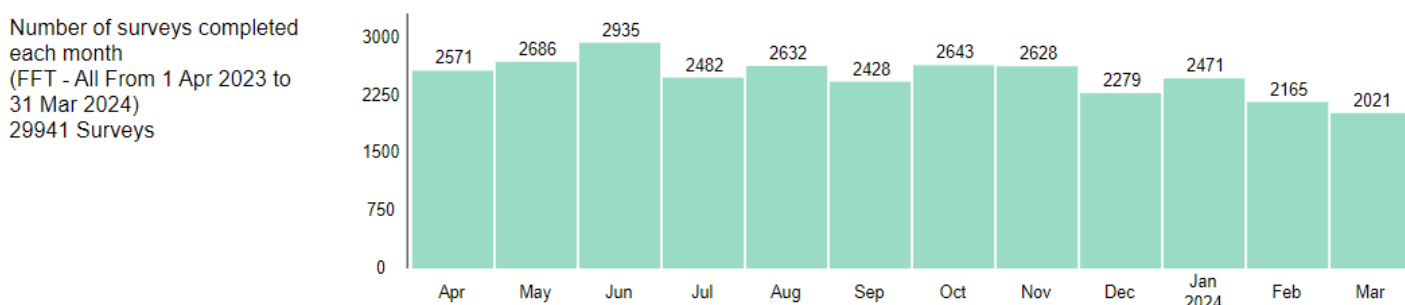
Family & Friends Test (FFT)

Response Rates

A total of 29,941 Friends & Family Tests (FFT) were completed for the year, this is an increase on the previous year of 1,269 (28,672)

June 2023 received the highest volume of submissions of 2,935, coinciding with focused intervention from the Patient Experience team in supporting the completion of FFT's through the use of volunteers.

Figure 1: Number of FFT Surveys completed in the Trust by month



Work continues within the Patient Experience Team and Voluntary Services to promote and collect FFT responses, with a focus for 2024-25 on recruiting ward befriender and FFT volunteers to support the completion of FFT's and improve on our patients' experience. This includes the ongoing work of collecting handwritten postcards to upload to the electronic reporting system. Volunteers provide additional support with FFT's in outpatients, maternity, and imaging with face-to-face collections.

The Patient Experience team have secured an additional 7 iPads to support volunteers obtaining feedback. The team introduced QR cards, these cards are attached to staff lanyards and acts as a reminder to staff to encourage feedback from patients. The QR cards are scanned, and the patient is then taken to an online survey. Our Day treatment centre has added their QR code to the appointment letters, and posters informing patients of our FFT's have been reintroduced in outpatient clinics and being placed in prominent positions.

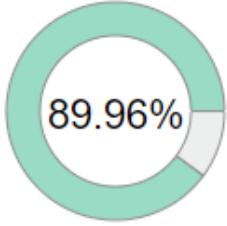
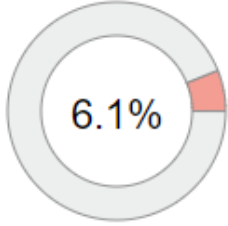
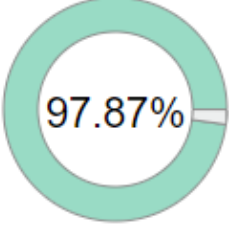
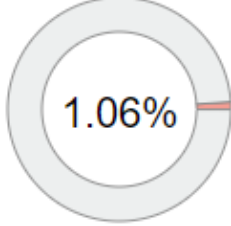
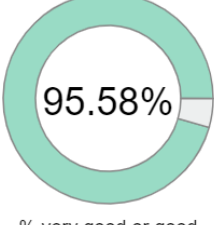
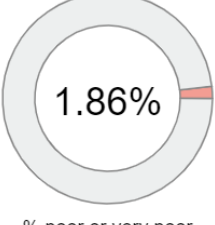
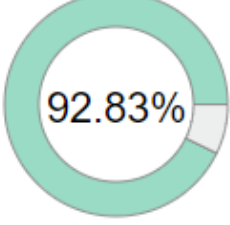
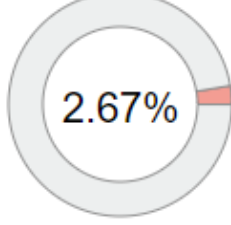
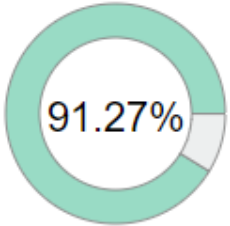
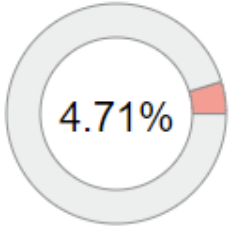
FFT responses are received from a range of sources, including:

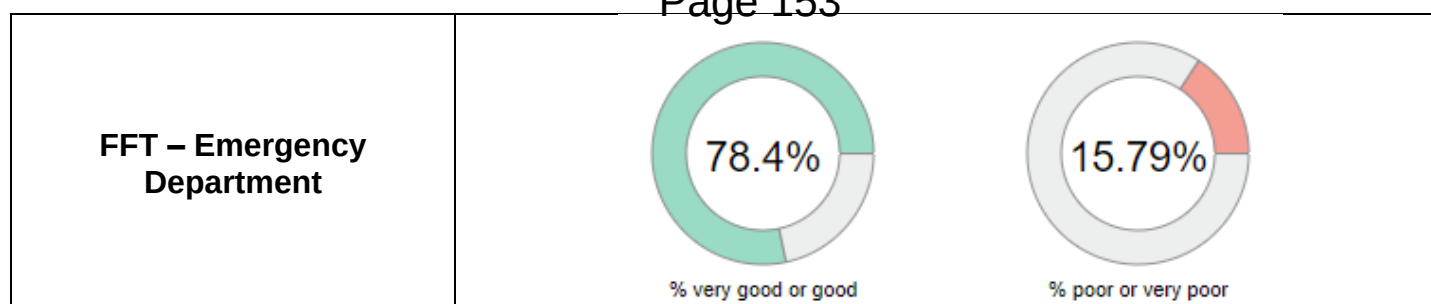
- SMS/text (11,138 responses)
- Smartphone app/tablet/kiosk before or at point of discharge or at appointment (7,285) responses
- Paper/postcards at the point of discharge (6,471 responses)
- Online survey after discharge/appointment (5,044 responses)
- Telephone survey after discharge of appointment (3 responses)

QR codes have been introduced across the Trust for each service, enabling patients to provide feedback from their own devices, as well as reducing the need for manual collection and inputting of data. The automated SMS/text message is in place, with the largest number of SMS/text responses being received for the Emergency Department FFT 7,767.

Scoring

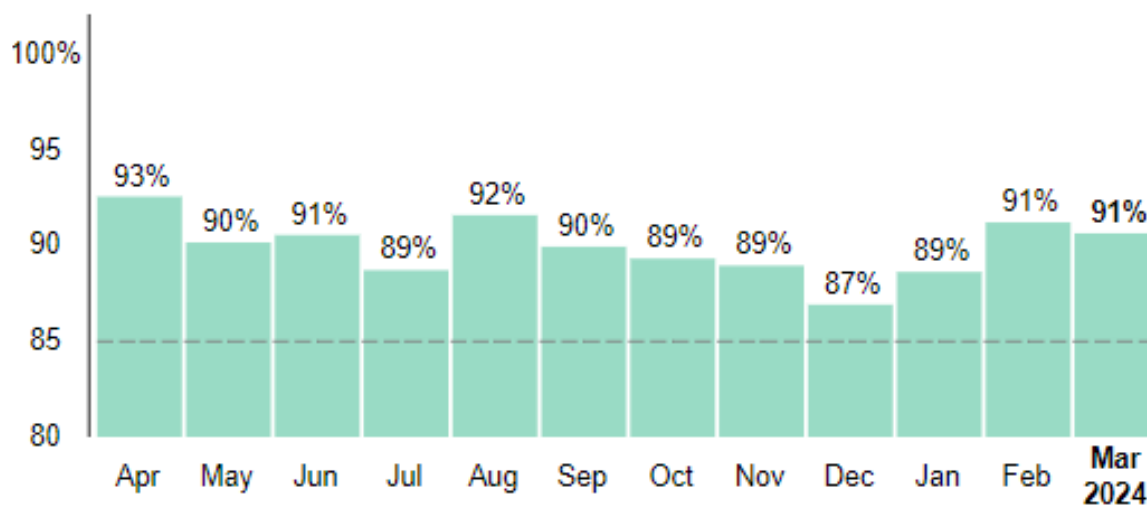
The below charts demonstrate the percentages of “very good/good” versus “poor/very poor” responses.

FFT - All	 89.96% % very good or good	 6.1% % poor or very poor
FFT – Maternity Combined	 97.87% % very good or good	 1.06% % poor or very poor
FFT - Community	 95.58% % very good or good	 1.86% % poor or very poor
FFT - Inpatient	 92.83% % very good or good	 2.67% % poor or very poor
FFT - Outpatient	 91.27% % very good or good	 4.71% % poor or very poor



Overall positive scoring has increased by 6% from 84% to 89.96%, and we have seen a decrease in negative response from 7% to 6%. It is noted that the lowest scoring is within the Emergency Department and Outpatient FFTs, which has been significantly impacted by operational pressures, OPEL 4 and industrial action throughout the year. On further analysis, a success is that the Trust has maintained a level above the 85% NHS benchmark month on month.

Figure 2: Very good and good responses for all FFTs.



The Patient Experience and Engagement Strategy for 2023-2025 has been written and an action plan drawn up and includes:

Ambition 1: Ensure that FFT questions are accessible to as many patients and carers as possible to ensure the responses reflect the diverse patient population.

Year 1 target: Return to baseline response rate from pre-COVID, ensuring that each area has the questions available in a range of languages and formats to maximise accessibility.

Ambition 2: To increase active patient involvement and participation throughout the Trust at all levels.

Year 1 target: Recruit patient experience and safety partners and evidence of co-design in QI projects; create a page on the patient facing internet for 'You Said We Did' which will be updated at least quarterly.

Ambition 1: Creating a standardised dashboard or report each quarter for each ICSU.

Ambition 2: Create a toolkit for staff around how to engage with patients and with advice about different forms of patient engagement.

Ambitions actioned during 2023-2024 include:

Ensure that FFT questions are accessible to as many patients and carers as possible to ensure the responses reflect the diverse patient population

Recruit additional volunteers to support face to face FFT collection for further areas: including ED, Maternity, Inpatients – **action complete, ongoing recruitment of FFT volunteers**

Implement “You Said, We Did” internet page – **action complete** [You said, we did \(whittington.nhs.uk\)](https://www.whittington.nhs.uk)

Co-ordinate timetable for current volunteers and Patient Experience team to gather outpatient responses in person at least once a week – **action complete ongoing recruitment of FFT volunteers**

Trial individual QR codes for active survey: Make new QR posters for specific surveys develop business cards including QR codes – **action complete, QR cards & posters provided to department**

Return to baseline response rate from pre-COVID, ensuring that each area has the questions available in a range of languages and formats to maximise accessibility

Create dashboard and dashboard report – **action complete, dashboard of FFT, Complaints performance by trust and ICSU created and shared**

FFT available in other languages and in easy read.

Development of toolkit (e.g., de-escalation training, open discussions, PALS route/understanding, listening & communication skills, provision of patient information) – **action complete** **Complaints training reinstated**

Consider making mandatory training / part of induction - Complaints, PAL & patient experience part of the corporate welcome

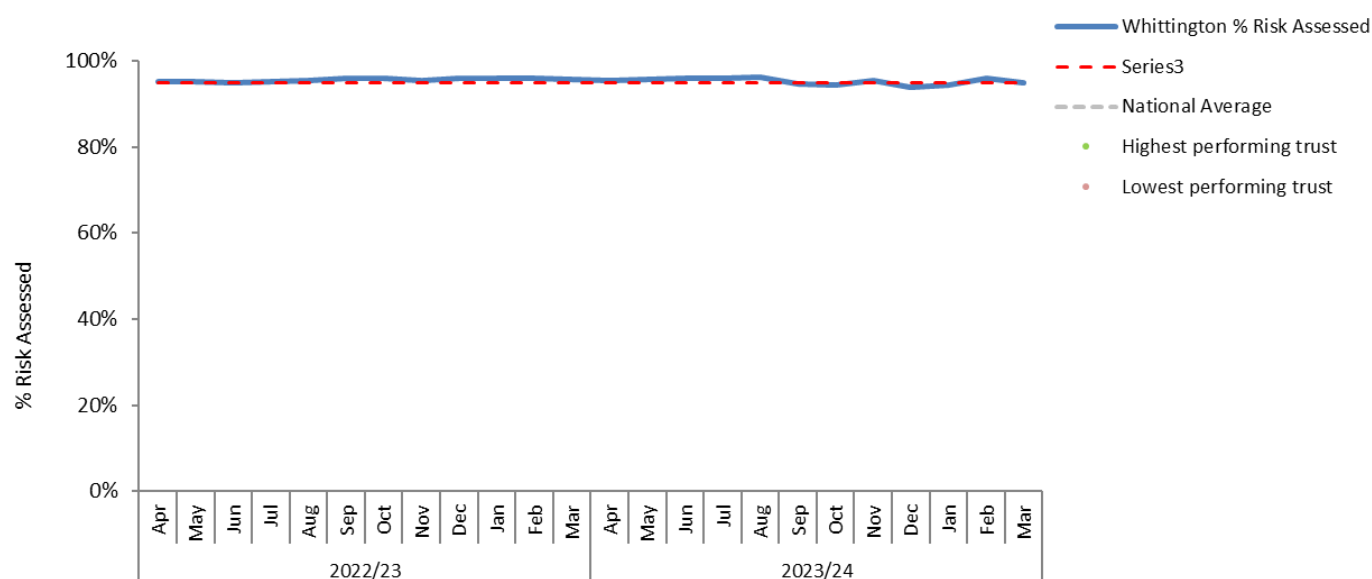
Work alongside our local partners to improve patient experience

Scope out network of local partners – **action complete** – **list of community stakeholders created, volunteer team attend community events to raise awareness**

Create a toolkit for staff around how to engage with patients and with advice about different forms of patient engagement - **action complete and available on the intranet** [Engagement Toolkit \(whittington.nhs.uk\)](https://www.whittington.nhs.uk)

Venous Thromboembolism (VTE)

VTE Risk Assessment Rates 21/22 & 22/23 to date



**From Q4 2019/20 the VTE data collection and publication had been suspended to release capacity for providers and commissioners to manage the COVID-19 pandemic. This was communicated on 28th March 2020.*

Every year, thousands of people in the UK develop a blood clot within a vein. This is known as a venous thromboembolism (VTE) and is a serious, potentially fatal, medical condition. The Trust policy requires all admitted patients to be individually risk assessed and have appropriate thromboprophylaxis prescribed and administered.

In the last financial year (April 2023 – March 2024), the Trust VTE Risk assessment (RA) compliance has overall averaged above 95%, as per the National Standards. The Trust monthly VTE risk assessment compliance has been consistently above 90%. We are providing continuous education and training and working with teams to ensure we are meeting the national standard monthly.

The following actions have been taken:

- Continuous close co-operation between the VTE pharmacist and Information Technology (IT) to ensure continuation and monitoring of mandatory VTE risk assessment completion on the Careflow clinical noting system.
- Education and training sessions to nurses, health care assistants, doctors, and pharmacists to ensure teams are completing VTE risk assessments for all admitted patients.
- Introducing the implementation of the electronic VTE RA in the paediatric patient cohort, this is currently a work in progress.

- A quality improvement project with pre-assessment clinic to convert paper bridging plans for anticoagulated patients to electronic to avoid issues with peri-operative bridging ensuring patient safety. This involves multidisciplinary working with the pre-assessment clinic consultant, IT, VTE pharmacist and the anticoagulation team.
- Weekly VTE team meetings to review actions to be taken to increase VTE RA compliance and update policies/guidelines.
- Weekly MDT meeting with the haematology consultant, anticoagulation team and VTE pharmacist to follow up complex VTE patients who need bridging plans or haematology reviews.
- A quarterly Thrombosis Committee meeting with a multidisciplinary representation.

Root Cause Analysis:

Root cause analysis represents an educational tool for healthcare professionals on VTE thromboprophylaxis. The VTE pharmacist and the haematology team are working together to ensure we continue to collect and analyse data to ensure we meet trust standards.

- A report system is in place to provide data on Hospital Acquired Thrombosis (HAT) which occurred annually in the Trust.
- Serious Incidents management (Datix) and co-operation with the Medication Safety Officer and Patient Safety Group leads to help increase awareness of incidents occurring related to anticoagulation.

The team continues to work towards an application as VTE Exemplar Centre.

Infection prevention and control

The Head nurse for Infection Prevention and Control (IPC) services, in collaboration and under the direction of the Chief Nurse and Director of Allied Health Professionals, who is the Accountable Officer, and Director of Infection Prevention and Control, provide an IPC service to the hospital, dental and community services across Whittington Health NHS Trust, Monday to Friday with an out of hours support from Microbiology and the site team.

Operationally, IPC are a team of senior IPC nurses, and an IPC support team of admin, auditor and an information analyst who, whilst supporting national, regional and local reporting on health care acquired infections (HCAI), ensure the focus is firmly on infection prevention through surveillance, audit, education, training. Wherever incidence of acquired or known transmission of a high-profile (e.g., MRSA bacteraemia) and / or communicative pathogen (e.g., Covid-19) occurs, transmission-based precautions are applied, cases are reviewed and when necessary, closure of beds recommended.

The IPC team perform post infection reviews which surveys all aspects of the patient journey from pre-admission through to discharge when the patient acquires a Healthcare acquired infection (HCAI). This often includes a multi-disciplinary team review with rapid feedback of shared learning with the aim to identify how a case occurred and to identify actions that will prevent similar cases reoccurring in the future. The Infection Prevention and Control Committee (IPCC) meets quarterly to review, gather and evaluate the HCAI data, and related information (tables below) to ensure Trust-wide shared learning and to provide an appropriate platform for escalating outstanding actions.

Health Care Acquired Infections (HCAI)

Whittington Health's IPC policy documents the importance of preventing and reducing rates of HCAI and the surveillance of potential incidents namely: Trust attributable bacteraemia's such as Methicillin Resistant Staphylococcus Aureus (MRSA and MSSA) and Escherichia Coli (E. Coli), Clostridium Difficile infection (CDI), HCAI outbreaks, Acute Respiratory Infections (ARI) (e.g., Influenza and COVID-19) across the Trust. This remains critical for inpatients who are at risk as they provide essential information on what and where the problems are and how well control measures are working.

Nosocomial, or HCAI, are defined as those occurring:

- as a direct result of treatment in, or contact with, a health or social care setting
- because of healthcare delivered in the community healthcare-associated infections
- outside a healthcare setting (for example, in the community) and brought in by patients, staff or visitors and transmitted to others (for example, norovirus).

(NICE Quality Standard- 13 - 2016)

The UK Health Security Agency (UKHSA) monitors the numbers of certain infections that occur in healthcare settings through routine surveillance programmes and advises on how to prevent and control infection in establishments such as hospitals, care homes and schools.

Whittington Health, alongside other NHS commissioned services, refer to the [NHS England National infection prevention and control manual \(NIPCM\) for England](#) for best practice of IPC in both the acute and community settings. The Trust follow, among other important national mandatory and recommended guidance:

- Mandatory UKHSA Data Capture System, this is an integrated data reporting and analysis system for the mandatory surveillance of Staphylococcus aureus, Escherichia coli, Klebsiella spp., Pseudomonas aeruginosa bacteraemia and Clostridioides difficile infections, with the intention of reducing such infections through building better evidence base and allowing us to target problem areas.
- Acute Respiratory Infection (ARI), this guidance is consistent with the approach of managing COVID-19 increasingly in line with other ARIs, made possible by high vaccination coverage, high immunity amongst the population, and increased access to COVID-19 treatments.
- [NHS Standard Contract 2023/24: Minimising Clostridioides difficile and Gram-negative bloodstream infections](#), set out the requirements to minimise rates of both Clostridioides difficile (C. difficile) and of Gram-negative bloodstream infections to threshold levels set by NHS England.
- Surgical Site Infection Surveillance Service, jointly run by UKHSA healthcare associated infection and antimicrobial resistance department (HCAI & AMR) this service helps hospitals in England record and follow up incidents of infection after surgery and use results to review or change practice as necessary. This service supports both the mandatory surveillance of SSI in 4 categories of orthopaedics and voluntary surveillance in 13 categories of surgical procedures.

Mandatory UKHSA Data Capture System**Methicillin Resistant Staphylococcus Aureus (MRSA)**

Notwithstanding, [NHS England's Patient Safety document](#), to deliver zero tolerance on MRSA bloodstream infections (BSI), the Trust have two bacteraemia's this year end 2023/24. Case one (December 23) was an unavoidable BSI in a very unwell ICU patient who was previously not known to WH as colonised with MRSA. The blood culture, screening and treatment was carried out well. The source of the second MRSA BSI (March 24) was from an infected peripheral vascular device site with delayed suppression treatment given. This case was deemed avoidable.

There is an extensive peripheral vascular device (PVD) quality improvement (QI) project underway within the Trust, incorporating education, training, audit and feedback around PVD care, communications through posters and reminders are given in handovers, and huddles reinforcing PVD care standards. This work will have implications for all blood stream infections acquired through a PVD. More work is in planning for suppression therapy and compliance with in 2024/25.

Methicillin Sensitive Staphylococcus Aureus (MSSA)

WH saw 6 healthcare-acquired cases of MSSA for 2023/24. There is no NHS standard contract for MSSA. However, there has been a 50% decrease in cases over the last 5 financial years (12 vs 6).

Gram-negative bacteraemia's

Due to the national rise in Gram-negative bloodstream infections (GNBSIs); namely *E. coli*, *Pseudomonas aeruginosa* and *Klebsiella* spp., and their increasing resistance to key antibiotics, the NHS long-term plan aims to reduce GNBSIs by 50% by 2024/25.

The national increase is reflected in our Trust levels of healthcare acquired GNBSIs. Year-end 2023/24 figures for Whittington Health Trust against the [NHS standard contract thresholds](#) are as follows:

- WH saw 3 healthcare-acquired cases of *Pseudomonas aeruginosa* for 2023/24 against an annual threshold of 2. There has been a 40% decrease in cases over the last 5 financial years (3 vs 5).
- WH saw 21 healthcare-acquired cases of *E. coli* for 2023/24 against an annual threshold of 19. There has been an 16% decrease in cases in the last five financial years (21 vs 25).
- WH saw 13 healthcare-acquired cases of *Klebsiella* spp. for 2023/24 against an annual threshold of 13. There has been a 16% increase in cases in the last five financial years (13 vs 11).

Although over annual thresholds (*P. aeruginosa* and *E. coli*) and equal to threshold (*Klebsiella* spp.) set by the NHS Standard Contract, numbers are considerably low.

Clostridioides difficile Infection (CDI)

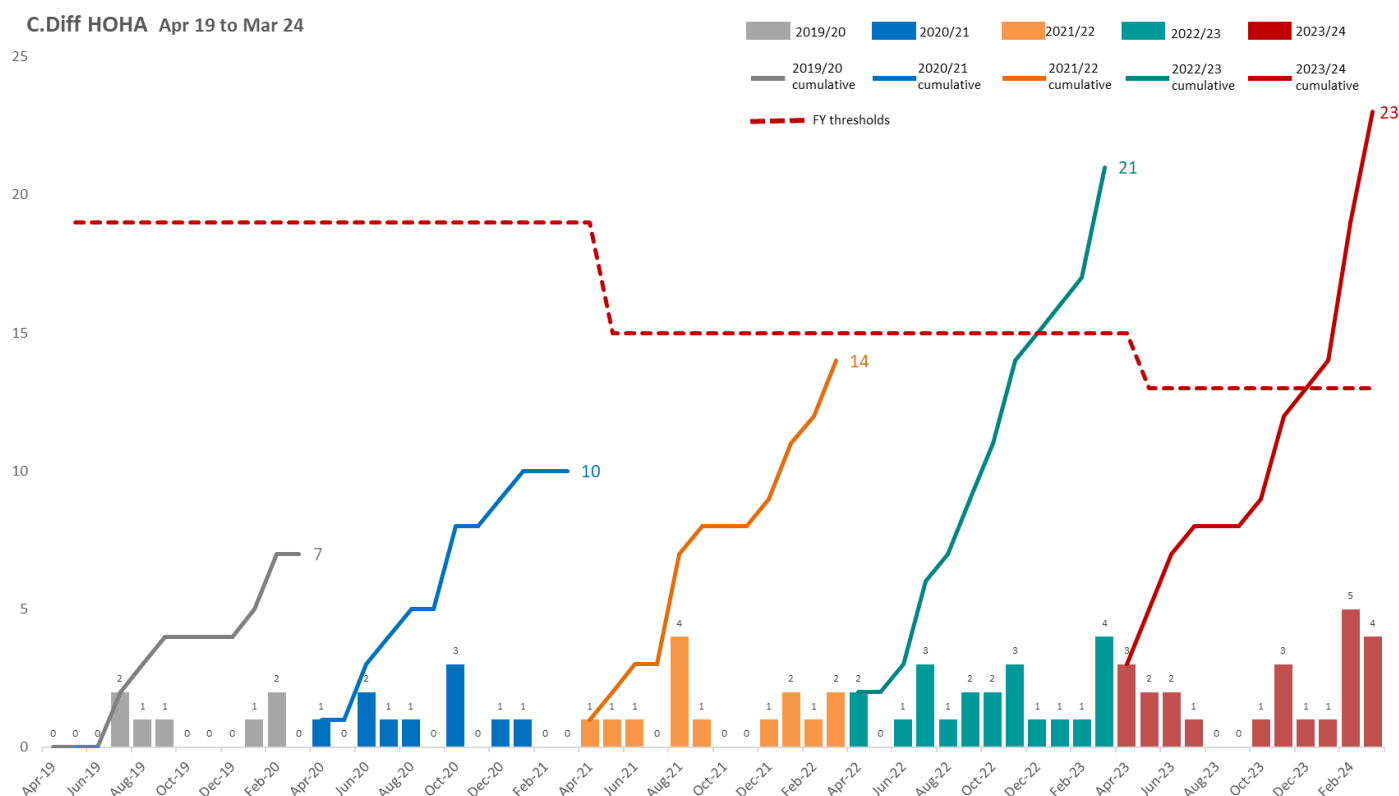
Whittington Health have passed the hospital acquired toxin+ *Clostridioides difficile* infection (CDI) trajectory [13], with 23 cases. Year end 23/24, with one case pending, there are 10 different ribotypes from 16 cases, whereby six could not be tested (unviable). Ten cases, who although shared the same ribotype(s) (002, 015, 014, 106, 023) were not linked in time or location, illustrating very low patient to patient transmission in hospital. However, a care of the elderly ward was the same location for the latter (023) which may indicate environmental transmission. There has been one probable

transmissible infection (076) linked to a lapse in policy (delay to isolate a relapse case of CDI). Unprecedented unviable samples may indicate local processing issues. Whittington Health microbiology laboratory is currently undertaking a review of standard operating procedures for CD testing.

GDH (Glutamate dehydrogenase) positive, toxin negative cases (meaning *Clostridioides difficile* carriage), coupled with GDH positive, toxin positive (meaning infection and reportable) represented seven (n=19 cases) individually reported outbreaks to UKHSA.

UKHSA state ‘Since January 2021 there has been an increase in *Clostridioides difficile* infections (CDI) for which there is no clear explanation. In addition to this national increase, a local change to testing in November 2022, resulting in more testing, is reflected in our Trust levels of hospital onset, healthcare associated (HOHA) CDI toxin+ cases as demonstrated in table one.

Table one. Trust levels of hospital onset, healthcare associated (HOHA) CDI toxin+ cases over five years. Whittington Health. 2019 – 2023.



A CDI exception review was carried out in July 2023 and again in February 2024. Key findings indicate speed of diagnosis is important for the efficient use of isolation facilities, and that clinicians should ensure that stool specimens are sent for toxin testing as soon as infective diarrhoea is suspected. The latter potentially preventing HOHAs if within the first 48 hours of admission.

Acute Respiratory Infection, including Covid-19

Acute respiratory infection (ARI) is defined as the acute onset of one or more of the respiratory symptoms listed at [People with symptoms of a respiratory infection including COVID-19](#) and a clinician’s judgement that the illness is due to a viral acute respiratory infection (for example COVID-19, influenza A and B, respiratory syncytial virus (RSV)).

Covid-19. Year end 23/24, there have been 89 definite COVID-19 HCAI cases and a reduced number of COVID-19 outbreaks (n=30) requiring management. Also seen nationally are reduced COVID-19 hospitalisations and mortality, and a reduced clinical severity of COVID-19 infection.

Influenza A and B. Year end 23/24, 25 patients acquired influenza A from a of total 308 (276 type A and 34 type B) influenza cases in the hospital. With 'flu season' starting in December (n=73), January peaked with 107 cases falling in February (n=55) and March (n=21) and reporting a total four outbreaks of influenza A (Dec23 – Mar24).

Respiratory Syntical Virus (RSV). Year end 23/24, 25 patients acquired RSV from a of total 279 RSV cases in the hospital. Incidence of RSV began in November (n=105), December (n=94), dropping in January (n=30). There were no outbreaks.

Surgical Site Infection Surveillance Service (SSISS)

It is recommended by UKHSA that surveillance should be undertaken in more than one consecutive period or continuously so that 'more precise rates can be estimated from a larger set of cumulative data' (UKHSA 2013 – Protocol for the Surveillance of Surgical Site Infection).

Whittington opted to report four quarters in 2023/24 on repair of neck of femur fracture surgery, with zero reported infection in quarters one (operations n=20), two (operations n=20) and four (operations n=21). There was one infection reported in quarter three from 31 operations performed.

A sample review of Caesarean section operations (n=123) was undertaken in the month in October 2023 for consideration to opt into the voluntary surveillance category of surgical procedures in 2024/25. This data is under review with key stakeholders.

Patient Safety Incidents

Serious incidents

During 2023/24 the Trust has been intensively preparing for its transition from the Serious Incident Framework (SIF) to the new Patient Safety Incident Response Framework (PSIRF). This is a statutory requirement for all NHS provider organisations. This will ensure the Trust can focus more time and resource on learning and improving and less on repetitive investigations; this is the very essence of the PSIRF.

An Executive-led implementation group has been established to drive this forward and additional project management support has been procured to ensure the Trust's transition is both effective and timely. Currently, the Trust is in the latter stages of its implementation plan and has recently provided the first tranche of required training to specific staff groups in human factors and systems methodologies, which are central to the PSIRF approach. The Serious Incident Executive Action Group (SIEAG) has been reconfigured to align with the requirement of PSIRF and is now the Whittington Improvement & Safety Huddle (WISH) so there is a greater focus on learning, improvement, compassionate engagement, and supportive oversight. The Trust is in the process of completing the transition, in agreement with the ICB, and will no longer be investigating incidents under the SIF.

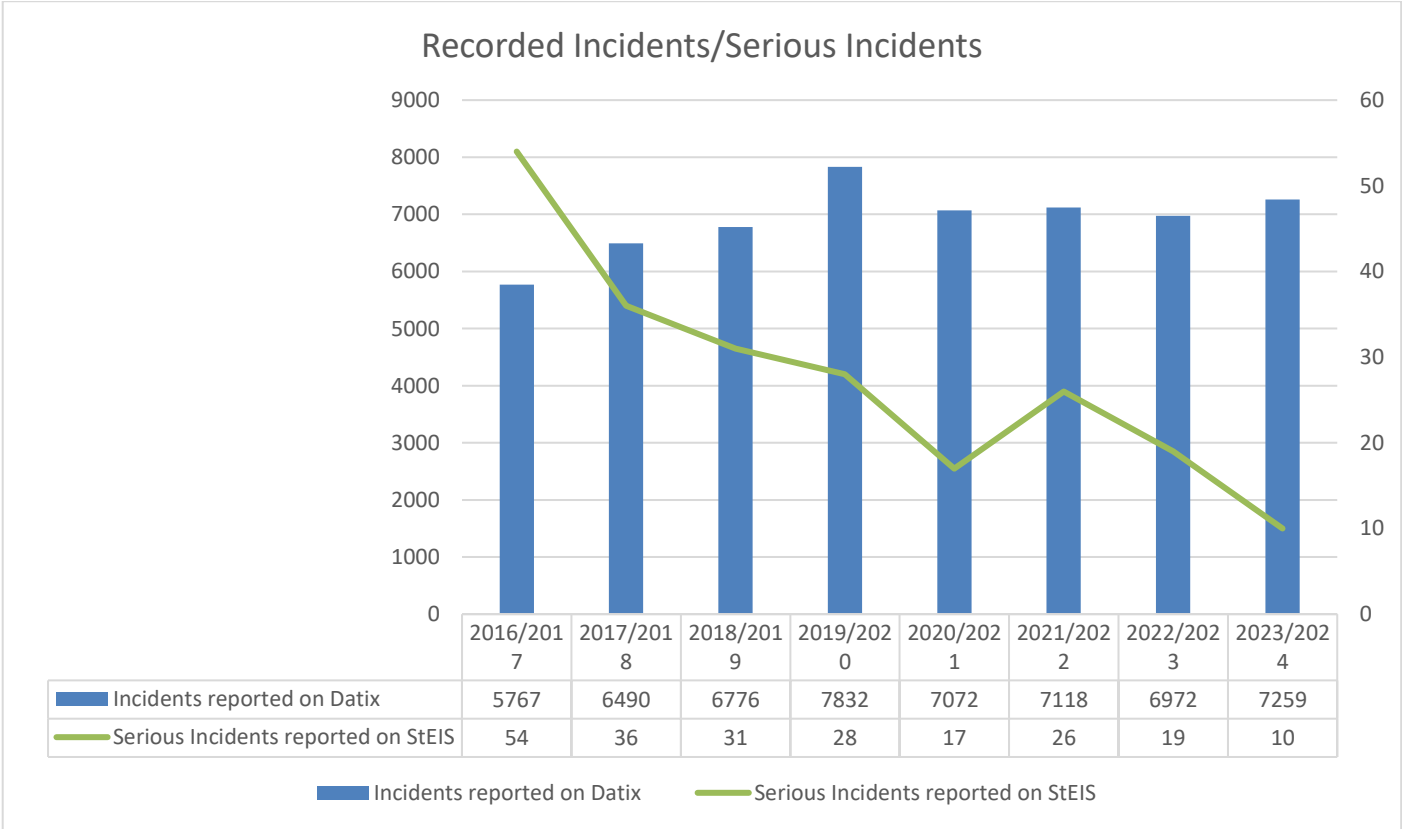
Under the PSIRF the Trust will no longer be required to declare serious incidents based on predefined thresholds. Instead, the Trust must select incidents that provide the greatest opportunities for new learning utilising the most appropriate learning response tool. The Trust will have improvement plans

and workstreams in place in relation to types of incidents where causal and contributory factors are well understood from analysis of multiple historic data sources (such as pressure related skin damage, falls and medication safety). This will ensure the Trust can focus more time and resource on learning and improving and less on repetitive investigations; this is the very essence of the PSIRF.

The PSIRF represents a significant culture shift for NHS organisations, and it is recognised that the Trust’s approach and arrangements will take time to evolve and mature.

During 2023/24 there were 10 serious incidents reported on StEIS. As illustrated in the graph below, the number of Serious Incidents declared as a proportion of all patient safety incidents has been reducing since 2016. This is a positive trend, indicative of an open, transparent safety culture where reporting of incidents is encouraged, with a higher volume of incidents which are near misses or low harm incidents.

Figure 1: Serious Incidents declared, as a proportion of all patient safety incidents 2016-2024



In preparing for the new Patient Safety Incident Response Framework (PSIRF), Whittington Health have reviewed processes to ensure that the identification of systems issues and human factors remain at the forefront of the Trust’s work with a focus on learning and improving practice. WISH have supported the use of alternative tools, such as After-Action Reviews, SWARMS, and a Multidisciplinary team (MDT) approach, Quality Improvement (QI) projects and audit projects, to drive change.

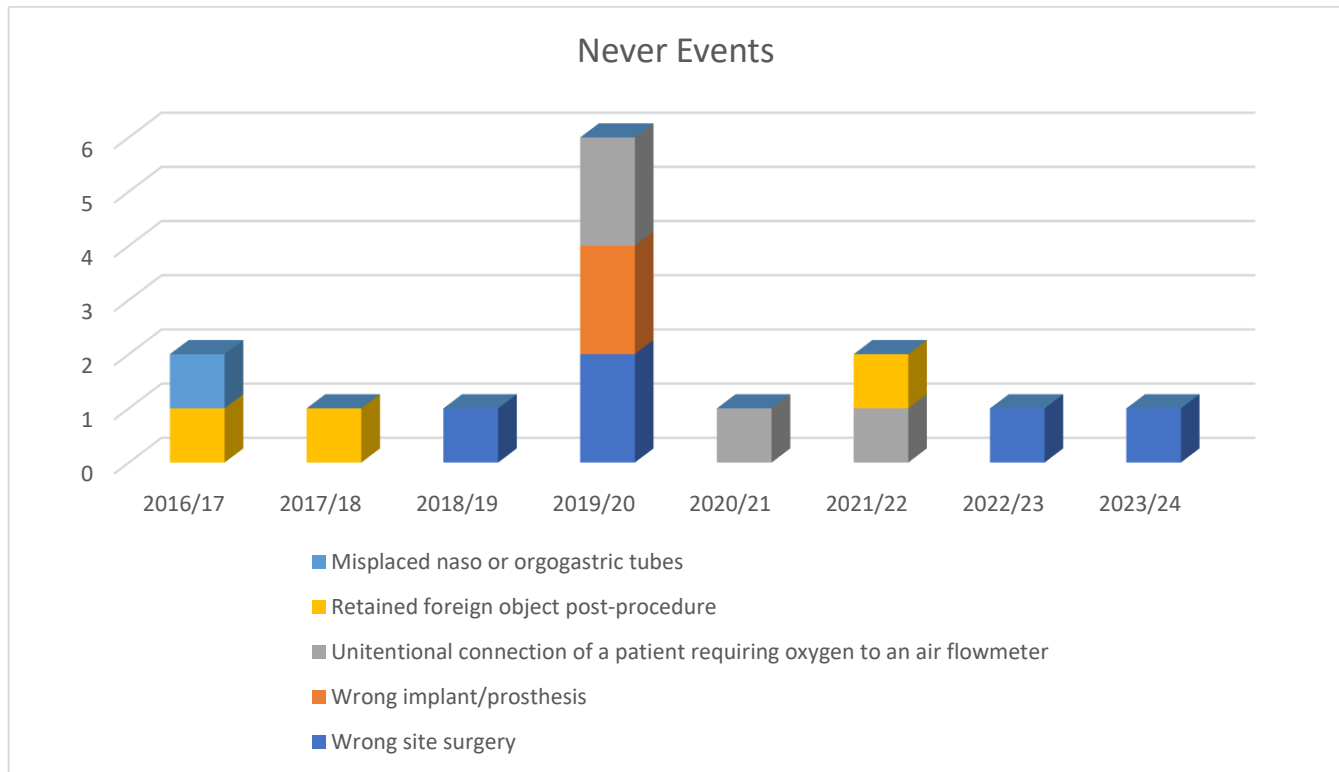
Completed investigation reports with a summary letter, highlighting key findings and changes made as a result, are shared with the patient and/or family member with an offer of a meeting with the Trust to discuss the findings.

Lessons learned following each investigation were shared with all staff and ICSUs involved in the care provided, through various methods including the 'Big 4' in theatres, and 'message of the week' in Maternity, Obstetrics, and other departments. Learning from incidents is shared through Trust-wide multimedia such as a regular patient safety newsletter, as well as at local ICSU Quality & Risk meetings and other internal media sources.

Never Events

A Never Event is defined as a serious, largely preventable, patient safety incident that should not occur if the available preventative measures have been implemented; this is a list of specific events defined nationally.

Figure 2: The number of Never Events reported by Whittington Health from 2016 to 2024



During 2023/24, the Trust reported one Never Event which was a wrong site surgery.

A patient underwent ureteric stenting and was discharged. An x-ray was used as a guide for the stent insertion procedure, but the imaging appeared to have been inverted at some point as it shows that the stent was in the correct position.

The patient returned via the emergency department with pain and abnormal renal function. Imaging showed that the stent was in the left ureter while the consent and intention of the original procedure was to stent the right ureter. The stent was removed, and the correct ureter stented.

Although this is a rare occurrence there is learning that can be embedded to mitigate the risk of recurrence:

- Urologists and theatres team to embed the process whereby it is ensured that both ureteric orifices are located prior to stent insertions.

- A second check should be done intraoperatively before the insertion of the guide in order to review the patient's imaging and correlate it with the surgical site.
- Imaging will implement a chart which will be placed on each theatre x-ray machine to aid decision making regarding orientation.

Maternity and Newborn Safety Investigations (MNSI) former Healthcare Safety Investigation Branch (HSIB) Maternity incidents

The Maternity and Newborn Safety Investigations (MNSI) programme is part of a national action plan to make maternity care safer. MNSI undertakes approximately 1,000 independent maternity safety investigations a year to identify common themes and influence systemic change. All NHS Trusts with maternity services in England refer incidents to MNSI.

MNSI investigates incidents that meet the criteria as previously defined within the Each Baby Counts programme or MNSI defined criteria for maternal deaths. During the investigations MNSI investigates all clinical aspects of the incident, as well as aspects of the workplace environment and culture surrounding the incident.

On 17 of July 2023 the Trust received updates on the HSIB maternity programme, the Maternity and Newborn Safety Investigation (MNSI) programme's transition to the Care Quality Commission (CQC):

- The MNSI is transitioning into new hosting arrangements with the Care Quality Commission (CQC) on 1 October 2023.

Between the 1 of April 2023 to the 31 of March 2024, Whittington Health one incident met MNSI criteria (Datix A101530/ MNSI MI-026257). The case was referred to MNSI (potential hypoxic ischaemic encephalopathy (HIE)). The family consented for MNSI to undertake the investigation. Following, initial internal multidisciplinary review care and service delivery problems were identified – Inconsistent, inaccurate or absence of documentation of fluid input/output/totals between practitioners.

To prevent recurrence the following immediate actions have been instigated:

- Professional Development Midwifery team undertaking daily ward rounds / spot checks – This allows individual feedback and 1:1 training.
- MEOWS, Fluid Balance, Fresh Eyes – included on the Maternity Mandatory update.
- Rolling monthly MEOWS, Fluid Balance, Fresh Eyes Audit - presented as a standing agenda item at the Maternity Clinical Governance and Safety Champions Meeting.
- Use of helicopter review stickers which require 2 hourly fluid balance documentation on the sticker.
- MEOWS/fluid balance charts to be checked / reviewed as part of a holistic review.

The MNSI final report for this patient safety incident made one safety recommendation:

"The Trust to ensure that staff are supported to follow the guidance for fluid balance in labour and the maternity pathway for sodium monitoring to reduce the risk of hyponatraemia in a mother and baby".

This aligned with the findings of the internal review and the actions to address this recommendation were already implemented as described above.

Perinatal Mortality Review Tool (PMRT)

Perinatal Mortality Review Tool (PMRT) supports systematic, multidisciplinary, high-quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and babies who die in the post-neonatal period having received neonatal care. PMRT provides a structured process of review, learning, reporting and actions to improve future care.

Between 1 April 2023 and the 31 March 2024, twelve cases met the eligibility criteria for PMRT review. The eligible cases were:

- Four stillbirths (24 weeks and 6 days; 35 weeks and 5 days; 34 weeks and 6 days and 27 weeks and 1 day gestational age)
- Two pregnancy loss at 22 weeks and 5 days and at 23 weeks and 4 days gestational age. The first baby was diagnosed with Trisomy 15 following genetic testing after birth. baby was diagnosed antenatally as severe Intrauterine Growth Restriction(IUGR) and has been care for under the FMU team the second baby was diagnosed antenatally as severe Intrauterine Growth Restriction(IUGR).
- Three neonatal deaths – These babies were known to have fetal abnormalities antenatally, and a poor outcome was inevitable. The antenatal care was led by the Fetal Monitoring Unit (FMU) with input from the neonatal and palliative care teams. All cases have been subjected to PMRT review and the reports completed.
- Three terminations of pregnancy for fetal abnormalities detected antenatally.

Overall, for the year 2023 both the Trust's stillbirth and neonatal death rates were higher than for 2021. However, still within England stillbirth and neonatal death rates – As per table below:

Table 1: Still birth rates

Classification	Total Numbers	Possible exclusions	Total Rate 2023	Total Rate 2021	Rate with exclusions 2023	Rate with exclusions 2021	England Rates for 2021
24+0 weeks and over – Stillbirth	10	1 x TOP 2 x known anomalies. 1 x not booked, not delivered but counted in figures.	3.5 per 1000	2.47 per 1000	3.17 per 1000 2.81 per 1000 2.46 per 1000	2.47 per 1000	3.52 per 1000
Neonatal Death any gestation	5	2 x extreme prem 3 x known anomalies antenatally	1.76 per 1000	0.83 per 1000	0.7 per 1000	0.55 per 1000	1.60 per 1000

The use of the PMRT is a requirement for the Safety Action 1 of the Maternity Incentive Scheme Year 5. The Trust are currently on target for all PMRT reviews. Families have been involved in the PMRT reviews.

Central Alerting System (CAS) Alerts

Patient safety alerts are issued via the CAS, which is a web-based cascading system for issuing alerts, important public health messages and other safety information and guidance to the NHS and other organisations. The Trust uses a cascade system to ensure that all relevant staff are informed of any alerts that affect their areas.

In 2023/24 the Trust received 26 safety alerts (Of which one was National Patient Safety Alerts issued by NHS Improvement/NHS England). One is currently overdue for closure, and one was closed 3 weeks after the deadline. The one overdue is being chased for an appropriate resolution and closure by the patient safety team. The rest were closed appropriately in time to meet the deadline.

Safety alerts are reviewed by the relevant group — for example Patient Safety Alerts are reviewed at Patient Safety Group, and Estates and Facilities alerts are reviewed at Health and Safety Committee — in addition there is a six-monthly Safety Alert Group in place to review performance regarding the closure of all CAS alerts.

The Quality Governance Committee monitors compliance with CAS alerts, and the Quality Assurance Committee receive updates on any concerns as part of the quarterly Quality report.

Freedom to Speak Up

The Freedom to Speak Up Guardian (FTSUG) for Whittington Health is continuously working to engage with teams and services across Community and Hospital departments and strengthen its relationships across the trust. FTSUG is working with trust leadership teams to create a culture where staff can speak up to protect patient safety and empower workers. As well as providing a safe and impartial alternative channel for workers to speak up to, the Guardian identify themes and provide challenges to their organisation to work proactively to tackle barriers to speaking up.

The successful collaboration model between the Freedom to Speak Up Guardian and our Non-Executive Director (NED) for FTSU will serve as an example to future FTSU NEDs. Our collaborative work, characterised by continuous support, has positively impacted the Guardian's well-being, safety, and overall work development and confidence. In response to a request from the National Guardian Office, our example will be utilised as a reference for the training of future FTSU NEDs. Our NED for FTSU is crucial in supporting the Guardian, addressing concerns related to the Executive team, and providing ongoing support and advice. This collaborative model showcases the NED as a 'Guardian to the Guardian', emphasising the importance of their role in ensuring a supportive and effective FTSU environment.

The Guardian is taking proactive steps to enhance the effectiveness of the reporting system by engaging with the Datix team, Safeguarding, and PALS. This triangulation of information aims to provide senior leadership with a clearer picture for prompt action while also identifying areas of potential resistance to change. The Datix form has been updated to include the Guardian as a designated recipient for concerns.

Communication and visibility remain crucial, with the Guardian collaborating closely with the Communications Department to review media activity, ensuring broader outreach and clarification of roles.

Recognising the urgency of fostering a safe environment for employees to voice concerns, we have implemented a new and revised FTSU policy in alignment with national guidelines from NHS England and Education. This policy is designed to be accessible, user-friendly, and comprehensive, serving as a valuable tool for anyone seeking to raise concerns. It outlines various routes and key contacts available to assist individuals, ensuring a clear and supportive framework for addressing and resolving issues within our organisation.

The Guardian actively participates in key educational initiatives, including preceptorship study days, Newly Qualified Nurses Orientation Training, the Health Care Support Worker (HCSW) Development Programme, and medical education inductions. Through these engagements, the Guardian educates attendees on the safe and confidential means of raising concerns, elevating the visibility of FTSU. Additionally, the Guardian remains involved in the corporate induction day for new starters, and in instances of unavailability, Speak Up Advocates step in to provide coverage, further promoting their role and expanding their experience.

The FTSU Guardian and Human Resources (HR) Business Partners continue their close collaboration, listening and supporting colleagues in particular areas of concern.

The collaboration between the FTSUG, Head of Well-being and Staff Engagement and the Organisational Development (OD) team remains integral, fostering continuous learning and action on concerns received. This partnership enables the Trust to address cultural behaviours, bullying, harassment, and detriment in a serious, committed, and constructive manner, contributing to ongoing improvement in services and staff experience. The OD team actively participates in developing and training the Speak Up Advocates network. Additionally, the Freedom to Speak Up Guardian plays a key role in de-escalating conflicts, enhancing communication at both individual and team levels, and supporting the OD team in mediations, conflict resolutions and facilitated conversations.

In order to align of Network with the national guideline we will be renaming the Speak Up Advocates to Speak up Champions. The Guardian provides supervision and support to strengthen the Network of Speak Up Champions, which currently comprises 45 Champions, with over half being from a black and minority ethnic background (BAME). New Champions are actively sought to ensure continuity when some leave the Trust. The Guardian regularly holds Network and one-to-one meetings with FTSU Champions, offering support and collecting valuable feedback from various areas. Contrary to previous trends of staff disengagement in raising concerns, there is now a noticeable increase in engagement and a rise in concerns. To further encourage this positive trend, the Guardian collaborates with Champions to visit teams and services throughout the Trust, actively listening to individuals, identifying barriers, and promoting a safe culture for raising concerns, enhancing overall engagement, visibility, and awareness of FTSU.

In the current reporting period (April 2023 to March 2024 - quarters one to four), the Freedom to Speak Up Guardian received 73 initial concerns that required action. Quarter 1 and 2 had 38 concerns, Quarter 3 and 4 had 35 concerns. Notably, all of them were raised without anonymity. This absence of anonymous concerns underscores a noteworthy level of Trust in the FTSU as a secure and confidential channel for expressing concerns. While there is a slight increase in the number of concerns in Q4, it shows less concerns if compared to the preceding year (April 2022 to March 2023) when 84 initial cases were reported. The ongoing upward trend in concerns suggests a potential return to previous patterns, indicating a need for continued attention and analysis. For the first time since the

start of recording concerns in 2018, a quarter (Q3) shown an absence of concerns from register nurses and midwives. This professional group has been consistent in raising high numbers of concerns. This aspect require further reflection and engagement with Senior nursing leaders to promote visibility and learning. On the other hand, it is noticeable an Increase of concerns raised by Administrative and clerical staff.

The Guardian has identified several priorities for the next six months to re-enable staff engagement regarding raising concerns, and they include:

- In light of the identified challenges and opportunities for improvement in the speaking-up culture within the NHS, it is imperative to prioritise the implementation of comprehensive Freedom to Speak Up training for all staff. This training initiative aims to address barriers, enhance confidence, and empower individuals at all levels to voice concerns and contribute to a positive and responsive organisational culture. By promoting FTSU training, we seek to foster a workplace environment where every member feels supported and encouraged to speak up, ultimately contributing to improved patient safety, worker well-being, and organisational excellence.
- Prioritise regular visits to both community and hospital sites to maintain ongoing visibility of Freedom to Speak Up. Ensure that the FTSU Guardian is accessible and approachable during these visits to foster a culture of Trust and openness.
- Acknowledge and prioritise initiatives by the Speak Up Network. Consider further efforts to enhance promotion, visibility, education, and encouragement within the Network.
- Continue the recruitment and training of Advocates, focusing on areas not yet covered by the Network.
- Provide support and raise the FTSU profile in all the Staff Networks.

Guardian for safe working hours – (GoSWH)

The Guardian of Safe Working Hours (GoSWH) presents a quarterly report to the Board with the aim of providing context and assurance around safe working hours for Whittington Health junior doctors. There continues to be a significant emphasis on the safety of junior doctors' working hours. This has been reflected in the ongoing engagement with the exception reporting process by both junior doctors and their supervisors. These clearly document the extra hours worked over and above their rostered hours, as well as the breaks that are missed. The time accrued through exception reports continue to be reimbursed with either time off in lieu or payment. The reasons for extra hours worked are analysed to try and effect change to prevent this from recurring where possible.

This year has covered a period of intermittent industrial action by most junior doctors. This, coupled with high levels of acuity of patients has led to high levels of exception reporting over the year. Nationally there are lower than previous numbers of junior doctors available to fill bank and agency shifts which leaves on-call teams very stretched. There continue to be high levels of fatigue and burnout amongst all staff across the NHS and this has affected the Trust's doctors and dentists in training. Despite these challenges, the hard work and resilience of junior doctors is to be commended.

There continues to be good engagement with the process of exception reporting as laid out in the 2016 terms and conditions. There has been an ongoing effort to encourage all specialities to promote and encourage the use of exception reporting and a particular emphasis on those at higher levels of training where low levels of exception reporting is typically seen. The reasons for this are multifactorial.

The Guardian of Safe Working Hours has worked closely with the junior doctors' forum to ensure there is a proactive approach to compliance with the 2016 terms and conditions. This is also where the spending of monies generated from exception reporting is discussed and decided. This process will continue.

Seven Day Service Standards

Whittington Health is committed to the 7 Day Hospital Services (7DS) Programme. The programme supports providers of acute services in tackling the variation in outcomes for patients admitted to hospitals in an emergency, at the weekend across the NHS in England. The Trust has made progress with all 4 priority standards, particularly Standard 6 where the Trust is now fully compliant for the first time this year. The Trust continues to do focussed improvement work on the remaining priority standards to move towards 100% compliance:

- **Standard 2:** Time to initial consultant review: From previous rounds of national Society of Acute Medicine Benchmarking Audit (SAMBA) and the Trust have consistently showed that we meet time to initial consultant review with the exception of patients arriving between 1500 and 2000 as this would require significant investment as would require an extension of the standard working day of General Medical consultants to midnight. Currently the acute medical admissions are covered by a consultant on the floor from 0800 to 2000 in line with most acute medical units which allows for the teams to ensure the sickest and most complex patients are prioritised for review which may well explain why no complaints, clinical incidents or feedback from mortality reviews have included lack of timely consultant review as a quality concern over the last year when the Acute Medicine team have monitored for this outcome.
- **Standard 5:** Access to diagnostics: The magnetic resonance imaging (MRI) service is now available during daytime hours 7 days a week on site for spinal cord compression with out of hours cover still provided at The National Hospital for Neurology and Neurosurgery (NHNN). Echo cover increasing with training programme underway of Intensive Care Unit, Emergency Department, and acute medical staff to provide 7-day cover by 2025. This is taking longer than anticipated last year due to key staff being required to cover acute work.
- **Standard 6:** Access to consultant led interventions: All areas are compliant with either onsite or as network pathway with partner Trusts. Access to 24/7 Interventional Radiology is via an onsite 6-day daily service with emergency out of hours cover provided via transfer to University College London Hospital which has worked well and will continued to be monitored via the clinical incident reporting system.
- **Standard 8:** Ongoing daily consultant-directed review: In most specialities this is place- Obstetrics and Gynaecology, Surgical specialities, ITU, Paediatrics but remains challenging in Medicine. The electronic record and handover system and effective daily meetings (Board Rounds) has allowed effective prioritisation for daily review, but it must noted that at weekends the weekend consultant staffing in medicine not adequate to allow consultant level ward reviews rather this task is delegated to the ward registrar who asks for consultant input from the on-site consultant if required. EIM will review if the change required to consultant job planning (with implications for weekday elective work particularly) is possible during 2024-25.

The Trust is fully compliant with the remaining standards 1, 3, 4, 7, 9 and 10 which are assessed through self-assessment annually.

Part 3: Review of Quality Performance

This section provides details on the progress the Trust is making with the Quality Account priorities 2020-24. the Key milestones and targets were identified for Year 4 (2023/24).

Priority 1: Reducing harm from hospital acquired deconditioning.

Aims for 2023/2024:

What did we achieve in 2023/24? – Project 1: Pressure Care

Project 1: Pressure Care:

- Goal 1: To ensure 100% of patients have documentation of a full pressure ulcer risk assessment within 6 hours of admission, and an action plan (including all required pressure relieving equipment required) to manage risks identified in place within 24 hours of admission.

This priority has not been achieved in 2023/24, this has been due to challenges with the pressure care equipment provider NRS which have been reported nationally. As well as national changes to pressure ulcer reporting that were released in November 2023, and have come into effect as of the 1st April 2024.

Progress in 2023

In May 2023, an improvement meeting was held with representation from across the acute services, facilitated by Quality Improvement, focussing on process mapping the patient's journey from front door to discharge. This resulted in dynamic discussions about what already works well and what can be improved, with key themes including Quality of Care, Documentation, Education & Training and Equipment. In response to this, Pressure Care was the theme for the month of June at Back to the Floor sessions. Back to the Floor is a visible nursing leadership programme, launched in April 2023, where each Wednesday, senior nursing and AHP leads take the time to return to the floor with the aim of:

- Providing and cascading education
- Identifying potential solutions to problems
- Supporting junior staff with practical skills
- The topics for Pressure Care included:
 - Assessment and Care Plans
 - Documentations
 - Categorisation & Escalation
 - Equipment & Surfaces

Sessions were well attended by senior leads and key areas for improvement were identified, with opportunities for frontline staff to receive ad hoc training and support when gaps in knowledge and confidence were identified.

During Q2 and Q3, electronic nursing documentation was reviewed and updated to include Pressure Care Assessment, with prompts to signpost nursing staff on what assessments need to be done and any actions that need to be undertaken. An electronic documentation

template for Pressure Ulcer Plan was drafted. The publication of this documentation is under review, in order to ensure that the documents are up to date with NHSE Guidance, released in November, that changes the current Pressure Ulcer management and documentation, affecting categorisation, reporting and pressure ulcer assessment.

Aside from the Quality Account goal set, wider improvements within Pressure Care have continued throughout the year, resulting in an overall reduction in number of patients who have developed pressure damage attributable to Whittington Health. Achievements have included:

- Amendments to the acute equipment delivery service, increasing from 5 to 6-day service and inclusive of bank holidays.
- Nomination of skin care ambassadors in over 90% of clinical areas
- Guidance on skin assessment in range of skins tones
- Hospital wards achieving 129- and 140-days Pressure Ulcer free.

World "Stop the Pressure" Day was held in November, with events including hosting a stand in the Atrium to raise awareness, making pledges to make every contact, and free educational webinars were available. A Stop the Pressure Conference was held, with topics including Assessing skin (including in dark skin tones), Learning Disability and Mental Capacity, Nutrition, Podiatry, OT and Physio. The conference finished with a Patient Story about their experiences of Pressure Ulcers and the impact it has on their life. Talks were given by a range of MDT members and the conference was fully booked by a range of clinical frontline staff.

Work continues with transitioning from paper to electronic patient record care planning for pressure area care to allow more timely and accessible care records; but progression has been temporarily paused due to the prioritisation of undertaking similar activity for core general nursing care records on pilot wards.

As a result of this inaccurate data compliance with the KPI is not available without potential misrepresentation of the results. The workstream is planned to be recommenced in Q1 2024/25.

The NWCSF guidance document on the new Pressure Ulcer Care Pathway released in November 2023 has been a focus for the Trust pressure Ulcer Group in Quarter 4 necessitating a review and update of the Trust Pressure Ulcer Improvement Plan.

As well as work undertaken on Datix platform remodelling, communicating, and implementing the changes in the new categorisation and Datix reporting of pressure ulcer incidents. The changes to categorisation and Datix reporting was implemented on the 1st April 2024.

What did we achieve in 2023/24? – Project 2: Discharge & Reducing Admissions

Project 2: Discharge:

- Goal 1: To manage 4 patients per month (2 from Islington borough, 2 from Haringey borough) via the delirium discharge pathway.
- Goal 2: To reduce medically optimised patients that are unable to be discharged by 50% daily.
- Goal 3: To utilise up to 28 Virtual Ward beds daily, including 8 technology enabled virtual ward patients and those on the delirium pathway.
- Goal 4: For Urgent Response and Recovery Care Group to ensure patients are seen within the national guidance of 2 to 24 hours for >80% of referrals

- Goal 5: To implement pathway for 'Trial without Catheter' (TWOC) at home, reducing the length of stay by at least one day.

What did we achieve

- Goal 1: To manage 4 patients per month (2 from Islington borough, 2 from Haringey borough) via the delirium discharge pathway.

This target was not achieved. There were 8 patients that were admitted on the delirium pathway in 2023/24. Low utilisation has been attributed to awareness of the pathways available, especially among junior doctors who complete the most referrals. The low utilisation has been raised with the acute consultant geriatricians, and they have been asked to cascade this information to junior colleagues.

Islington complex virtual ward has accepted more patients with reduced 4AT scores, (4AT is a screening tool designed for rapid and sensitive initial assessment of cognitive impairment and delirium.) whereas these patients could have been referred via the delirium pathway.

The current capacity for delirium beds is 2 for Islington patients and 1 for Haringey. There will be an increase in beds in Haringey in 2024/25 bringing the total to 2 beds in line with Islington's capacity.

- Goal 2: Goal 2: To reduce medically optimised patients that are unable to be discharged by 50% daily.

Medically optimised patients are managed by Islington and Haringey social services, so this target was not able to be tracked as this data is not shared with the Trust. However, non-medically optimised patients were regularly stepped down onto the virtual ward step down pathway, and there was noticeable improvement in these patients' length of stay during 2023/24.

Information for 01/04/2023 to 31/03/2024

Total Patients accepted onto Virtual Wards: 1,508

Step-Up from Community: 90

Step-Down from Ward: 1,418

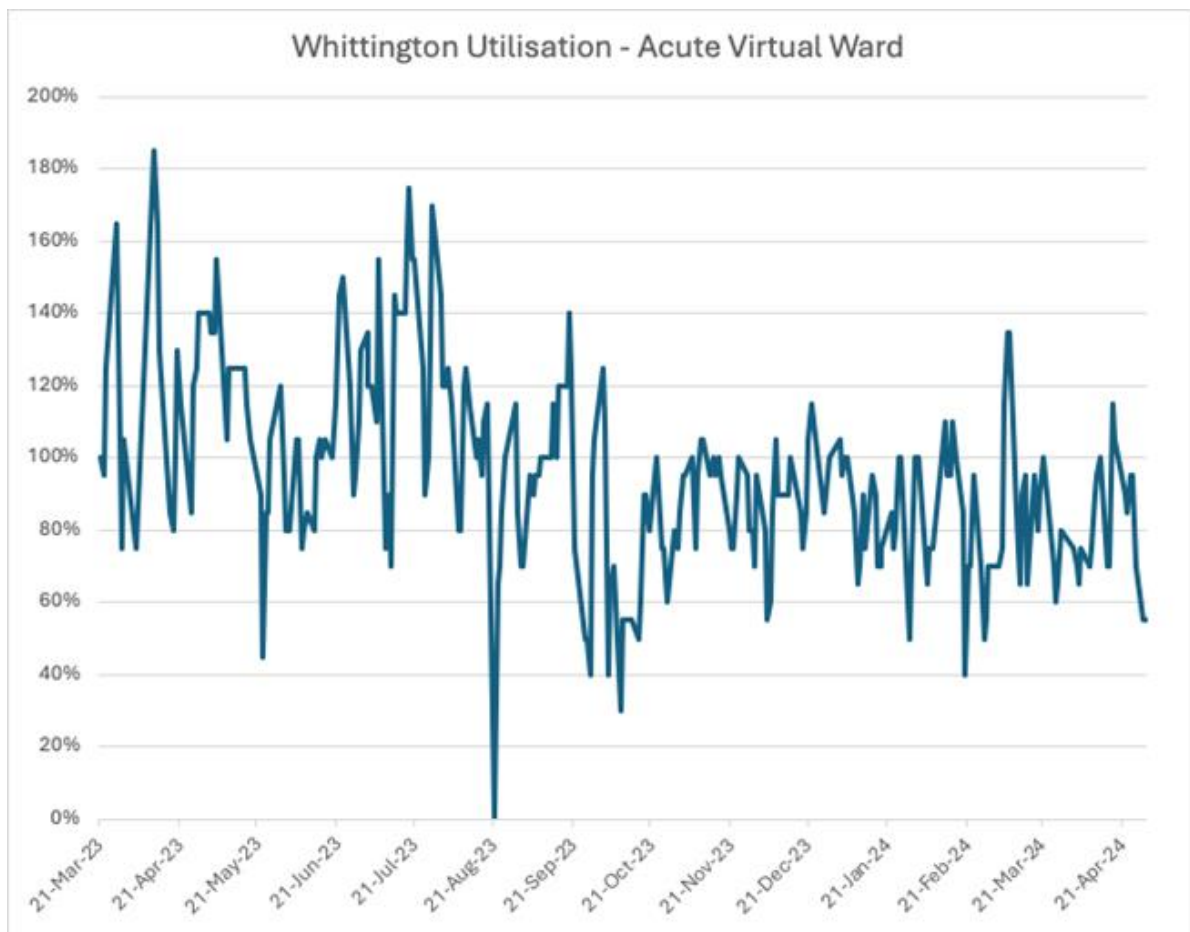
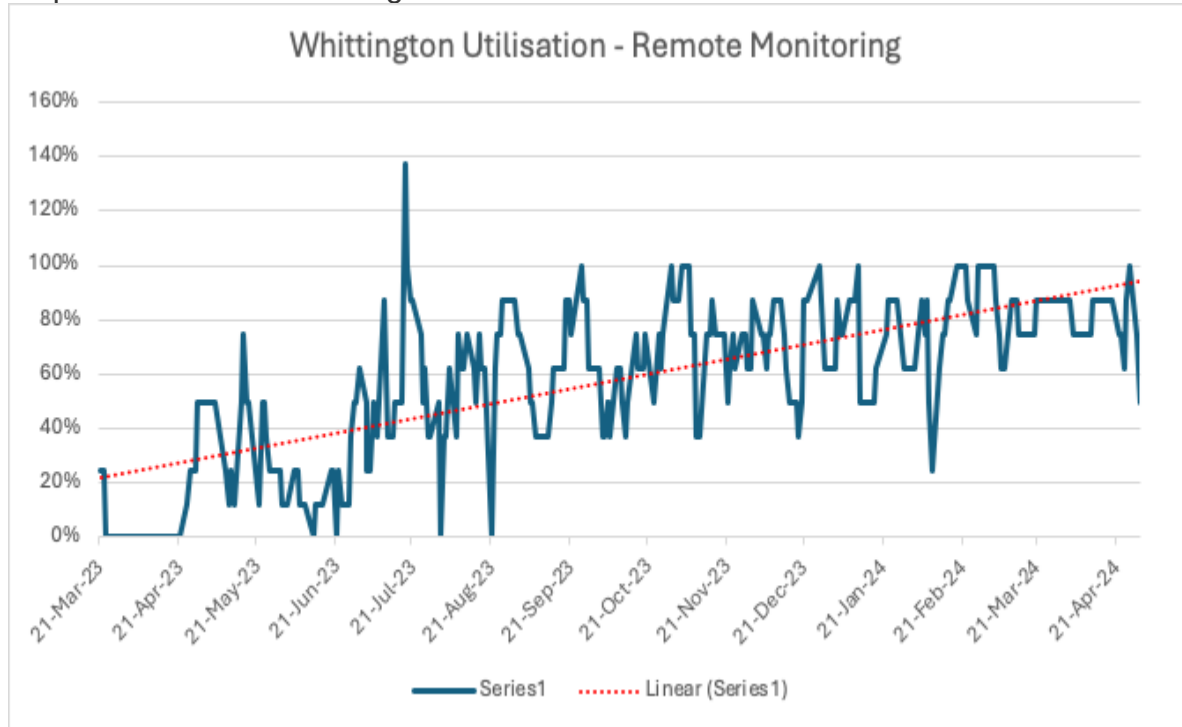
Average LOS:

- 1 to 4 Days - 56%
- 5 to 9 Days - 29%
- 10 to 14 Days - 0%
- 14 Days Plus - 15%

- Goal 3: To utilise up to 28 Virtual Ward beds daily, including 8 technology enabled virtual ward patients and those on the delirium pathway.

This target was achieved. Virtual ward bed utilisation for 2023/24 was a total average of 95%. Remote monitoring beds ranged between 80% - 140%. As shown in the graphs below:

Graph 1: Remote Monitoring utilisation 2023/24



Graph 2 – Virtual Ward Utilisation 2023/24

- Goal 4: For Urgent Response and Recovery Care Group to ensure patients are seen within the national guidance of 2 to 24 hours for >80% of referrals.

Haringey data

The data for Haringey for patients being seen within the response timeframes of 2hrs, 4hrs and 24hrs has been achieved. Haringey has consistently met all targets during Q1, Q2, Q3 and Q4 for the 4-hour and 24-hour response times. In regard to the 2 hour target the only quarter that did not achieve the target was Q4 and this was due to winter pressures. The teams have done excellently in ensuring that patients are seen in a timely manner.

Islington data

The data for Islington patients being seen within the response timeframes of 2hrs, 4hrs and 24hrs was more variable. In regard to the 2-hour response times this was only achieved in Q1. The 4-hour target was achieved in Q3 and Q4 but not Q1 and Q2. However, the 24-hour target was consistently achieved across all quarters. There are larger numbers of patients being referred from Islington than Haringey and this has contributed to not achieving the 2-hour and 4 hour targets consistently.

- Goal 5: To implement pathway for 'Trial without Catheter' (TWOC) at home, reducing the length of stay by at least one day.

This target was not achieved. Referrals from Trust into the community TWOC have been low - only 2 since the pathway went live. The lead District Nurse (DN) for QI, the bladder and bowel service lead and one of the acute geriatricians continue to work on making sure acute staff are aware of the pathway and send more referrals in for community TWOC. They look at all referrals coming from other sources including other healthcare professionals and from primary care. The communications team has also been involved in developing screensaver reminders to raise the profile of the service. The team have also included catheterisation training sessions for patients and are reviewing existing patients on the DN caseload with link nurses to see if suitable for the Community TWOC pathway.

What did we achieve in 2023/24? Project 3: Nutrition

- Goal 1: For patients with Dementia & Learning Disability who are admitted to hospital to have eating and drinking preferences and information about support required available within 24 hours of their admission. This requires 100% of this cohort to have accurate and up-to-date next of kin and emergency contacts who will be able to supply this

information, and for them to be contacted in regard to the individual's care needs within 24 hours of admission.

Throughout 2023-2024, work on improving nutrition and hydration for vulnerable patients, including those with Dementia and/or Learning Disabilities has been carried out.

A project in the community worked with a local care home on increasing hydration of their residents through adapting communication to personalise, encourage and give direction to enable residents to take drinks more regularly.

In the hospital, an increase in nutritional screening being completed was noted following awareness raising via the Back to the Floor programme. The month-long programme also highlighted further need for training in feeding, nutrition and hydration and an online learning package was designed to provide to all staff involved in support patients with eating and drinking. Alongside this, face to face training was provided to health care support workers. A renewed focus on Nutrition has also been implemented via the introduction of Nutrition Champions being identified amongst the nursing staff.

Speech and Language Therapy and Dietetic documentation has been updated to include dietary preferences, cultural and allergy considerations and this change has also been reflected in nursing admission documentation to ensure this information is obtained as early as possible in admission.

Learning Disability:

An audit was conducted during Quarter 3 which demonstrated 121 alerts were received by the Learning Disability Clinical Nurse Specialist (LD CNS) for those with Learning Disability attending ED or admitted to the hospital. These alerts were reviewed daily from Monday-Friday and accepted as referrals. The LD CNS was able to provide support to these individuals, including ensuring that hospital passports are available and raising awareness to ensure that staff refer to this document as they contain specific eating, drinking and assistance levels required for each individual.

Dementia:

In Quarter 2, an audit demonstrated that 100% of patients with Dementia had a record of their next of kin (NOK) contact details. Contact with NOK was achieved within 24 hours of admission for 64% of patients, with an overall average of contact with NOK within 0.63 days of admission.

In Quarter 4, an audit of "What Matters to Me" was conducted of all patients with a diagnosis of dementia who were admitted to hospital. Of 41 patients, 32% had evidence of "What Matters to Me" uploaded to their electronic documentation. This percentage was noted to increase (45%) when there was active involvement from the Dementia CNS. Of those that had a "What Matters to Me" document, 100% had clear food preferences recorded that were personalised to the individuals.

Priority 2: Improving access and attendance for appointments.

Aims for 2023/24:

What did we achieve in 2023/24? Project 1: Zesty	
	Goal 1: For 60% of outpatients to be using Zesty by end of March 2024.
What did we achieve in 2023/24?	
	Goal 2: For DNA rates reduced in line with booking amendments functionality being introduced by end of March 2024.
What did we achieve in 2023/24? Project 2: Patient letters	
	Goal 3: For outpatient letters to be reviewed and updated to ensure location correctly matches hospital signage. During 2023, work was undertaken by IT and Quality Improvement to assess letters sent out for outpatient appointment. 1008 letter templates were identified as having a hospital site location associated with it. These were cross referenced with locations and 48 letter locations were identified. These locations have all been reviewed and cross-matched with signage and it was confirmed that letters correctly reflect signage in place. One letter location was identified as no longer in use and IT worked with the relevant service to remove this clinic location from the system. A new map and way-finder guide was produced with all letter locations and circulated to the way-finder volunteers. During 2023-2024, a further 25 volunteers were recruited, with a key role of way-finding in order to support people to find their appointments easily. Feedback has been received from service users about confusion caused by historical Covid signage, directing people via one-way routes in order to maintain distance. This signage has been reviewed by Communications and Estates and Facilities in order to facilitate removal of any signage that is no longer required and has the potential to cause confusion when directing people around sites. A challenge identified during the project is that when letter amendments are required, it requires significant manual burden, requiring each letter to be accessed individually. IT are reviewing options to create a central letter library for ease of access and allow changes to be made centrally.
What did we achieve in 2023/24? Project 3: Wood Green CDC	
What did we achieve in 2023/24? Project 4: Accessible information for Learning Difficulties Patients	

Priority 3: Reducing Health Inequalities in our local population

Aims for 2023/24

What did we achieve in 2023/24? Project 1 Sickle Cell

- Goal 1: Deliver training to 60% of ED staff to educate on the condition, ensuring unconscious bias does not exist in the treatment of patients with sickle cell anaemia by end of March 2024.
- Ensure 80% of sickle cell patients receive 1st dose of pain relief within 30mins of attendance to ED by end of March 2024.

Training:

A project focussing on training staff continued during 2023-2024, with service users involved in the design and implementation of staff training to include education on the condition. Up to a third of ED staff had previously been trained, but this number reduced due to staff turnover. In quarter 2, 23 current nursing staff had received training, including education on the condition and potential bias, and further training sessions were delivered in February 2024, with 25 staff receiving training.

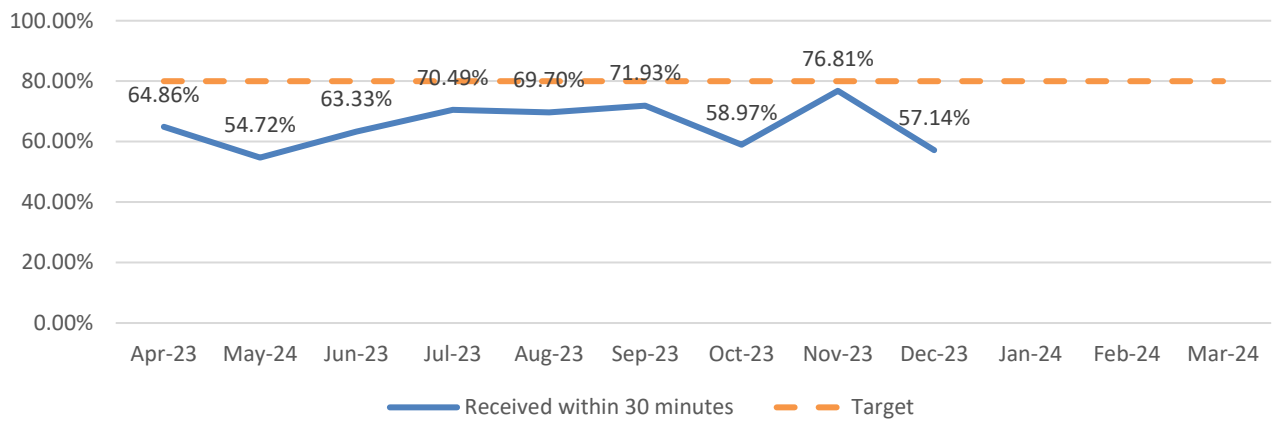
An e-learning package is additionally planned to be eliminated to be offered out to staff across the Trust.

In Quarter 3, Sickle Cell was one of the topics for a Back to the Floor session. Back to the Floor is a visible nursing leadership programme, run weekly with senior nursing and AHP leads in order to educate, problem solve and determine solutions within clinical settings across the Trust. The session was led by the Sickle Cell Lead Nurse and an Expert by Lived Experience who shared their experiences and provided further education around time to analgesia, recognising and acknowledging pain, and how to improve the patient journey during hospital admissions. The session was well received and the group discussed opportunities to improve the sickle cell pathway for patients when attending our hospital, as well as using the opportunity to raise awareness of the NHS England's Sickle Cell card.

In addition to training provision, ED and Ambulatory care have implemented Sickle Cell Nursing Advocates within their services to aid sharing of learning and training materials.

Pain Relief:

1st Dose Pain Relief Provided within 30 minutes



A new data collection tool was developed to accurately capture time between attendance and first dose of analgesia. The accuracy of the data collection continues to be monitored to ensure that it accurately captures timings and does not result in duplicated data. Challenges in achieving the target have been impacted by Trust wide inpatient bed capacity pressures which impact on ED overcrowding and subsequent delays in treatment, particularly noted in December 2023. Although numbers remain below target, however the Sickie Cell Lead Nurse reported that service users are reporting a subjective improvement in their waits.

What did we achieve in 2023/24? Project 3: Prostate Cancer

- To expand on the previous success of Prostate cancer events, we will hold up to 6 specific cancer events by the end of March 2024.

Part 4: Other Information

Local Performance Indicators

Goal	Standard/benchmark	Whittington performance				
		23/24	22/23	21/22	20/21	19/20
ED 4 hour waits	95% to be seen in 4 hours	65.30%	68.40%	78.30%	87.4%	83.8%
RTT 18 Week Waits: Incomplete Pathways	92% of patients to be waiting within 18 weeks	66.2%	67.8%	74.4%	65.6%	92.1%
RTT patients waiting 52 weeks	No patients to wait more than 52 weeks for treatment	8007	6182	7093	11094	2
Waits for diagnostic tests	99% waiting less than 6 weeks	86.9%	85.9%	94.1%	72.1%	99.3%
Cancer: Urgent referral to first visit	93% seen within 14 days	51.8%	45.8%	74.8%	94.6%	94.8%
Cancer: Diagnosis to first treatment	96% treated within 31 days	93.4%	90.2%	95.3%	98.1%	98.8%

Cancer: Urgent referral to first treatment	85% treated within 62 days	63.3%	48.2%	61.1%	73.8%	84.0%
Improved Access to Psychological Therapies (IAPT)	75% of referrals treated within 6 weeks	93.2%	92.8%	91.4%	93.8%	95.1%

Summary Hospital-Level Mortality Indicator (SHMI)

Summary Hospital-Level Mortality Indicator (SHMI)

The most recent data available (published 8 February 2024) covers the period October 2022 to September 2023

Whittington Trust SHMI score:	0.99	Compared to 0.94 reported for July 2022 to June 2023 period
Lowest National Score:	0.62	Royal Surrey County Hospital NHS Foundation Trust
Highest National Score:	1.18	Norfolk and Norwich University NHS Foundation Trust

13 Trusts were graded as having a lower-than-expected number of deaths.

10 Trusts were graded as having a higher-than-expected number of deaths.

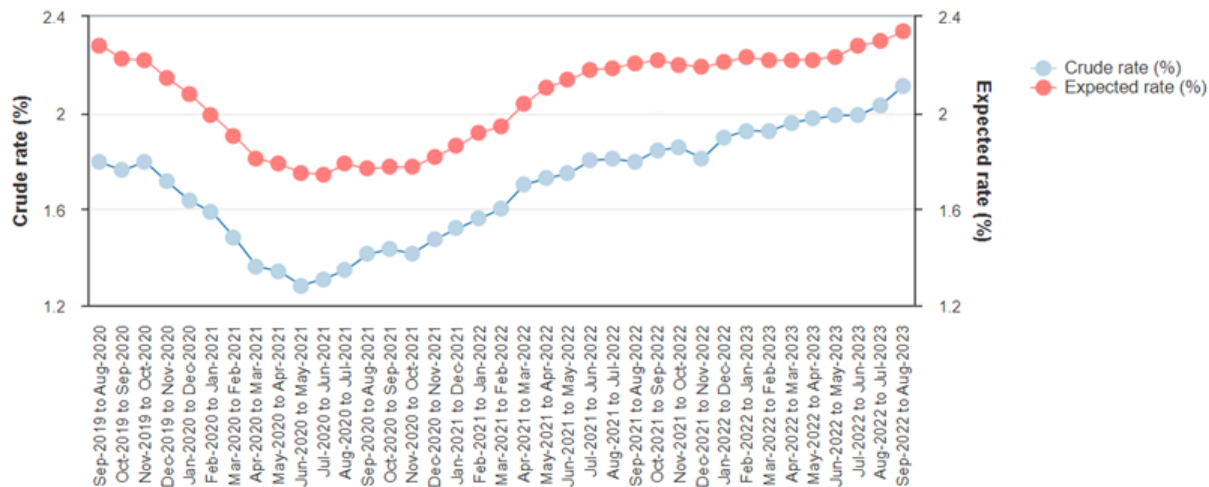
96 Trusts, including Whittington Health, were graded as showing the number of deaths in line with expectations.

The SHMI represents a comparison against a standardised National Average. The 'national average' therefore is a standardised 1.0 and values significantly below 1.0 indicate a lower-than-expected number of mortalities (and vice versa for values significantly above). Historically the Whittington had a lower SHMI, shown in the graph below. Factors which may have influenced the increase in SHMI are an increase in crude death rates, potential under-coding which is currently being audited, increase in elective admissions, an overall decrease in hospital admissions and delays in discharging patients.

Diagnoses | Mortality (in-hospital) | Aug-20 to Aug-23 | Trend (rolling 12 months)

Patient classification: Ordinary, Mothers and babies | COVID-19 Y/N: 'No'

Period: Rolling 12 months | Measure: Crude rate (%) | Additional measure: Expected rate (%)



Annex 1: Statements from external stakeholders

Joint Health Overview and Scrutiny Committee for North Central London feedback

Feedback awaited once draft reviewed

HealthWatch Haringey feedback

Feedback awaited once draft reviewed

Commissioner feedback

Feedback awaited once draft reviewed

How to provide feedback

If you would like to comment on our Quality Account or have suggestions for future content, please contact us either:

By writing to:

The Communications Department,
Whittington Health,
Magdala Avenue,
London. N19 5NF

By telephone:

020 7288 5983

By email:

communications.whitthealth@nhs.net

Publication:

The Whittington Health NHS Trust 2023/24 Quality Account will be published on the Trust website by the 30th June 2024. A copy is also sent electronically to NHS England as per national requirements.

<https://www.nhs.uk/pages/home.aspx>

Accessible in other formats:

This document can be made available in other languages or formats, such as Braille or Large Print.

Please call **020 7288 3131** to request a copy.

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

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance in the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amended Regulations 2011).

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

The Quality Account presents a balanced picture of the Trust's performance over the period covered, in particular, the assurance relating to consistency of the Quality Report with internal and external sources of information including:

- Board minutes.
- Papers relating to the Quality Account reported to the Board.
- Feedback from Health Watch.
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009.

- the latest national patient survey.
- the latest national staff survey.
- feedback from Commissioners.
- the annual governance statement; and
- CQC Intelligent Monitoring reports.

The performance information reported in the Quality Account is reliable and accurate. There are proper internal controls over the collection and reporting of the measures of performance reported in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and The Quality Account has been prepared in accordance with the Department of Health guidance.

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

Signatures to be added post Trust Board Meeting

Clare Dollery
Interim Chief Executive

Baroness Julia Neuberger DBE
Chair

Appendix 1: National Mandatory and Non-Mandatory Audits 2023/24

Title of Audit	Management Body	Participated in 2023/2024	If completed, number of records submitted (as total or % if requirement set)
National Bariatric Surgery Registry	British Obesity & Metabolic Surgery Society	✓	Data submitted: 84 cases
National Early Inflammatory Arthritis Audit	British Society for Rheumatology	✓	Data submitted: 13 cases
Adult Respiratory Support Audit	British Thoracic Society	✓	Data submitted: 19 cases
Improving Quality in Crohn's and Colitis [Note: previously named Inflammatory Bowel Disease Audit]	IBD Registry	✓	Data submitted: 49 cases
Case Mix Programme	Intensive Care National Audit & Research Centre	✓	Data submitted: 556 cases
National Cardiac Arrest Audit	Intensive Care National Audit and Research Centre (ICNARC) / Resuscitation Council UK (RCUK)	✓	Data submitted: 49 cases
Sentinel Stroke National Audit Programme	King's College London	✓	Data submitted: 85 cases
Myocardial Ischaemia National Audit Project	National Institute for Cardiovascular Outcomes Research (NICOR) hosted at NHS Arden and Greater East Midlands CSU	✓	Data submitted: 81 cases
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research (NICOR) hosted at NHS Arden and Greater East Midlands CSU	✓	Data submitted: 198 cases
National Audit of Care at the End of Life	NHS Benchmarking Network	✓	Data collection period from January - December 2024
Audit of NICE Quality Standard QS138	NHS Blood and Transplant	✓	Data submitted: 37 cases
Bedside Transfusion Audit	NHS Blood and Transplant	✓	Data collection period from March 2024 - May 2024

Breast and Cosmetic Implant Registry	NHS England	✓	Data submitted: 18 cases
Learning from lives and deaths – People with a learning disability and autistic people	NHS England	✓	Data submitted: 5 cases
National Core Diabetes Audit	NHS England	✓	Data submitted: 1274 cases
National Diabetes Footcare Audit	NHS England	✓	Data submitted: 171 cases
National Diabetes Inpatient Safety Audit	NHS England	✓	Data submitted: 1 case
National Obesity Audit	NHS England	✓	Data submitted: 65 cases
National Pregnancy in Diabetes Audit	NHS England	✓	Data submitted: 34 cases
National Emergency Laparotomy Audit	Royal College of Anaesthetists	✓	Data submitted: 90 cases
Perioperative Quality Improvement Programme	Royal College of Anaesthetists	✓	Data submitted: 6 cases
Care of Older People	Royal College of Emergency Medicine	✓	Data submitted: 117 cases
Mental Health (Self-Harm)	Royal College of Emergency Medicine	✓	Data submitted: 250 cases
National Maternity and Perinatal Audit	Royal College of Obstetricians and Gynaecologists	✓	Data submitted: 2822 cases
National Neonatal Audit Programme	Royal College of Paediatrics and Child Health	✓	Data submitted: 348 cases
National Paediatric Diabetes Audit	Royal College of Paediatrics and Child Health	✓	Data submitted: 124 cases
National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy12)	Royal College of Paediatrics and Child Health	✓	Data submitted: 44 cases
National Audit of Inpatient Falls	Royal College of Physicians	✓	Data submitted: 3 cases
National Hip Fracture Database	Royal College of Physicians	✓	Data submitted: 167 cases
National Audit of Dementia: Care in general hospitals	Royal College of Psychiatrists	✓	Data submitted: 45 cases
National Audit of Metastatic Breast Cancer	Royal College of Surgeons of England	✓	If cases identified to WH then participate - none to date
National Audit of Primary Breast Cancer	Royal College of Surgeons of England	✓	Data submitted: 144 cases
National Lung Cancer Audit	Royal College of Surgeons of England	✓	Data submitted: 82 cases
National Prostate Cancer Audit	Royal College of Surgeons of England	✓	Data submitted: 103 cases

National Bowel Cancer Audit	Royal College of Surgeons of England	✓	Data submitted: 32 cases
National Oesophago-Gastric Cancer Audit	Royal College of Surgeons of England	✓	Data submitted: 9 cases
Society for Acute Medicine Benchmarking Audit	Society for Acute Medicine	Trust decision not to participate (rationale provided above)	N/A
BAUS Nephrostomy Audit	The British Association of Urological Surgeons	✓	Data submitted: 3 cases
The Trauma Audit & Research Network	The Trauma Audit & Research Network /University of Manchester	✓	Due to TARN's cyber attack data not able to be submitted. 450 suitable cases have been identified for submission.
UK Renal Registry National Acute Kidney Injury Audit	UK Kidney Association	✓	Data submitted: 5102 cases
National Child Mortality Database Programme	University of Bristol	✓	Review of published reports
National Audit of Cardiac Rehabilitation	University of York	✓	Data submitted: 419 cases

Mental Health Clinical Outcome Review Programme

Suicide and Homicide	National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) - University of Manchester	✓	If cases identified to WH then participate - none to date
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Maternal, Newborn and Infant Clinical Outcome Review Programme

data on 11 cases were submitted to MBRRACE-UK who allocate to the appropriate work stream

Maternal mortality confidential enquiries	MBRRACE-UK, led from the University of Oxford	✓	Ongoing
Maternal mortality surveillance	MBRRACE-UK, led from the University of Oxford	✓	Ongoing
Perinatal mortality and serious morbidity confidential enquiry	MBRRACE-UK, led from the University of Oxford	✓	Ongoing
Perinatal mortality surveillance	MBRRACE-UK, led from the University of Oxford	✓	Ongoing
National perinatal mortality review tool	MBRRACE-UK, led from the University of Oxford	✓	Ongoing

Medical, Surgical and Child Health Clinical Outcome Review Programme

Testicular Torsion	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	3/3 cases submitted
Juvenile idiopathic arthritis	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	4/4 cases submitted
Community Acquired Pneumonia Hospital Attendance	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	6/6 cases submitted
Crohn's Disease	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	6/6 cases submitted
End of Life Care	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	5/5 cases submitted
Endometriosis	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	5/5 cases submitted
Epilepsy: Hospital attendance	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	5/6 cases = 84%
Rehabilitation following Critical Illness	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	Study recently commenced

National Asthma and Chronic Obstructive Pulmonary Disease Audit programme			
Paediatric Asthma in Secondary Care	Royal College of Physicians	✓	Data submitted: 210 cases
Pulmonary rehabilitation	Royal College of Physicians	✓	Data submitted: 101 cases
COPD in Secondary Care	Royal College of Physicians	✓	Data submitted: 148 cases
Adult Asthma in Secondary Care	Royal College of Physicians	✓	Data submitted: 110 cases

Non-Mandatory National Audits 2023/2024

Project Title	Management Body	Status
Infection Prevention and Control	Royal College of Emergency Medicine	Completed
British Society of Dermatological Surgery 2022 Sustainability Audit	British Society of Dermatological Surgery	Completed
United Kingdom Obstetric Surveillance System – national audits of rare conditions of pregnancy	UKOSS National Perinatal Epidemiology Unit	Data submitted
Management of self-harm in children and young people presenting to A&E	Student Psychiatry Audit and Research Collaborative Steering Group	Data submitted
StarSurg: Operative and non-operative management of emergency presentations of colon and rectal cancer	STARSurg	Data submitted
NDA Integrated Specialist Survey	NHS Digital, NCAPOP	Data submitted
National study of HIV in Pregnancy and Childhood (NSHPC)	NSHPC	Data submitted
National Ovarian Cancer Audit	National Cancer Audit Collaborating Centre	Data submitted
National Pancreatic Cancer Audit	National Cancer Audit Collaborating Centre	Data submitted
National Non-Hodgkin Lymphoma Audit	National Cancer Audit Collaborating Centre	Data submitted
National Kidney Cancer Audit	National Cancer Audit Collaborating Centre	Data submitted
Mandatory Surveillance of Healthcare Associated Infections	Public Health England	Data submitted
Surgical Site Infection Surveillance Service	Public Health England	Data submitted
Vascular Access in Complicated Paediatric Appendicitis	University Hospital Southampton NHS Foundation Trust	Data submitted
London-wide audit of TB management in patients with ocular TB – led by Moorfields	Pan-London LOOP TB pathway guidance	Ongoing
NHS Digital Tobacco Dependence national data collection	NHS Digital	Ongoing
A 'Flash-Mob' UK national audit of the use of Reversal Agents in Patients anticoagulated with Direct Oral anticoagulants (HaemSTAR RAPIDO)	national audit - HaemSTAR RAPIDO	Ongoing
Time critical medications	RCEM	Ongoing
Implementation of Hybrid Closed Loop technologies	NHS Digital	Ongoing
Audit of admissions to acute medical units of patients with eating disorders: assessing use and adherence to "Medical Emergencies in Eating Disorders (MEED)" guidelines.	The Student Psychiatry Audit and Research Collaborative, affiliated with the Royal College of Psychiatrists	Ongoing

Appendix 2 - Subcontracted Services

Organisation	Service Details
Camden and Islington NHS foundation trust	Psychological service
UCLH foundation trust	South Hub Tuberculosis resources
UCLH foundation trust	Ear Nose and Throat services
UCLH foundation trust	Provision of PET/CT scans
The Royal Free London NHS foundation trust	Ophthalmology services
Whittington Pharmacy CIC	Provision of pharmacy services
WISH Health Ltd A network of 8 local practices – four in north Islington and four in west Haringey	Primary care services to the urgent care centre at the Whittington hospital
The Thrombosis Research Institute	The Provision of 2 clinical sessions
Camden and Islington NHSFT	Provision of associate hospital managers panels and training under MHA
Tavistock and Portman NHSFT	CCN209- Agreement for the provision of services from Tavistock and Portman NHS Foundation Trust – CAMHS OOH consultants
UCLH	SLT 4 days per week provision at Whittington
NHS Blood and Transplant	Contract for the supply of blood, blood components and services
NHS Blood and Transplant	Contract for the supply of Tissue and Ocular products
UCL Foundation Trust	Renewal addendum of combined screening services detailed in COMB1
Newcastle Upon Tyne Hospital NHS Foundation Trust	Department tests a wide range of patient and environmental specimens to detect the presence of

	pathogenic micro-organisms.
Epsom & St Helier University Hospital NHS Trust	Pathology Testing Service
Calderdale and Huddersfield NHS FT	Agreement relating to National Pathology Exchange Service (NPEX)
Islington GP Group Limited (trading as Islington GP Federation)	Provision of ENT service
Healios Limited	Provision of • Neurodevelopmental screening • Autism Assessments • ADHD Assessments • Dual Autism/ADHD Assessments • Post diagnostic support
Health Services Laboratory	From 1 st April 2024 pathology services provided
Everlight Radiology Limited	Out of hours imaging reporting.

Appendix 3 - Patients 0-15 and 16+ readmitted within 28 days of discharge

Year and Month		0-15 years			16 Years +		
		Readmissions	Discharges	Readmission rate	Readmissions	Discharges	Readmission rate
2019/20	Apr	7	639	1.1%	205	2913	7.0%
	May	2	688	0.3%	163	2791	5.8%
	Jun	9	629	1.4%	143	2899	4.9%
	Jul	6	664	0.9%	167	2860	5.8%
	Aug	6	601	1.0%	179	2582	6.9%
	Sep	3	615	0.5%	177	2556	6.9%
	Oct	9	669	1.3%	187	2842	6.6%
	Nov	5	675	0.7%	166	2780	6.0%
	Dec	7	645	1.1%	157	2532	6.2%
	Jan	7	621	1.1%	169	2703	6.3%
	Feb	4	607	0.7%	151	2616	5.8%
	Mar	3	525	0.6%	117	1977	5.9%
2020/21	Apr	1	308	0.3%	96	967	9.9%
	May	2	387	0.5%	109	1220	8.9%
	Jun	6	447	1.3%	137	1748	7.8%
	Jul	3	547	0.5%	171	2296	7.4%
	Aug	3	570	0.5%	160	2042	7.8%
	Sep	6	630	1.0%	140	2302	6.1%
	Oct	7	715	1.0%	165	2353	7.0%
	Nov	7	683	1.0%	193	2383	8.1%
	Dec	10	674	1.5%	183	2322	7.9%

	Jan	13	599	2.2%	156	1853	8.4%
	Feb	8	632	1.3%	153	1922	8.0%
	Mar	14	875	1.6%	110	2442	4.5%
2021/22	Apr	4	573	0.7%	111	2132	5.2%
	May	5	595	0.8%	111	2134	5.2%
	Jun	14	1549	0.9%	167	4476	3.7%
	Jul	10	805	1.2%	213	2476	8.6%
	Aug	8	704	1.1%	164	2464	6.7%
	Sep	3	762	0.4%	209	2657	7.9%
	Oct	2	722	0.3%	162	2583	6.3%
	Nov	4	670	0.6%	140	2431	5.8%
	Dec	11	684	1.6%	132	2521	5.2%
	Jan	10	790	1.3%	111	2329	4.8%
	Feb	6	765	0.8%	128	2392	5.4%
	Mar	5	639	0.8%	113	2049	5.5%
2022/23	Apr	1	645	0.2%	151	2104	7.2%
	May	13	728	1.8%	150	2337	6.4%
	Jun	3	725	0.4%	123	2321	5.3%
	Jul	12	687	1.7%	138	2339	5.9%
	Aug	5	649	0.8%	130	2267	5.7%
	Sep	9	683	1.3%	99	2405	4.1%
	Oct	2	748	0.3%	118	2386	4.9%
	Nov	14	761	1.8%	103	2473	4.2%
	Dec	5	699	0.7%	106	2099	5.1%
	Jan	20	767	2.6%	99	2392	4.1%
	Feb	12	673	1.8%	70	2117	3.3%
	Mar	9	720	1.3%	95	2254	4.2%
2023/24	Apr	4	583	0.7%	106	2040	5.2%
	May	9	734	1.2%	113	2247	5.0%
	Jun	7	689	1.0%	122	2522	4.8%
	Jul	8	668	1.2%	152	2073	7.3%
	Aug	7	637	1.1%	119	2337	5.1%
	Sep	12	728	1.6%	114	2320	4.9%
	Oct	6	748	0.8%	97	2408	4.0%
	Nov	6	836	0.7%	126	2475	5.1%
	Dec	11	758	1.5%	132	2136	6.2%
	Jan	11	735	1.5%	106	2259	4.7%
	Feb	22	683	3.2%	121	2280	5.3%
	Mar	9	740	1.2%	72	2490	2.9%

Appendix 4 – Staff Survey score matrix 2023

Whittington Health Directorate/ICSU Reporting

The directorate/ICSU results for Whittington Health contain the results by directorate or ICSU for People Promise elements and theme results from the 2022 NHS Staff Survey. The below directorate results are compared to the unweighted average for the organisation.

**Each 2023 theme score for ICSUs and Directorates is graded in green if the score is above organisational average, and red where the score is below organisational average. Where an ICSU or Directorate has scored the same as the organisation's average it is graded black.*

Theme	WH Overall	ACW	ACS	COO	CYP	EIM	Facilities	Finance	IT	Medical Dir.	Nursing & Patient Exp.	Procurement	S&C	Trust Secretariat	Workforce
We are compassionate and inclusive	7.3	6.9	7.4	6.9	7.8	7.2	6.9	7.2	7.1	7.4	7.5	7.4	7.1	7.4	8.1
We are recognised and rewarded	6.0	5.5	6.1	6.2	6.5	5.8	5.8	6.3	5.5	6.4	6.5	6.3	5.7	6.6	7.2
We each have a voice that counts	6.8	6.3	6.9	7.4	7.2	6.7	6.5	6.7	6.5	6.6	7.3	6.9	6.6	7.0	7.2
We are safe and healthy	6.0	5.8	5.9	5.9	6.2	5.6	6.1	6.6	6.1	6.6	6.4	6.6	5.7	6.2	7.1
We are always learning	5.7	5.0	6.0	5.9	6.0	5.9	5.6	5.1	5.4	5.4	5.8	5.6	5.4	6.8	6.4
We work flexibly	6.2	5.4	6.2	6.2	6.7	5.9	6.4	6.9	6.2	6.1	6.5	6.6	5.7	7.2	8.0
We are a team	6.9	6.3	7.0	6.7	7.3	6.7	6.3	6.6	6.6	7.2	7.2	7.0	6.5	7.1	7.8
Staff Engagement	6.9	6.6	6.9	7.2	7.3	6.9	6.8	7.0	6.6	6.9	7.4	7.1	6.9	7.0	7.6
Morale	5.8	5.3	5.7	6.3	6.0	6.7	5.8	5.9	5.5	6.0	6.1	6.2	5.9	5.5	6.6

Appendix 5 – Equalities Indicators from the Staff Survey 2023

WDES (Workforce Disability Equality Standards) indicators reported in the Staff Survey Results 2023

The table below provides a comparison of the Workforce Disability Equality Standard (WDES) results in 2022 and 2023. WDES results are based on a series of indicators, of which 4, 5, 6, 7, 8 and 9 are drawn from the NHS Staff Survey. Each 2023 response has been colour graded, green indicates a positive improvement for staff with a Long-Term Condition (LTC) or illness and red indicates a decline from the previous year.

Table to show WDES Indicators			2022		2023	
Indicator	Question	Description	LTC or illness	WITHOUT LTC or illness	LTC or illness	WITHOUT LTC or illness
4a	Q14a Q14b Q14c	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Patients, Managers or Colleagues	53.1%	38.7%	50.9%	37.7%
4b	Q14d	Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or colleague reported it	46.5%	47.7%	44.6%	51.5%
5	Q15	Percentage of disabled staff compared to non-disabled staff believing that their trust provides equal opportunities for career progression or promotion	40.1%	51.8%	39.4%	54.2%
6	Q11e	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their managers to come to work, despite not feeling well enough to perform their duties	29.5%	20.7%	29.2%	19.2%
7	Q4b	Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	34.7%	45.6%	38.4%	49.6%
8	Q30b	Percentage of staff with a long-lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work	64.7%	N/A	66.1%	N/A
9a	E_4	Staff engagement score (0-10)	6.3	7.0	6.4	7.1

WRES Indicators Reported in the Staff Survey Results 2023

In its sixth year of reporting there are four indicators comparing the experience of Black, Minority, Ethnic staff (B.M.E) and white staff in Whittington Health. This table shows a comparison of the Workforce Race Equality Standard (WRES) indicators over a six-year period. Each 2023 response is graded in green if there has been an improvement for B.M.E staff; or red, if there has been a decline compared to the previous year.

The table below shows improvement in three out of the four WRES indicators i.e. the percentage of BME staff experiencing harassment, bullying or abuse from staff; BME staff believing that the organisation provides equal opportunities for career progression or promotion; and BME staff experiencing discrimination at work from manager/team leader or other colleagues. Fairness in career progression for BME staff has shown the greatest improvement and this reflects the increased career development opportunities available across the Trust for example the Band 2-7 BME Career Development Programme, as well as the Trust-wide listening event held last year. However, there has been a negative increase in staff experiencing harassment, bullying or abuse from patients, relatives, or the public of 0.7%.

Table to show WRES Indicators	2018		2019		2020		2021		2022		2023	
Question	BME staff	White staff	BME staff	White staff	BME staff	White staff	BME staff	White staff	BME staff	White staff	BME staff	White staff
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months	35.9%	30.5%	32.5%	30.6%	30.3%	28.9%	28.6%	27.9%	29.3%	30.4%	30.0%	27.2%
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	36.2%	31.4%	31.9%	29.9%	29.7%	24.2%	27.7%	25.7%	25.4%	24.3%	25.1%	21.6%
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	35.8%	56.2%	39.7%	58.2%	39.7%	56.4%	39.9%	54.4%	41.2%	57.5%	46.3%	56.4%
Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months	20.3%	9.5%	16.1%	7.8%	16.9%	8.2%	15.2%	8.3%	15.0%	9.4%	11.8%	7.4%

Appendix 6 – Clinical Coding External Audit Results 2023/24

Primary Diagnosis		Number of cases	% coding correct
	Number of primary diagnoses	200	
	Number of primary diagnoses Correct	175	87.50 %

Secondary Diagnosis		Number of cases	% coding correct
	Number of secondary diagnoses	600	
	Number of secondary diagnoses correct	543	90.2 %

Primary Procedures		Number of cases	% coding correct
	Number of primary procedures	159	
	Number of primary procedures correct	147	92.45 %
Secondary Procedures		Number of cases	% coding correct
	Number of secondary procedures	384	
	Number of secondary procedures correct	306	87.93 %

Appendix 7 – CQUIN progress for 2023/2024

The CQUINs are clinically lead by the medical directorates and overseen by the performance team.

	Achieved
	Not achieved
	No requirement to report for the quarter

CQUIN Scheme	Rationale/Objectives	Compliance		
CQUIN01 - Flu vaccinations for frontline healthcare workers (Target)	Achieving 80% uptake of flu vaccinations by frontline staff with patient contact.	Q1	Q2	Q3
CQUIN02 - Supporting patients to drink, eat and mobilise (DrEaM) after surgery (Target)	Ensuring 80% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending.	Q1	Q2	Q3
CQUIN03 - Prompt switching of intravenous to oral antibiotic (Target)	Achieving 40% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria.	Q1	Q2	Q3
CQUIN05 - Identification and response to frailty in emergency departments (Reporting only)	Achieving 30% of patients aged 65 and over attending A&E or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up.	Q1	Q2	Q3
CQUIN06 - Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service (Reporting only)	Achieving 1.5% of acute trust inpatients having changes to medicines communicated with the patient's chosen community pharmacy within 48 hours following discharge, in line with NICE Guideline 5, via secure electronic message. Despite there not being a requirement to report this CQUIN, it was achieved.	Q1	Q2	Q3
CQUIN07 - Recording of and response to NEWS2 score for unplanned critical care admissions (Target)	Achieving 30% of unplanned critical care unit admissions from non-critical care wards having a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in clinical notes.	Q1	Q2	Q3
Local CQUIN - Core20plus5 (Target)	Part A) Establish baselines for ethnicity recording, interpreting services, people accessing services who are experiencing homelessness and women experiencing moderate to severe or complex mental health difficulties directly arising from, or related to, their maternity experience. Part B) To identify those at greatest risk of a negative experience of healthcare.	Q1	Q2	Q3