NOTICE OF MEETING

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday 6th June 2025, 2:00pm

Venue: Committee Room 6, Islington Town Hall, Upper Street N1 2UD

Contact: Dominic O'Brien, Principal Scrutiny Officer

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Councillors: Paul Edwards and Philip Cohen (Barnet Council), Larraine 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 Joseph Croft (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 for live or subsequent broadcast via the Council's internet site 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 - 144)

- Royal Free London NHS Foundation Trust
- Whittington Health NHS Trust

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Thursday, 29 May 2025

Agenda Item 6

Royal Free London
NHS Foundation Trust

Striving Together - Unified for Excellence

Quality Account 2024 – 2025 (DRAFT)

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Part 1

Achievements in quality

1.1 Statement on quality from the chief executive

We would like to open this Quality Account publication with a huge thank you to our staff, and everyone who has supported them, for their incredible efforts over 2024-25.

The Quality Account will give you, the people we serve, an idea of what we have achieved over the last year and our priorities for the period ahead, including some of the activities that we believe will yield further improvements in the quality of care we offer. This has been another remarkable, exciting, and at times difficult year. But despite the challenges we have much to celebrate this year.

I want to take a moment to reflect on the significant milestones achieved by the Royal Free London (RFL) and the unwavering commitment of our staff across the trust. On 1st January 2025, we were proud to welcome North Middlesex University Hospital (North Mid) and its community services into the RFL group. This merger is the culmination of several years of collaboration in clinical partnership, and I have no doubt that it will improve the care the NHS provides to communities across North London. By combining our strengths, while retaining the unique identities of each hospital site, we can reduce waiting times, improve access to specialist services, and create better opportunities for our staff. For this reason, we have chosen **Striving together – Unified for Excellence** as a theme for this year's quality account and we have included examples of improvement work undertaken and North Mid data (where available) in the report.

Excitingly we also launched our **five-year clinical strategy** this year, which is our blueprint for bringing the best of the NHS to all our patients by delivering world class expertise and local care. It was a significant moment for our trust as we look to meet the growing demands on our services and create a healthier future for our local communities.

Our reputation for delivering some of the best outcomes in the NHS, supported by innovation, research and best in class education and training, continues to grow. Through merging with North Mid, we will deliver benefits to patients via **four early clinical service integration opportunities**, with further areas to be identified over the coming year.

Oncology

What patients can expect:

- increased access to specialist advice and cancer treatments
- more care closer to home
- greater opportunities to take part in clinical trials and research

Colorectal surgery

What patients can expect:

- more care closer to home
- more specialist nursing care, with a focus on recovery, so patients can go home earlier
- greater opportunities to take part in clinical trials and research

Surgical hubs

What patients can expect:

- outpatient appointments at whichever of our hospitals is closest to their home
- less risk of surgery being cancelled
- shorter hospital stays

Research

What patients can expect:

- more choice of trial opportunities
- earlier access to new drugs and interventions
- service improvements driven through our greater understanding of our population's health

The RFL quality strategy in its first year has been a steppingstone in providing direction for how we are developing excellent care together, for all our patients and the communities we serve.

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.

Part 2 of this report summarises the quality priorities identified for 2025-26. These priorities have been aligned to our Excellent Health Outcomes governing objective and build on the progress achieved in 2024-25.

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 Our governing objectives

Our governing objectives set out how we will achieve our mission by making sure that everything we do helps us to meet one of more of these:

Innovative healthcare and positive results for our patients.

Ensure staff go above and beyond to care for their patients.

Ensuring staff are cared for and valued is a key area of focus at the RFL.

Achieving our sustainability goals is a priority for the RFL, and we want to highlight the ways in which our staff are working towards achieving them.

1.3 Striving together

The examples below represent a selection of improvement work undertaken in the trust over the last year. These initiatives demonstrate our commitment to working together across the Royal Free London group and beyond to provide high quality care for our population.

Striving together to improve population health:

Welcoming North Mid into the group this year is enabling the trust to go further and faster in our approach to improving population health and reducing health inequalities. Population health and addressing health inequalities are key overarching principles of our new clinical strategy.

As an enlarged group of hospitals, RFL now employs over 17,000 staff, making us the largest employer in North Central London. The combined commitment to our anchor institution responsibilities and priorities increases our wider contribution to the community and creates a platform for shared learning across the enlarged organisation.

This year RFL launched the **Faculty of Population Health** which is the vehicle to ensure our population health approach is embedded as our cultural norm. The Faculty of Population Health is leading a three-year culture change programme, focusing on four key health behaviours: **smoking, alcohol intake, physical activity and diet.** This work is essential to address the rise in long term conditions; by 2040 we will diagnose one case of cancer every minute in the UK. This increase is matched by increases in other long-term conditions such as cardiovascular disease, respiratory disease, liver disease and kidney disease. We know that smoking, alcohol, physical activity and diet are the major modifiable factors for all these long-term conditions and that they are spread unequally across our diverse population, contributing to health inequalities.

Figure 1.1: Inequalities in life expectancy in NCAL

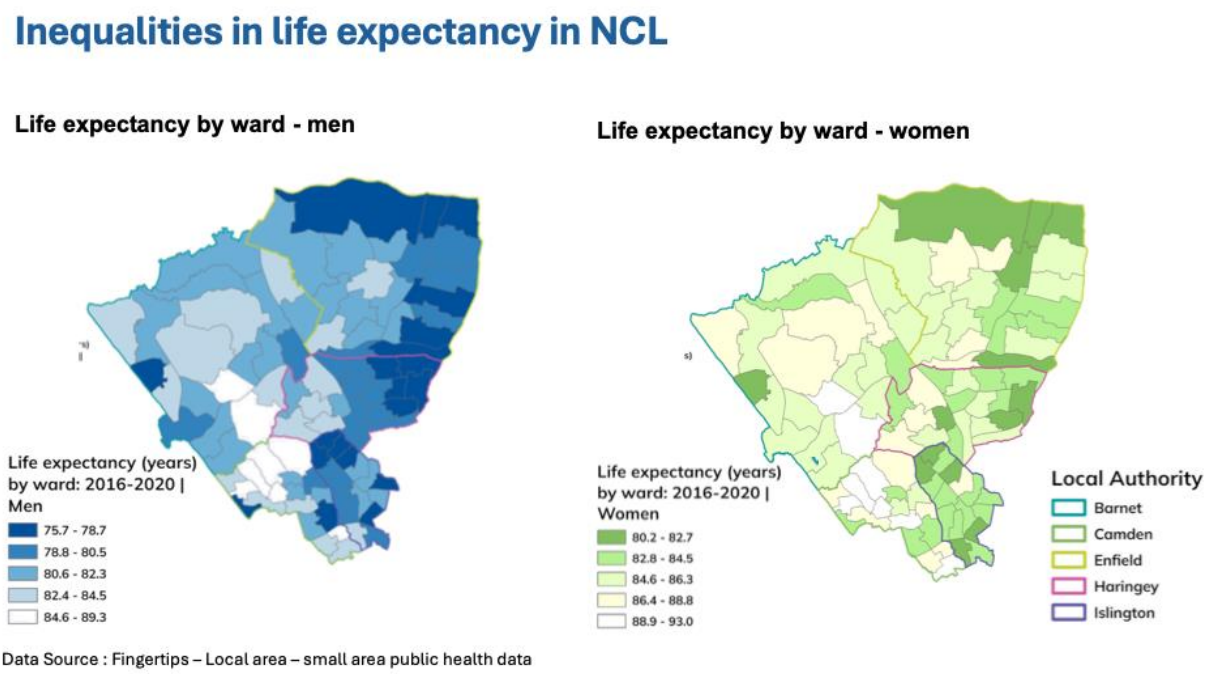
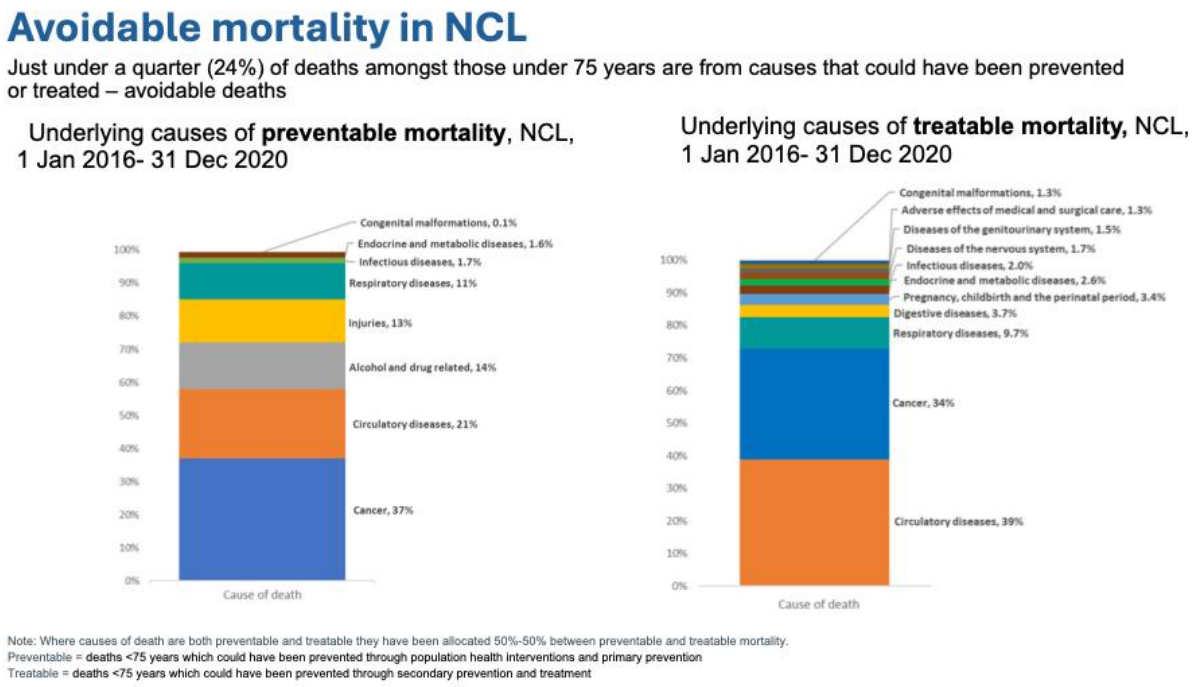


Chart 1.2: Avoidable mortality in NCL



The Faculty aims to empower staff and patients to have healthy conversations to live well, improve their health and prioritise prevention.

The programme is co-designed and co-developed with patients and staff to be culturally sensitive, person-centred, cost-effective and sustainable. We are making sure that every contact counts.

RFL introduces new nursing mental health roles

A new head of nursing for mental health was appointed at the Royal Free London in November 2024 – a brand-new role for the trust. The role has been introduced to improve organisational knowledge of the duty of care to patients with mental health needs on site, as well as contribute to mental health training, site support and improved clinical practice.

The head of nursing for mental health will lead on the trust's strategic plan for mental health including regulatory compliance and clinical practices on various sites, whilst supporting the matrons who will be leads on Barnet Hospital and Royal Free Hospital sites and this approach will also be extended to North Mid.

Improving care for patients with long-term conditions

Patients with long-term conditions (LTCs) and co-morbidities currently often have a disconnected experience of care. Around 70% of healthcare spend is on managing patients with LTCs, and in NCL alone, 430,000 people are living with at least one long term condition. A Royal Free London (RFL) respiratory consultant is working across north central London to improve the experience of care for patients with long-term conditions (LTCs).

The aim of the programme is to bring changes across the system for the management of these conditions. This will include finding ways for consultants and coordinators to access information safely and appropriately from across different trusts and finding ways to reliably update patient records across different hospitals.

Equitable diagnosis and access to healthcare, as well as population health, are key parts of the RFL's clinical strategy.

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

Part 2

Priorities for improvement and statement of assurance from the board

2.1 Priorities for improvement

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

The purpose of this Quality Account is to:

1. Summarise our performance and improvements against the quality priorities and objectives we set ourselves for 2024-25. (North Mid quality priorities 2024-25 performance is included in annex 1)
2. Set out our quality priorities and objectives for 2025-26.
3. Provide feedback and assurance statements in relation to key quality measures.

Review of 2024-25
Look back

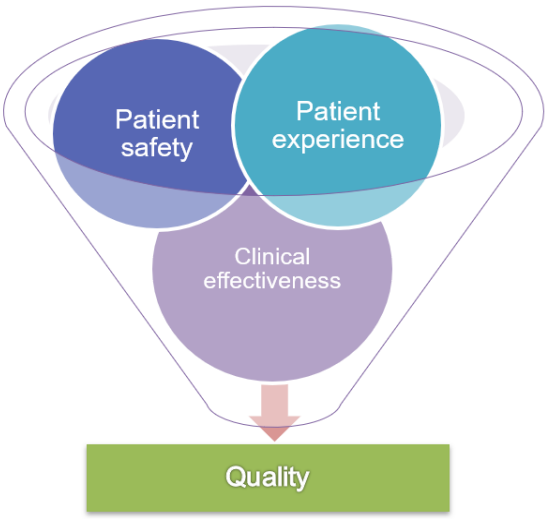
Set out priorities 2025-26
Look forward

To begin with, we will give details of how we performed in 2024-25 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.



What were our priorities for 2024-25 and how did we do?

The trust developed the 2024-25 priorities through engagement with relevant stakeholders and committees. The engagement process included the Trust Quality Group, Quality Committee, Council of Governors, Group Executive Management Meeting, stakeholder consultation and events, and the Trust Board.

Performance against the North Middlesex University Hospital NHS Trust quality priorities for 2024-25 is included in Annex 1.

Our priorities for 2024/25 were:

Priority 1: Patient experience	
1a	Embed shared principles for involving patients and carers in our services to better monitor their experiences and make relevant improvements.
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.
1c	We will improve how we communicate with patients regarding cancellation of clinic appointments.
1d	To increase compassion and kindness within the care we deliver, we will deliver a civility and kindness project.
1e	To increase patient experience feedback using digital technology to improve the number of patient survey responses received by the trust.
Priority 2: Clinical effectiveness	
2a	Standardised reporting format within all mortality and morbidity (M&M) groups and standardised escalation reports from M&M groups to CPPSs.
2b	Achieve 75% recruitment in-year to open research studies.
Priority 3: Patient safety	
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.
3b	Achieve zero trust attributable Clostridium difficile (C. diff) infection cases with a lapse in care.
3c	Getting escalation for patients with deteriorating conditions always right, as reported in Patient Safety Incident Investigations (PSIIs).
3d	All ward areas and divisions have an established practice of reviewing shared learning and produce their own improvement plans.

Our progress in 2024-25:

Priority 1: Patient experience — improving patient experience — delivering excellent experiences

Priority 1a	**Patient involvement:** **Embed shared principles for involving patients and carers in our services to better monitor their experiences and make relevant improvements.** This is an existing priority from 2023-24
What success looks like	1. We will build on the patient involvement framework to facilitate and embed high quality, diverse involvement work across the trust. 2. We will work collaboratively with patients to identify and act on areas for improvement and better understand health inequalities through changes in service utilisation. 3. 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.

Our progress in 2024-25

"We will continue to build on the patient involvement framework to facilitate and embed high quality, diverse involvement work across the trust."

The patient involvement framework has six main parts: defining involvement, principles of involvement, levels of involvement, the involvement register, patient voices groups, and the recompense policy.

As of March 2025, 79 people have joined the trust's involvement register. 73 involvement activities were advertised to members in 2024-2025, with 273 expressions of interest received.

During 2024-25, members of the involvement register have reviewed patient information, participated in quality improvement training events, helped with assessing the care environment, sat on the Royal Free Charity patient experience grants panel, and joined project groups for new initiatives.

Patient voices groups at Barnet Hospital, Chase Farm Hospital & Group Clinical Services, and Royal Free Hospital are set up and working well.

The recompense policy is in place and being used. The patient experience team reviews all claims. Not all activities are reimbursed, potentially due to some members of the involvement register opting not to receive payment for their contributions.

Due to limited capacity in the patient experience team, the strategic development of the involvement framework has progressed more slowly than planned. A steering group was created in 2023-24 to monitor patient involvement across the trust. Its terms of reference will be reviewed in 2025-26 to ensure it remains relevant and responsive.

"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 are using data to support our services to address unwarranted variation in patient access.
We have developed a report that highlights equity of access by age, ethnicity, gender, and deprivation for three key NHS performance indicators (the percentage of patients waiting less than

four hours to be seen and treated within four hours in emergency departments, the number of patients waiting longer than 65 weeks from referral to treatment (RTT) for planned care and the percentage of patients waiting less than six weeks for diagnostic tests). In Q2, we analysed data on equity of patient experience, showing the profiles of patient experience survey respondents by age, disability, and gender, and the percentage reporting positive care experiences. In November 2024, these data were discussed in the patient experience committees at Barnet Hospital, Chase Farm Hospital/ Group Clinical Services and Royal Free Hospital, each of which includes one or more patient representatives.

The trust has worked with a group of three patient representatives from the involvement register with lived experience of disability to incorporate patient perspectives into the development and rollout of a new way of recording reasonable adjustment requirements in the electronic patient record. Further work to create an alert to flag any reasonable adjustments recorded here to staff is expected to be ready for testing in 2025-26.

We have widened our engagement on improving reasonable adjustments by working with Camden Learning Disability (LD) Provider Forum and Enfield Carer Partnership Board. RFL and North Mid were also successful in applying for an Institute for Voluntary Action Research (IVAR) connecting communities capacity development project in Barnet and Enfield. This project will be delivered in partnership with voluntary sector organisations that work with disabled people, the integrated care board (ICB) and borough public health teams to develop a more collaborative approach to talking about and responding to reasonable adjustments. Initial steering group meetings have been held with voluntary and community representatives from Barnet and Enfield.

“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.”

In our preoperative assessment Clinical Practice Group (CPG), we worked with voluntary sector partners through Barnet Together to develop expectations for patients who are homeless, have learning disabilities or have language support needs. The expectations of care will be embedded with the preoperative assessment CPG. An “Access to Services” report has been developed to enable us to evaluate changes made for these groups of patients as well as improve our ability to analyse preoperative assessment access by age, ethnicity, gender and deprivation.

We delivered three learning disability and autism engagement events in Barnet, Camden and Enfield to highlight existing support available to these patients at RFL, hear and learn from their experiences of accessing services and capture their ideas on how we can improve.

We have established a learning disability and autism steering group to oversee improvements in identification, communication, support planning, training and service development for patients with learning disability and autism. The steering group includes a patient representative with lived experience.

We are using data to enable benchmarking and improvement for patients with learning disabilities. Analysis of outpatient attendances showed that did not attend (DNA) rates were higher for patients with learning disabilities. This was highlighted at the action on DNA working group with advice to specialities to adhere to the trust’s “Was Not Brought” policy following these DNAs. a report on average waiting times for patients with LD to enable benchmarking and improvement. In addition, we have developed a report highlighting waiting times for patients with learning disabilities.

The trust's learning disability clinical policy has been reviewed. Work has started on developing a business case for improving easy-read provision across the trust and will continue throughout 2025-26.

This priority will continue into 2025-26.

Priority 1b	**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.** **This is an existing priority from 2023-24**
What success looks like	1. We will establish a group-wide nutrition group; to include patients, speech and language therapist, dieticians and estates and facilities. 2. We will co-design and publish a food and drinks strategy.

Our progress in 2024-25

Nutrition and hydration are an essential part of a patient's 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. Recognizing nutrition as one of the four pillars of Fundamentals of Care, RFL has strengthened its approach by establishing nutrition-focused forums across each hospital. These forums now align under the Fundamentals of Care (FOC) group. The objectives are:

- To improve patients' nutrition across the group so that it meets our patients' needs.
- To be compliant with the requirements of the Independent Review of NHS Food and National Standards for Hospital Food
- To address health inequalities related to nutrition in patients that are vulnerable (nonverbal patients, non-English speaking patients and patients from an ethnic minority background)

The Care Quality Commission benchmarks patient feedback on the quality of care nationally. There are several questions which ask specifically about nutritional management. We use this survey together with our local surveys to inform key areas of improvement across three years to:

- Enhance Care Coordination: Delve into strategies for better care coordination across clinical teams and catering systems, aimed at improving patient access to appropriate meals and snacks
- Improving Patient Pathways: Explore strategies for developing more efficient processes for patient access to food both at mealtimes and outside of mealtimes ensuring a cohesive patient journey during the hospital admission.
- Leveraging Technology for Patient Nutritional Care: Discover how the development of the electronic patient record, dynamic electronic menus and data analytics can be utilised to improve patient nutritional care and alleviate pressures on clinical and catering teams.
- Focus on Patient Experience: Discuss initiatives designed to improve patient experience with access to food and drinks.
- Enhancing nutrition care quality: By staff on the ward and timely access to specialist support from dietitians, nutrition nurses and speech and language therapists and will be confirmed in the next quarterly update.

Progress:

A group-wide nutrition sub-group has been formed under the Fundamentals of Care framework, with leads across all four health units (Barnet Hospital, Chase Farm Hospital & Group Clinical

Services, North Mid and Royal Free Hospital) contributing to its development. Each health unit has actively co-designed a food and drink strategy with patient partners to ensure high nutritional care standards. The first draft of the food and drink strategy was presented in March 2025 and it will be finalised during 2025-26. The aim of the strategy is to ensure a consistent and high-quality approach to meeting the nutritional needs of all RFL patients.

To ensure our continued commitment to this agenda, we will be taking forward this priority into 2025-26.

Priority 1c	**How we communicate with patients (on cancellations):** **We will improve how we communicate with patients regarding cancellation of clinic appointments**. This is an update priority from 2023-24.
What success looks like	1. 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. 2. We will monitor our progress using patient experience to collect patient and carer feedback.

Our progress in 2024-25

*(*This section reflects the trust's Q3 position at the time of drafting. Data and information may be updated upon validation.)*

This two-year project aims to enhance patient-led appointment rescheduling and increase the success rate of patients avoiding a 'Did Not Attend' (DNA) status following their rescheduling request.

The project was framed to focus on improving communication and trust's response to patients seeking to reschedule their outpatient appointments.

Project outline

Patients have four routes by which to change an outpatient appointment:

- Calling the contact centre;
- Post a request on the trust website;
- Reply to a 2way SMS
- Using self-service options on the patient portal

To reduce missed appointments, we have given patients the SMS option (introduced October 2023) and new rule sets in the patient portal (April 2024). Data shows that patients seeking to rebook an appointment via two-way SMS are not well supported and are sometimes recorded as a DNA because their request has not been met in advance of the appointment. Staff often discover these issues in clinics when following up on missed appointments.

We will now work to improve our response to two-way SMS communication and monitor the other routes that are open to patients in order to avoid DNAs.

What we are hoping to achieve and measure

Project objectives:

1. Patients are effectively supported to reschedule appointments (measured by the volume and rate of patient-led appointment reschedules)

2. Patients and staff report fewer issues with patient-initiated appointment cancellations (measured by the volume of patients who request a reschedule but go on to be recorded as a DNA)

We will monitor:

Measure	Baseline	Draft 2024-25 goal	Draft 2025-26 goal
Rate of patient led appointment reschedules (monthly value)	9.9%	11%	12%
Volume of patient led appointment reschedules (monthly value)	17,244	19-20k	20-21k
volume of patients who request a reschedule but go on to be recorded as a DNA (weekly value)	76	0	-

Progress:

This project was taken forward via the Action on DNAs Working Group and also reports to the Quality Strategy Steering group.

The project monitored local rebooking arrangements based on appointment type, and early monitoring data suggests progress is being made. The data for 2024 -25 sees us meeting our goal of 11% of patient led appointment reschedules most months as shown in table below. However, further work is needed to fully optimise patient experience and we will aim to increase the proportion of patient led appointment reschedules next year.

Table 2.1.1: 2024-25 monthly progress for appointment reschedules measures

Measure		2024-25 Baseline	2024-25 Goal	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
rate of patient led appointment reschedules	monthly	9.9%	11.0%	10.8%	11.2%	10.8%	10.9%	10.5%	11.6%
volume of patient led appointment reschedules	monthly	17,244	19-20k	21,093	19,345	19,837	21,736	19,459	19,060
volume of patients who request a reschedule but go on to be recorded as a DNA	weekly snapshot	274	0	205	226	164	187	219	127

[Final data to be confirmed]

The Action on DNAs Working Group has also carried out a patient survey seeking to understand the issues and barriers patients face to attending appointments.

The scope of the survey was to contact every patient who missed an appointment within a two-week period with a structured survey using targeted questions. Approximately five thousand patients were contacted using Friends and Family technology. A thematic analysis of the patient level data is underway. Survey results will be shared along with recommendations and next steps toward improving patient experience. [Further update will be included in the final report]

Priority 1d	**Compassion and Kindness:** **To increase compassion and kindness within the care we deliver, we will deliver a civility and kindness project.** This is a new priority for 2024-25.
What success looks like	1. Deliver civility and kindness project. * This is a three-year project. In year one (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.

Our progress in 2024-25

Project

We know that if we increase staff to staff civility, our patients should experience more compassion and kindness from our staff. This project focused on improving staff-to-staff civility through multiple initiatives in the first year. In subsequent years we will be monitoring the impact of staff civility initiatives on patient experiences.

The specific project objectives focus on

- Improving measures of civility through a change of culture of civility
- Improving the proportion of patients who report greater levels of kindness experienced from our staff when receiving services in our trust.

Progress

A program of staff civility initiatives was delivered in year one across the health units and was monitored through the anti-bullying & harassment steering group.

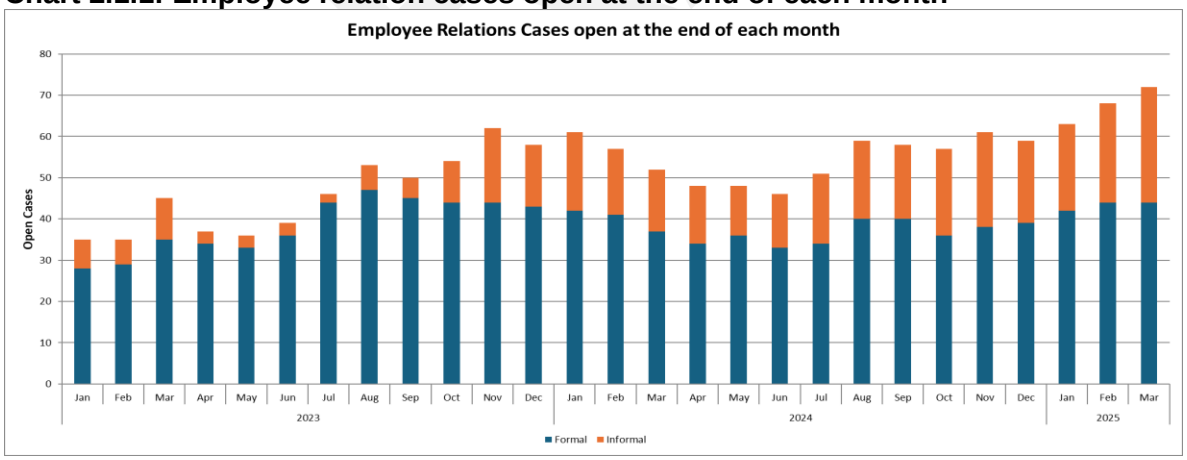
After a review of our civility and respect toolkit we developed our program, including:.

- Review of the bullying & harassment (B&H) policy (and affiliated employee relation (ER) policies e.g., disciplinary, Freedom to Speak Up policy).
- Skills development through several civility initiatives.
- Monitoring the success of our civility initiatives through the improvement in the proportion of numbers of bullying and harassment cases, at informal and formal level.
- Quality (just and restorative) outcomes from case resolution (anecdotal and learning).

To allow the civility initiatives to be delivered and have an impact on patient experience, patients' ratings for kindness and compassion as measured on the inpatient survey will be monitored in year two and three.

The proportion of informal compared with formal cases opened in relation to bullying and harassment is increasing (chart below).

Chart 2.1.1: Employee relation cases open at the end of each month



This priority will be taken forward into 2025-26.

Priority 1e	**Patients experience feedback:** To increase patient experience feedback using digital technology to improve the number of patient survey responses received by the trust. **This is a new priority for 2024-25.**
What success looks like	1. We will establish a baseline of services where surveys are undertaken and number of responses. 2. We will increase the number of services undertaking surveys across all sites. 3. We will work with services to improve the number of responses received. 4. We will launch action plans in response to survey results.

Our progress in 2024-25

At the end of Q1 (June 2024), the new digital system for the collection of Friends and Family Test (FFT) feedback was implemented. The level of response received from the new system (predominantly via text message) has far exceeded expectations. Based on the value of the contract which runs until the end of 2026-27, restrictions have needed to be applied to the number of FFT text messages sent to patients who attend out-patient appointments. The number of messages sent, and responses received (#R) by quarter can be seen in the table below.

Table 2.1.2: The number of messages sent, and responses received (#R) by quarter.

	Q1 (June 2024)		Q2 – Jul-Sep 2024		Q3 – Oct-Dec2024		Q4 Jan-Mar 2025	
	Sent	#R	Sent	#R	Sent	#R	Sent	#R
In-patients	3,593	829	12,105	3,254	9,864	2,673	11,029	2,654
Out-patients	37,477	9,816	116,318	28,936	92,165	22,505	83,807	20,638
Day case	6,056	1,696	15,392	5,545	13,850	4,912	15,740	5,928
ED/UTC	12,266	2,781	46,546	10,036	48,231	9,440	49,998	10,249
TOTAL	**59,392**	**15,122**	**190,361**	**47,771**	**164,110**	**39,530**	**160,574**	**39,469**

Whilst the new system has worked well in most areas, it has highlighted an issue within the health services for elderly people (HSEP) (elderly care) wards, particularly at Barnet Hospital. In Q4, the FFT question was reintroduced into the local inpatient survey on these wards, which are carried out by staff on the ward. As a result, these wards have seen an increase in responses and work is underway to review data completeness.

Local surveys are undertaken within services the result of which inform local action plans which are outside of the control or knowledge of the patient experience teams.

As part of the board assurance framework (BAF), Health Units are required to respond to the results of national patient surveys with action plans, which are presented at their patient experience committees.

At the end of 2024-25, this priority was fully achieved.

Priority 2: Clinical effectiveness — improving clinical effectiveness – delivering excellent outcomes

Priority 2a	**Learning from mortality reviews:** **Standardised reporting format within all mortality and morbidity (M&M) groups and standardised escalation reports from M&M groups to CPPSCs.** **This is an updated priority from 2024-25.**
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.

Our progress in 2024-25

Within healthcare, a key component of workplace-based learning is the morbidity and mortality meeting (M&M). The goal of an M&M meeting is to provide clinicians with the opportunity to discuss adverse events in an open manner, review care standards, and make changes if required. In this one-year project we wanted to ensure that we had a consistent way of documenting the outcomes from M&M meetings and create an electronic repository that all clinicians can freely access.

The objectives were:

1. To quantify how many services are using the soft launched M&M meeting templates.
2. Once the electronic form has been created by Datix, to measure how many Learning from Deaths reviews are completed in real time electronically.

By the end of 2024-25, the electronic M&M form had been developed and trialled. Following evaluation of the feedback, it became clear that the initial ambition of fully aligning the content of the M&M to the Learning from Deaths (LfD) process was not practical due to the amount of documentation required for the LfD process. The refined template remains aligned to the LfD process but has been reduced for M&Ms and is now a document repository capturing key information such as outcomes and learning themes. Health units have collated local M&M data including the frequency of M&Ms and have identified 56 M&M meetings to date.

Once additional feedback has been received after trialling this new template, a plan will be developed to roll out the template across all M&M meetings.

At the end of 2024-25, this priority was fully achieved.

Priority 2b	**Research and development (R&D):** **Achieve 75% recruitment in-year to open research studies.** **This is a new priority for 2024-25.**
What success looks like	1. >/= 75% of studies open in year will show recruitment.

Our progress in 2024-25

*(*This section reflects the trust's Q3 position at the time of drafting. Data and information may be updated upon validation.)*

Increasing research studies is vital to Royal Free London's tripartite mission as it directly enhances our ability to deliver cutting-edge patient care through evidence-based practice as well as providing

access to new therapies and procedures. Research not only improves clinical outcomes for our diverse North Central London communities but also attracts and retains staff.

As an organisation with a rich history of medical innovation, expanding and diversifying our research portfolio strengthens our reputation as a centre of excellence, creates valuable partnerships with academic and life science leaders, and generates additional funding streams that can be used to generate Royal Free initiated research and innovation in service departments. Ultimately, a robust research program ensures we influence globally while acting locally. The trust target for this year is to achieve recruitment of 75% to open research studies.

Monthly progress is shown in the table below*. There has been an increase in the number of open studies recruited to from 373 in 2023-24 to 390 in 2024-25. Since the overall number of studies open has increased the percentage of open studies recruited to has remained approximately stable.

The R&D Office has been clearing the historical backlog of studies which has resulted in a large number of studies opening as shown in the last row of the table below. The Research Data, Analytics and Systems section of the R&D Office has created an email macro to provide monthly recruitment reports to investigators of their studies' performance as well as providing them a list of studies marked as open to recruitment. Studies inappropriately marked open to recruitment adversely affect the proportion of open studies recruiting. The macro was launched at the end of September 2024, and 57 studies by the beginning of December 2024 have now been marked as closed to recruitment as a result of the macro. As the macro is adopted we expect study status to be updated more frequently and progress made towards achieving this target. Principal Investigators will be asked to ensure their study status is correct and all recruitment has been inputted into the recruitment database (EDGE).

Table 2.1.3 : Monthly progress for patient recruitment.

Indicators	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec (to 11/12)
Patient recruitment to clinical trials	1086 (in month) 1086 (cumulative)	1091 (in month) 2177 (cumulative)	1185 (in month) 3362 (cumulative)	1391 (in month) 4753 (cumulative)	1183 (in month) 5936 (cumulative)	1480 (in month) 7416 (cumulative)	1178 (in month) 8594 (cumulative)	1079 (in month) 9673 (cumulative)	135 (in month) 9808 (cumulative)
Achieve recruitment in-year to open research studies. (Target 75% for 24-25)	54.8%	53.7%	54.1%	54.4%	54.4%	54.2%	54.1%	54.3%	53.9%
Number of Studies Open to recruitment	681	694	698	721	713	714	735	739	726

Note: *The data pull date for this table was the 11th December 2024 and many large studies only report recruitment at month end. Thus, data for December is currently incomplete and will be provided in the final accounts.

Further work will be undertaken in Q4 to tag studies that are not likely to recruit yearly. For example, studies that recruit participants with conditions that are considered as rare or very rare

Regular emails to principal investigators highlighting studies which are under target for recruitment and support of research nursing teams is in place and expected to improve open studies recruiting.

We aim to retain this target for 2025-26.

Priority 3: Patient safety — improving patient safety — delivering safe care

Priority 3a	**Infection Control: MRSA:** **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 is an existing priority from 2021-22.**
What success looks like	1. Implementing an education and training plan to improve (intravenous) line care practice. 2. Undertake post infection reviews (PIRs) carried out to identify and act on key areas of improvement.

Our progress in 2024-25

*(*This section reflects the trust's Q3 position at the time of drafting. Data and information may be updated upon validation.)*

From April 2024 to December 2024 [Final data to be added], the trust recorded five MRSA blood stream infections (BSI). All cases were unavoidable.

- MRSA bloodstream infections in Q1 to Q3.

Table 2.1.4: RFL attributable MRSA cases for each quarter

	Q1	Q2	Q3	Q4
MRSA BSI	2	2	1	TBC

Chart 2.1.2: RFL attributable MRSA cases by month and site

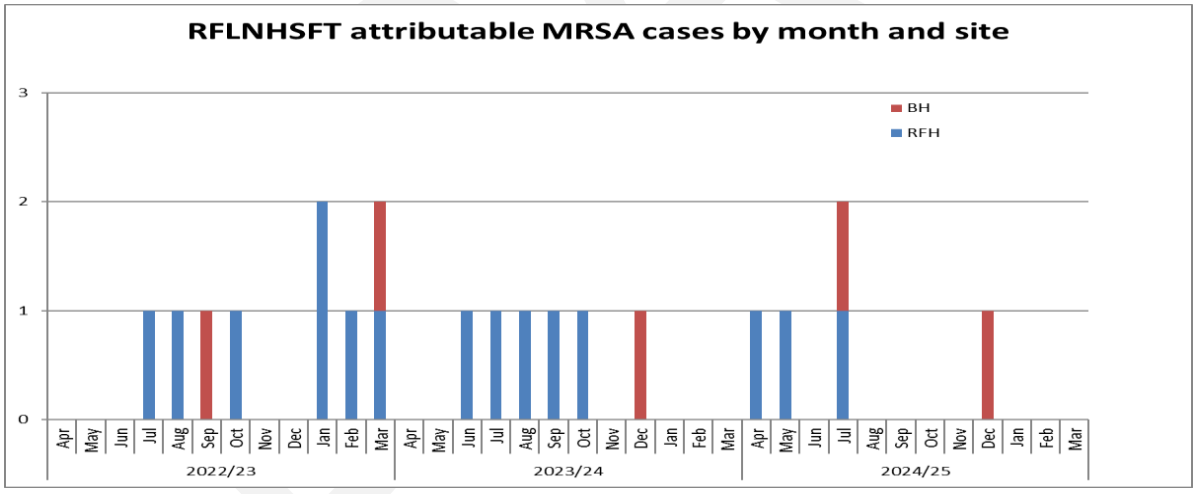
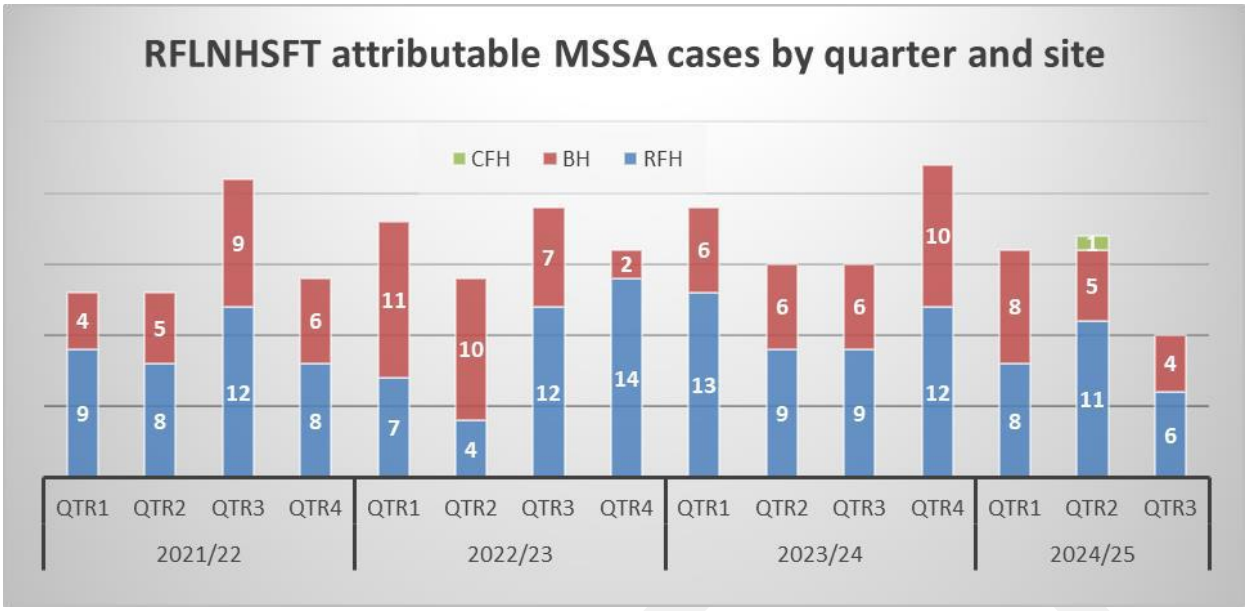


Table 2.1.5: MSSA BSI attributable cases in Q1 to Q3

	Q1	Q2	Q3	Q4
MSSA BSI	16	17	10	TBC

Chart 2.1.3: RFL attributable MSSA cases by quarter and site



There was reduction of seven cases of MSSA BSI for Q3 in comparison with Q2. Out of ten cases in Q3, two cases had no healthcare related aetiology. Five cases were identified as having intravenous line related aetiology. Of those, two were renal patients and identified learning was to ensure timely decolonisation, and one oncology case had incomplete documentation.

RFL is provided an annual threshold for healthcare associated (HCA) gram-negative blood stream infections (GN BSI) for 2024-25. It is *E. coli* 138*, Klebsiella* 80*, Pseudomonas* 37*.*

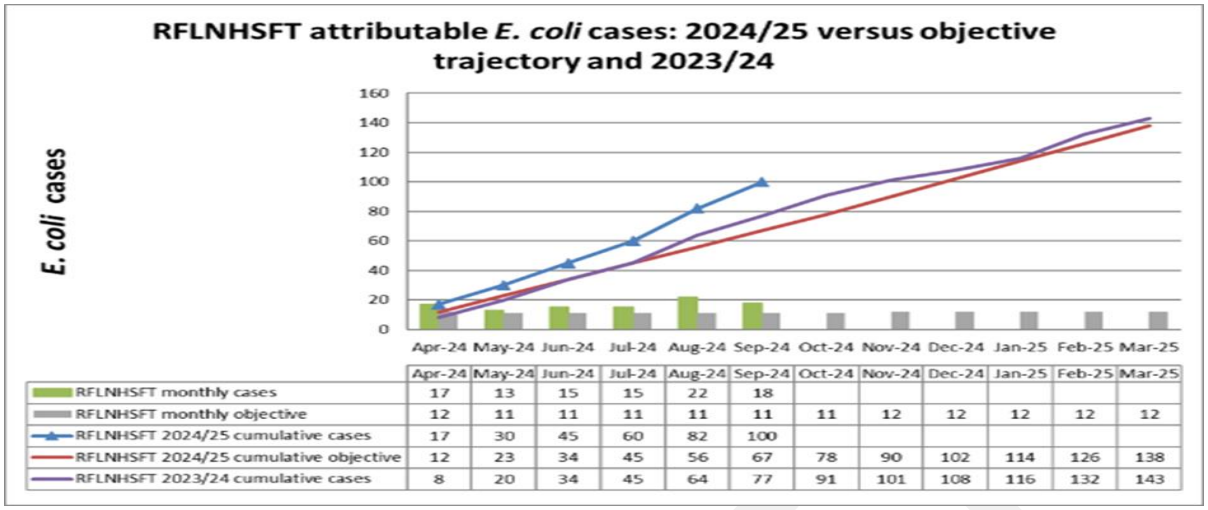
The UK Health Security Agency (UKHSA) defines a bloodstream infection as healthcare associated if the positive blood culture sample was taken > 2days after admission, or if the patient had prior contact with the trust in the previous 28 days prior to the blood culture being taken (e.g. previous admission, Emergency Department (ED) or day unit presentation)

- Gram Negative BSI (GNBSI) attributable cases in Q1 to Q3

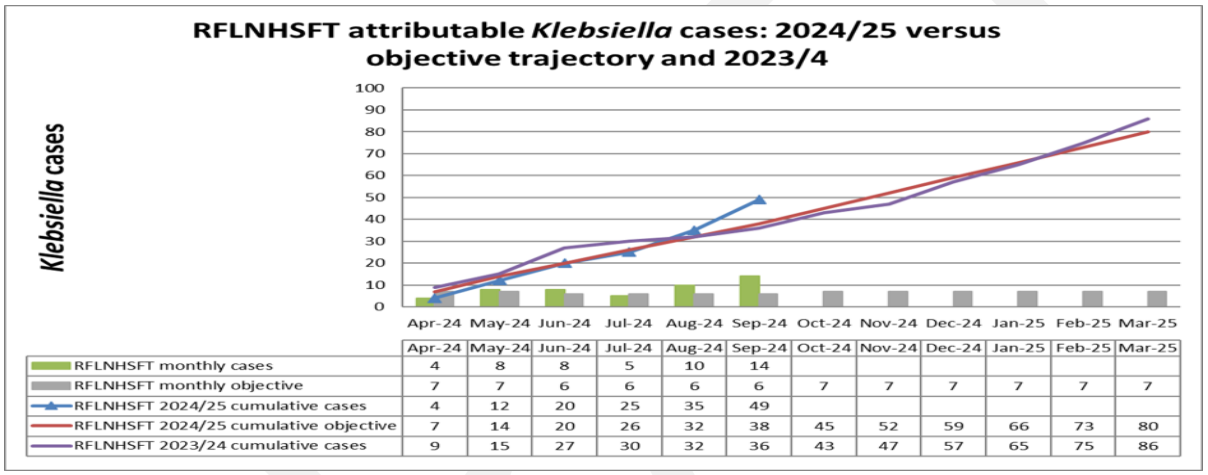
Table 2.1.6: RFL Gram Negative BSI (GNBSI) attributable cases in Q1 to Q3

	Q1	Q2	Q3	Q4
E.Coli	45	55	37	TBC
Klebsiella spp.	20	29	23	TBC
Pseudomonas aeruginosa	13	10	9	TBC

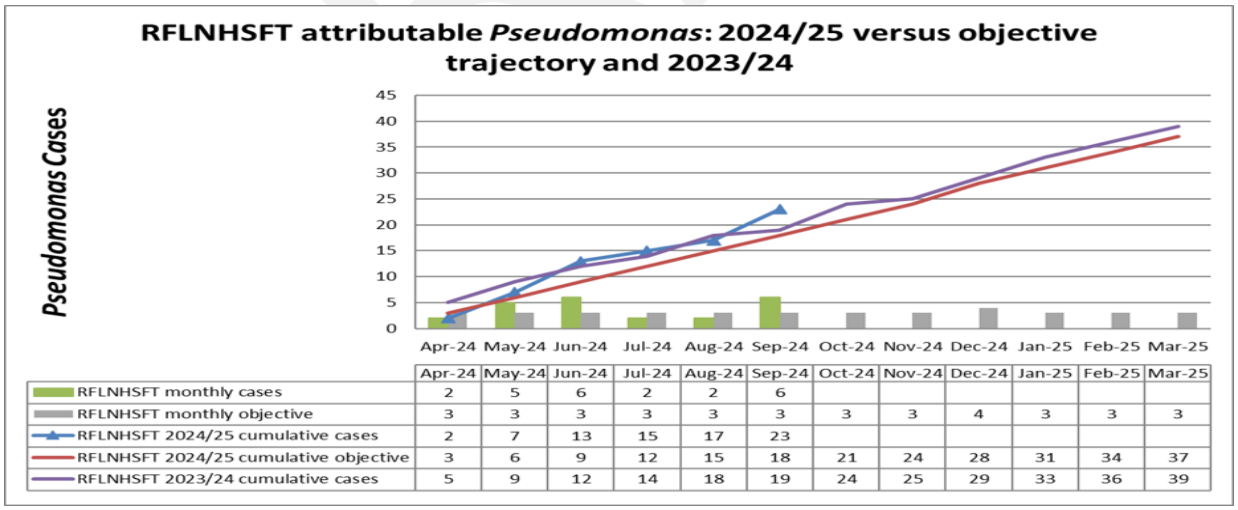
Chart 2.1.4: RFL attributable E.coli, Klebsiella and Pseudomonas: 2024-25 versus objective trajectory and 2023-24.



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
RFLNHSFT monthly cases	17	13	15	15	22	18						
RFLNHSFT monthly objective	12	11	11	11	11	11	11	12	12	12	12	12
RFLNHSFT 2024/25 cumulative cases	17	30	45	60	82	100						
RFLNHSFT 2024/25 cumulative objective	12	23	34	45	56	67	78	90	102	114	126	138
RFLNHSFT 2023/24 cumulative cases	8	20	34	45	64	77	91	101	108	116	132	143



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
RFLNHSFT monthly cases	4	8	8	5	10	14						
RFLNHSFT monthly objective	7	7	6	6	6	6	7	7	7	7	7	7
RFLNHSFT 2024/25 cumulative cases	4	12	20	25	35	49						
RFLNHSFT 2024/25 cumulative objective	7	14	20	26	32	38	45	52	59	66	73	80
RFLNHSFT 2023/24 cumulative cases	9	15	27	30	32	36	43	47	57	65	75	86



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
RFLNHSFT monthly cases	2	5	6	2	2	6						
RFLNHSFT monthly objective	3	3	3	3	3	3	3	3	4	3	3	3
RFLNHSFT 2024/25 cumulative cases	2	7	13	15	17	23						
RFLNHSFT 2024/25 cumulative objective	3	6	9	12	15	18	21	24	28	31	34	37
RFLNHSFT 2023/24 cumulative cases	5	9	12	14	18	19	24	25	29	33	36	39

All HCA BSIs are reviewed by microbiology and infection prevention and control (IPC) teams to assess the focus of infection and potentially preventable causes. Ongoing monitoring shows that the majority of HCA GNBSIs do not have a potentially preventable cause. These include hepatobiliary conditions, intra-abdominal, and urinary tract infections (no catheter).

Infection Prevention and Control Team activities in 2024-25:

- Successfully launched the North Central London (NCL) Urinary Catheter Passport in Q2
- Continued implementation of a robust education and training plan that ensures staff competence and compliance with the Aseptic Non-Touch Technique Framework for line/device care and management.
- Introduced an improvement plan to reduce the incidence of bloodstream infections with *Staphylococcus* species and Gram-negative organisms.
- Organised a successful winter summit and winter roadshow with positive feedback from staff who engaged with the variety of activities in Q3.
- Participated in various clinical practice events and used these opportunities to share and feedback the outcome of the urinary catheter (HOUDINI) and peripheral cannula (including central venous catheter) audits. Clinical staff knowledge was refreshed by scenarios and discussions.
- Developed training plans with the following priorities: lines and device care, personal protective equipment (PPE) policy, 5-moments of hand hygiene, 7-steps of hand hygiene, PPE donning and doffing, promoting the trust '*Gloves off awareness'* campaign amongst clinical staff.

MRSA cases will continue to be a key focus for the trust and will be reported as part of the national indicators in the 2025-26 quality accounts.

Priority 3b	**Achieve zero trust attributable Clostridium difficile (C. diff) infection cases with a lapse in care.** **This is an existing priority from 2021-22.**
What success looks like	1. C. diff knowledge and practice audit amongst staff. 2. Audits of commodes, mattress and pillows. 3. Develop a robust and practical action plan with clinical team to reduce rates of C. diff infection. 4. Review of all cleaning audit reports at site divisional lead meetings. 5. Root cause analysis will be carried out to identify what changes would prevent reoccurrence. 6. 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 2024-25

*(*This section reflects the trust's Q3 position at the time of drafting. Data and information may be updated upon validation.)*

The trust reported 72 C.diff toxin (CDT) cases from April 2024 to December 2024 [Final data to be added], against a threshold of 85.

C.diff toxin attributable cases against annual threshold of 85 for 2024-2025

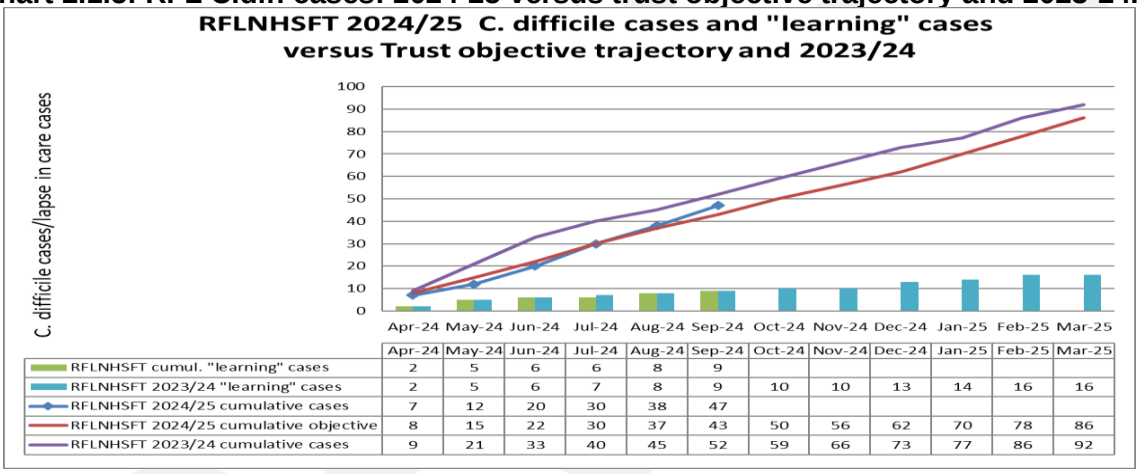
Table 2.1.7: RFL C.diff toxin attributable cases in Q1 to Q3

	Q1	Q2	Q3	Q4
C.diff toxin	20 (13 HOHA, 7 COHA)	27 (22 HOHA, 5 COHA)	25 (17 HOHA, 8 COHA)	TBC

Note: 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).

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).

Chart 2.1.5: RFL C.diff cases: 2024-25 versus trust objective trajectory and 2023-24.



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
RFLNHSFT cumul. "learning" cases	2	5	6	6	8	9						
RFLNHSFT 2023/24 "learning" cases	2	5	6	7	8	9	10	10	13	14	16	16
RFLNHSFT 2024/25 cumulative cases	7	12	20	30	38	47						
RFLNHSFT 2024/25 cumulative objective	8	15	22	30	37	43	50	56	62	70	78	86
RFLNHSFT 2023/24 cumulative cases	9	21	33	40	45	52	59	66	73	77	86	92

What have we done to reduce C. diff infection?

- There is no evidence of HCAI transmission
- All cases were reviewed using the Patient Safety Incident Framework (PSIRF). If any serious cases are identified, this is escalated to Patient Safety Event Review Panel (PSERP). Thematic analysis is shared at relevant meetings, such as the site-based IPC leads' meeting and the trust IPC committee meeting.
- The thematic analysis has identified learning regarding improvement in the Bristol stool chart documentation, delay in treatment and using the IPC risk matrix to ensure appropriate patient placement and documentation of duty of candour discussions.
- Annual audits of commodes, mattress and pillows demonstrate that no major issues were identified.
- The deep cleaning programme has been successfully embedded across all sites with effective monitoring to facilitate timely completion of targets.

C.diff infections will continue to be a key focus for the trust and will be reported as part of the national indicators in the 2025-26 quality accounts.

Priority 3c	**Patients with deteriorating conditions** Getting escalation for patients with deteriorating conditions always right, as reported in Patient Safety Incident Investigations (PSIIs). **This was a new priority for 2024-25.**
What success looks like	1. At the end of 2024-25 we aim for a reduction by 30% of patient safety event reports (PSIIs) where these have been identified as contributing factors.

Our progress in 2024-25

*(*This section reflects the trust's Q3 position at the time of drafting. Data and information may be updated upon validation.)*

This project focuses on ensuring timely escalation of deteriorating patients, as reported in Patient Safety Incident Investigations (PSIIs). It incorporates Martha's Rule, the Worry and Concern Project, the National Paediatric Early Warning Score (PEWS), and the sepsis identification audit.

This is a three-year initiative, with the first-year objective (2024-25) being to achieve a 30% reduction in PSIIs where failure to escalate deterioration has been identified as a contributing factor.

Martha's Rule:

Martha's Rule is being introduced in response to the death of Martha Mills and other incidents when patient deterioration was not recognised or acted upon. It has three elements:

1. All staff in NHS trusts must have 24/7 access to a rapid review from a critical care outreach team, who they can contact should they have concerns about a patient.
2. All patients, their families, carers, and advocates must also have access to the same 24/7 rapid review from a critical care outreach team, which they can contact via mechanisms advertised around the hospital, and more widely if they are worried about the patient's condition.
3. The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily. In the first instance, this will cover all inpatients in acute and specialist trusts.

Progress:
All three elements of Martha's Rule are now live in relevant inpatient areas in RFH and BH. Wellness questions have been piloted in select wards at NMUH. Patient/family referral phone numbers are live on all acute sites.

RFL is recognised as a national exemplar with regards to wellness questions/new element 1 of Martha's Rule and will feature in national publicity and communications (filming date to highlight clinical case study confirmed)..

Findings from thematic reviews have helped refine daily patient inquiries and test tools for non-verbal patients. Common themes identified include:
• Patient symptoms such as pain, constipation, and sleeplessness.
• A lack of understanding regarding clinical progress, prompting updates from the clinical team.
• Delays in imaging and investigations.

Although few cases of acute deterioration have been identified through this process, these conversations have reinforced the importance of proactive communication with patients and families, which is critical for improving patient safety.

A new way for Patient at Risk and Resuscitation Teams and critical care outreach teams to document reviews triggered by patient/relative referrals has been developed and approved for implementation in the electronic patient record. A daily iView assessment is also being built within the electronic patient record to capture element 3 – how the patient is feeling.

North Mid also participated in the Phase 1 pilot of Martha's Rule implementation prior to joining the RFL group.

National Paediatric Early Warning Score (PEWS):
Following the NHSE refresh of the Paediatric Early Warning System, the trust is now implementing an electronic version of PEWS on our Electronic Patient Record (EPR). The first draft is expected to be ready for review in June. Implementation will follow, along with potential iterations based on early rollout findings.

Sepsis:
Sepsis screening and bundle compliance are currently audited manually. We are working on integrating an updated sepsis workflow into our Electronic Patient Record which is based on recent NICE and UK Sepsis Trust guidance. This will then allow us to embed sepsis screening and bundle elements and enable accurate audits and further refinement.

Priority 3d	**Learning from safety incidents** All ward areas and divisions have an established practice of reviewing shared learning and produce their own improvement plans. **This was a new priority for 2024-25.**
What success looks like	2. 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.

Our progress in 2024-25

Project details:

This project has the objective of effective learning from safety incidents (safety events). It works to establish more interactive learning from safety events that is appropriate and meaningful to the clinical teams and to ensure appropriate learning takes place for the clinical area. It utilises the quality walkabout methodology as recorded on Tendable, to monitor if clinical teams are aware of their most frequent safety events and are able to articulate their team's improvement plans to address these.

The specific project objectives focus on

- All ward areas and divisions have an established practice of reviewing shared learning and produce own improvement plans.
- On Quality Walkarounds , staff are aware of three top safety shared learnings as applicable to their clinical area and able to describe the improvement plans.

This is a three-year project. In year one (2024-25), the objective was to see all ward areas have established practice of reviewing shared learning and produce own improvement plans. The objective is to improve Quality Walkarounds rating by 10%.

The main objective is to learn from safety events and also build on our strengths to continuously reduce the occurrence of patient safety events and improve patient outcomes.

The project focus will be on better learning resources, engage with compassion and kindness, and involve staff and patients in learning responses.

To facilitate this the trust will:

- Develop mechanisms for more interaction sharing of learning.
- Develop mechanism and tools to assist learning and improvement actions for clinical teams.
- To monitor retained learning, we have set ourselves the goal that on our Quality Walkarounds we see on increase ward staff awareness of local safety events and improvement plans. The measure was: Quality Walkarounds data in %– Monthly on 'Can you tell me what the top three incidents are for your area and what you are doing to reduce the risks associated with these'.

Progress:

The Patient Safety Specialists working within the Patient Safety Team, continue to participate in the monthly Quality Walkarounds, this gives insight into the recall of staff in relation to patient safety events within their areas. On walkarounds staff have been able to demonstrate what the most prevalent patient safety events have been within their areas. This has been demonstrated in subsequent Quality Walkarounds data. Quality Walkarounds results have shown improvement across the trust of 13% during 2024/25.

The Patient Safety Team are now delivering trust developed PSIRF training to staff. This takes the form of a 2-day Learning Response Lead, 1-day Compassionate Engagement Lead and a 1-day PSIRF awareness training, to staff involved in the management of patients. The team also deliver on the Leading Through Education to Excellent Patient Care (LEEP) Leadership programme, the FY2 programme and deliver ad hoc training as requested. Utilising a trust approach to training delivery, is allowing us to refine our focus on trust wide issues.

Following an increase in the numbers of Never Events and our coroners issuing more Prevention of Future Deaths verdicts, we are undertaking thematic reviews to support our learning from these safety events. Improvement actions from these are taken forward as part of our learning responses.

This is a three-year project and will be taken forward in 2025-26.

Our priorities for improvement for 2025-2026

The trust is committed to delivering world-class clinical care, education, and research that enhances the health and well-being of both the local community and the wider populations we serve. This ambition is rooted in our strategic objectives and is guided by our quality strategy and goals.

How we developed our priorities

For 2025–26, we have identified a set of quality priorities that align with our various overarching strategies and have integrated these across the trust through our executive assurance committees. The selection of quality priorities for 2025–26 is based on insights from our quality strategy, clinical strategy, healthcare digital strategy, NHS Long Term Plan objectives, governing objectives, and stakeholder feedback. Stakeholder engagement included dedicated consultation events and survey responses, capturing perspectives on an extended list of priorities. Following this, the trust executive conducted a final review and approval process to confirm the priorities for the year ahead.

Progress in achieving these priorities will be monitored by our Quality Committee and reported to the Trust Board. In addition, updates will be shared with the trust infection prevention and control committee and health unit clinical performance and patient safety committees, chaired by the respective medical directors.

Certain 2024–25 priorities have been carried over into 2025–26, reflecting their role in long-term strategic plans or ongoing quality initiatives within the trust. Certain priorities have been adjusted or rephrased to reflect shifts in focus for 2025-26.

Furthermore, all quality priorities have been strategically linked to the trust's governing objectives, ensuring that our quality performance efforts contribute to the overall long-term ambitions of the organisation.

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. **This is an existing priority from 2023-24.**	• **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 and work with patients and carers in the co-production and design of our services.
Priority 1b	**Fundamentals of care: nutrition** Ensuring all adult inpatients and those having a procedure receive appropriate nutrition and hydration	**What success looks like:** •We will establish a group-wide nutrition group; to include patients, speech and

Source: Quality Strategy	and where necessary support them to meet nutritional and hydration requirements. **This is an existing priority from 2023-24.**	language therapist, dieticians and estates and facilities. • We will co-design and publish a food and drinks strategy.
Priority 1c Source: Quality Strategy	**Improving communication with patients and trust's response to patients seeking to reschedule their outpatient appointment.** We will improve how we communicate with patients seeking to reschedule their outpatient appointments. **This is an update priority from 2023-24.**	**What success looks like:** • Patients are effectively supported to reschedule appointments. • Patients and staff report fewer issues with patient-initiated appointment cancellations. • 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. **This is an existing priority from 2024-25.**	**What success looks like:** • This is a three-year project. 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.
Priority 1e Source: Fundamentals of care	**Dignity and Kindness for End-of-Life Care (EoLC)** The trust will improve dignity and kindness for our patients at the end of their lives. We will do this by • Identifying patients at the end of life, and explicitly planning their care accordingly. • supporting the communication training needs of all staff involved in end-of-life care • providing sensitive, clear communication and support for bereaved carers. **This is a new priority for 2025-26.**	**What success looks like:** • Improve the proportion of bereaved people that rated the overall care and support given to themselves and others by all hospitals within the RFH Group as excellent or good. • Improve the proportion of expected deaths managed with an evaluated and holistic MDT individualised EoLC plan. • Achieve parity across all sites on the provision of sustainable communication training available to all levels of staff who care for the deteriorating and dying patient and those important to them.

Priority 2: Our clinical effectiveness priorities — improving clinical effectiveness — delivering excellent outcomes		
Priority 2a	**Patient with additional support needs and learning disabilities:**	**What success looks like:**

Source: Quality Strategy	In patient, safety events, elimination of the identification as a contributory factors: a)where English was not the patient's first language or b) navigate our appointment system was identified for patients with a learning disability. **This is an existing quality strategy priority from 2024-25 and included in quality account for 2025-26.**	• Reduction by 70% of patients safety events (PSIIs) where these have been identified as contributing factors.
Priority 2b Source: Governing objectives	**Research and development** Achieve 75% recruitment in-year to open research studies. **This is an existing priority from 2024-25.**	**What success looks like:** • >/= 75% of studies open in year will show recruitment.

Priority 3: Our patient safety priorities — improving patient safety — delivering safe care		
Priority 3a Source: AMRNAP	**Infection Control: Optimising the use of antimicrobials.** As part of 2024-2029 Antimicrobial Resistance (AMR) National Action Plan (NAP). **This is a new priority for 2025-26.**	**What success looks like:** • Improved compliance with local and national antimicrobial policies
Priority 3b Source: Quality Strategy	**Patients with deteriorating conditions** Getting escalation for patients with deteriorating conditions always right, as reported in PSIIs. **This is an existing priority from 2024-25.**	**What success looks like:** • At the end of 2025-26 we aim for a reduction by 70% of patient safety event reports (PSIIs) where these have been identified as contributing factors.
Priority 3d Source: Quality Strategy	**Learning from safety incidents** All ward areas and divisions have an established practice of reviewing shared learning and produce their own improvement plans. **This is an existing priority from 2024-25.**	**What success looks like:** • All divisions areas have established practice of reviewing shared learning and produce own improvement plans. Improve Quality Walkabouts rating by 60% 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 2024-25, the Royal Free London NHS Foundation Trust provided and/or subcontracted 52 relevant health services.

The Royal Free London NHS Foundation Trust has reviewed all the data available to them on the quality of care in 52 of these relevant health services.

The income generated by the relevant health services reviewed in 2024-25 represents 100% of the total income generated from the provision of relevant health services by the Royal Free London NHS Foundation Trust for 2024-25.

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 2024-25, 65 national clinical audits and 7 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 94% 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 2024-25 are detailed in table 2.2.1 and 2.2.2 below.

The national clinical audits and national confidential enquiries the Royal Free London NHS Foundation Trust participated in during 2024-25 are detailed in table 2.2.1 and 2.2.2 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 2024-25, 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 2.2.1 and 2.2.2 below. (table2.2.1 and 2.2.2 incorporate North Middlesex Hospital data also)

The reports of 55 national clinical audits were reviewed by the provider in 2024-25 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 2.2.3.

The reports of 116 local clinical audits were reviewed by the provider in 2024-25 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 2.2.4.

Note: 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.

Table 2.2.1 and 2.2.2 – includes North Middlesex Hospital data as well

Where 2024-25 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 2.2.1: National Clinical Audit; eligibility and participation

National Clinical Audit	Data collection completed in 2024-25	Data collection applicable for:	Reporting period & case ascertainment
National Cancer Audit Collaborating Centre (NATCAN) **National Bowel Cancer Audit (NBOCA)**	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2022-23: Royal Free London: n=310 NMUH* n=57
National Cancer Audit Collaborating Centre (NATCAN) **National Oesophago-Gastric Cancer Audit (NOGCA)**	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2021-23: Royal Free London: n = 156 NMUH* n = 3

National Clinical Audit	Data collection completed in 2024-25	Data collection applicable for:	Reporting period & case ascertainment
National Cancer Audit Collaborating Centre (NATCAN) **National Lung Cancer Audit (NLCA)**	Yes	Royal Free Hospital North Middlesex University Hospital	2024: Royal Free London: n = 470 NMUH: n = 37
National Cancer Audit Collaborating Centre (NATCAN) **National Non-Hodgkin Lymphoma Audit (NNHLA)**	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2023: Royal Free London: n = 171 NMUH* n = 27
National Cancer Audit Collaborating Centre (NATCAN) **National Kidney Cancer Audit (NKCA)**	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2023: Royal Free London: n = 193 NMUH* n= 9
National Cancer Audit Collaborating Centre (NATCAN) **National Pancreatic Cancer Audit (NPaCA)**	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2023: Royal Free London: n = 160 NMUH* = 7
National Cancer Audit Collaborating Centre (NATCAN) **National Prostate Cancer Audit (NPCA)**	Yes	Royal Free Hospital North Middlesex University Hospital	2023: Royal Free London: n = 835 NMUH* n= 209
National Cancer Audit Collaborating Centre (NATCAN) **National Audit of Primary Breast Cancer (NAoPri)**	Yes	Royal Free Hospital North Middlesex University Hospital	2019-21: Royal Free London: n=2205 NMUH*: Results based on low case volumes have been suppressed
National Cancer Audit Collaborating Centre (NATCAN) **National Audit of Metastatic Breast Cancer (NAoMe)**	Yes	Royal Free Hospital North Middlesex University Hospital	2019-21: Royal Free London: n=129 NMUH*: Results based on low case volumes have been suppressed
National Respiratory Audit Programme (NRAP) **COPD Secondary Care**	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	April 24 to 13 Feb 25: Barnet Hospital: n = 249 Royal Free Hospital: n = 131 NMUH: n = 129
National Respiratory Audit Programme (NRAP) **Adult Asthma Secondary Care**	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	April 24 to 13 Feb 25: Barnet Hospital: n = 134 Royal Free Hospital: n = 75 NMUH: n = 0
National Respiratory Audit Programme (NRAP): **Paediatric Asthma Secondary Care**	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2024-25: Barnet Hospital: no data submitted Royal Free Hospital: n = 25 NMUH: n=111
National Respiratory Audit Programme (NRAP):	Yes	North Middlesex University Hospital	2024-25: NMUH = 51

National Clinical Audit	Data collection completed in 2024-25	Data collection applicable for:	Reporting period & case ascertainment
Pulmonary Rehabilitation			
National Adult Diabetes Audit (NDA): **National Foot Care in Diabetes Audit (NFCA)**	Yes	Barnet Hospital Royal Free Hospital Chase Farm Hospital North Middlesex University Hospital	2023-24: Barnet & Chase farm Hospital: n= 110 Royal Free Hospital: n = 155 NMUH*: n= 184
National Adult Diabetes Audit (NDA): **National Diabetes Inpatient Safety Audit (NDISA)**	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	April 24 to 13 Feb 25: Royal Free Hospital: n = 16 Barnet Hospital: n = 12 NMUH: n = 8
National Adult Diabetes Audit (NDA): **National Pregnancy in Diabetes audit (NPID)**	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2024-25: Barnet Hospital: n = 115 Royal Free Hospital: n = 65 NMUH: n=27
National Adult Diabetes Audit (NDA): Transition (Adolescents and Young Adults) and Young Type 2 Audit	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2024-25: Ongoing
National Adult Diabetes Audit (NDA): **National Diabetes Core Audit**	Yes	Royal Free Hospital North Middlesex University Hospital	2023-24: Royal Free Hospital (Type I and II): n = 3145 NMUH (Type I and II): n = 1040
National Paediatric Diabetes Audit (NPDA)	Yes	Barnet Hospital Chase Farm Hospital Royal Free Hospital North Middlesex University Hospital	2024-25: Barnet Hospital: n = 145 Chase Farm: n = 71 Royal Free Hospital: n = 99 NMUH* = 277
Falls and Fragility Fractures Audit Programme (FFFAP): **Fracture Liaison Service Database (FL-SD)**	Yes	Barnet Hospital North Middlesex University Hospital	2024: Barnet Hospital: n=381 NMUH = 0
Falls and Fragility Fractures Audit Programme (FFFAP): **Inpatient Falls**	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	07 Feb 24 to 31 Dec 24: (confirmed falls only) Barnet Hospital: n = 4 Royal Free Hospital: n = 6 NMUH* n = 8
Falls and Fragility Fractures Audit Programme (FFFAP): **Hip Fracture Database (NHFD)**	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2023-24: Barnet Hospital: 95.5% Royal Free Hospital: 125.2% NMUH*: n=246
National Cardiac Audit Programme (NCAP):	Yes	Barnet Hospital	2023-24: Barnet Hospital: n = 327

National Clinical Audit	Data collection completed in 2024-25	Data collection applicable for:	Reporting period & case ascertainment
Cardiac Rhythm Management (CRM)		North Middlesex University Hospital	NMUH* n= 122
National Cardiac Audit Programme (NCAP): **Myocardial Infarction National Audit Project (MINAP)**	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2023-24: Barnet Hospital: n = 191 Royal Free Hospital: n = 712 NMUH* n = 223
National Cardiac Audit Programme (NCAP): **National Audit of Percutaneous Coronary Interventions**	Yes	Royal Free Hospital	2022-23: Royal Free Hospital: n =928 *(Minimum required is 400)*
National Cardiac Audit Programme (NCAP): **National Heart Failure Audit (NHFA)**	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2023-24: Barnet Hospital: n = 637 Royal Free Hospital: n = 479 NMUH* n = 100
National Audit of Cardiac Rehabilitation (NACR)	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2024: Barnet Hospital: 7/7 KPIs submitted Royal Free Hospital: 7/7 KPIs submitted NMUH* n = 716
Intensive Care National Audit and Research Centre (ICNARC): **Case Mix Programme (CMP)**	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2023-24: Barnet Hospital: n = 561 Royal Free Hospital: n = 2411 NMUH*: n=451
Intensive Care National Audit and Research Centre (ICNARC): **National Cardiac Arrest Audit (NCAA)**	Yes	Barnet Hospital Royal Free Hospital	2023-24: Barnet Hospital: n = 71 Royal Free Hospital: n = 183
National Audit of Dementia	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	Aug 2023 – Jan 2024: Barnet Hospital n=40 Royal Free Hospital: n=51 NMUH: n = 65
National Audit of Pulmonary Hypertension Audit (NAPH)	Yes	Royal Free Hospital	2023-24: Royal Free Hospital: n = 848 (Minimum required is 300)
National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy12)	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2024: Royal Free London: n = 33 (66%) NMUH*: n=20
National Clinical Audit of Care at the End of Life (NACEL)	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2024: Barnet Hospital: n=255 Royal Free Hospital: n=280 Data collection underway at NMUH

National Clinical Audit	Data collection completed in 2024-25	Data collection applicable for:	Reporting period & case ascertainment
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Barnet Hospital Chase Farm Hospital Royal Free Hospital North Middlesex University Hospital	2023-24: Barnet Hospital: n = 21 Chase Farm Hospital: n = 88 Royal Free Hospital: n = 28 NMUH* n= 89
National Emergency Laparotomy Audit (NELA)	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	Year 11 as of 10 Feb 25 Barnet Hospital: n = 17 Royal Free Hospital: n = 75 NMUH = 0
National Joint Registry (NJR)	Yes	Barnet Hospital Chase Farm Hospital Royal Free Hospital North Middlesex University Hospital	2023: Barnet Hospital: n = 84 Chase Farm Hospital: n = 777 Royal Free Hospital; n = 70 NMUH*: n= 221
National Maternity and Perinatal Audit (NMPA)	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	Report not published yet.
National Neonatal Audit Programme (NNAP)	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2024: Barnet Hospital: 100% Royal Free Hospital: 100% NMUH = TBC
National Vascular Registry (NVR)	Yes	Royal Free Hospital	2023: Royal Free Hospital: n=279
Emergency Medicine National Quality Improvement Programme **Mental health self-harm**	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	Ongoing
Emergency Medicine National Quality Improvement Programme **Care of Older People**	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	Ongoing
Emergency Medicine National Quality Improvement Programme **Time Critical Medications**	Yes	Barnet Hospital Royal Free Hospital	Ongoing
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2023-24: Barnet Hospital: 90%+ Royal Free Hospital: 90%+ NMUH* n = 216
National Major Trauma Registry (NMTR)	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2023-24: Royal Free Hospital: n=71 Barnet TBC (Report not yet available) NMUH* n = 145

National Clinical Audit	Data collection completed in 2024-25	Data collection applicable for:	Reporting period & case ascertainment
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	Barnet Hospital Chase Farm Hospital Royal Free Hospital North Middlesex University Hospital	2023: Royal Free London: n = 37 NMUH: n = 9
National Comparative Audit of Blood Transfusion: Bedside Transfusion Audit	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2024: Barnet Hospital: n = 22 Royal Free Hospital: n = 31 NMUH = 0
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2024: Barnet Hospital: n = 54 Royal Free Hospital: n = 28 NMUH: n = 60
Chronic Kidney Disease registry	Yes	Barnet Hospital Royal Free Hospital	2022: Royal Free London: n = 249 (incidence)
Learning disability and autism programme **Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)**	N/A	Barnet Hospital Chase Farm Hospital Royal Free Hospital North Middlesex University Hospital	2024-25: Royal Free London = 13 NMUH: n=7
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal mortality and serious morbidity confidential enquiry	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2024-25: 100%
Maternal, Newborn and Infant Clinical Outcome Review Programme Perinatal mortality surveillance	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2024-25: 100%
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal mortality surveillance	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2024-25: 100%
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal morbidity confidential enquiry - annual topic based serious maternal morbidity	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2024-25: 100%
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal mortality confidential enquiries	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2024-25: 100%
MBRRACE-UK: **Perinatal Mortality Review Tool (PMRT)**	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	2024-25: 100%
National Child Mortality Database (NCMD)	Yes	Barnet Hospital Royal Free Hospital	2024-25: 100%

National Clinical Audit	Data collection completed in 2024-25	Data collection applicable for:	Reporting period & case ascertainment
		North Middlesex University Hospital	
National Ophthalmology Database (NOD) **Adult Cataract Surgery**	Yes	Barnet Hospital Chase Farm Hospital Royal Free Hospital North Middlesex University Hospital	2022-23 Royal Free London: 97.9% NMUH*: 100%
National Ophthalmology Database (NOD) **Age-related Macular Degeneration**	Yes	Barnet Hospital Chase Farm Hospital Royal Free Hospital North Middlesex University Hospital	2021-22: Royal Free London: 266 NMUH*: 100%
Breast and Cosmetic Implant Registry	Yes	Royal Free Hospital	2023-24: Royal Free Hospital: n=31
Perioperative Quality Improvement Programme (PQIP)	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	18 Mar 23 and 18 Mar 24: Royal Free Hospital: n=60 Barnet Hospital: n=5 NMUH*: n=8
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS) **Trauma**	No	Barnet Hospital Chase Farm Hospital Royal Free Hospital	The Max Fax service didn't submit data during 2024 due to the lack of resources
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS) **Orthognathic Surgery**	No	Barnet Hospital Chase Farm Hospital Royal Free Hospital	The Max Fax service didn't submit data during 2024 due to the lack of resources
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS) **Non-melanoma skin cancers**	No	Barnet Hospital Chase Farm Hospital Royal Free Hospital	The Max Fax service didn't submit data during 2024 due to the lack of resources
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS) **Oral and Dentoalveolar Surgery**	No	Barnet Hospital Chase Farm Hospital Royal Free Hospital	The Max Fax service didn't submit data during 2024 due to the lack of resources
National Obesity Audit (NOA)	Yes	North Middlesex University Hospital	2024-25: NMUH: n = 1130

*** 2024-25**

Table 2.2.2: National Confidential Enquires; participation and case ascertainment

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Data collection completed in 2024-25	Data collection applicable for:	Case ascertainment
Rehabilitation following critical illness	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	RFL: 100% NMUH: 85%
End of Life Care	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	RFL: 90% NMUH: 58%
Juvenile idiopathic arthritis	Yes	Barnet Hospital Royal Free Hospital	RFL:100%
Emergency procedures in children & young people	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	RFL: 98% NMUH:0%
Blood Sodium	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	RFL: 88% NMUH: 71%
Acute Limb Ischaemia	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	Enquiry in process
Managing acute illness people with learning disability	Yes	Barnet Hospital Royal Free Hospital North Middlesex University Hospital	Enquiry in process

Table 2.2.3: National Clinical Audits; actions for improvement.

National clinical audit	Actions to improve quality
National Diabetes Audit Foot Care Audit	Royal Free Hospital (RFH), Barnet Hospital & Chase Farm Hospital (BCF) • Currently BCF and RFH podiatry teams are under separate management which causes issues in data control. Ongoing work to align RFL hospital foot care units continue. • There is ongoing work with the electronic patient record (EPR) team to see if podiatry pages can be built for audit purposes. • To improve the service, capacity needs to be increased by recruiting more full-time podiatrists and establishing additional podiatry clinics. Currently, podiatrists provide wound care for all foot wounds (diabetic and non-diabetic), which reduces capacity for diabetes foot patients, therefore additional resources are needed. Additionally, the lack of availability of clinic rooms means that running more clinics is not possible.
National Audit of Cardiac Rehabilitation (NACR)	Royal Free Hospital • Some scores were not documented as patients did not return the necessary questionnaires. Collecting the questionnaire during the exercise capacity test instead of doing it during a telephone assessment has provided good results. Barnet Hospital • To ensure that data is added to NACR, has already been implemented in recent months, and the team will continue to add this information in order to improve data quality • No cholesterol data is currently being included. Explore ways in which this information can be obtained and implemented
National Audit of Percutaneous Coronary Intervention (NAPCI) & Myocardial Infarction National Audit Programme (MINAP)	Royal Free Hospital and Barnet Hospital • The issue with accurate documentation for the year 2022-23 has been confounded by a change in reporting software for the catheter lab and change in audit facilitation with sub-optimal handover between staff members. The following steps will address this: 1. Regular meetings between the Revascularization lead and audit facilitator to ensure correct collection and reporting of data. 2. Training of doctors regarding correct recording of mandatory data in NAPCI reports. 3. Regular (quarterly) reports from NAPCI database to correct data errors. 4. Twice yearly presentation of data at cardiology clinic governance meeting to ensure awareness of data collection issues amongst clinicians.
National Cardiac Arrest Audit (NCAA)	Royal Free Hospital • Feedback on cardiac arrest rate to whole site and specific teams.

National clinical audit	Actions to improve quality
	• Ongoing treatment escalation and advance care planning work. • EPR auto-text proforma to record resuscitation attempts. Working with EPR team and West Herts on improved workflow to document resuscitation attempts
National Lung Cancer Audit (NLCA)	Royal Free Hospital • Referral to treatment times are longer due to a combination of factors such as a frail, elderly, comorbid population and diagnostic tests being undertaken at distant sites and being run by different departments, which is difficult to co-ordinate and influence working patterns. • Long term funding to be secured for prehabilitation, and to support rates of utilisation. • A one-stop diagnostic service is planned at the RFH site, enabled by the lower radiation doses from the new Positron Emission Tomography (PET) scanner.
Falls and Fragility Fractures Audit Programme - Inpatient falls	Royal Free London • Underreporting of falls remains unlikely as 92% of hip fractures are attributed to falls. This improved last year and has been maintained. • Full compliance with 2 of the 6 components of the multifactorial risk assessment (MFRA) medication review and mobility assessment and similar or better than national averages for hip fracture care. • However, there was low completion of the 6-point MFRA, specifically lying and standing blood pressure measurements, assessment of vision and continence assessment are well below national average • EPR modification to optimise recording of risk factors and documentation of individualised falls prevention plan is in progress. • Improvement projects focusing on lying and standing blood pressure and delirium, particularly in the Acute Assessment Unit are ongoing as is training for recognition of hip fracture after a fall.
Perioperative Quality Improvement Programme (PQIP)	Royal Free Hospital • Presentation of national and local reporting to key stakeholders. • Clarification of whether there is more work to be done on naso-gastric tubes (NGTs) and abdominal drains or whether the performance is appropriate to the nature of the surgery. • Service evaluation project in the conduct and variations of analgesic regimens for major Hepato-Pancreato-Biliary (HPB) surgery. • Clarification of how complex vs complex major is recorded, as most HPB cancer surgery would fall into the category of major complex, which is not reflected in our dataset. • Service evaluation project into the impact of increasing the proportion of total IV anaesthesia (TIVA) vs volatile

National clinical audit	Actions to improve quality
	anaesthesia on the delivery of drinking, eating and mobilising DrEaMing results. • Evaluation of our antimicrobial prophylaxis regimen with microbiology given the higher proportion of infective complications.
National Audit of Dementia	Royal Free Hospital • The new delirium pathway built into EPR to facilitate delirium assessment is now live and the correct digital pain assessment tool has been built in EPR since the time of the data collection for this audit • Delirium column introduced on whiteboard • Extensive training undertaken across the site on how to spot and assess for delirium and how to correctly record it including for medics • Trust-wide Delirium Awareness week planned for March 2025 • Medic focused education rolled out regarding timely and adequate assessments for pain and delirium as part of clerking patients with dementia.
NATCAN Non-Hodgkin Lymphoma	Royal Free London • The 62-day target is better than national target but requires improvement, this is mainly affected by late referrals in from other specialities. A straight to test pathway to improve compliance with 62-day target. is being developed • The clinical nurse specialist (CNS) team has expanded and electronic record keeping has improved. However, there is a need to better document CNS interactions with patients and further improve documentation
NATCAN Metastatic Breast Cancer and Primary Breast Cancer	• The service run one-stop triple assessment clinics every day of the week. • All patients have a clinical nurse specialist at diagnosis • Triple assessment diagnosis and clinical nurse specialist figures data entry to be reviewed
NATCAN National Oesophago-gastric Cancer Audit (NOGCA)	Royal Free London • Patients completing chemotherapy and radiotherapy are both above the national average, as too are patients receiving Positron Emission Tomography (PET) scans. • Although 83% of RFL patients undergoing curative treatment access pre-treatment assessment and advice from dieticians which is higher than the nationally recorded result of 76.2%, NICE recommend that all patients undergoing curative treatment should be offered nutritional assessment and specialist dietetic support before, during and after treatment. Adherence to this metric will be closely monitored. • The team will investigate referral pathways and any delays in organising clinic appointments and treatment to reduce the number of patients waiting more than 62 days from urgent GP referral to first treatment. The RFL median time from referral to start of curative treatment was 64.5 days.

National clinical audit	Actions to improve quality
National Early Inflammatory Arthritis (NEIAA)	Barnet Hospital: • The longer waiting times for new and follow up appointment has been caused by the loss of the rheumatology consultant, which has impacted capacity. A business case has been submitted for a whole-time consultant post, which will improve delays in both first encounter and subsequent initiation and review of follow ups.
National Paediatric Diabetes Audit (NPDA)	Barnet Hospital • The audit lead continues to work with the EPR and TWINKLE (a hosted patient management system) team to improve the interface between EPR and TWINKLE. Funding is causing a delay, which is a risk and is also time-consuming. • Continue to push for hybrid closed loops for insulin pumps for which administrative support is required. • One collective purchase order (PO) number per Pump Company is preferable, rather than having an individual PO number for each pump. This will reduce administrative time for staff involved. • Problems with getting young people access to the Omnipod 5 system have been resolved. More young people now have access to hybrid closed pumps, improving results overall. Work continues to improve the process and education as this is a new process. • Nurse-led appointments have also improved blood results at CFHGCS and this continues to improve over time.
Epilepsy 12	Barnet Hospital • Monitoring of data submission. • Integrating the necessity of electrocardiograms (ECGs) into junior doctor training. Additionally, the clinic sends patients for outpatient ECGs if they do not have one on file. • Mental health support is currently being provided, and a Quality Improvement Project involving the screening of our patients' mental health needs is in place. The service has a plan to develop a business case for specific mental health support for patients with epilepsy. • A risk acknowledgement form is filled out for any girls over 12 on valproate. Monitoring of completion of form to continue.
National Respiratory Audit Programme (NRAP) COPD & Adult Asthma	Barnet Hospital • Audit results indicate that RFL inpatient asthma care is well above the national average and truly excellent in parts. Particularly impressive is the figure for smoking cessation of 100% (national average 69.4%) and receipt of inhaled steroids at discharge 99% (national average 89%). • The service is aiming to improve the respiratory reviews within 24 hours metric, which is currently 53% (national average 48%).

Table 2.2.4: Local Clinical Audit; actions for improvement

Local clinical audit	Actions to improve quality
The RFH HIV Two-tier Screening Pathway	• Stop dividing patients into High Inflammation, Chronic Growth (HICG) and non-HICG for HIV screening. • Stop routinely sending Roche reactive but Abbott-, Bioplex- and Polymerase chain reaction (PCR) negative samples from HICG to UKHSA. • Stop requesting an ethylenediamine tetraacetic acid (EDTA) in 14 days for viral load testing. • Develop evidence-based stringent criteria for the use of the reference laboratory. • To reduce trans-activator of transcription protein (TAT), decrease the interval between the first and the second samples. • Advise patients on the prevention of transmission of HIV when they are under investigation for indeterminate HIV status. • At authorisation, change the word “indeterminate” in the result field to “see comment” to avoid the misinterpretation of false Roche reactivity by service users.
Retrospective audit in the practice of renal biopsy in Fabry disease patients.	• There is a need to consider additional explanations for renal impairment in females and late-onset patients with Fabry disease (FD) as a low threshold for renal biopsy is indicated in this group. • Non FD contributing causes are mostly hypertension and diabetes, and renal biopsy performed in such patients would not alter their clinical management as they would already be on treatment. • A targeted approach to renal biopsy is advocated in late-onset group of Fabry patients to consider other underlying causes of renal impairment.
Surgical Site infections in Hepato-Pancreato-Biliary and Transplant patients	• To extract information on the organism isolated, and match with antibiotic sensitivity to evaluate prophylactic antibiotics used. • To analyse isolated organisms in patients with preop stenting, and whether prolonged course of antibiotics could present such complication • To do a repeat audit when Prevena dressing is available and compare cohorts of patients
Re-Audit Excision Rates of Basel and Squamous cell cancers	• Close attention to ensuring compliance with margin standards. • State margins in all operation notes and in lab requests. • If there is a reason that margins not achievable due to anatomical site then ensure to document. • Op note to state if the sample has been biopsy proven for evidence of margins chosen; not always apparent on EPR. • Mandatory documentation of op notes on Pathpoint.
An audit of compliance with Royal College of Emergency Medicine guidance on assessment and management of pain in adults in Emergency Department triage	• Use of the pain triage tool on the EPR needs to be more commonly used, both for medicolegal recording keeping and as a prompt to encourage use of analgesia from triage. An understanding of why it is not used will help to direct efforts to improve its usage. • An increase in awareness of the importance and usefulness of pain scoring and early analgesia should help to improve compliance • Improvements in the logistical pathways to achieving appropriate documentation of pain scores and administration of analgesia, e.g. improving the ease of use of the EPR pain score triage tool,

Local clinical audit	Actions to improve quality
	increasing availability of simple analgesia that can be administered by nurses, and improving availability of doctors around the triage area who can prescribe other forms of analgesia.
Adnexal surgery outcomes	• Aim to have measurements documented pre-operatively and 2 months post-operatively for individuals undergoing surgery • Alternative methods to collate patient satisfaction data • Provide more opportunity for teaching
A re-audit of turnaround times for out of hours non-contrast computed tomography (CT) of head, spine and facial bones reported by Everlight Radiology	• Targeting busier hours/days e.g. Friday and 17:00-01:00 through better resource/staffing management • Additional staffing e.g. porters, radiographers at busier hours • Monitoring CT numbers to create a business case for more scanner capacity • Examining the reasons behind the positive skew in the data • Finer analysis to find patterns in outlier data • Comparison with in-house reporting
Amputee Therapies audit	• Development of an EPR Pathway to reflect the Enhanced Recovery After Surgery (ERAS) protocol at RFH. • Development of occupational therapy rehabilitation competencies within the amputee pathway. Patients to be offered more Activities of daily living based rehabilitation. • Sourcing an evidence based psychological screening tool to use with people who've recently had a major amputation. • Based on feedback received from prosthetic centres, appropriate patients may benefit from having their cognition screened to help determine outcomes. • To use the gym space effectively, in an efficient manner (both in time and staff), groups programs could be adopted. • Therapists could adopt regular goal setting throughout the patient journey (primarily on first treat). Added into Pre-operative and Discharge proforma. • Improve space and equipment in the 6 West gym. Funding granted by Vascular charity to purchase new parallel bars. • A falls risk and floor transfers education resource could be developed to provide to patients on discharge. • The therapy team should consider using the discharge tab on EPR to input ongoing rehabilitation plans and information/contact details of services the patient has been referred to
Hyperemesis management at Barnet hospital	• Increase use of hyperemesis pathway on EPR, Include explanation for juniors doctor induction • Create hyperemesis out of hours Multi-Patient Task List (MPTL) and contact change lead to create list
Trauma computed tomography (CT) head scan requesting indications, scanning and reporting times in accordance with NICE	• Improvement can be made with CT head scans required to take place within an hour and with reporting times within an hour through education. • Further review can be made into discrepancies between in-hour reporting times and out-of-hours.

Local clinical audit	Actions to improve quality
guidelines at Chase Farm Hospital	• All CT heads that were required to take place within 8 hours met the target.

3.Participating in clinical research

*(*This section reflects the trust's Q3 position at the time of drafting. Data and information may be updated upon validation.)*

The number of patients receiving NHS services provided or sub-contracted by Royal Free London NHS Foundation Trust in 2024-25 that were recruited during that period to participate in research approved by a research ethics committee was 11,856. [Final data to be confirmed]

4.CQUIN payment framework

No proportion of Royal Free London NHS Foundation Trust income in 2024-25 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 2024-25, the CQUIN scheme was paused and was therefore worth 0% of the fixed element of the annual contract value; hence no amount of the trust's income was conditional upon achieving quality improvement and innovation goals.

There was a local CQUIN which we reported upon though (with no financial element attached) around Core20plus5 that was a continuation of previous work in 2023-24:

CQUIN scheme priorities 2024-25	Objective rationale
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 the following conditions on registration:

- The registered provider must not provide assessment or medical treatment for persons detained under the Mental Health Act 1983 in a specialist service to people whose presenting need for assessment or treatment is as a direct result of the person's learning disability and or autism at or from North Middlesex University Hospital.

The Care Quality Commission has not taken enforcement action against Royal Free London NHS Foundation Trust during 2024-25 reporting period.

The Royal Free London NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during 2024-25.

CQC registration

In October 2024, prior to the merger, North Middlesex University Hospital NHS Trust deregistered St Annes Hospital and registered St Michaels Hospital.

In December 2024, as part of the North Middlesex University Hospital NHS Trust merger process, the Royal Free London Foundation Trust registered the following sites: North Middlesex University Hospital, St Michaels Hospital, Town Clinic (Enfield) and White Lodge Medical Practice.

North Middlesex University Hospital NHS Trust, as part of the same merger process, deregistered North Middlesex University Hospital, St Michaels Hospital, Town Clinic (Enfield) and White Lodge Medical Practice.

CQC assessment

The CQC undertook an unannounced assessment of the maternity service at North Middlesex University Hospital in January 2025. As the report is yet to be published, the action plan for improvement will be developed and reported in the 2025-26 Quality Account.

6. Information on the quality of data

The Royal Free London NHS Foundation Trust submitted records during 2024-25 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 which included patient's NHS number for 2024-25 is as follows:

NHS Number	2024-25
For admitted patient care	99.76%
For outpatient care	99.66%
For accident and emergency care	98.69%

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.

The percentage of records in the published data which included the patient's valid General Medical Practice Code for 2024-25 was:

General Medical Practice Code	2024-25
For admitted patient care	99.20%
For outpatient care	99.40%
For accident and emergency care	99.24%

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 2024-25 DSPT submission deadline of June 2025. 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 2024-25 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:

- 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.
- 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
- The data quality dashboard is in development. This will be monitored and updated to ensure ongoing due diligence of internal and external submissions.
- More data quality awareness sessions will be carried out to raise issues caused by incorrect usage of the electronic patient record (EPR) system
- 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.
- 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

*(*This section reflects the trust's Q3 position at the time of drafting. Data and information may be updated upon validation.)*

During 2024-25, 1925 [Final data to be confirmed],of the Royal Free London NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 479 in the first quarter; 462 in the second quarter; 542 in the third quarter; [Final data to be confirmed] in the fourth quarter.

By 18/03/2024, 66 case record reviews have been carried out in relation to 1483 [Final data to be confirmed] of the deaths included above.

In 3 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: 1 in the second quarter; 2 in the third quarter; 0 in the fourth quarter. [Final data to be confirmed]

1 representing 0.06% of the patient deaths during the reporting period is 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; 1 representing 0.2% 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 Patient Safety Event Response Panel (PSERP).

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 2.2.5: Summary of learning from death reviews

Reporting period		Number of deaths	Number of reviews completed	Number of Patient Safety Incident Investigations	Number of patient deaths considered to be avoidable	Percentage of patient deaths considered to be avoidable
Q1	April 2024 to June 2024	479	24	0	0	0%
Q2	July 2024 to September 2024	462	22	1	1	0.2%
Q3	October 2024 to December 2024	542	20	2	0	0%
Q4	January 2025 to March 2025	TBC	TBC	TBC	TBC	TBC
Year	2024-25 (Q1-Q3)	1483	66	3	1	0.2%

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
• Good documentation • Appropriate reviews took place • Good communication with patient's family • Good management of a complex case • Early medical consultant review • Clear TEP on admission • Early involvement from chest physio • Patient and patients' family gave informed consent • Appropriate involvement from all medical teams • Excellent advanced care planning and end-of-life care were noted. • Effective communication was established with the family members. • The medical team had multiple discussions with the Intensive Therapy Unit (ITU) to thoroughly consider the decision not to admit the patient to ITU, prioritising the patient's best interests.	• Staff reminded to tell patients to ask for assistance when mobilising or offer walking aids to patients when seen outside of bays without them • Earlier transition to EoL care • Earlier involvement of palliative care team / early transplant decision • Potential underestimation of the complexities of the high-risk surgery

The cases 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
INC41845	2024-25	Q2	2 Strong 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

Information awaiting validation and will be included in the final report in May 25.

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 (e.g., bullying and/or harassment) or alleged criminal activity for further investigation (e.g., fraud). The policy is supplemented by a repository-based local intranet page which is accessible from handheld and portable 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 Group Executive Management Meeting (GEMM) and the sub-board level people and education committee to provide updates on speaking up activity, cases, themes and learning outcomes for the organisation. Assurance as to the delivery of the rolling action plan is also provided to this forum. The Freedom to Speak Up Guardian compiles 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 which appears as a stand-alone paper on the relevant public Trust Board meeting.

In year, our Trust Board has also been through the continuation 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. An internal audit exercise has also been undertaken so as to assure as to system efficacy and inform areas of improvement in the coming year.

13. Junior Doctor's rota gaps

Information awaiting validation and will be included in the final report in May 25.

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 show 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.

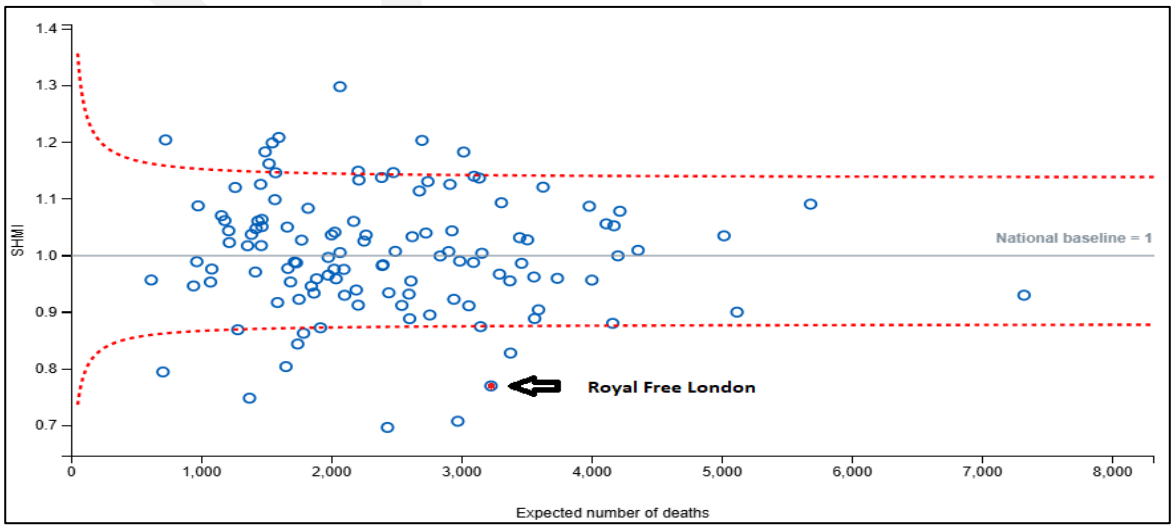
A) Summary of hospital-level mortality indicator (SHMI)

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

SHMI 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 2023 to October 2024. During this period, the Royal Free London had a mortality risk score of 0.7700, representing a risk of mortality lower than expected for our case mix.

Chart 2.3.1: RFL SHMI – November 2023 to October 2024



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 2023/24		
2019/20	2020/21	2021/22	2022/23	2023/24	Average Performance	Highest Performing NHS Trust Performance	Lowest Performing NHS Trust Performance
0.8501	0.8192	0.8367	0.8055	0.7700	1.0036	0.6967	1.2985
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 23 to October 24

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 2023-24		
2019-20	2020-21	2021-22	2022-23	2023-24	Average Performance	Highest Performing NHS Trust Performance	Lowest Performing NHS Trust Performance
37%	40%	37%	36%	30%	44.65%	17%	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)

PROMs measures patients' health status or health-related quality of life at a single point in time, and is collected through short, self-completed questionnaires. This health status information is collected before and after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients. Clinicians must regularly review the service's scores and trust levels to ensure that insights from patient feedback are incorporated into our quality improvement programs

During 2024, the trust did not submit PROMs data as it was awaiting the final stages of the procurement process.

In 2024-25, progress was made with the procurement work initiated in 2023 for Trauma and Orthopaedic elective knee and arthroplasty surgery to align the Royal Free London PROMs supplier

with that of the North Middlesex Hospital. The trust anticipates implementation and data collection to commence 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 both adult patients and paediatric cohorts; however, remains below national averages for both cohorts in 2023-24. 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.

Royal Free London Performance					National 2023-24		
2019-20	2020-21	2021-22	2022-23	2023-24	Average Performance	Highest Performing NHS Trust Performance	Lowest Performing NHS Trust Performance
Patients aged 0 to 15 years old							
9.1%	9.2%	8.7%	8.5%	9.2%	12.8%	4.4%	33.9%
Patients aged 16 years old or over							
13.9%	13.3%	11.0%	11.7%	12.5%	13.4%	4.9%	21.4%

Note: The emergency rate is the percentage of patients readmitted to a hospital within 30 days of being discharged from a hospital. 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 (No further update for 2025)

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 2023-24		
2019-20	2020-21	2021-22	2022-23	2023-24	Average Performance (2019-20)	Highest Performing NHS Trust Performance (2019-20)	Lowest Performing NHS Trust Performance (2019-20)
66.7	No data	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 2024		
2020	2021	2022	2023	2024	Average Performance	Highest Performing NHS Trust Performance	Lowest Performing NHS Trust Performance
77%	71%	66.1%	69.0%	69.4	63.3%	89.6%	39.7%

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 2024 from 2023 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 2023 - 2024		
2020	2021	2022	2023	2024	Average Performance	Highest Performing NHS Trust Performance	Lowest Performing NHS Trust Performance
N/A	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 decreased in 2023-24 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 2023-24		
2019-20	2020-21	2021-22	2022-23	2023-24	Average Performance	Highest Performing NHS Trust Performance	Lowest Performing NHS Trust Performance
14.6	16.1	16.0	25.0	18.3	18.8	4.5	56.6

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 Patient Safety Event Response Panel (PSERP) at each health 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 2024 to March 2025. 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	20,003

The number and percentage of such patient safety events that resulted in severe harm or death.	Royal Free London
Number	84 (58+26)
Percentage	0.42% (0.29+0.13)

Part 3

Overview of the quality of care in 2024-25

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 2024-25 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 • Maximum 6-week wait for diagnostic procedures • Average length of stay (elective and non-elective) • 30-day emergency readmission rates for elective patients
Section 3: Patient experience	• National surveys • Friends and Family Test • Volume of cancelled operations

Section 1: Patient safety

1.1 Methicillin-resistant staphylococcus aureus (MRSA)

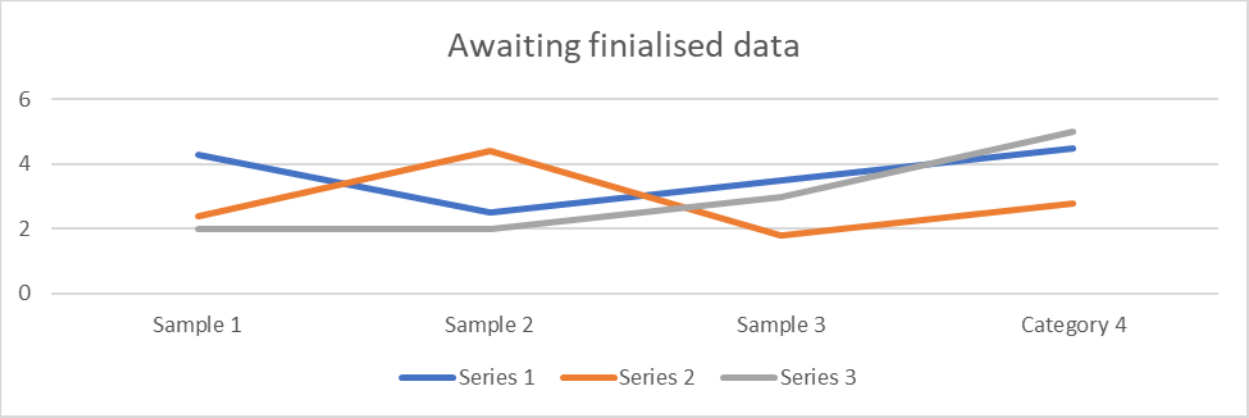
*(*This section reflects the trust's Q3 position at the time of drafting. Data and information may be updated upon validation.)*

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.

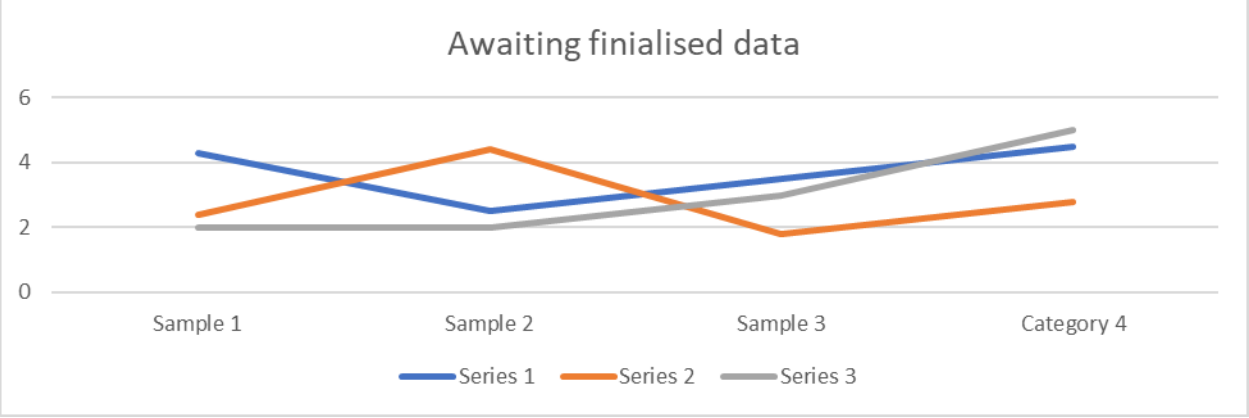
During 2024-25, the trust recorded seven MRSA [Final data to be confirmed] trust attributable infections, which is up from six recorded in 2023-24. North Middlesex University Hospital recorded one and the remaining six were reported from Royal Free and Barnet Hospitals.

Chart 3.1.1: MRSA infections: trust attributable



Source: Royal Free London W2B PBI 2024-25

Benchmarking Chart 3.1.2: total volume of MRSA bacteraemia, April 2024 – March 2025



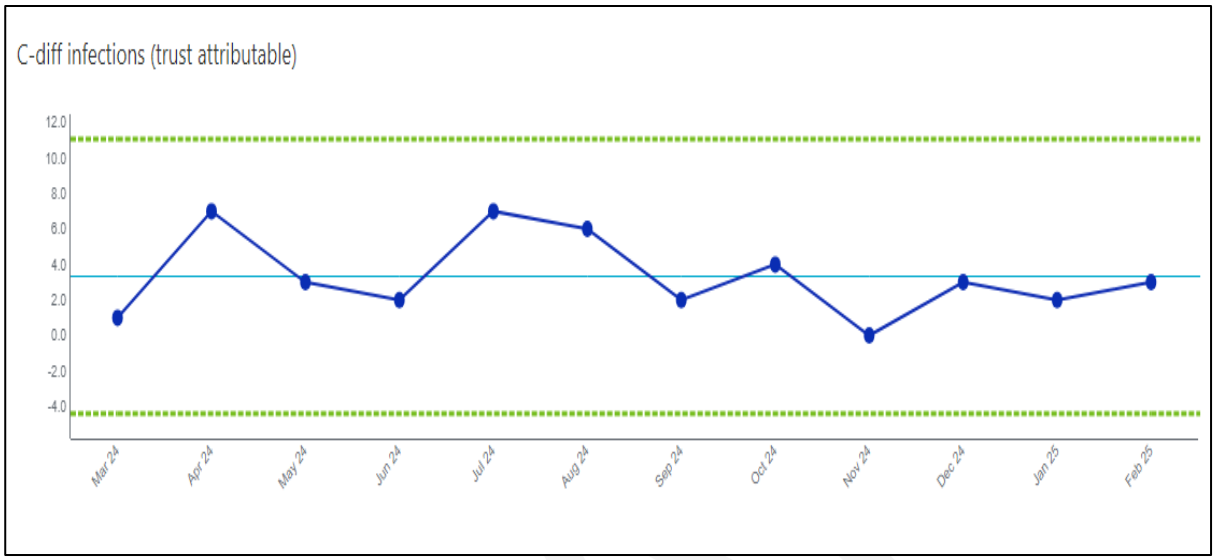
Source: UK government to be updated in May 25 for final report.

1.2 C. difficile infections

*(*This section reflects the trust's Q3 position at the time of drafting. Data and information may be updated upon validation.)*

In relation to C. diff infections, the trust saw an upward trajectory against our threshold for 2024-25. Over this period, the Royal Free London reported 87 [Final data to be confirmed]infections compared to 91 in 2023-24. As a group including North Middlesex University Hospital, 127 infections were reported [Final data to be confirmed].

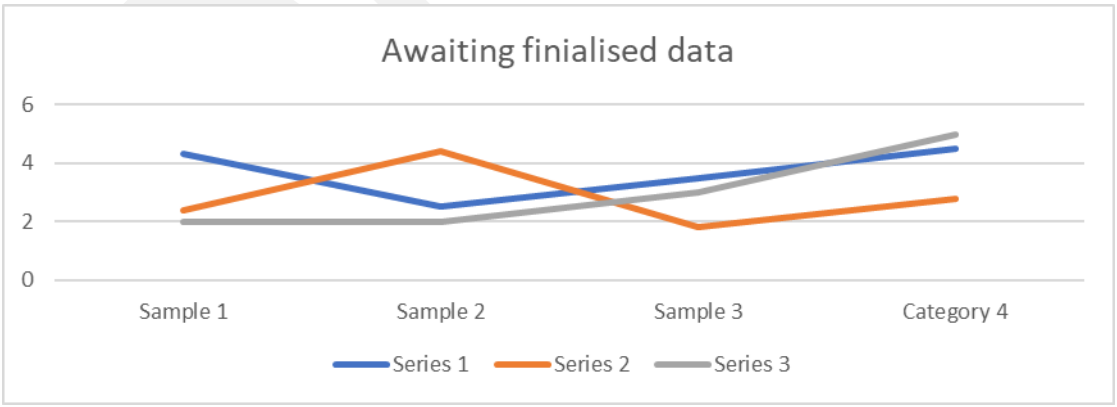
Chart 3.1.3: C.diff infections: trust attributable March 2024-March 2025



Source: Royal Free London IBR PBI 2024-25

Benchmarking Chart 3.1.4: Total volume of C. diff infections, April 2024 – March 2025

Source: Royal Free London W2B PBI 2023-24 to be updated in final report.



Section 2: Clinical effectiveness

2.1 Referral to treatment (RTT):

18-week waiting times

*(*This section reflects the trust's Q3 position at the time of drafting. Data and information may be updated upon validation.)*

The trust is one of the largest providers of elective care (including specialist tertiary care) nationally. With North Mid joining the RFL group in January 2025, the trust now has the largest waiting list in London, and the third largest nationally.

In line with the NHS priorities, our focus has been on continuing to reduce the number of our longest waiting patients, and we will finish the year with no one waiting more than 104 weeks and have significantly reduced the number of patients waiting over 78 weeks and 65 weeks by the end of March 2025 [Final data to be confirmed]. In January 2025, RFL Group had the second highest RTT performance of the top ten providers by Patient Tracking List (PTL) size and the fourth lowest 52week wait patients of the largest providers, although continue to report a low volume of 78+week and 65+week breaches. At the start of 2024-25 the trust had 5,639 [Final data to be confirmed] patients waiting over 52 weeks on a RTT pathway, by January 2025 [Final data to be confirmed] this had reduced to 3,365.

Key improvements include:

- Continued delivery on reducing the longest waiting patients throughout 2024-25. This included:
- Continuing to reduce the number of patients waiting more than 78-weeks, with the aim to eliminate 78+week waits in the first quarter of 2025-26 [Final data to be confirmed]
- Significant reduction in patients waiting more than 65 weeks, from 1,433 in April 2024 to 261 in January. This will continue to reduce in March 2025 [Final data to be confirmed]
- Delivered a significant reduction in patients waiting over 52 weeks.

The trust remained in quartile 3 for RTT performance but has been in Tier 2 by NHSE for RTT long wait for the majority of the year.

Looking ahead:

During 2025-26, we will aim to continue to reduce the time patients wait for treatment and improve access to outpatient services. In line with NHS priorities, RFL Group will ensure more patients have their first appointment within 18 weeks of referral, reduce the number of patients waiting over 52 weeks to no more than 1% of the total PTL size, and improve our RTT performance by at least 5%, achieving at least 63% performance by March 2026.

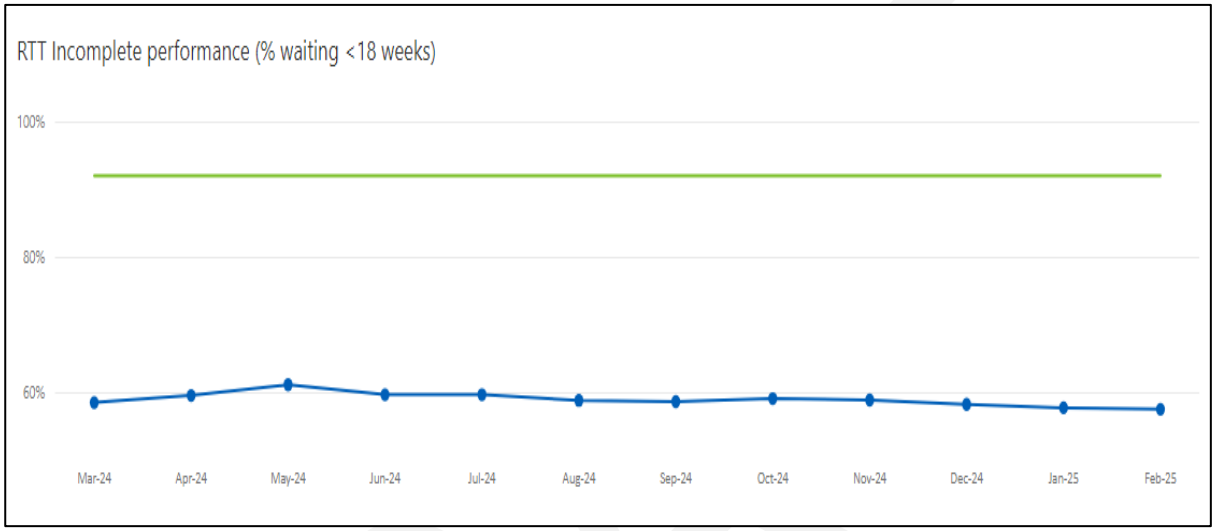
These priorities will be achieved through successful implementation of transformation projects, particularly those focusing on outpatient productivity and theatre productivity. We will also invest time and expertise in training our teams across the group on best practices in validation and application of RTT rules as well as optimal PTL management.

Our key access priorities are to ensure we:

- have no patient waiting more than 78 weeks by the end of the first quarter 2025-26

- have no patient waiting more than 65+ weeks for treatment by September 2025.
- have no more than 1% of the total PTL waiting over 52wks (currently 3%) by the end of the year (March 2026).
- Continue to make improvements in data quality building on the improvements delivered and audited in 2023-24.
- Invest time and expertise in training teams across the group to improve PTL management and processes.

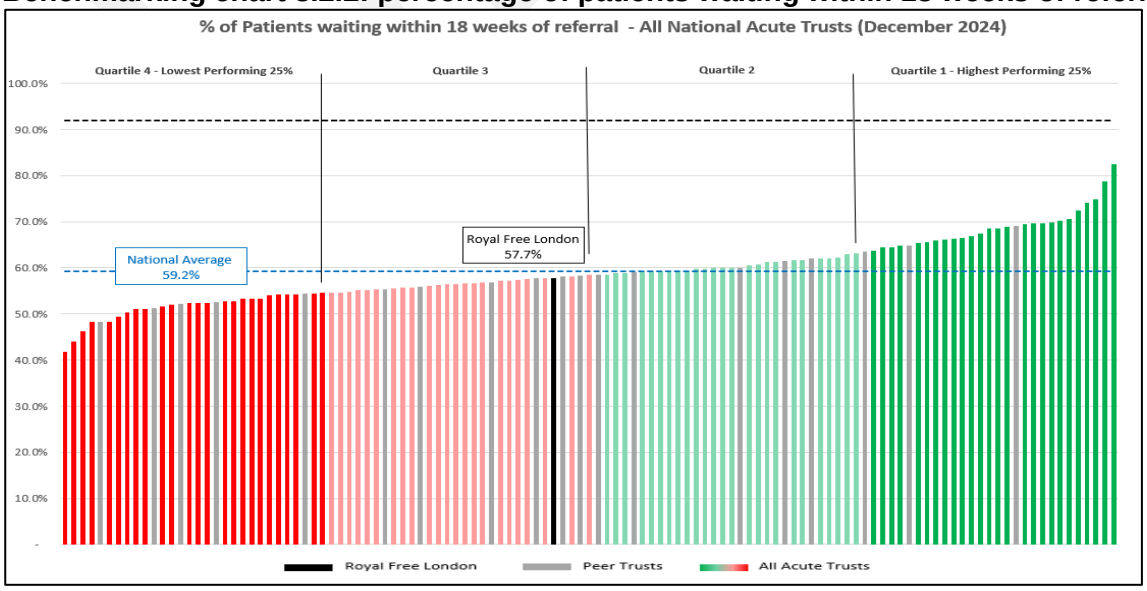
Chart 3.2.1: RTT incomplete performance (percentage patients waiting <18 weeks) [Final data to be confirmed]



Source: Royal Free London W2B PBI 2024-25

The chart below shows the Royal Free London performance December 2024 [Final data to be confirmed] benchmarked against all national acute trusts and peer providers for 18 weeks performance. The Royal Free London remains in the lower third quartile with 57.7% of patients waiting within 18 weeks of referral. The Royal Free London is ranked 64 out of 119 trusts and is ranked 11out of 20 peer trusts [Final data to be confirmed].

Benchmarking chart 3.2.2: percentage of patients waiting within 18 weeks of referral

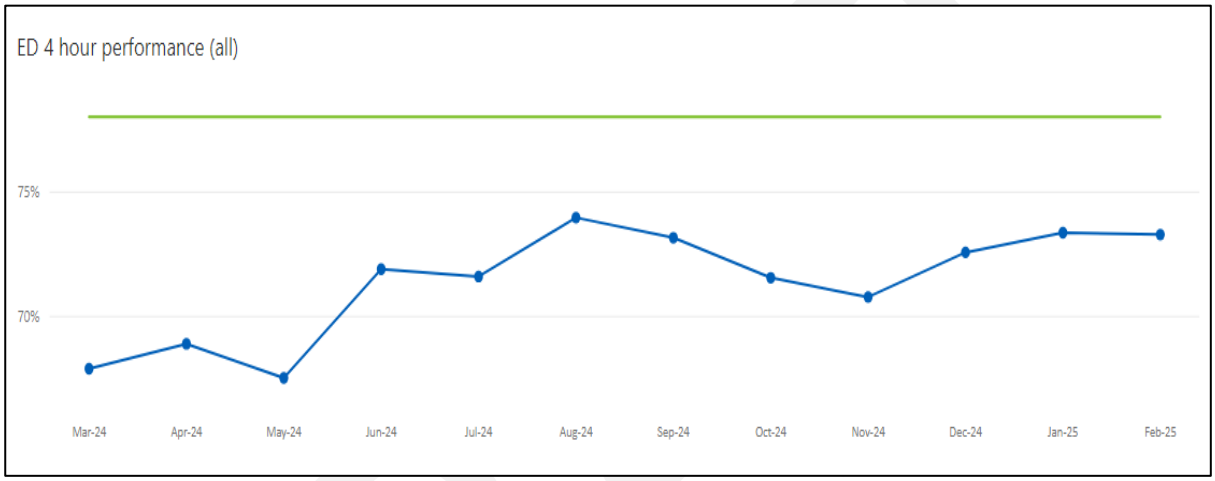


2.2 Accident and Emergency performance

*(*This section reflects the trust's Q3 position at the time of drafting. Data and information may be updated upon validation.)*

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 Mar-24 to Feb-25 [Final data to be confirmed], the Royal Free London NHS Foundation Trust achieved an average monthly performance of 71.4%, higher than in 2023-24 which averaged at 68.0% [Final data to be confirmed]. Pre-merge the monthly averages were 74.8% for Royal Free and 65.6% for North Middlesex University Hospital.

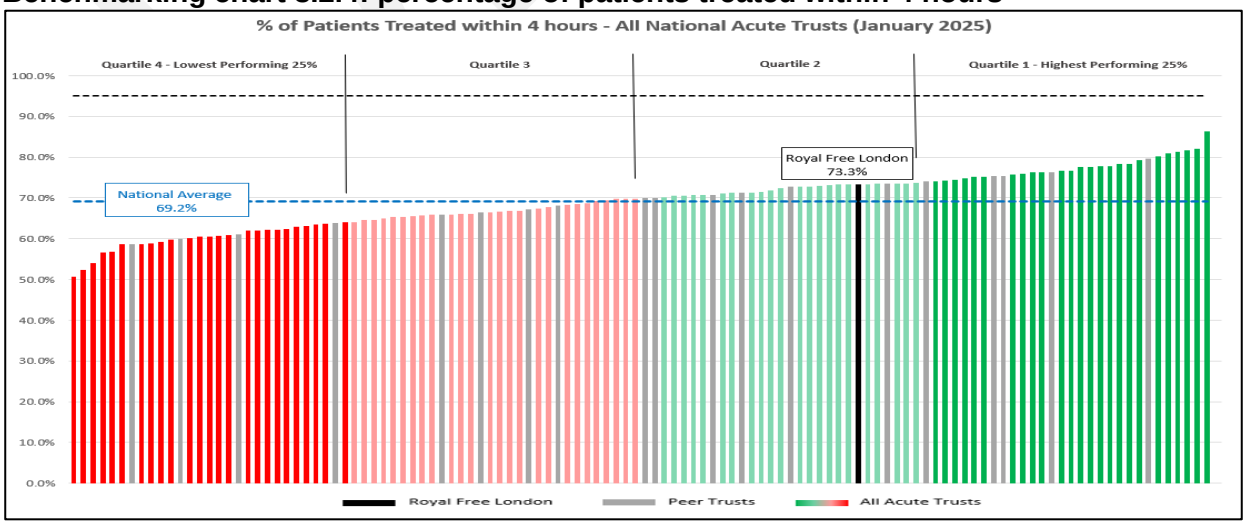
Chart 3.2.3: RFL emergency department 4-hour performance



(Source: Royal Free London W2B PBI 2024-25)

The chart below shows the Royal Free London performance for Jan 2025 [Final data to be confirmed], benchmarked against all national acute trusts and peer providers for four-hour emergency department performance. The Royal Free London is ranked 37 out of 119 trusts and is ranked 7 from 20 peer trusts [Final data to be confirmed].

Benchmarking chart 3.2.4: percentage of patients treated within 4 hours



Source: NHS Digital, 2024-25

2.3 Cancer waiting times:

*(*This section reflects the trust's Q3 position at the time of drafting. Data and information may be updated upon validation.)*

Cancer waits

This year, our focus has been to reduce the backlog of patients waiting over 62-days for treatment, and to increase the number of patients receiving either a ruling out of cancer or a diagnosis of cancer by day 28.

NHS England set two 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 77% of patients to be given either a diagnosis of cancer or the ruling out of cancer within 28 days of referral.

Royal Free London (incorporating North Middlesex Hospital from 1 Jan 2025) received the largest volume of urgent suspected cancer referrals of any London provider and the second largest in England and commenced the second largest number of first treatments for patients with confirmed cancer in London.

This year, RFL 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 tracking by the actions required to ensure patients are escalated and moved through their pathways as quickly as possible. The other focus this year has been on the delivery of the best practice timed pathways, using a pathway analyser tool to identify which pathway steps are out of line and required improvement.

In 2024-25 RFL & NMUH received X% [Final data to be confirmed]more urgent suspected cancer referrals than in 2019-20, approximately X more cancer referrals than the trust received before the COVID-19 pandemic and X% more referrals than 2023-24.

The 28-day faster diagnosis standard (77%) has been a challenging standard to deliver, RFL have improved from 64.4% in April 2024 to X% in March 2025 [Final data to be confirmed]. In August 2024 RFL commenced a new initiative 'Cancer Pathway Improvement Programme' which focused on improving the faster diagnosis standard in high volume tumour sites. These projects have been MRI at RFH (breast & prostate pathways), Endoscopy at RFH (GI pathways), Lower GI for BH and Bladder for BH and RFH.

Recovery and transformation of endoscopy services post-pandemic is a national priority given the key role that endoscopy performs as a diagnostic service in GI cancer pathways. Collaborative working across NCL has enabled RFL to make use of endoscopy capacity at both University College London Hospital & Whittington Hospital. This has enabled more patients to receive their endoscopy procedures more quickly, and reduced the average wait for a suspected cancer endoscopy from X to Y.

RFL has continued to be committed to service development and redesign with a patient centred approach to improving services. This has led to new initiatives being introduced such as a nurse led prostate diagnostic service. This service utilised ANP and CNS workforce to facilitate the diagnostic pathway, up to and including, the breaking of bad news. The pathway has improved FDS performance significantly from 50% to 80%. It has also improved patient experience, providing results in a shorter time frame in a manner appropriate to the patient.

RFL has introduced a Breast Pain Service across part of the group with plans to expand to all sites within the trust. This pathway provides clinical assessment and support to patients with low risk of breast cancer, this reduces pressure on breast one stop clinics whilst improving experience for patients with breast pain. The pathway allows appropriate assessment and triage. This reduces unnecessary tests and increases patient information and support.

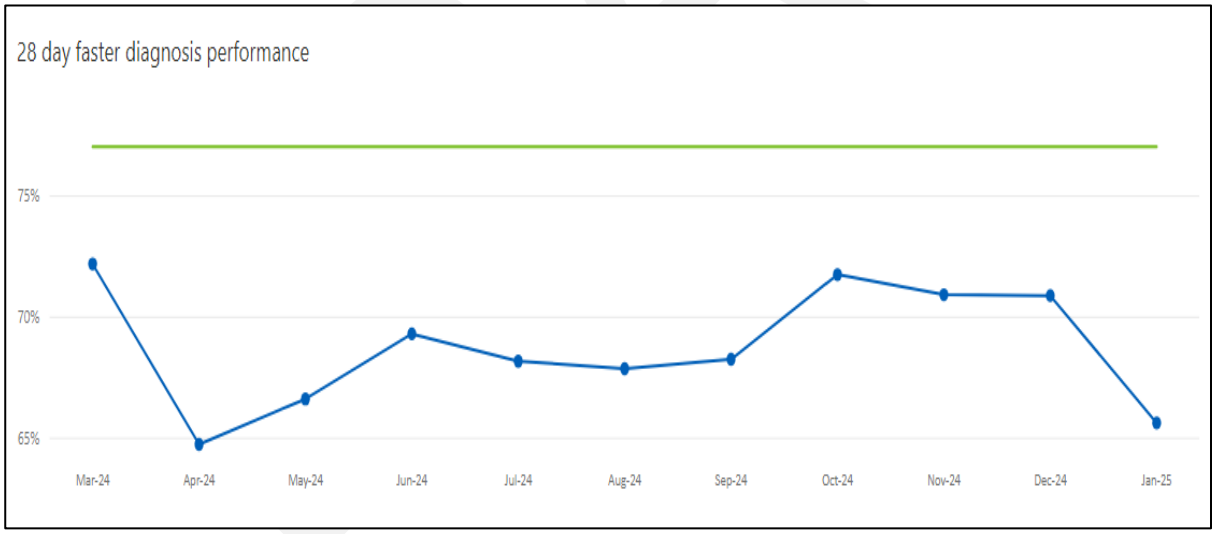
The introduction of Tele-dermatology pathway has been highly successful. This pathway utilises clinical photography of skin lesions that are then reviewed by a consultant, eliminating the first appointment with the clinician. This has reduced delays, reduced unnecessary clinical appointments by allowing triage and appropriate redirection of referrals. This service is currently being utilised for 30% of the Urgent Suspected Cancer referrals with 60% of those being discharged. Expansion is planned to 50% of the USC and GP practices given the success.

The trust is committed to improving patient experience and this is evidenced in the improvement in National Cancer Patient Experience Survey outcome this year. The trust overall score improved to 8.9 (previously 8.7) with a significant reduction in questions outlying below national average (previous 39 questions below national average, now 6). This ongoing commitment is evidenced in the expansion of health and wellbeing events and supportive services. The trust will be refreshing its patient experience strategy with a focus on ensuring equality of care and experience for all patients

Diagnosis communicated to the patient within 28 days

In 2024-25, the trust was below the standard to communicate a diagnosis of cancer or ruling out of cancer to 77% of patients by day 28. The trusts averge performance is X% [Final data to be confirmed].

Chart 3.2.5: RFL 28 days diagnosis performance

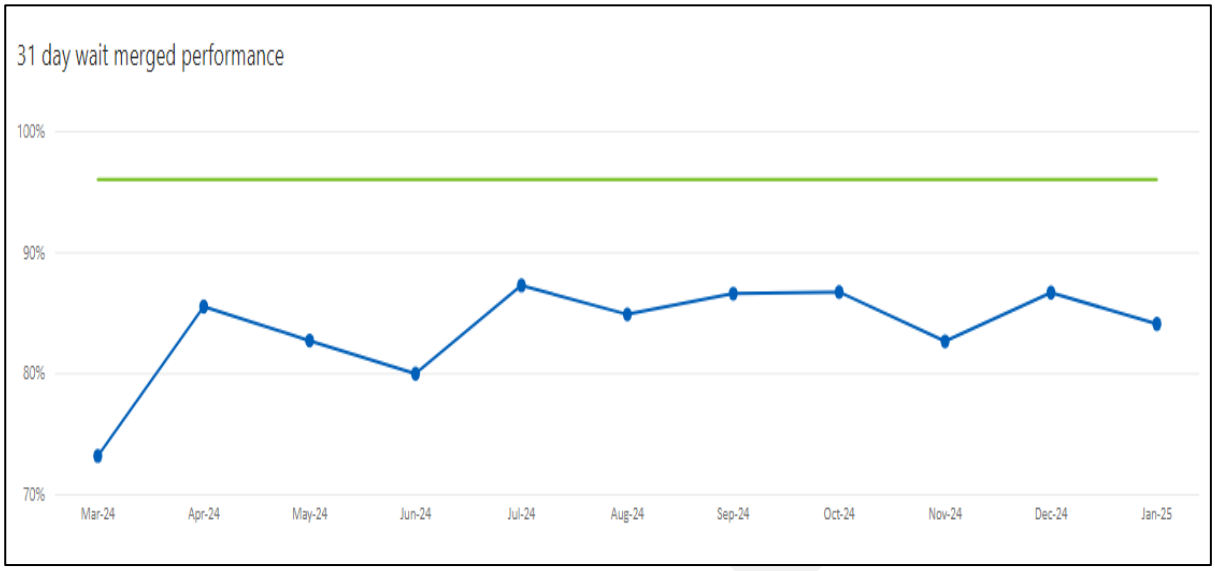


Source: Royal Free London W2B PBI 2024-25 [Final data to be confirmed]

First and subsequent treatment within 31 days

In 2024-25, the trust was below the standard to treat 96% of patients within 31 days of a decision to treat cancer, with an average of X% [Final data to be confirmed].

Chart 3.2.6: RFL 31 day wait merged performance

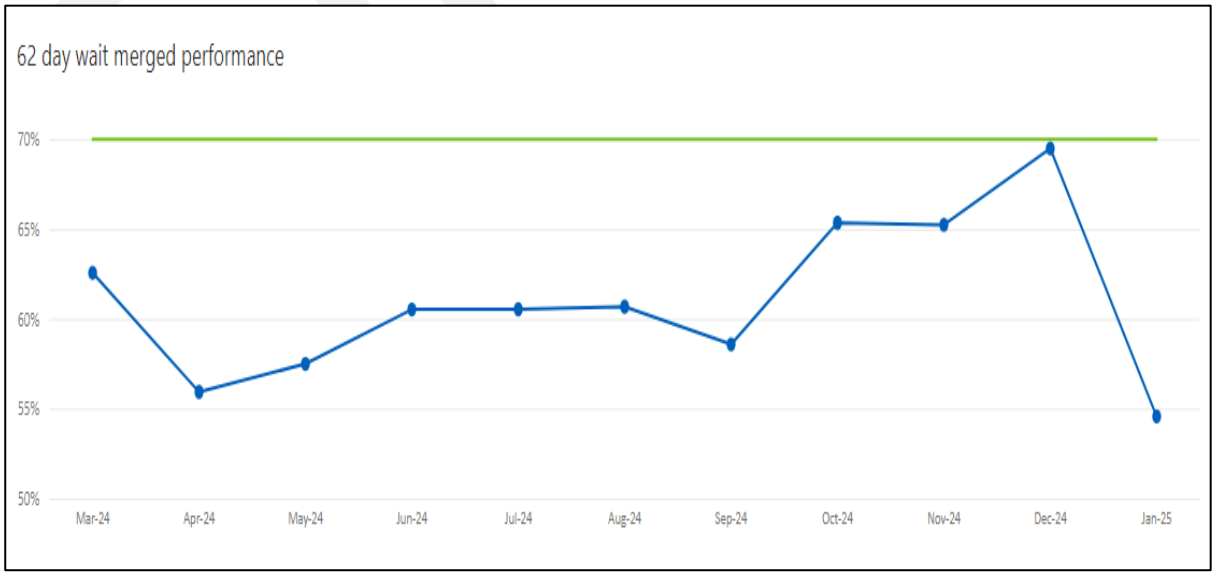


Source: Royal Free London W2B PBI 2024-25 [Final data to be confirmed]

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

The trust did not meet the 62-day standard in 2024-25, with an average of X% 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 [Final data to be confirmed].

Chart 3.2.7: RFL 62 day wait merged performance

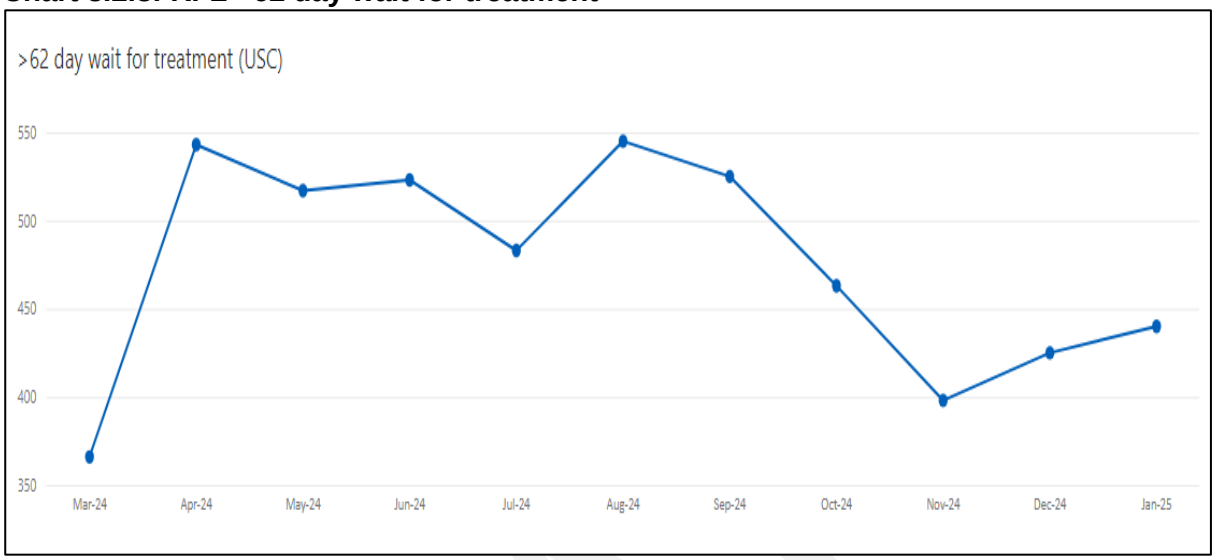


Source: Royal Free London W2B PBI 2024-25 [Final data to be confirmed]

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

At each health unit the backlog is reviewed three times per week, and patients are being booked on clinical priority and highest risk basis. The trust has reduced the backlog down to 549 patients which is better than trajectory of XXX. [Final data to be confirmed].

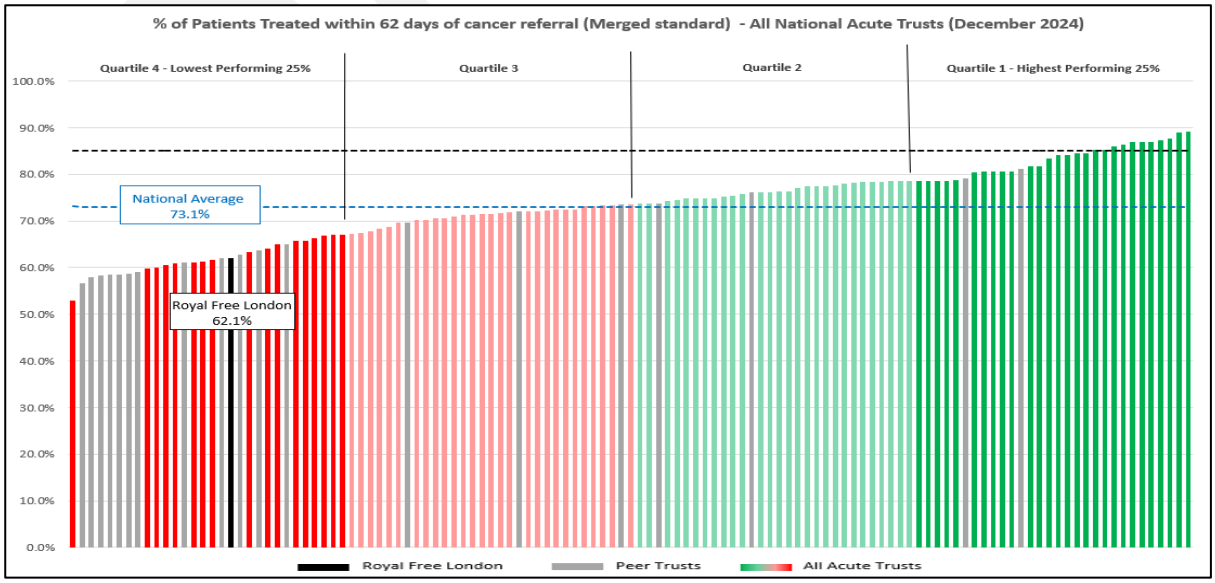
Chart 3.2.8: RFL >62 day wait for treatment



Source: RFL weekly cancer PTL 2024-25

The chart below shows the Royal Free London performance for December 24 (To be updated for March 25), benchmarked against all national acute Trusts and peer providers for 62 day waits for treatment. The Royal Free London is in Quartile 4 with 62.1% of cancer patients treated within 62 days of referral). The Royal Free London is ranked 104 out of 121 trusts and is ranked 13 from 20 peer trusts [Final data to be confirmed].

Benchmarking chart 3.2.9: Percentage of patients treated within 62 days of cancer referral



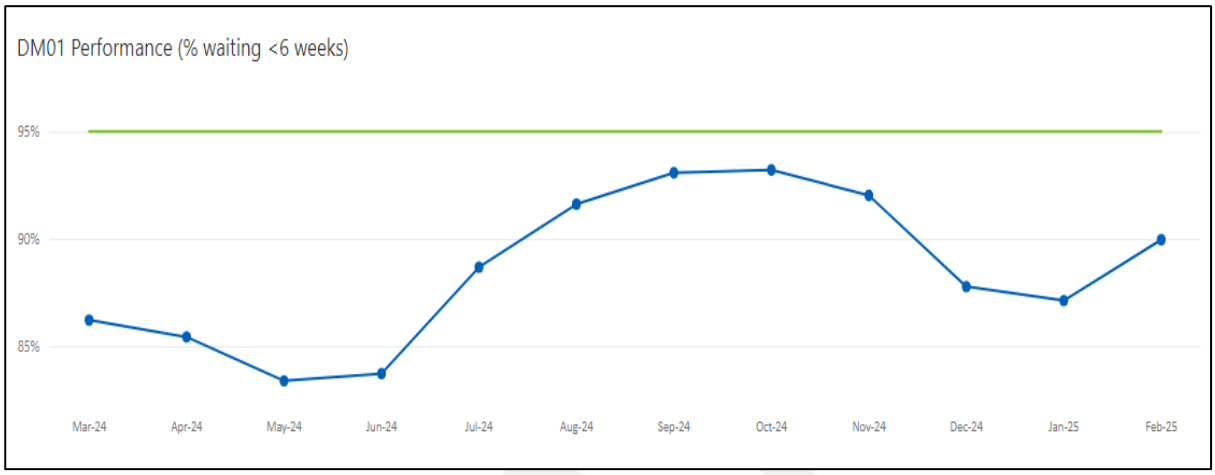
Source: NHS Digital, 2024-25

2.4 Diagnostics waiting times:

*(*This section reflects the trust's Q3 position at the time of drafting. Data and information may be updated upon validation.)*

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 (To be updated for March 25) reported 90.0% (North Middlesex reported 90.1%) against a 95% target. The performance increase is being driven by improvement in Imaging access compliance.

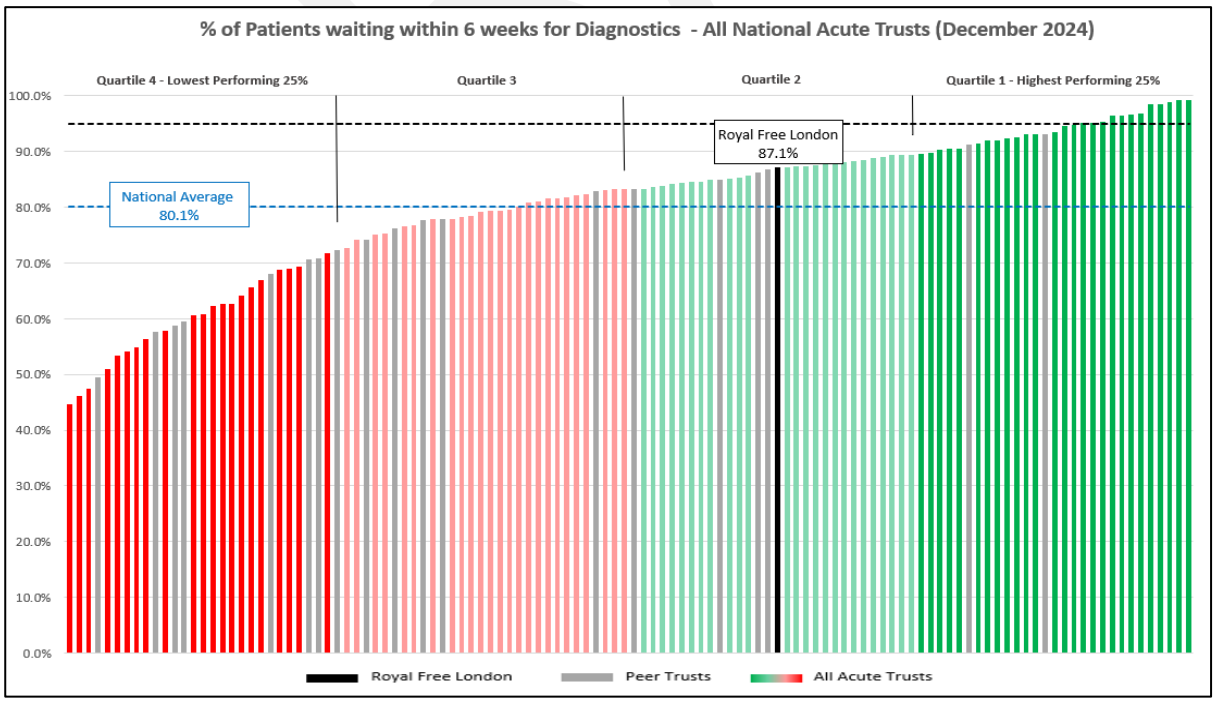
Chart 3.2.10: Percentage of patients waiting <6 weeks for diagnostics



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

RFL 6-weeks diagnostics waits performance in December 2024 (To be updated with March 25) remains strong with 90.0% in the 1st Quartile. RFL ranked 44 highest from 118 Trusts and third highest amongst the 20 peer trusts Group.

Benchmarking chart 3.2.11: Percentage of patients waiting 6 weeks for diagnostics

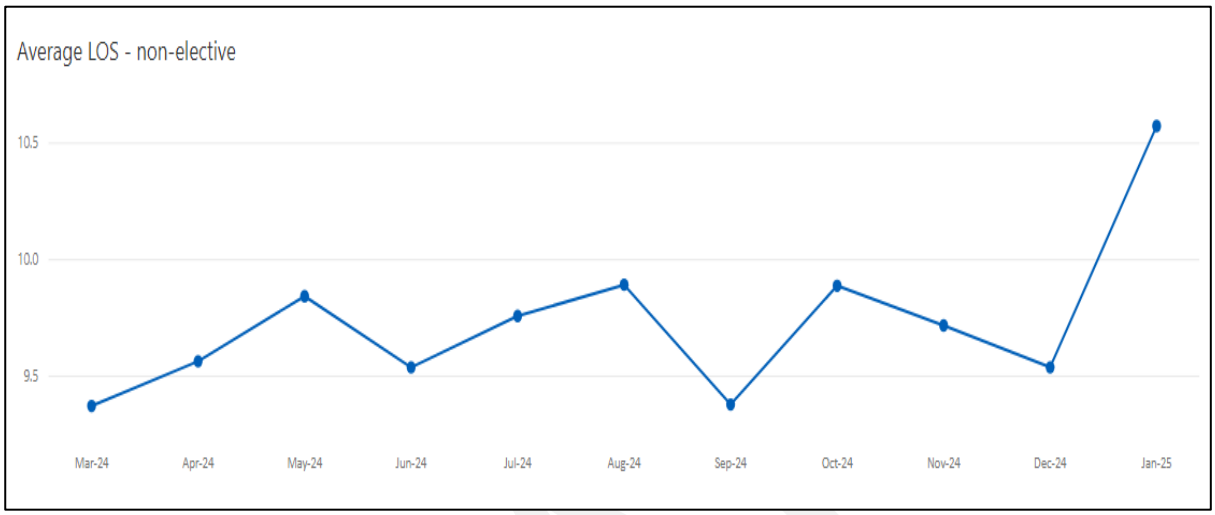


Source: NHS Digital 2024-25

2.5 Average length of stay (non-elective mean length of stay)

The trust average inpatient length of stay for patients admitted as non-elective from Mar 2024 to Jan 2025 shows that the trust average length of stay was 9.0 days per month, which is an increase from 8.9 in 2023-24. With the inclusion of North Middlesex Hospital performance, the average inpatient length of stay was 9.7.

Chart 3.2.12: Average Length of Stay – non elective



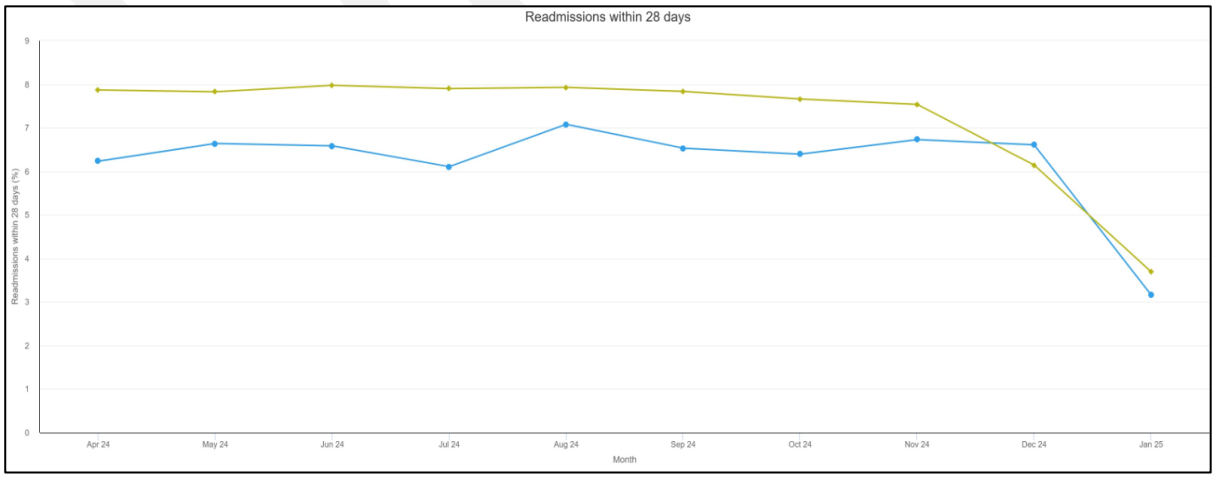
Source:Royal Free London W2B PBI 2024-25

2.6 28 days re-admissions 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 April 2024 and January 2025 (To be updated for March 2025).

Re-admissions performance from April 2024 – Jan 2025 shows that RFL (blue line) has a lower re-admissions rate overall (6.2%) than the peer group (green line) average (7.4%) over that period.

Chart 3.2.13: 28 days re-admissions following inpatient admissions



Source: CHKS Benchmarking 2024-25 - **Note:** The dip in the Jan 2025 figures is due to data awaiting revalidation and expected to be back up in line with the trend once data is refreshed.

Section 3: Patient experience

3.1 National patient survey programme

In 2024-25, the results of three national surveys were published:

- In-patient 2023 – (published in August 2024)
- Urgent and emergency care 2024 – (published in November 2024)
- Maternity 2024 – (published in November 2024)

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

Please note: Separate reports were received for the Royal Free London NHS Foundation Trust and North Middlesex University Hospital Trust for all the national surveys published in 2024-25. The results reported here refer only to the Royal Free London NHS Foundation Trust. North Middlesex University Hospital Trust survey results are shown separately in Annex 1.

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 were 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

Adult inpatient survey

In total, 423 patients responded to the survey, giving the trust response rate of 36% compared to the national response rate of 42%. Both response rates have increased by 2% when compared to the 2022 survey.

The 49 scored questions in the survey are split into 11 sections. The trust scored 'about the same', i.e. as expected, for each section, the same as it has for each inpatient survey since 2014.

The trust did not score better than expected in any questions but scored 'somewhat worse' in one and 'worse' in another.

Table 3.1.1: Adult inpatient survey

Question		RFL score	Average score	Range of scores
Somewhat worse than expected				
13	How would you rate the hospital food?	6.4	6.9	5.8 – 8.7
Worse than expected				
8	How clean was the hospital room or ward that you were in?	8.5	9.0	8.2 – 9.8

Where comparable data is available, statistical significance testing has been carried out against the 2022 and 2021 survey results for each question. Where a change in results is shown as 'significant', this indicates that the change is not due to random chance but is likely due to a particular factor at trust level.

The trust did not score significantly higher or lower in 2023 for any question when compared to the 2022 or 2021 surveys.

Urgent and emergency care survey

In 2024, the survey underwent a large-scale redevelopment, including changes to the methodology, the sampling month and the questions asked.

- **Survey methodology** – the survey has moved from solely a paper-based questionnaire to a mixed-mode approach, providing patients with the opportunity to complete an online or paper questionnaire.
- **Sample month** – the sample month has changed from September to February.
- **Questions asked** – the changes to methodology and sample month provided the opportunity for the questionnaire to be revised and redesigned, following current policy and practice.

The changes described above mean that there is **no historical comparison available** for this 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, 229 responses were received to the type 1 survey, giving a response rate of 25% compared to the national response rate of 29%. When the survey was last undertaken in 2022, the trust response rate was 18% and the national response rate was 23% so an increase in response rate has been seen across the country.

The questions in the survey are split into 11 sections. One section, 'hospital environment and facilities' fell outside of the expected range and is rated 'worse' than expected.

Out of the 29 scored questions in the survey, 26 of them were rated 'about the same' as most other trusts (or scored within the expected range). Questions where the results fell outside of the expected range can be seen below.

Table 3.1.2: Urgent and emergency care survey

Question		RFL score	Average score	Range of scores
Much worse than expected				
32	While you were in A&E, were you able to get food or drinks?	4.2	6.2	4.2 – 7.6

Somewhat worse than expected				
37	To what extent did you understand the information you were given on how to care for your condition at home?	8.0	8.6	7.8 – 9.2
Worse than expected				
41	Did doctors and nurses talk to each other about you as if you weren't there?	8.2	8.9	7.7 – 9.5

Type 3 results

132 patients who attended the Urgent Treatment Centre at Chase Farm Hospital completed the Type 3 survey, giving a response rate of 23% compared to the national response rate of 26%. In 2022, the trust response rate was 20% compared to the national response rate of 22%. Again, an increase in response rate has been seen nationally.

All 10 sections and all 28 scored questions in the survey scored 'about the same' as expected.

The trust uses these survey results to design future services and has been working throughout the year to make continuous improvements.

Children and young people's experience survey

*This survey is due to be published in May 2025 and information will be include in the final report if available at the time of publication.

Maternity survey

A total of 34% of women completed the 2024 maternity survey compared to an average response rate for all trusts of 41%.

All 10 sections in the survey scored 'about the same'.

Four questions scored outside of the expected range, two 'better' and two 'somewhat better' than expected.

The results can be seen in the table below:

Table 3.1.3a: Maternity survey

Question		RFL score	Average score	Range of scores
Better than expected:				
C9	If your partner, or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	9.7	9.4	8.1 – 10.0
F13	Were you given information about your own physical recovery after the birth?	7.6	6.7	5.5 – 7.9
Somewhat better than expected:				
C19	After your baby was born, did you have the opportunity to ask questions about your labour and birth?	6.8	6.2	4.6 – 7.4

F12	Were you told how you could contact if you needed advice about any changes you might experience to your mental health after the birth?	8.9	8.2	7.0 – 9.2

The trust saw a statistically significant increase (▲) in the scores of two questions when compared to the 2023 survey:

Table 3.1.3b: Maternity survey

Question		2023 score	2024 score	
D2	On the day you left hospital, was your discharge delayed for any reason?	5.3	6.6	▲
F11	Were you given information about any changes you might experience to your mental health after having your baby?	6.6	7.6	▲

Actions and changes as a result of national survey feedback

Action plans to address areas where the trust does not perform as well as expected in national surveys have been devised. One major focus for the trust in 2024-25, which will extend into 2025-26 is on the quality and availability of food. This was highlighted as an area for improvement in most national surveys during 2024-25.

A trust-wide nutrition and hydration meeting has been set up with a focus on ensuring that patients across our hospitals have equitable access to food and drink. The group will use its findings and action plan to develop a RFL food and drink strategy.

National cancer patient experience survey

Although not part of the official national survey programme, the 2023 national cancer patient experience survey results were published in July 2024. The trust's response rate was 43% compared to the national response rate of 52%.

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

Table 3.1.4: Royal Free London score across key themes through the cancer pathway compared to the national average

Theme and question	RFL score 2023	National score 2023
Support from your GP practice Q.3 Referral for diagnosis was explained in a way the patient could completely understand.	**60%**	**67%**
Diagnostic tests Q.9 Enough privacy was always given to the patient when receiving diagnostic test results.	**94%**	**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.	**74%**	**81%**
Support from a main contact person	**90%**	**91%**

Q.17 Patient had a main point of contact within the care team.		
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.	**77%**	**80%**
Care planning Q.24 Patient was definitely able to have a discussion about their needs or concerns prior to treatment	**73%**	**72%**
Support from hospital staff Q.27 Staff provided the patient with relevant information about available support or self-help groups, events, and resources	**90%**	**91%**
Hospital care Q.31 Patient had confidence and trust in all of the team looking after them during their inpatient stay.	**79%**	**77%**
Treatment Q.43 Patient felt the length of waiting time at clinic and at the day unit for cancer treatment was about right.	**78%**	**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	**58%**	**60%**
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.	**58%**	**62%**
Living with and beyond cancer Q.55 Patient was given enough information about the possibility and signs of cancer coming back or spreading.	**59%**	**64%**
Cancer research and clinical trials Q.58 Cancer research opportunities were discussed with patient	**54%**	**45%**
Overall rating of cancer care Q59. Patient's overall rating of care out of 10	**8.9**	**8.9**

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 June 2024, the trust rolled out a new system for collecting this valuable feedback. Following an admission to hospital, an attendance at one of our emergency departments or urgent treatment centres or an outpatient appointment, patients are sent a text message asking them to respond to the FFT.

Patients also have the option to complete longer surveys about their experience via tablets or QR codes linked to online surveys. Information about these surveys can be found on posters around our hospitals and on our website.

In maternity services, women are given the opportunity to tell us about their experience at different points in their pathway via surveys, which include the FFT question.

From January 2025, North Middlesex Hospital FFT responses have been included in the trust's figures.

Inpatient FFT

Table 3.1.5: Inpatient FFT – number of responses and % of patients reporting a good/very good experience

Inpatient FFT	Percentage patients reporting a good/very good experience	Number of responses
April 2024	95%	222
May 2024	95%	646
June 2024	92%	1420
July 2024	91%	1125
August 2024	92%	1062
September 2024	91%	1067
October 2024	90%	1078
November 2024	91%	932
December 2024	90%	660
January 2025	93%	2460
February 2025	93%	2168
March 2025	94%	2157

Outpatient FFT

Table 3.1.6: Outpatient FFT – number of responses and % of patients reporting a good/very good experience

Outpatient FFT	Percentage patients reporting a good/very good experience	Number of responses
April 2024	96%	138
May 2024	97%	866
June 2024	94%	11512
July 2024	93%	15843
August 2024	95%	7925
September 2024	95%	10713
October 2024	95%	11712
November 2024	95%	8847
December 2024	95%	6187
January 2025	94%	11816
February 2025	94%	10378
March 2025	93%	8426

Maternity FFT

Table 3.1.7: Maternity survey – number of responses and % of patients reporting a good/very good experience

Maternity FFT	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 2024	100%	6	100%	3	100%	3	100%	9
May 2024	80%	15	93%	30	93%	28	100%	27
June 2024	100%	1	100%	11	100%	11	100%	17
July 2024	91%	56	100%	2	96%	65	100%	33
August 2024	93%	60	100%	23	93%	5	100%	51
September 2024	96%	46	95%	87	96%	139	100%	42
October 2024	94%	34	95%	58	96%	116	100%	11
November 2024	89%	27	98%	53	96%	126	82%	28
December 2024	95%	20	95%	19	97%	72	100%	10
January 2025	87%	99	96%	89	92%	281	100%	25
February 2025	74%	66	95%	115	93%	255	100%	18
March 2025	90%	137	88%	126	89%	135	95%	55

Emergency Department survey

Table 3.1.8: Emergency department – number of responses and % of patients reporting a good/very

Emergency Department FFT	Percentage patients reporting a good/very good experience	Number of responses
April 2024	82%	2885
May 2024	79%	3218
June 2024	78%	2781
July 2024	82%	3229
August 2024	87%	3462
September 2024	84%	3233
October 2024	83%	3414
November 2024	80%	2923
December 2024	78%	2750
January 2025	77%	5417
February 2025	75%	4742
March 2025	76%	4903

Caring for patients with learning disabilities

Health inequalities for people with autism and learning disabilities remain an unacceptable issue. The latest Learning from Lives and Deaths (LeDeR) report, published in November 2023, highlights that life expectancy for this group of people remains lower than for the general population.

We continue to participate in the NHS England learning disability improvement standards benchmarking project. As part of this work, Community Service User Engagement meetings were delivered in Barnet, Enfield and Camden during 2024. These were attended by autistic service users and parents of children with learning disabilities. The aim was to inform them of ongoing work within the Trust and obtain their views and experiences when attending or contacting the Trust.

The trust's quality strategy makes increasing support for autistic patients and patients with a learning disability a strategic priority. The learning disability and Autism steering group has been established to monitor delivery of this commitment. This group is chaired by the director of nursing for Chase Farm and includes a service user with experience. Key members of staff from the North Middlesex University Hospital have recently joined the group. An action plan has been established using the following priorities:

- improve the identification of people with a learning disability. This includes work to introduce disability and reasonable adjustment requirement fields on our electronic patient record system and improve recording in these fields.
- improve how we communicate with people with a learning disability. This includes improving easy read information for patients in every health unit of the Royal Free group.
- train our workforce in caring for patients with a learning disability. This includes the delivery of Oliver McGowan training to all staff.
- support people with a learning disability and their families or carers. This includes the work of our Acute Learning Disability nurses at each health unit.

Number of cancelled operations on the day

Information for this section will be included in the final QA.

3.2 Performance against key indicators summary

*(*This section reflects the trust's Q3 position at the time of drafting. Data and information may be updated upon validation.)*

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

Table 3.2.1 :Operational performance indicators summary 2024-25

Metric	Target	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
ED 4 hour performance (all)	78%	67.9%	68.9%	67.5%	71.9%	71.6%	73.9%	73.1%	71.5%	70.8%	72.6%	73.3%	73.3%
ED 4 hour performance (type 1)	76%	54.0%	53.7%	52.7%	57.6%	57.0%	60.9%	59.3%	56.9%	56.4%	59.3%	60.2%	60.0%
ED 4 hour performance (UTC)		90.3%	93.1%	90.9%	94.7%	94.4%	96.3%	95.1%	95.3%	94.0%	92.7%	93.4%	93.6%
ED 12hr breaches (from arrival)		4,098	4,129	4,503	3,556	3,717	2,783	3,120	3,606	3,666	3,999	3,856	3,503
ED 12hr breaches (from arrival) %		9.1%	9.8%	10.0%	8.4%	8.7%	7.4%	7.8%	8.4%	8.7%	9.2%	9.4%	9.1%
ED 12 hour wait from decision to admit	0	1,603	1,739	1,813	1,348	1,332	1,259	1,438	1,683	1,592	1,787	1,939	1,691
ED 30 mins Ambulance handover performance	80%	54.2%	52.7%	53.7%	60.4%	60.5%	61.3%	63.5%	59.0%	57.4%	48.0%	47.1%	52.9%
ED 30 min ambulance handover delay	0	2,359	2,290	2,253	1,876	1,946	1,898	1,706	2,039	2,128	2,358	2,398	2,150
ED 60 min ambulance handover delay	0	762	687	658	437	416	466	432	442	544	676	831	580
ED attendance (all types)		45,080	42,310	45,076	42,580	42,911	37,658	40,034	42,978	42,164	43,611	41,017	38,525
Admissions from ED		5,739	5,461	5,735	5,554	5,636	5,401	5,411	5,700	5,499	5,548	5,254	4,577
ED conversion rate		12.7%	12.9%	12.7%	13.0%	13.1%	14.3%	13.5%	13.3%	13.0%	12.7%	12.8%	12.5%
Bed occupancy rate (G&A)	92%	96.7%	97.2%	96.9%	96.2%	96.0%	95.7%	96.5%	96.9%	96.9%	96.4%	97.2%	97.3%
Bed occupancy rate (CC)	92%	89.5%	92.5%	92.7%	88.7%	88.6%	91.1%	89.6%	92.1%	93.2%	91.3%	93.1%	92.8%
Long LOS - >21 Days (incidences)*		321	353	372	310	340	340	321	345	349	367	369	360
Long LOS - >21 Days %		21.8%	23.7%	25.2%	23.0%	23.7%	24.1%	24.4%	22.9%	22.3%	22.9%	24.2%	24.0%
Average LOS - non-elective		9.4	9.6	9.8	9.5	9.8	9.9	9.4	9.9	9.7	9.5	10.6	
Average LOS - elective (excluding daycases)		4.6	3.1	3.5	5.1	3.1	4.3	3.6	4.0	5.0	4.5	2.9	
Medically optimised patients		300	278	291	303	332	315	305	275	309	312	354	339
Medically optimised patients %		22.0%	20.2%	21.7%	22.3%	24.4%	23.2%	22.5%	20.1%	22.2%	22.4%	24.8%	23.9%
Discharges by midday %		15.8%	17.8%	16.7%	15.8%	16.0%	16.5%	14.3%	15.5%	15.7%	14.8%	16.2%	12.8%
DNA rate	0%	8.3%	8.2%	8.2%	7.8%	7.9%	8.3%	8.0%	7.9%	8.1%	8.1%	8.0%	8.4%
Outpatient cancellation rate	0%	28.7%	29.6%	26.6%	27.4%	28.1%	29.7%	28.1%	28.0%	27.0%	28.6%	27.7%	28.0%
Daycase rate		89.5%	90.3%	90.8%	90.3%	90.0%	90.3%	89.7%	90.1%	89.7%	90.9%	90.9%	
Theatre utilisation - number of cases		3,024	3,246	3,286	2,935	3,475	3,133	3,194	3,516	3,260	2,781	3,331	3,183
Theatre utilisation - in session (uncapped)		78.3%	80.4%	79.5%	81.6%	79.3%	80.8%	79.8%	79.8%	81.1%	79.0%	80.0%	79.3%
Theatre utilisation - in session (capped)	85%	75.6%	77.1%	76.4%	78.2%	75.9%	77.6%	76.5%	75.9%	77.2%	75.5%	76.3%	76.4%

3.3 Actioning our plans for improvement

3.3.1 The Care Quality Commission

The Royal Free London NHS Foundation Trust (RFL) and North Middlesex University Hospital NHS Trust merged into a single organisation on 01 January 2025.

As reported in our 2023-24 Royal Free London Quality Account, the trust has undertaken significant improvement work towards completing the improvement actions arising from previous CQC inspections.

CQC assessments during 2024-25

On 28/29 January 2025, the CQC undertook an assessment of the maternity service at North Middlesex University Hospital. As the report is yet to be published; the action plan for improvement will be developed and reported in the 2025-26 Quality Account.

Current, historical CQC action plans for improvement following inspections

Health Unit:	North Middlesex University Hospital
Date of inspection:	24 May 2023
Inspection type:	Unannounced
Report published:	08 December 2023
Core-service:	Maternity care

CQC finding:	
The service must ensure there are sufficient midwives. The service must ensure there are sufficient numbers of suitably qualified, competent, skilled, and experienced midwives in order to provide safe care and treatment across the service and reduce delays in provision of safe care to reduce the risk of harm for women, birthing people, and babies. (Regulation 18: Staffing)	These actions are closed with ongoing monitoring: ✓ Ensuring the maternity vacancy rate does not rise above 12% (North Central London Integrated Care Board average). ✓ Ensuring that women receive 1:1 care in labour. ✓ Undertaking an establishment review every 6 months. ✓ The 'birth rate plus' report was commissioned. ✓ Bi-annual midwifery staffing paper and the 'birth rate plus' report was presented to the nursing & midwifery executive committee (NMEC) and the Trust Board. ✓ Maternity workforce reports go to Trust Board for oversight and the Clinical Negligence Scheme for Trusts (CNST). ✓ Vacancies are monitored monthly by the maternity board. ✓ Staffing metrics are reported and monitored via perinatal quality surveillance model. This action is currently in progress with monitoring at a divisional and health unit level: ▪ Ensuring that induction of labour (IOL), artificial rupture of membranes (ARM) and augmentation of labour are not delayed due to staffing shortages. Where any delays occur, we ensure they are risk assessed appropriately.
The service must ensure training is completed and that staff are compliant against national and local trust targets, including but not limited to emergency evacuation of the birth pool, patient group directive medicine, human factors training, safeguarding, and that all staff complete risk assessment training. Any staff who have not received the appropriate training must have adequate mitigation in place. (Regulation 12: Safe care and treatment)	These actions are closed with ongoing monitoring: ✓ Compliance with Saving Babies Lives (SBL) care bundle (90% compliance). ✓ Ensure Maternity Skills 'B' compliance is above 90% for all midwives. o The Maternity Skills 'B' covers - risk update, venous thromboembolism update, bereavement update, blood transfusion update, equality, diversity and inclusion/personalised care, perinatal mental health update, pelvic health update, obstetric anal sphincter injury (OASI) bundle), safeguarding vulnerable women update, avoiding term admissions into neonatal units (Atain) update, management of labour including birth trauma, vaginal birth after caesarean (VBAC), multiple pregnancy). ✓ Training needs analysis has been reviewed and updated. ✓ Emergency pool evacuation training to meet standards of 90% which is included in the Practical Obstetric Multi-Professional Training (PROMPT). ✓ Safeguarding level 2 and 3 to achieve trusts standards of 90%. These actions are currently in progress with monitoring at a divisional and health unit level:

CQC finding:	

	▪ Ensure maternal basic life support compliance meets trust standards of 90% for all groups.
	▪ Training needs analysis to be reviewed in alignment with the Maternity Core Competence Training Framework.
	  ○ human factors (included in PROMPT)
	  ○ patient group directions
	  ○ risk assessment
	▪ Skills and Drills programme to be formally scheduled for the year and include -emergency pool evacuation.
	▪ Standard operating procedure for the management of non-compliance in training.

The service must ensure staff are up to date with maternity mandatory training modules and that all staff complete regular skills and drills training. (Regulation 18: Staffing)	These actions are closed with ongoing monitoring: ✓ PROMPT training compliance at or above 90% across all staff groups and be reported from one data source to avoid discrepancy between internal and external reporting. ✓ Ensuring training compliance is pulled and reported from one data source to avoid discrepancy between internal and external reporting and ensure reporting mirrors CNST safety action: 8. ✓ Ensuring safeguarding (children) training compliance is above 90%. ✓ Ensuring that safeguarding (adult) training compliance is above 90%. ✓ Ensuring that governance training compliance is >90%. ✓ Ensuring that Saving Babies Lives training compliance for midwives is >85%. These actions are currently in progress with monitoring at a divisional and health unit level: ▪ Ensuring the cardiotocography (CTG) training compliance of 90% to be achieve for all staff groups (particularly for obstetric medical staff). ▪ Ensuring PROMPT training compliance is above 90% (including skills and drills emergency pool evacuation). ▪ Ensuring the Saving Babies Lives care bundle v3 training compliance is above 90%. ▪ Ensure maternal basic life support compliance is above 90%. ▪ Ensure foetal monitoring training compliance is >90%.
The service must ensure staff are competent in the use of foetal scalp electrodes, carrying out cardiotocography (CTG) and in the interpretation of CTG monitoring on reviewing, escalating an emerging or evolving concerns appropriately. (Regulation 12: Safe care and treatment)	These actions are closed with ongoing monitoring: ✓ Learning from CTG cases; Friday case reviews. ✓ Ensuring that all appropriate staff group posted or assigned to labour ward, birth centre and home birth team are trained to use foetal scalp electrodes achieving 100% by March 2025. ✓ Ensuring that all appropriate staff groups are trained to use foetal scalp electrodes to achieve trust standard 85%. These actions are currently in progress with monitoring at a divisional and health unit level: ▪ Ensuring that CTG training compliance of 90% is achieved for all staff groups (particularly obstetric medical staff). ▪ Develop a Guideline for Clinical Escalation (including interprofessional differences of opinion Ockenden immediate and essential actions).

CQC finding:	
The service must ensure all staff receive an annual appraisal. (Regulation 18: Staffing)	This action is currently in progress with monitoring at a divisional and health unit level: ▪ Ensure appraisal rates for staff to achieve trust standard of 85%.
The service must ensure there is sufficient equipment including emergency resuscitation and CTGs to care for women, birthing people, and babies throughout the unit. (Regulation 15: Premises and equipment)	These actions are closed with ongoing monitoring: ✓ Ensuring that an adequate number of Dawes-Redman specific CTG's are available in all appropriate areas. ✓ Undertaking resuscitaire readiness audit/spot checks to ensure that a resuscitaire can be made available should one be required in the birth centre or maternity triage in under 2 minutes. ✓ Audits undertaken to assess resuscitaire checking for the birth centre, ensuring compliance with equipment checks even on days the birth centre is closed. This action is currently in progress with monitoring at a divisional and health unit level: ▪ Ensure the centralised CTG monitoring system is functional.
The service must ensure that the appropriate risk assessment takes place at each contact when women, birthing people are admitted to the service, or when attending triage. (Regulation 12: Safe care and treatment)	These actions are closed with ongoing monitoring: ✓ Ensuring that patients are risk-assessed using the Birmingham Symptom-specific Obstetric Triage System (BSOTS) risk assessment tool in triage - 90% of all women assessed with BSOTS tool. ✓ Ensuring there is a clear standard operating procedure and pathway for the risk assessment of women attending triage. This action is currently in progress with monitoring at a divisional and health unit level: ▪ Undertake an audit of all maternity risk assessment pathways.
The service must review processes within the maternity triage and ensure that care, reviews and waiting times for women are appropriate, risk based and monitored for efficacy and safety. (Regulation 12: Safe care and treatment)	These actions are closed with ongoing monitoring: ✓ Review of the staffing model to ensure that there is 7 day a week triage telephone cover that is in line with national, Ockenden and the Royal College of Obstetricians and Gynaecologists (RCOG) recommendations, monitoring through the health roster system. ✓ Escalation of excessive wait times through unit coordinator walk-abouts, 3 times a day. ✓ Implementation of BSOTs in maternity triage. These actions are currently in progress with monitoring at a divisional and health unit level: ▪ Develop standard operating procedure for the recording of triage calls, monitor repeat callers and track non-attendance. ▪ Review staffing model to ensure that there is 7-day a week triage telephone cover that is in line with national, Ockenden and RCOG recommendations. ▪ Undertake compliance audit for BSOTs.
The service must ensure systems and processes for maternity triage	**All actions for this CQC finding have been delivered and are subject to ongoing monitoring, with evidence being compiled.**

CQC finding:	
are reviewed so to deliver a safe service in line with national guidance. (Regulation 17: Good governance)	✓ Development of a triage improvement plan.

The service must ensure adequate standards of documentation is maintained, including but not limited to CTG monitoring, patient observations, medicine charts and handover of care. The Service must ensure that patient records are stored securely at all times.
 	
(Regulation 17: Good governance)
	These actions are closed with ongoing monitoring:
	
	✓ The service has ensured that staff have completed the information governance training and compliance remains at or above 95%.
	
	These actions are currently in progress with monitoring at a divisional and health unit level:
	
	▪ Undertake audits of documentation in:
	  ○ CTG
	  ○ medicines management
	  ○ handover
	  ○ huddles
	  ○ Modified Early Obstetric Warning Score (MEOWS)
	▪ The service to procure an end-to-end digital system to provide a standardised way to document care and treatment.

The trust must ensure a just and safe culture to support staff in their work and strive for improvement in the quality and safety of care. (Regulation 12: Safe care and treatment)	These actions are closed with ongoing monitoring: ✓ The service has engaged with staff to co-design a communication strategy using the quality improvement strategy. ✓ Ensured ward/team meetings have an agreed standing agenda that includes shared learning from Datix, complaints, incidents, women and birthing people feedback. ✓ Ensured staff feedback and feedback from the staff survey is populated into an agreed action plan, with staff engaged in the workstreams identified to improve service. ✓ Ensured that shared learning from Datix, complaints and incidents, Maternity and Neonatal Voices Partnership (MNVP) and women's feedback is displayed on the learning boards. These actions are currently in progress with monitoring at a divisional and health unit level: ▪ Ensured that there is a comprehensive plan for education and learning from governance incidence. ▪ Designed and shared the cultural improvement plan. ▪ Ensured that the maternity cultural improvement plan contains actions for psychology safety and Freedom to Speak Up/FTSU and 'just' culture.
The trust should ensure effective measurement of acuity in all areas to enable appropriate and sufficient staffing to provide safe care. (Regulation 12: Safe care and treatment)	These actions are closed with ongoing monitoring: ✓ The 'Birth Rate Plus' was commissioned and presented to NMEC and Trust Board to support safe staffing of all maternity areas. ✓ The service undertakes daily safety huddles in each setting with concerns reported to manager on-call/unit-coordinator and mitigations documented on the Datix system. ✓ Monthly monitoring takes place at ward/team meetings, via safer staffing meetings and at maternity and Trust Board. ✓ Staffing reports are seen by the Trust Board.

CQC finding:	
	✓ Staff are encouraged to report issues of acuity and staffing via Datix or unit-coordinator. ✓ Monitoring acuity daily via locally developed tool. ✓ Monthly monitoring will take place at ward/team meetings, via safer staffing meetings and at maternity and Trust Board via perinatal surveillance model. ✓ Exploration for procuring Birthrate Plus acuity tool app. These actions are currently in progress with monitoring at a divisional and health unit level: ▪ Implement twice daily safety huddles to discuss acuity, staffing and escalation (Ockenden). ▪ Huddles and Handovers to be in alignment with NHS Improvement Huddles and Handover Document (2017) and Ockenden. ▪ Undertake compliance audit on huddle (sheets). ▪ Observe Huddles and Handovers and undertake a snapshot audit.
The service must ensure staff complete daily checks of emergency equipment. (Regulation 15: Premises and equipment)	These actions are currently in progress with monitoring at a divisional and health unit level: ▪ Undertake compliance audit with daily safety checks of emergency equipment - Compliance expected standard of 100%.
The service must ensure clinical observations, screening and testing are carried out in a timely way, reviewed, and escalated appropriately. (Regulation 12: Safe care and treatment)	These actions are closed with ongoing monitoring: ✓ Ensuring staff new to the service receive a documented local induction when they are trained to use clinical observation charts, use of equipment and escalate concerns in line with local and national guidance. ✓ Daily review of staffing to ensure activity and acuity align to enable staff to care for women, birthing people and babies according to clinical need. ✓ Actions/learning with escalations of good practice and or concerns shared during learning events, ward/team meetings and monitored through maternity board and divisional governance. These actions are currently in progress with monitoring at a divisional and health unit level: ▪ Service to provide monthly audits of women/birthing people and neonatal observation charts (MEOWS and the Newborn Early Warning Track and Trigger v2 (NEWTT2s)). ▪ Standard operating procedure for investigations and results management in maternity. ▪ Digital audit of the standard operating procedure foy Investigations and results management in maternity.
The service must ensure completion of risk assessments of women, birthing people, and babies to ensure safe care and improved outcomes throughout pregnancy, delivery, neonatal, and postnatal care.	These actions are closed with ongoing monitoring: ✓ Implementation of personalised care planning for all service users and use risk assessment at every opportunity (same proforma). ✓ Undertake compliance audit of risk assessment tool (current).

CQC finding:	
(Regulation 12: Safe care and treatment)	These actions are currently in progress with monitoring at a divisional and health unit level: ▪ Antenatal, intrapartum, triage and postnatal risk assessment audit. ▪ Develop a comprehensive risk assessment tool. ▪ Implementation of personalised care planning tool for all service users incorporating a risk assessment at every opportunity.
The service must ensure there are effective governance processes and systems to identify and manage incidents, risk, issues, and performance and to monitor progress through completion of audits, actions and improvements and reduce the recurrence of incidents and harm. (Regulation 17: Good governance)	These actions are closed with ongoing monitoring: ✓ Share learning from governance incidents but more particularly any themes arising are shared with all staff regularly. ✓ Perinatal Quality Surveillance Model reported to Board includes safety incidents moderate and above and the Perinatal Mortality Review Tool (PMRT), new Maternity and Newborn Safety Investigations (MNSI) cases etc. These actions are currently in progress with monitoring at a divisional and health unit level: ▪ The service to review the terms of reference for both safety champions and maternity board, ensuring the reporting structure aligns with local and national requirements. ▪ Review the maternity risk and governance team establishment, roles and annual workplan aligning it with the Maternity Safety Self-Assessment Tool, with the Maternity Safety Support Programme (MSSP) assistance. ▪ Ensure there all open incidents are closed in a timely fashion with feedback to reporters. This action should include that there is no backlog of old incidents. ▪ Ensure all open actions from rapid reviews and serious incidents are logged onto Datix and actioned within appropriate time frames. ▪ Ensure Maternity board, sub-board safety committees and Trust Board receive a regular report regarding safety incidents in maternity (quarterly).
The service must ensure that all incidents are reported internally and externally in line with trust policy and national requirements, investigated thoroughly and that learning from incidents is shared. (Regulation 17: Good governance)	**All actions for this CQC finding have been delivered and are subject to ongoing monitoring, with evidence being compiled.** ✓ Ensure that all cases are reported to MNSI as per guidance and confirm with 100% compliance. ✓ Ensure the service transitions from the Serious Incident framework to the Patient Safety Incident Response Framework (PSIRF). Learning from incidents. ✓ Ensure that all Early Notification cases are reported to NHS Resolution via wizard.
The service must ensure performance audit programmes are carried out, completed appropriately, and reported in line with national standards and guidance. (Regulation 17: Good governance)	These actions are currently in progress with monitoring at a divisional and health unit level: ▪ Ensure that there is a robust audit program for the service that confirms with local and national requirements - audits to include Situation, Background, Assessment, Recommendation (SBAR), risk assessment training and learning from incidents training. ▪ Ensure audits as per the program are carried out in a timely fashion.

CQC finding:	
	▪ Ensure where appropriate there is an action plan following audit. ▪ Report and monitor learning from audit recommendations, ensure that audit recommendations are shared at maternity board, audit afternoons and safety champions.
The service must ensure compliance with recommendations and reviews are carried out effectively to ensure actions and changes in practice are completed and performance is reported correctly. (Regulation 17: Good governance)	These actions are currently in progress with monitoring at a divisional and health unit level: ▪ Compliance with all MNSI and Health Service Safety Investigations Body (HSIB) actions. ▪ Ensure compliance with all PMRT actions.
The service must evidence lessons learned and changes to practice and care following on from reviews, recommendations, and reports. (Regulation 17: Good governance)	**All actions for this CQC finding have been delivered and are subject to ongoing monitoring, with evidence being compiled.** ✓ Sharing of lessons through various avenues to be completed monthly (safety huddles, 7-minute learning, message of month, governance white boards,). ✓ Service to ensure learning is shared sector wide at the Local Maternity & Neonatal System (LMNS) and Integrated Care Board monthly perinatal quality surveillance meeting.
The service must ensure the culture within the service significantly improves so that it does not impact upon service user safety and care. (Regulation 18: Staffing)	These actions are closed with ongoing monitoring: ✓ Ensure the service includes staff with the development and implementation of a communication strategy that is in line with trust values and recommendations set out in the maternity and neonatal 3-year delivery plan. ✓ Ensure staff participate and can contribute to the agenda and feedback at monthly ward/team meetings and use feedback Plan, Do, Study, Act (PDSA) through the quality improvement strategy to revise or co-design services/pathways/ processes. ✓ Ensure unit meetings are advertised and accessible for all staff ensuring that meeting minutes are shared electronically. ✓ Ensuring learning is shared from established governance process through – lesson of the week, 7-minute learning, maternity hub on the intranet establish learning cafe to firmly establish a no blame culture. ✓ Share actions and improvements at maternity board/safety champions meeting, at staff meetings to ensure all stakeholders are engaged with service improvement. ✓ Ensure quadrumvirate participation with perinatal culture and leadership programme. ✓ Delivery of culture training (building resilient teams via Mycelium) to improve culture. ✓ Participation in the Safety, Communication, Operational, Reliability, and Engagement (SCORE) Survey and develop action plan. These actions are currently in progress with monitoring at a divisional and health unit level: ▪ Develop of an overarching cultural improvement plan.
The service must ensure they engage with women, birthing	**All actions for this CQC finding have been delivered and are subject to ongoing monitoring, with evidence being compiled.**

CQC finding:	
people, the local communities and groups, the Maternity Voices Partnership representatives, and families to listen and involve them in service investigations, reviews, and jointly develop a 'personal care' service to meet the needs pertinent to the services demographics & population. (Regulation 17: Good governance)	✓ Ensure the service has bi-monthly meetings scheduled with the local MVP chair to review action plans and feedback from women and birthing people. ✓ Ensure the service and local MVP chairs have an agreed improvement plan, with focus on feedback from the CQC maternity patient experience survey, published yearly. ✓ Evidence service user input in the development of services and evidence of receiving feedback from service users (outside of MVP networks if necessary). ✓ Consultant midwife and multi-disciplinary team to provide birth reflections service to all service users with amalgamated report and action plan discussed at maternity safety champions meeting. ✓ Women's feedback to be shared with MNVP, Safety Champions and the maternity board and Trust Board, via the perinatal surveillance model and new quarterly maternity experience report. ✓ Resolve fundings issue of MNVP with the Integrated Care Board. ✓ Recruitment of new MNVP as per new job description. ✓ Develop action plan in response to the CQC women's experience survey 2023 completed (2024 in development).
The service must ensure Duty of Candour is carried out appropriately. (Regulation 20: Duty of candour)	**All actions for this CQC finding have been delivered and are subject to ongoing monitoring, with evidence being compiled.** ✓ Ensure Duty of Candour is completed for 95% of cases.
The service must ensure that they have effective systems and processes as to not delay the safe care of women, birthing persons attending the service for induction of labour (IOL) or artificial rupture of membranes (ARM). In the event of the induction of labour (IOL) and the artificial rupture of membranes (ARM) care been delayed the service must risk assess and ensure individualised person-centred care plans are in place to mitigate risks delays may pose to these persons. (Regulation 12: Safe care and treatment)	These actions are closed with ongoing monitoring: ✓ Update the service induction of labour guideline, providing clear pathway for risk assessing and escalating any delays in treatment/care. ✓ Implement the pan-London escalation framework to ensure the process for escalations is in line with regional and local guidance to support the timely induction of labour. These actions are currently in progress with monitoring at a divisional and health unit level: ▪ Undertake audit of compliance against the induction of labour guideline ▪ Review operational working and oversight i.e., situation report and unit co-ordination. ▪ Review process for the oversight of, and risk assessments of delayed care.
The service must ensure that they have effective systems and processes as to not delay the safe care of women, birthing persons attending the service for induction of labour (IOL) or artificial rupture of membranes (ARM). In the event of the induction of labour (IOL) and the artificial rupture of membranes (ARM) care been delayed the service must risk assess and ensure	**All actions for this CQC finding have been delivered and are subject to ongoing monitoring, with evidence being compiled.** ✓ The service to review each clinical setting to ensure sufficient Dawes-Redman machines are available.

CQC finding:	
individualised person-centred care plans are in place to mitigate risks delays may pose to these persons. (Regulation 12: Safe care and treatment)	
The service must offer translation services for all women, birthing persons where English is not their first language for all risk assessments, advice, plans of care and when seeking consent. (Regulation 12: Safe care and treatment)	These actions are closed with ongoing monitoring: ✓ Undertake audit of maternity clients to confirm breakdown of various languages spoken to ensure appropriate translation services are in place based on data. ✓ The trust to procure an approved interpretation service. ✓ The service to provide information for women in the top 3 languages to reduce inequalities: induction of labour o pain relief options ✓ Development of improvement plan for translation. ✓ Working with system partners to improve translation services/offer across the Local Maternity & Neonatal System and wider. ✓ The trust to procure approved interpretation services: o DLA languages o Card Medic ✓ The service will Datix any issues regarding translation services within the maternity services, and/or use of the interpretating service, results and escalations to be shared at the maternity board and safety champions meeting. ✓ Signposting of women to antenatal and newborn screening platform from UK Gov in multiple languages, (digital screening information) at booking, for digitally excluded copies are printed, and on the trust website. ✓ Signposting of women to NHS England screening for you and baby. Multiple languages printed out for digitally excluded women, and on the Trust website. These actions are currently in progress with monitoring at a divisional and health unit level: ▪ The service will audit the maternity use of the interpretating service and provide results and escalations at the antenatal, intrapartum and postnatal forums.
The trust should ensure staff are encouraged and supported to report staffing problems and act upon them appropriately.	These actions are closed with ongoing monitoring: ✓ The Freedom to Speak Up guardian to do monthly walk abouts and team engagement. These actions are currently in progress with monitoring at a divisional and health unit level: ▪ Speak up posters to be refreshed. ▪ Implementation of a daily situation report with RFL across the sites.
The trust should ensure leaders are visible, approachable, acknowledge and manage the issues throughout the service.	These actions are closed with ongoing monitoring: ✓ New interim director of midwifery appointed. ✓ New interim associate director of midwifery.

CQC finding:	
	✓ Post merger with RFL Group director of midwifery. ✓ Midwifery professional leads meeting implemented for senior midwifery leaders. These actions are currently in progress with monitoring at a divisional and health unit level: ▪ All risks to be identified and managed proactively via maternity/divisional risk register. ▪ Revise midwifery exception/quarterly reports: for content, style, SMART action planning. ▪ Regular walkarounds for senior operational quadrumvirate. ▪ Regular walkarounds for the director of midwifery. ▪ Develop key messages for staff on the improvement journey to be communicated. ▪ Identification of training/development needs in staff in leadership positions, via self-assessment/ development packages ▪ Appointment of new obstetric clinical director and deputy clinical director. ▪ Improve collaborative working in multi-disciplinary teams, with working groups (anaesthetics) o Maternal transfer to Intensive Therapy Unit thematic reviews. ▪ Improve collaborative working in wider multi-disciplinary teams with working groups (neonates) on projects. o Neonatal ATain/Neonatal Transitional Care framework. ▪ NHS Resolution thematic review.
The service should use translation services, systems, and processes to gain service user feedback.	These actions are closed with ongoing monitoring: ✓ MNVP 'Walk the Patch' reports to the maternity board for oversight. These actions are currently in progress with monitoring at a divisional and health unit level: ▪ Work with MNVP to use translators to seek women's feedback on services in real time i.e. 'walk the patch' reviews. ▪ Work with MNVP and patient experience team to run local. survey into women's experiences at North Middlesex in top 3 languages. ▪ Schedule of MNVP lead 'Walk the Patch' events scheduled.
The service should accurately communicate reported findings shared by agencies in reports, recommendations, and actions.	These actions are currently in progress with monitoring at a divisional and health unit level: ▪ Development of NHS Resolution thematic review action plan. ▪ Benchmark Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) 2024. ▪ Design and implement a sign off process for Rapid reviews, HSIB actions etc. ▪ Share maternity claims score card with the team.
The trust should ensure a just and safe culture to support staff in their work and strive for improvement in the quality and safety of care.	These actions are currently in progress with monitoring at a divisional and health unit level: ▪ FTSU guardian to do monthly walk abouts and team engagement.

CQC finding:	
	▪ Ensure all required staff in quality and safety team have read NHS England's 'just culture' from 2025. ▪ Ensure 'just culture' is embedded into PSRIF.
The service should ensure that all members of the multi-disciplinary team (MDT) attend delivery suite ward rounds and safety huddles. The service should ensure there is a records system that is clear, complete, and up to date to enable staff to provide safe and effective care.	These actions are currently in progress with monitoring at a divisional and health unit level: ▪ Implement twice daily safety huddles to discuss acuity, staffing and escalation. ▪ Huddles and Handovers to be in alignment with NHS Improvement 'Huddles and Handover' Document (2017) and Ockenden. ▪ Undertake compliance audit on huddle (sheets). ▪ Observe 'Huddles and Handovers' and undertake a snapshot audit. ▪ Development of a standard operating procedure for the roles and responsibilities for obstetrician and gynaecology consultants providing acute care (RCOG) including ward rounds and huddles. ▪ Audit doctor's ward rounds.

Health Unit:	North Middlesex University Hospital
Date of inspection:	27 September, 5 – 6 December 2023
Inspection type	Unannounced
Report published:	28 March 2024
Core-service	Medical Care

CQC finding:	
The service must ensure medicines are available and administered as prescribed. (Regulation 12: Safe care and treatment)	These actions are closed with ongoing monitoring: ✓ Improved medicine management processes for safe stock management and controlled drugs, compliance oversight managed via the Tendable audit. ✓ Monitor the electronic prescribing and medicines administration (EPMA) missed dose reports: o Regularly review EPMA missed dose reports and daily medication stock levels to identify and address supply issues and reduce omitted doses. ✓ Ensure the nursing team are fully aware of out-of-hours medication sourcing. ✓ Reduce the missed medication incidents wherever possible ✓ Consideration review of EPMA functionality in relation to the 'Administered by previous shift' function. This action is currently in progress with monitoring at a divisional and health unit level: ▪ Medicine management training compliance to be at trust target of 85%.
The service must ensure vacant shifts are filled with appropriate staff so they can deliver the appropriate care for patients in line with their	These actions are closed with ongoing monitoring: ✓ E-roster publication to be 100% compliance in accordance with the agreed timetable.

CQC finding:	
care plans and risk assessments and keep them safe. (Regulation 18: Staffing)	✓ Twice daily safer staffing meeting held trust wide and led by a nominated Matron. ✓ Safer staffing assurance across the hospital. Daily production of a safer staffing plan shared across the trust. ○ Accessed by on-call managers and out-of-hours clinical site team for decision-making support on quality and safety. ✓ Maintain nursing vacancies at or below the trust target of 12%. These actions are currently in progress with monitoring at a divisional and health unit level: ▪ Establish grip and control in relation to bank and agency cascade. ▪ Support and monitor enhanced staffing and escalation areas, including emergency department as per the direct transfer admission standard operating procedure.
The service must ensure that staff have completed training on meeting the needs of patients with dementia. (Regulation 18: Staffing)	**All actions for this CQC finding have been delivered and are subject to ongoing monitoring, with evidence being compiled.** ✓ Facilitate IKON training: managing challenging behaviour/conflict resolution, rolling out summer 2024. ✓ Learning from RFH re: managing challenging behaviour/simulation training, to discuss with the dementia lead to define the delivery of training and support. ✓ To complete the dementia environmental assessment for the care of the elderly wards and emergency department from a dementia patient perspective.
The service must ensure all staff has up to date training in life support. (Regulation 18: Staffing)	These actions are currently in progress with monitoring at a divisional and health unit level: ▪ All the medicine and urgent care divisional areas to be compliant with basic life support (BLS), intermediate life support (ILS) and paediatric intermediate life support (PILS), supported by the divisional PDN and assistant deputy director of nursing (ADDoN).
The service must contribute to strengthening governance processes by supporting the timely completion of safety incident reviews, mortality reviews and complaints. The service must also ensure assurance checks are completed robustly and where needed improvements take place. (Regulation 17: Good governance)	These actions are closed with ongoing monitoring: ✓ Rapid-reviews prioritised and medicine and urgent care division is working to strict timelines for the completion of all new serious incidents (SI), compliance is monitored weekly through a quality review panel. ✓ All delayed SIs under continuous review with scrutiny at Quality Governance Committee and SDR to ensure closure. ✓ The Trust has developed its Patient Safety Incident Response Framework transition and adoption policies, moving to PSIRF in May 2024 for go-live. ✓ Mandatory training on PSIRF for all key managers has been completed, with continued training and development being undertaken in partnership with RFL colleagues. ✓ Medicine and Urgent Care Division to undertake a review of quality governance capacity and resource requirements to ensure it is aligned with demand. Presented and agreed options appraisal to increase the divisional resource to tackle the backlog and longer-term investment to maintain standard.

CQC finding:	
	✓ Implement a 'What's up gov' weekly bulletin to raise awareness and monitor progress of incident management. ✓ Learning cascaded through the monthly divisional governance meeting ✓ Mortality reviews are carried out and tracked each month through the mortality review committee, with a robust governance structure to review and close all incidents in month to avoid any backlog. ✓ Feedback and Continuous Improvement - The PE team will share an updated tracker with the assistant deputy director of nursing and divisional director of nursing, 48 hours before their weekly tracker meeting, to identify any delays and prevent responses from breaching deadlines. Attendance at these meetings should include assistant deputy director of nursing and divisional director of nursing or assigned senior leads. Performance meetings will analyse complaints handling performance, with the goal of closing 95% of complaints within the designated timescales and documenting improvements from review meetings by December 2024. This action is currently in progress with monitoring at a divisional and health unit level: ▪ Collaborative working between GM and divisional director of nursing with allocated ringfenced time to progress Duty of Candour and SI actions.
The service must ensure staff always plan discharges in advance to allow patients to make the necessary preparations, to ensure all appropriate arrangements are ready when required, and to manage bed capacity effectively. (Regulation 9: Person-centred care)	These actions are closed with ongoing monitoring: ✓ Establish and maintain a twice daily delays meeting led by the discharge team and Deputy Chief Operating Officer, supported by the local nurse in charge/ ward manager reviewing all inpatients line by line from a discharge perspective. ✓ Relaunch the weekly 'long length of stay' (LLOS) rounds with a focus on reviewing the 'super stranded patients, this is led and supported by the associate director of therapies. ✓ Optimise 'patient exchange' to accommodate 10 patients moved by 10am, a further 10 patients by 2pm and finally 10 more patients by 4pm ✓ Establish a daily huddle to provide key updates, capture a daily safety overview for the division including discharge forecasts, enhanced care, staffing, incidents and escalations. These actions are currently in progress with monitoring at a divisional and health unit level: ▪ Inpatient teams to fully adopt the 'patient flow system' to capture an estimated discharge date, discharge progress and evidence of 'Criteria to Reside'. As they familiarise themselves with the system, progress is monitored via the 'Flow Program Dashboard'. As the standard ways of working (SWW) become embedded, the delays meeting will eventually cease. ▪ Relaunch and embed 'standardised ward working' practices across all inpatient areas.
The trust should ensure that all medicines are stored at the recommended temperature and	This action is currently in progress with monitoring at a divisional and health unit level:

CQC finding:	
managed in line with the provider's policy	▪ Capturing medicine management monthly audit and monitoring of results, using Tendable.
The service should improve communication with staff regarding staffing decisions.	This action is currently in progress with monitoring at a divisional and health unit level: ▪ Twice daily staffing meeting, led by staffing matron of the day. Discussed at the multiple site meetings.
The service should enhance medication management and reporting processes to prevent medication errors.	This action is currently in progress with monitoring at a divisional and health unit level: ▪ Average of 20 medication errors per month, consistent reporting captured on Datix.
The service should strengthen safety monitoring procedures, especially for high-risk patients. They should ensure routine observations are always taken on time, patients who required repositioning to manage pressure ulcers should be repositioned as advised by their care plan.	This action is currently in progress with monitoring at a divisional and health unit level: ▪ E-Vitals system is embedded with an overview report and visibility of the senior team to monitor compliance.
The service should ensure staff have completed training in the Mental Capacity Act, and Deprivation of Liberty Safeguards.	This action is currently in progress with monitoring at a divisional and health unit level: ▪ Current compliance is 83.87% for the Medicine and urgent care division, just below the trust target.
The service should ensure all staff are appraised by managers to ensure they are competent and to identify their development needs.	This action is currently in progress with monitoring at a divisional and health unit level: ▪ 76.67% as of the 06 December 2024. Working with the local leaders to make improvements. Divisional personal assistant is providing summary of progress to the division.
The service should routinely monitor if staff takes prompt actions in response to sepsis.	This action is currently in progress with monitoring at a divisional and health unit level: ▪ Sepsis audit and neutropenic sepsis audit carried out in the November 2024.
The service should ensure staff undertakes a follow up assessment for patients who are at risk of malnutrition or obesity.	This action is currently in progress with monitoring at a divisional and health unit level: ▪ As part of the ward accreditation process, the next round is about to start.
The service should avoid patients' transfers at night.	These actions are currently in progress with monitoring at a divisional and health unit level: ▪ TBC

Health Unit:	North Middlesex University Hospital
Date of inspection:	27 September, 5 – 6 December 2023
Inspection type:	Unannounced
Report published:	28 March 2024
Core-service:	Well-led

CQC finding:	
The Trust must ensure that services where there is a poor culture are identified and offered appropriate support to bring sustained improvement (Regulation 17: Good governance)	**All actions for this CQC finding have been delivered and are subject to ongoing monitoring, with evidence being compiled.** ✓ Data triangulation to identify hot spots of poor culture. ✓ In May 2024, a senior organisational development lead appointed - one of their priorities will be to identify areas where there is a poor culture and support teams to bring and sustain improvement. ✓ Quarterly engagement score and appraisal compliance are highly correlated, this will be used as a measure for cultural improvement within the Trust. ✓ Organisational development and learning (ODL) consulting for bespoke interventions.
The Trust must ensure that staff in leadership roles have access to leadership development in a timely manner, particularly to ensure their people management skills are in place (Regulation 18: Staffing)	**All actions for this CQC finding have been delivered and are subject to ongoing monitoring, with evidence being compiled.** ✓ Enable managers and leaders at all levels to access development through assigning them onto appropriate executive sponsored courses throughout the year, including: o outstanding leadership programme o new manager induction o team leader ✓ Emerging leaders' programme.
The Trust must ensure that HR processes particularly in relation to performance are completed in a timely manner (Regulation 17: Good governance)	**All actions for this CQC finding have been delivered and are subject to ongoing monitoring, with evidence being compiled.** ✓ Weekly reporting to the executive team meeting (ETM) with an update on progress with employee relations cases with tracking information. ✓ Report trends and themes from employee relations case work to the people & culture committee and joint staff committee. ✓ Corporate Patient First priority for 24-25 employee relations casework by the employee relations team regarding improving timelines and processes. Scorecard and counter measurement updates will be reported quarterly at strategic deployment review (SDR). ✓ Managers' induction training, initiated in December 2023 and conducted quarterly, provides new managers with training on key human resource policies. Additionally, bespoke human resource training for divisions and services is available on an ad hoc basis, tailored as needed. Regular, bite-sized (2.5-hour) sessions on key human resource policies, such as probation, sickness, performance management, grievance, and disciplinary procedures, are provided at least monthly by employee relations and business partners and are bookable via the intranet. Tailored as appropriate, regular, mini monthly, bite sized (2.5 hours) sessions on key human resource policies: probation, sickness, performance management, grievance, disciplinary etc., Provided by employee relations and business partners, trust-wide. Bookable via the intranet – minimum monthly.
The Trust must keep under review the executive leadership capacity to	**All actions for this CQC finding have been delivered and are subject to ongoing monitoring, with evidence being compiled.**

CQC finding:	
ensure the delivery of existing priorities and manage the merger with the Royal Free London group. (Regulation 18: Staffing)	✓ The trust executive has created capacity within the executive team for a single executive senior responsible owner to focus solely on the merger. ✓ Each executive has undertaken a review of capacity to support merger related activities in conjunction with delivering existing priorities and identified support needs where necessary. ✓ Capacity continuously monitored through merger programme board and Trust Boards of the Royal Free London NHS Foundation Trust and the North Middlesex University Hospital NHS Trust. ✓ Both RFL and NMUH have undertaken a joint review of what additional expertise and support is required to deliver the integration plans for merger over the next 6-months.
The trust must ensure that learning and improvements take place in a timely manner by ensuring the investigations into complaints, incidents and mortality are concluded within stated timescales. (Regulation 17: Good governance)	These actions are closed with ongoing monitoring: ✓ Implement a structured investigation process: Existing process in place to ensure all complaints have an investigator assigned within 24 working hours of receipt, patient experience (PE) team to acknowledge receipt of concerns within 72 working hours. Implement a standardised complaints investigation process by ensuring 100% of complaints have an assigned investigator and timeline within 24 hours of receipt. (monitoring to be undertaken at divisional level). ✓ Training - drafting of complaints: As of November 2023, the trust has launched a training module on Phoenix focused on drafting complaint responses. This training, which has a duration of 90 minutes, is available both online and as a face-to-face session. Our goal is to have 90% of relevant staff trained by November 2024. Each division is responsible for assigning staff members for training, including service managers, general managers, matrons, consultants, and assistant directors of nursing. ✓ Divisions to standardise and include divisional learning forums (huddles, divisional quality meetings) to examine actions, learning, themes and trends from complaints and serious investigations (SIs). Starting with surgical, anaesthetics, critical care and associated services (SACCAS) in October 2024. ✓ First session was held in September 2024, we will hold a quarterly quality learning event (3 hours) focusing on insights from complaints, mortality, and serious incidents. Each division is tasked with agreeing a format for monthly shared learning sessions. ○ **Learning and action oversight:** The patient experience team will generate a divisional report detailing all current and overdue actions. The first report was completed in July 2024 and monthly thereafter. ○ **Action monitoring and service improvement:** monthly data on all open actions will be shared with divisions and reviewed at the monthly divisional governance meeting. Our objective is to ensure that 80% of the identified specific actions are completed and service improvements implemented. ○ **Monitor and review timeliness:** implement a tracking system to monitor the progress and completion of complaint investigations within the established timelines. Monthly reports will demonstrate 95% compliance with these timelines. ○ **Feedback and continuous improvement:** the patient experience team will share an updated tracker with the assistant deputy director of nursing and divisional director of nursing 48 hours before their weekly tracker meeting, to identify any delays and prevent responses from breaching deadlines. Attendance at these meetings should include

CQC finding:	
	assistant deputy director of nursing and divisional director of nursing or assigned senior leads. Performance meetings will analyse complaints handling performance, with the goal of closing 95% of complaints within the designated timescales and documenting improvements from review meetings. ○ **Regular reporting and accountability:** provide regular updates on complaints handling performance to the Trust Board, Executive Team Meeting, Patient Experience Committee, and Quality Governance Committee. Quality reports to the Trust Board should demonstrate improvements in the timeliness of complaints investigations, with a target of concluding 95% of complaints within the stated timescales. process now in place, improved position continues to monitor. ✓ In August 2023, over 1,000 mortality cases awaiting a structured judgement review (SJR). Although a standard operating procedure was written, this was done when the service was first set up and was not in line with national guidance or with peers. A detailed exception report was presented to the quality governance committee and the Quality Committee, and it was agreed that potential learning from non-reviewed category 'B' deaths was minimal, and these could be closed. The trust will continue to conduct SJRs on category 'B' deaths where there is an associated concern. Terms of reference for the mortality review group to be updated to reflect that cases will be discussed at each meeting rather than in batches. All outstanding category 'A' SJRs are closed. ✓ Implement a mechanism to monitor all new low and no-harm incidents to support reviewed and closed by divisions within 7-working days. ✓ Datix training to be made available for new starters using Datix ✓ Divisions and quality governance team, to co-produce a standard operating procedure regarding the implementation of a new monthly action review group which will monitor actions, recommendations, and progress following incidents. Standard operating procedure approved. ✓ Process of learning from incidents is shared trust-wide through the intranet. ✓ A quarterly newsletter will be produced by the governance team to aid cross-divisional learning. The first newsletter was published in November 2024. ✓ A quarterly trust-wide 'learning event', co-produced by divisional and governance teams, was introduced to share learning, with the first event scheduled for September 2024. Additionally, quarterly quality governance team drop-in sessions will be held in the Atrium, with the first session having taken place on 14th June 2024. ✓ PSIRF framework approved training to be provided by March 2024 to ensure the trust has sufficient members of staff and non-executive director – lead for quality trained in Lots A-C to enable formal transition to PSIRF away from SIF 2015 in Q1 2024-25. ✓ Incident management update/refresher training has been provided to all relevant staff. These actions are currently in progress with monitoring at a divisional and health unit level: ▪ All overdue incidents reported up to 31st of July 2024 will be reviewed by divisions and closed.
The trust should continue its work to ensure staff are trained in quality improvement approaches so they	**All actions for this CQC finding have been delivered and are subject to ongoing monitoring, with evidence being compiled**

CQC finding:	
can embed the Patient First strategy in their services	✓ Align training and development priorities in line with trust and divisional strategic priorities.
The trust should continue its work to develop the enabling strategies-clinical and estates to promote improved outcomes for patients.	This action is currently in progress with monitoring at a divisional and health unit level: ▪ Actions agreed by divisional leadership teams as part of annual strategy planning process and reviewed & revised as part of month divisional strategy deployment review meetings.

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 2024 and March 2025, 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 QI method we use at RFL (Barnet, Chase Farm & Group Clinical Services and Royal Free;
- 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.

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 2024/2025, the QI team have welcomed 3 cohorts 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 continued strong demand from staff, we now offer it as a standalone course.

Image of newly qualified QI Practitioners from Cohort 7 which had colleagues from all Health Units across the Trust. Below is some feedback from the participants.

"Methods and tools to empower me and push through for a better Trust and service."

"I found the training varied, insightful and informative. I thought each colleague presenting was very knowledgeable and helpful in explaining concepts."

"It was great to hear about patient experiences and to use case studies to help put theories into practise"

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.

Support improvement activities

Spotlight on 'Quality Time'

One of the ways that the QI team supports improvements across the organisation is through the help and advice directly to staff who are undertaking improvement projects. We do this through what we call "Quality Time" sessions – and which were originally called "Quality Clinics", because the approach was modelled on how clinicians use clinic slots: for the avoidance of any confusion, we soon move to the more appropriate name of "Quality Time".

Any member of staff at RFL can contact an Improvement Advisor in the QI team – to book a Quality Time session. The team member that they contact will depend on the Health Unit (Barnet, Chase Farm & Group Clinical Services or Royal Free) at which the staff-member is based. Sessions can last 30 to 60 minutes and are used to understand the queries and challenges colleagues have brought for discussion – and then guide them, accordingly.

In 2024, almost 800 Quality Time sessions were delivered across the group – so, on average, that's more than 3 per day. We are proud of the fact that we were always able to provide advice to staff when they asked for it. And, as with our clinical colleagues, there have been plenty of follow-up appointments too!

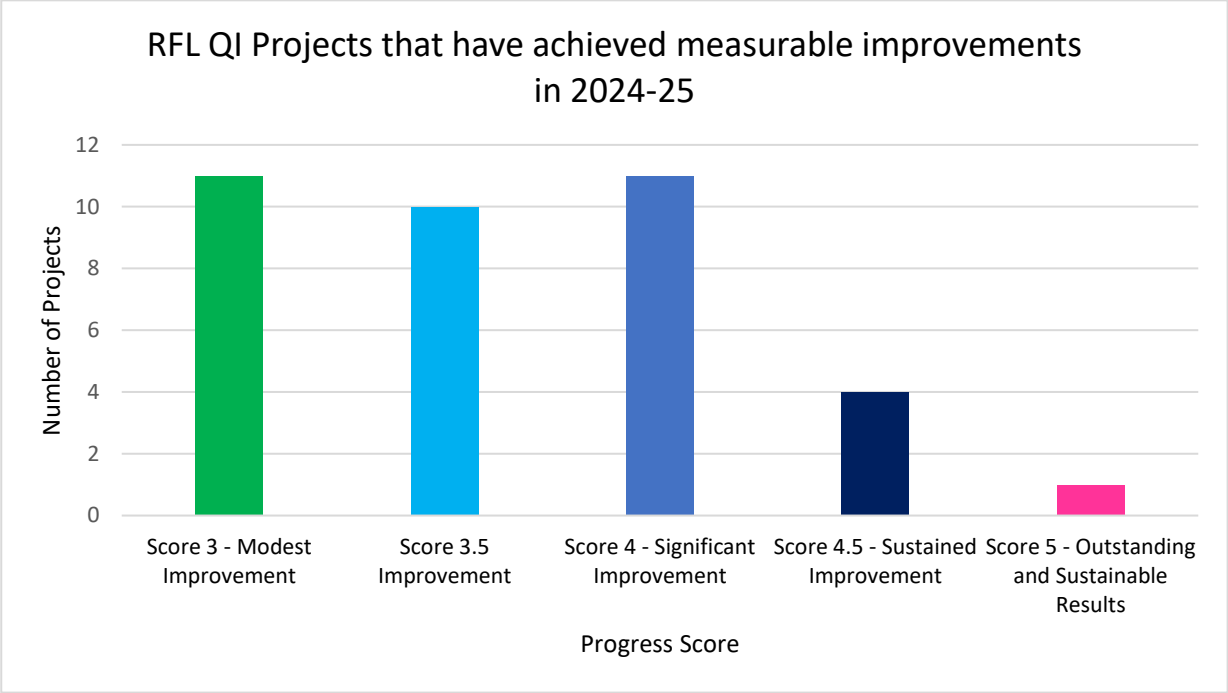
Much of the really good improvement work across the organisation has been cultivated through the help and advice delivered through Quality Time sessions. One striking example from 2024 involved a Medical Registrar who, after one session, led a project to reduce the use of one unnecessary pathology test by 95%. The impact of that was that patients avoided phlebotomy – which can be

painful and distressing – and the costs of processing those tests was also reduced, saving thousands of pounds.

Projects that have achieved improvements

The QI team are an essential source of coaching and advice for colleagues who are undertaking improvement activities in the organisation. A large part of the support is delivered through the Quality Time sessions as described above. The data below shows details for number of projects that have reached a progress score of 3 or higher in the last 12 months across the Trust (Barnet, Chase Farm & Group Clinical Services and Royal Free).

Chart 3.3.1: QI projects that have achieved measurable improvments



Projects achieving scores of 3 and above are delivering measurable improvements – which is one of our key indicators for success.

Improvement work across our sites

Barnet Health Unit: Diagnosis, Management and Prevention of Delirium in the ICU

Delirium in critically unwell patients is a common problem and is associated with worst outcomes. Accurate assessment using a clinically valid and reliable tool such as the Confusion Assessment Method for ICU (CAM ICU) is essential for the development of an appropriate treatment plan for our patients.

A clinical audit carried out by the project lead, Aibhilin O'Connor, Advanced Critical Care Practitioner, has identified the team's "pebble in the shoe" and saw this as an opportunity to carry out improvement. There was an opportunity to improve both the completeness and appropriateness of assessment.
The project aimed to improve the quality of CAM ICUs by reducing the percentage of incomplete assessments from 18.33% to 5% and by reducing the percentage of inappropriate assessments from 25.8% to 5%.

Four change ideas were tested which included:

- delirium presentation to the team,
- running simulation sessions,
- creating an interactive training session, and
- creating a video that demonstrated how to perform and document CAM ICU

As a result of these changes, these changes, the project made measurable improvements.

Chart 3.3.2: The percentage of incomplete assessments was reduced from 18.33% to 11.89%

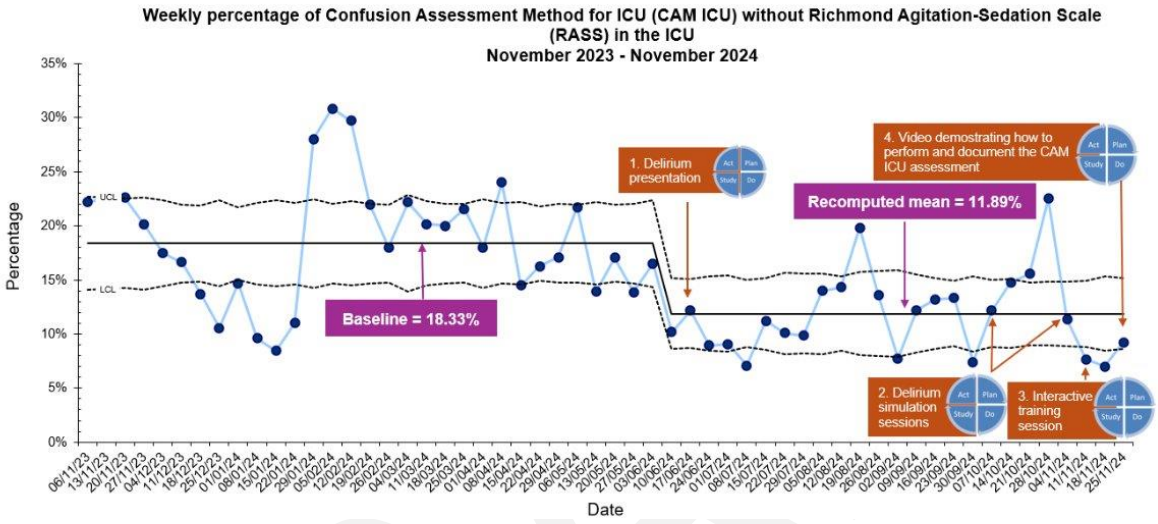
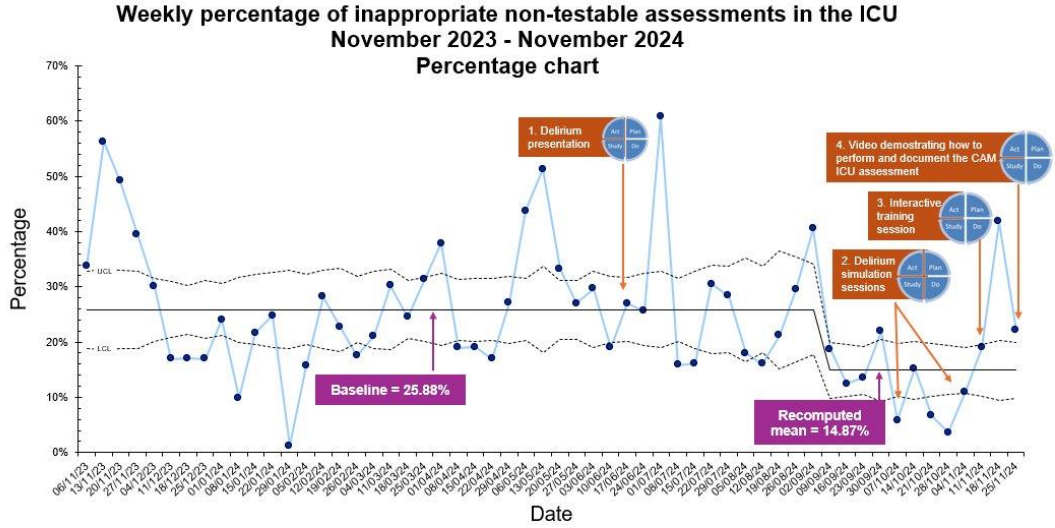


Chart 3.3.3: The percentage of inappropriate assessments was reduced from 25.8% to 14.87%



Whilst the team has yet to fully meet their aims, they are keen to continue with the project and monitor data over time. The project lead shared her learning and reflections in one of our QI Lunch clubs. She highlighted the value of including other staff members, the importance of planning and using the resources available to her.

Chase Farm Hospital & Group Clinical Services

Ophthalmology service at Finchley Community Diagnostic Centre (CDC)

The Ophthalmology team at Finchley CDC noticed a high number of service users not attending their appointments. Each DNA (Did Not Attend) costs £138, meaning there was scope to make financial savings.

A Quality Improvement project was started with an aim to reduce the DNA rate in ophthalmology diagnostic services from 17.4% to 10%.

The team had a change idea of carrying out calls to remind patients about their appointment. Using the Model for Improvement (MfI), the team were able to take their test idea through multiple PDSA cycles between June 2023 - December 2024. This involved calling patients 2 days before an appointment, calling on weekends and after 5pm, which helped capture the working population.

The result showed sustained improvement and has now been fully implemented. The current median DNA rate is 6.96 % and this work has also been scaled up to cardiology diagnostic services.

Improving pathology reporting

The Pathology service noticed too many cases at the Gynaecology multidisciplinary team (MDT) meetings were being rolled over to future meetings, leading to delays in the patient pathway and increased pressure on the consultant and MDT Admin teams.

A Quality Improvement project was started with an aim to reduce the number of cases being rolled over at the Gynaecology multidisciplinary team meetings from a baseline of 13.68% per week to 5% or less per week by February 2025.

Using the Model for Improvement, this team was able to test multiple change ideas, which included:

- Implementation of the Royal college of Pathologists Allocation System
- Gynaecology consensus meetings for peer review of cases
- Monitoring PTL's to prioritise cases.
- New rota system
- Education with MDT team on listings process and what is clinically appropriate.

The team have seen improvement in their data since June 2024. They are continuing to test change and sustain their improvement. The team is also scaling up to improve areas such as skin, gastroenterology, hepato-pancreato-biliary and urology.

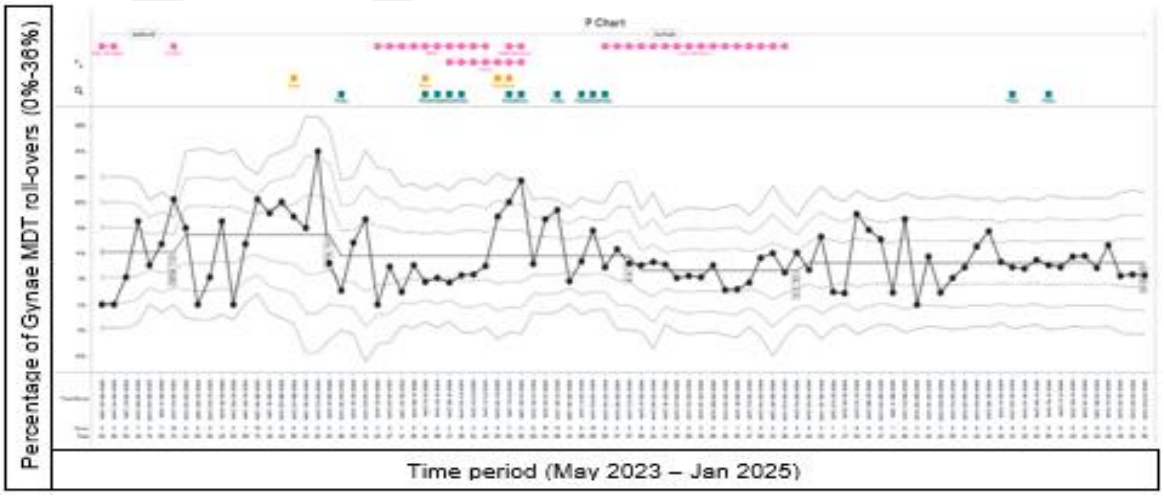


Chart 3.3.4: percentage of gynaecology MDT roll-overs between May 2023-Jan 2025

Royal Free Hospital

Medication Scanning – Sustaining and spreading improvements across Royal Free Health Unit

Scanning medication barcodes and patient wristbands at the point of administration is essential for ensuring patient safety. At the Royal Free Health Unit (RFHU), there has been a site-wide focus on improving compliance, with several wards undertaking local Quality Improvement (QI) projects. In March 2024, the average scanning compliance at RFH was 53% for medication barcodes and 73% for patient wristbands.

11E has been leading the way in using a QI approach to improve scanning compliance. From April to December 2023, 11E achieved their initial aim of increasing scanning compliance from 37% to 65% for medication barcodes and 49% to 84% for patient wristband scanning.

After sustaining these improvements for 10 months, in October 2024, 11E set out a new aim to increase their scanning compliance further to 75% (medication barcode) and 95% (patient wristband). Their improvements to date can be seen below.

Chart 3.3.5: 11E weekly medication barcode scanning QI project progress and improvement.

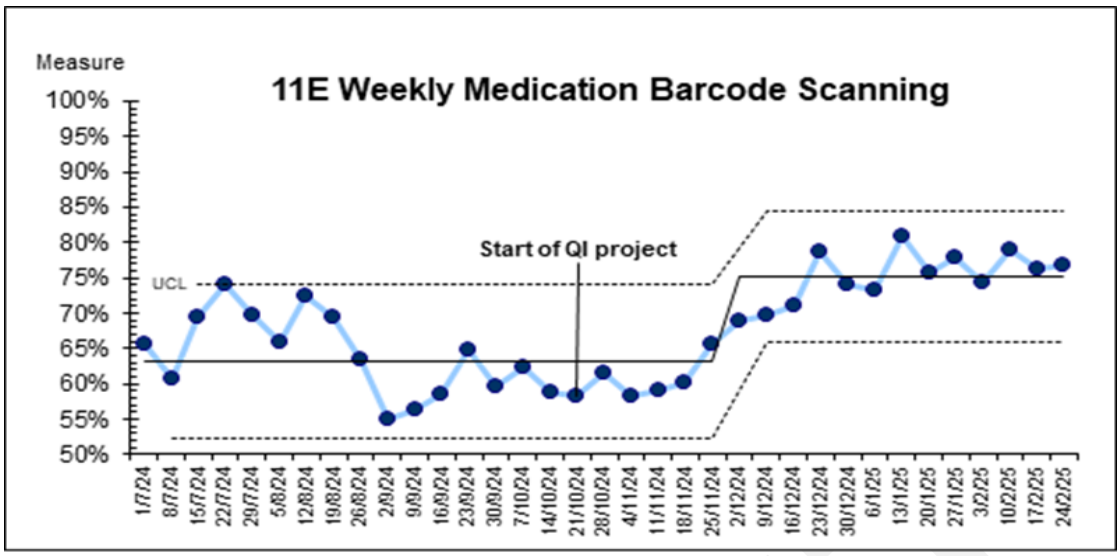
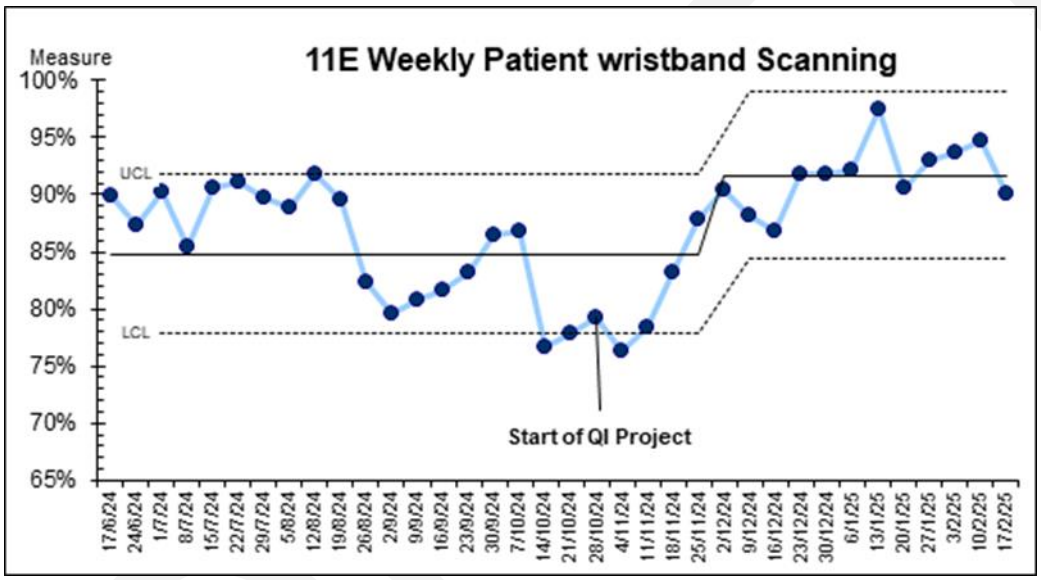


Chart 3.3.6: 11E weekly patient wristband scanning QI project progress and improvement.



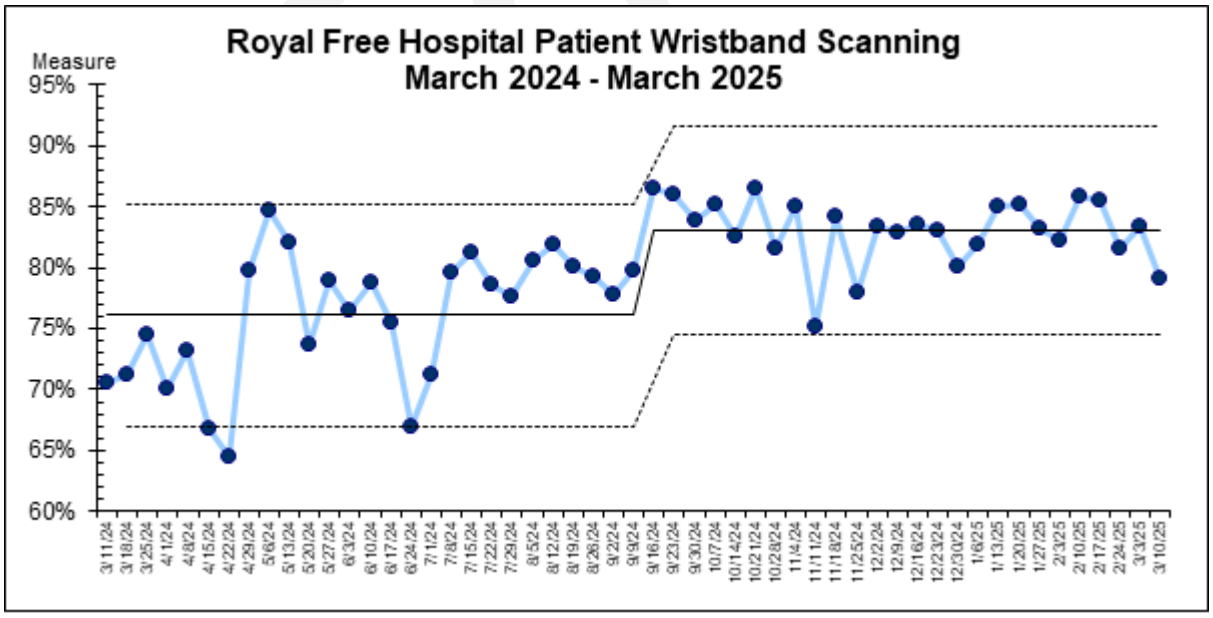
Wards 6S, 9W, 10E and 10W have also started scanning QI projects and registered them on Life QI. A key driver to improvements in the health unit has been collaboration and shared learning across the different wards.

Insights have been exchanged through presentations at senior nurse meetings, discussions between QI project teams, and clinical practice events.

Image: Ward Manager on 11E sharing learning with nursing students at Clinical Practice Event

The overall improvements in scanning compliance across the Royal Free hospital health unit can be seen below.

Chart 3.3.7: Overall improvements in wristband scanning compliance across the Royal Fee Hospital



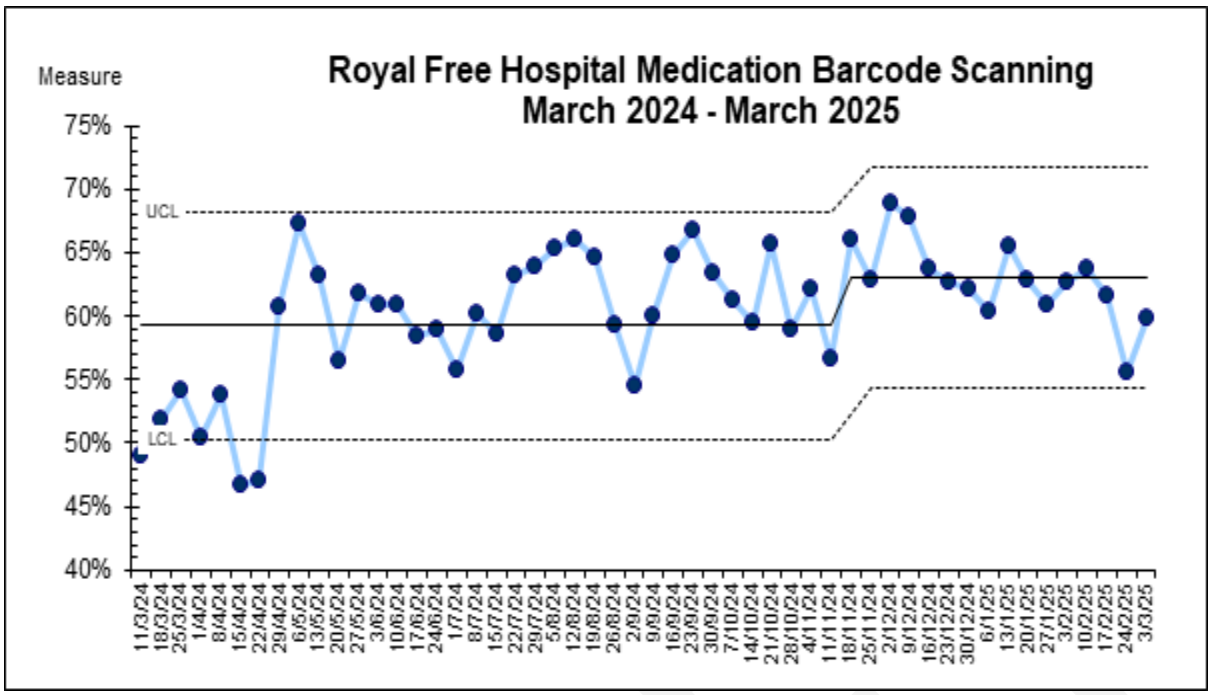


Chart 3.3.8: Overall improvements in scanning (medication barcode) compliance across the Royal Fee Hospital

Some of the change ideas tested and now implemented across multiple wards are as below:

- Monitoring and recognising individual scanning compliance through leaderboards and compliance reports
- Using QR codes to report non-scannable medications
- Agreeing process for managing WOW stocks
- Printing list of medications in WOWs on WOW doors
- Getting wireless scanners to support scanning in side-rooms

The QI approach also enabled ward teams to collaborate with the other departments supporting medication administration (e.g. the EPMA team) allowing some of the systemic barriers to scanning to be addressed.

Currently, some wards such as 11E, 9W and 6S, are focusing on sustaining their improvements, while many others continue to test and implement change ideas. Learning will continue to be shared through the relevant channels.

Reducing transport aborted journeys home from the Discharge Lounge

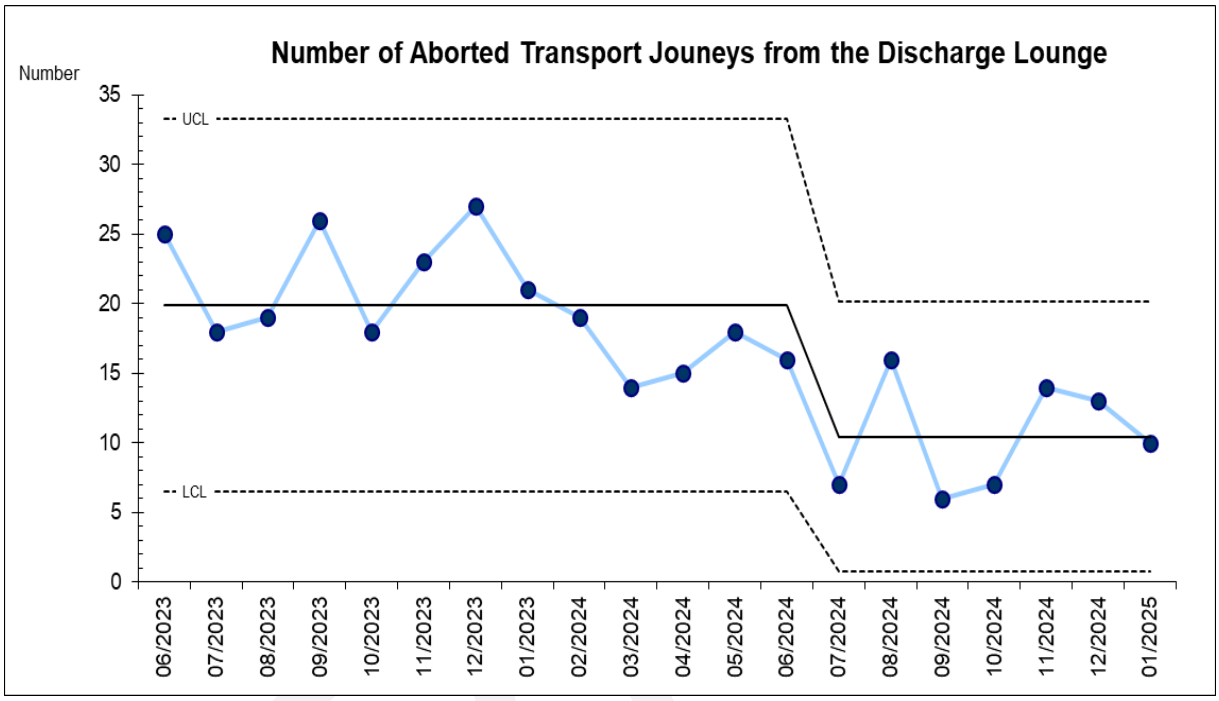
A high number of aborted transport journeys were being reported from the discharge lounge in 2023-24, leading to very poor patient experience, frustration for staff and a waste of resources and very high transport costs.

A QI project was started summer 2024 by a band 5 nurse who had undertaken the 3-day QI Practitioner Training course.

The aim was to reduce the number of aborted transport bookings from the discharge lounge at the Royal Free Hospital from average of 20 per month to 10 per month by June 2025.

It has been a multidisciplinary team approach focusing on prevention on early flagging of transport, counter checking all the information with patient and families and assessing eligibility criteria for transport.

Chart 3.3.9: Number of aborted transport journeys from the discharge lounge



The team have achieved their aim but are still working to sustain these improvements and reduce the number of errors that cause aborted transport journeys. The improvements so far have improved patient and staff experience and reduced financial waste.

Lead Improvement Activities of Strategic Importance

What Matters to Staff (WMTS) Programme

We have continued to run, grow, and develop the programme across the Royal Free Health Unit (RFHU). The programme has now been spread to the other Health Units within the Royal Free London (RFL) Group: Barnet, Chase Farm and more recently North Middlesex Health Units.

The WMTS programme follows a well-developed structured approach designed to support and empower leaders to 'Ask, Listen and Do' what matters to their staff. A facilitated team discussion is initiated during a workshop, based on anonymous survey feedback collected previously from the team.

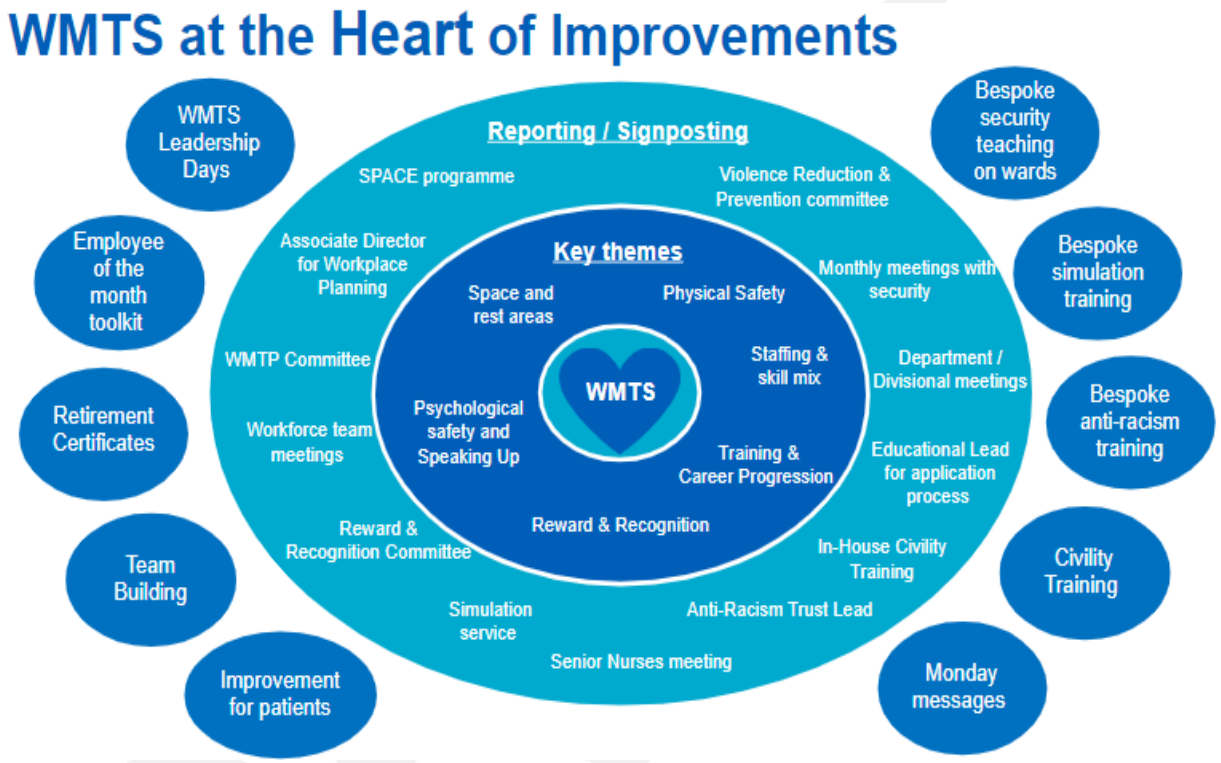
Based on discussion outcomes, themes and ideas, leaders are then supported to create an improvement plan including achievable actions, with the purpose of bringing about meaningful and relevant change to the team's experience at work.

As part of the spreading of the programme across the Trust, we have bi-weekly meetings with the other Health Units to support their implementation.

This is the structure we have set up over the last year to incorporate the other Health Units. NMUH Team to be added once all team roles established.

WMTS Updates for 2024-2025:

- The work was published Open Access in BMJ Leader in January 2025, 'What Matters To Staff' Programme: eight steps to improve staff well-being at work'.



https://bmjleader.bmj.com/content/early/2025/01/28/leader-2024-001071

- Currently in the testing phase of a Power BI Dashboard to enable safe storage and easy accessibility of the data.
- Continuing to develop close working relationships with the HR Business Partner Team.
- Supporting the spread of learning from the WMTS programme across the RFH HU to create robust networks for signposting/referring and reporting structures to ensure transparency and accountability. See graphic below.

Team Improvement Plan

Here is an example of one ward team's improvement plan (anonymised). Across the Royal Free Hospital HU there are 90 teams with Improvement Plans they are working through because of this programme.

XX Team WMTStaff Improvement Plan (created 13/11/2023 – Updated 03/03/25) 1/2

	Issues, Concerns, Themes	Key Actions	Person Responsible	Date actioned / Comments	Achieved / Rollover Actions Achieved Work Ongoing Needing escalation No longer applicable
Survey #2	Included Teamwork / teambuilding	1) As part of induction process for new Nurses/HCAs can shadow therapists where required on Orthopaedic equipment use. 2) Discussed within senior meeting – therapists provide daily list of priority patients for pain meds to support the therapist's interventions. 3) Nurses consistently responding to list of patients needing pain meds received from Therapists. 4) Joint Christmas party for whole MDT. 5) Extended Employee of the Month to therapists as well. 6) Birthday tracker in place – to be celebrated in monthly shout outs. 7) ABBEY Pain scale being integrated consistently into therapy working. 8) Update the team MDT photos and ensure that all current photos of nursing/HCAs/therapists on the ward and also in the staff room.	1) WM & Therapy Lead 2) Therapists 3) Staffing – Nurse in charge / WM etc 4) All 5) WM & Therapy Lead 6) Whole MDT 7) Therapy Lead 8) WM & Therapy Lead	1) 2023 2) 2023 3) 2025 ongoing 4) 2023 5) Nov 2023 6) 2023/2024 7) 2023 ongoing 8) 2023	1) Achieved 2) Achieved 3) Achieved 4) Achieved 5) Achieved 6) Achieved 7) Work Ongoing 8) Achieved
	Included Communication / meetings	1) Complaint / incidents shared within agenda for monthly team meeting for nursing. 2) Information from nursing team meeting to be shared with the therapy team particularly around sharing learning from complaint / incidents – information on visual management board – to be shared with therapy team (around 23rd/mth). 3) Suggestion box has been implemented on the ward – suggestions checked and shared within team meeting – open discussion around suggestions.	1) WM 2) WM & Therapy Lead 3) WM & Therapy Lead	1) 2023 2) 2023 3) Nov 2023	1) Achieved 2) Achieved 3) Achieved
	Safe Processes & protocols	1) Ensure that all MDT staff complete their MAST for manual handling – 80% compliance – Lilian is checking and reminding staff. 2) Therapists should complete the mobility chart on a daily basis – Band 4 therapy assistant to check each day that mobility chart has been updated each day – also embed in therapists at the end of interventions to check the chart 3) Ensure that all paperwork across MDT are completed.	1) WM 2) Therapy Lead 3) WM & Therapy Lead	1) 2024 ongoing 2) Dec 2024 3) 2024 ongoing	1) Achieved 2) Achieved 3) Achieved

We continue to receive positive feedback from leaders and team members regarding their experiences of being involved in the programme:

Thank you for listening"

(Team member, Ophthalmology)

This has been a useful process for me as a new manager in this team.

Thank you so much for taking the time to discuss staff feedback and improvement plans. It really helps to identify areas that need more focus. We truly appreciate your team's support.

(Ward Manager, Day Surgery)

Thank you for your support, this has been a really useful process."

(Service Manager, Lung Function)

Annex 1: North Middlesex University Hospital 2024-25 quality priorities update:

This annex details the progress made against the North Middlesex University Hospital NHS Trust 2024-25 quality priorities.

Priority 1: Patient First - Onward to 2024 and beyond	
Priority 1	The trust will continue the journey to embed and mature the Patient First strategy through training leaders and teams, experimenting with improvement tools and modelling the behaviours that develop and sustain a culture of continuous improvement.

North Middlesex University Hospital NHS Trust progress in 2024-25

*(*This section reflects the trust's Q3 position at the time of drafting. Data and information may be updated upon validation.)*

The Patient First strategy was successfully embedded across the trust, with North Middlesex Hospital continuing to drive Strategy Deployment Reviews (SDRs) at all levels.

These SDRs, which were held in March, June, July, August, October 2024, involve the executive team, as well as divisional and corporate teams. They serve as a key forum for monitoring performance metrics that define improvements within various areas—whether in routine operations or targeted enhancement initiatives—ensuring strategic alignment and accountability throughout the organisation.

Each SDR is guided by a scorecard, a visual tool that tracks performance over time. The scorecard distinguishes between driver metrics, which the Trust actively works to improve and watch metrics, which are closely monitored for emerging trends. This approach ensures that any adverse changes are quickly identified and can be addressed proactively. The Countermeasure Summary (CMS) further supports this work by detailing performance trends, stratified data, key contributing factors, and ongoing actions or experiments designed to achieve desired outcomes. Leaders use a consistent, concise script to present the CMS, encouraging clear communication and shared understanding.

Senior leaders are encouraged to collaborate with reporting teams, identify obstacles, offer support through direct "Gemba" visits, and celebrate progress and successful experimentation. This interactive and supportive leadership style reinforces a culture of continuous improvement, alignment with the trust's strategy, and high-quality patient care.

A highlight of the trust's commitment to continuous improvement and shared learning was the North Mid Improvement Expo 2024. The first event, held on 17 May, showcased a wide range of innovative projects driven by staff committed to enhancing patient care and operational efficiency. Improvement posters were submitted in five categories aligned with the Patient First strategy: Patient, Outstanding Care, People, Partnership, and Sustainability. These projects underscored the creativity and dedication of colleagues across the trust. Among the winners were:

- **Patient:** Bridging the gap between social media and the Patient Advice and Liaison Service (PALS), led by Zareen Munsoor and the PALS team, supported by the Communications team.
- **Outstanding Care:** A shared award among the coagulopathy, same day emergency care (SDEC), and sunrise neonatal teams.

- **People:** Hazel Manzano and her team won for the ‘What Matters To You?’ initiative.
- **Partnerships:** Akudo Okereafor and the ABC Parents Team were recognised for their work in co-production, community partnerships, and parent education.
- **Sustainability:** The Finance team was awarded for their project on financial services development.
- **People’s Choice:** Whitney Iheme and the PALS and Complaints Team were honoured for their staff well-being initiative.

These achievements were supported by the North Mid Charity in partnership with the Royal Free Charity, demonstrating the value of collaborative investment in innovation and staff engagement.

The second North Mid Improvement Expo 2024, held on 29 November, continued this momentum. Senior leaders, healthcare professionals, and community representatives came together for a day of insightful discussions and interactive sessions. Key topics ranged from patient experience and improvement culture to health equity and population health. Featured keynote speakers such as Miles Sibley, Stephanie Goodlet, and Dr. Chad Byworth highlighted the importance of understanding organisational culture, using everyday interactions as opportunities for positive health interventions, leveraging data to address health inequalities, and incorporating population health principles into quality improvement efforts. A community choir performance and interactive sessions further fostered a spirit of collaboration and innovation.

Priority 2: Looking forward for Patient Safety/ Clinical Effectiveness	
Priority 2	The trust will continue its implementation of the national patient safety strategy across the trust with a focus on embedding the Patient Safety Incident Response Framework and involvement of patients, families, carers and staff.

North Middlesex University Hospital NHS Trust progress in 2024-25

*(*This section reflects the trust’s Q3 position at the time of drafting. Data and information may be updated upon validation.)*

Patient Safety Learning and Continuous Improvement

During 2024, we held Patient Safety Learning Brief sessions in August and December to review our progress, share insights, and foster a culture of continuous improvement. We derive our learning from a wide range of data sources, including:

- Incident reporting
- Mortality reviews
- Complaints
- Claims
- National and local audits (NICE, GIRFT)
- Learning from excellence
- Staff raising concerns

Incident Management and Review
All incidents reported through DATIX undergo an initial review. While some require only a rapid

review, a small number warrant a more in-depth learning response. Under the Patient Safety Incident Response Framework (PSIRF), these responses may include a Patient Safety Incident Investigation (PSII), a multidisciplinary team (MDT) review, or a thematic review. Action plans arising from these processes are implemented and monitored to prevent the recurrence of similar incidents.

Mortality Reviews for Enhanced Patient Safety
Every death is initially assessed by our Medical Examiner team. If there is potential learning, we conduct a Structured Judgement Review (SJR) to understand contributing factors more thoroughly. This detailed review process applies to deaths involving:

- Patients with learning disabilities or severe mental illness
- Cases where families or staff raised concerns
- Identified patient safety issues during care
- Unexpected deaths
- Patients in our community wards
- Patients spending more than 12 hours in the emergency department (ED) during their final illness

We currently perform detailed reviews on approximately 25% of all deaths, significantly exceeding the national average of 10%. This heightened scrutiny reflects our commitment to learning, improvement, and providing the highest standards of care.

Innovations in Community Care: Virtual Ward Improvement Project
Our Virtual Ward initiative—"Great care at home for our patients"—continues to evolve. With 40 beds currently available and plans for further expansion, we are increasing patient acuity and complexity while broadening the pathways. We are strengthening governance, clinical oversight, staff training, and MDT collaboration. The project supports step-down care from inpatient wards for conditions like heart failure, intravenous antibiotic therapy, and medication titration. Soon, this model will also support post-hip surgery recovery, surgical pathways, and sickle cell care, as well as reciprocal and "horizontal" pathways from ED and Same Day Emergency Care (SDEC). We anticipate introducing "step-up" pathways in the coming year.

Looking Ahead: Strengthening Governance
As we move forward, the trust plans to introduce a recommended governance framework across our network. This will ensure that all specialties meet monthly to address structured objectives, maintain rigorous oversight, and continuously drive improvements in patient safety, quality, and care delivery.

Priority 3: Patient Experience	
Priority 3	At the North Mid, we value our relationship with our patients and the local community. Our vision is to deliver outstanding care to local people and is supported by our Patient First strategy, of which one of our three overarching objectives is to ensure we offer our patients and staff an excellent experience. The Patient Experience 5-year Strategy 2023-2028 was launched in August 2023 and reflects the recent changes within North Mid, which includes integrating community services from Enfield into our organisation over the last two years. **Priority 1: partnership (involve)** Together with our local communities we will increase the number of people who become involved in how our services are provided. This will recognise the rich culture and diversity of people using our services, as well as expanding the ways in which people can become involved. This will include reference to our Volunteer Strategy which recognises the

	importance of recruiting from the local community. We aim to ensure that the needs of our whole community are reflected, understood, and met. **Priority 2: improvement (listen)** We will support every patient, carer, and family member to give feedback about their care and experience so that we can learn from this, understand what matters most to people and use this to improve our services. Responding and acting on experiences in a timely way leads to change which improves our patient and carer experience. **Priority 3: excellent patient experience whilst in our care (respond)** What matters to our patients is a key priority - we know how important safety and clinical effectiveness is, but people want to know they will be treated with compassion, respect and be comfortable whilst in hospital. The trust has received feedback from patients that communication can be improved. As a direct result of this feedback, the patient experience team and service leads have worked with the Learning and Development Team to identify Customer care and Communication courses which we think would benefit our staff. These courses will be rolled out to all staff throughout the trust to enhance our patients experience.. **Priority 4: accessible & equitable (include)** It is imperative that fairness, diversity, and inclusion are carefully and thoughtfully considered to ensure health inequalities are minimised and that the services we provide are accessible to all. In 2023, Accessible carried out Access Audits for accessibility in our trust which is an assessment of physical and non-physical barriers to access using specific measurable criteria at a specific moment in time. As a result of this, user Access Guides have been produced which describe access throughout the hospital and a step-by-step guide which will enable patients, carers, and visitors to view the accessibility, physical / sensory and neurodiversity) of the area they are attending before they visit and ensure they have all the support they need in place.

North Mid progress in 2024-25

*(*This section reflects the trust's Q3 position at the time of drafting. Data and information may be updated upon validation.)*

North Mid business unit is committed to enhancing the patient experience through a unified approach that integrates key services under the Patient Experience (PE) umbrella. This includes complaints management to drive meaningful improvements, PALS (Patient Advice and Liaison Service) to resolve concerns efficiently, and volunteer support to enrich the care experience. These efforts align with our Patient Experience Strategy, focusing on four key priorities: Partnership (Involve), Improvement (Listen), Excellent Patient Experience Whilst in Our Care (Respond), and Accessibility and Equitability (Include).

By streamlining these services and focusing on our strategic priorities, NMUH BU fosters a cohesive framework that prioritizes patient needs and expectations. This integration ensures that we actively involve patients and carers in shaping care, listen to feedback to drive continuous improvement, respond effectively to enhance the care experience, and promote inclusive, equitable access to services for all.

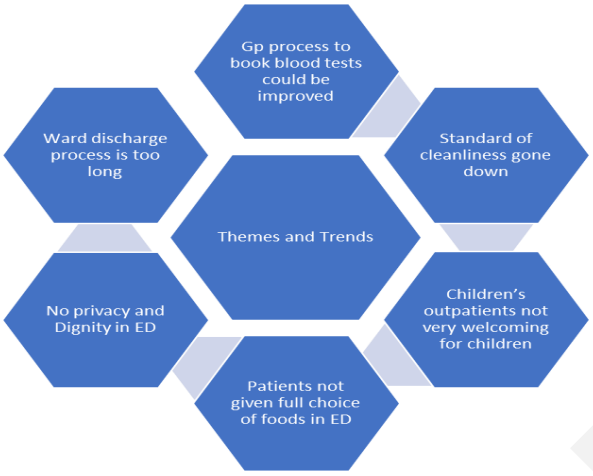
Patient Partnership Council (PPC)

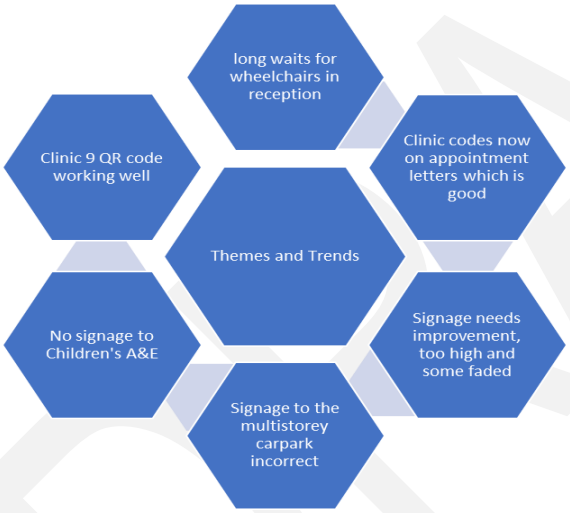
We currently have six Patient Partnership Council (PPC) members actively contributing to service improvements. PPC members engage with patients and provide feedback on both positive and negative care experiences. Their contributions cover various departments across the trust, including

Care of the Elderly wards, Accident & Emergency, Surgery & Critical Care, Maternity, Medicine and Urgent Care, Oncology and Cardiology.

Patient Partnership Council (PPC)- Quarterly Feedback meeting - Nov 2024

Feedback from PPC members:





Patient Involvement

Patient involvement is a cornerstone of our approach to delivering high-quality, patient-centred care. By actively engaging patients in the care they receive, we ensure their voices are heard and their experiences guide meaningful improvements. One of the keyways we achieve this is by inviting patients to share their stories at Trust Board meetings and improvement events.

Patient Story: Patient stories serve as a powerful tool for driving meaningful change. These firsthand accounts provide valuable insights into the patient journey, offering a clear understanding of both the strengths and areas needing improvement in our services. We incorporate patient stories into governance meetings, staff training, and service redesign discussions to ensure they remain central to our continuous improvement efforts.

At the Patient First Improvement Expo, held in November 2024 with the theme "Making Every Touchpoint Count," a patient from community services shared their story. Their account highlighted the impact of care delivery on their experience and provided actionable insights that have since inspired new improvement initiatives.

Volunteering strategy update

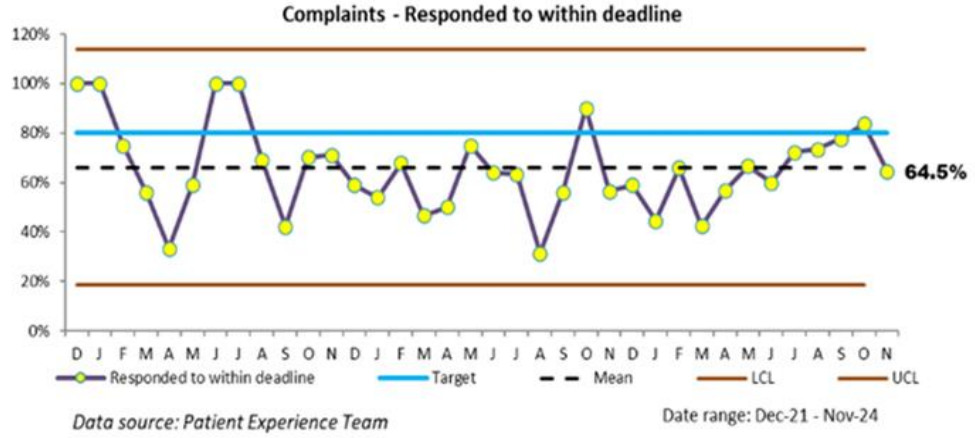
Objective 1: Aim to have 500 active volunteers aged 16+ by 2025 to enhance patient experience. Currently, there are 144 active volunteers with 488 in the processing stage.

Objective 2: Support, train, engage, and retain volunteers to ensure a positive experience. All volunteers have completed mandatory training for governance and assurance. Recent initiatives include ED induction training, training on patient self-check kiosks, and a volunteer coffee morning where volunteers shared their experiences and received support.

Objective 3: Build a reputation for excellence in volunteering and foster partnerships to achieve a more diverse volunteer pool reflecting the population. We continue to focus on recruiting volunteers from diverse backgrounds to reflect the communities the trust serves. Volunteer recruitment is paused until mid-January 2025 to prioritise the progression of the 488 applicants already in process.

Complaints - Performance against KPIs

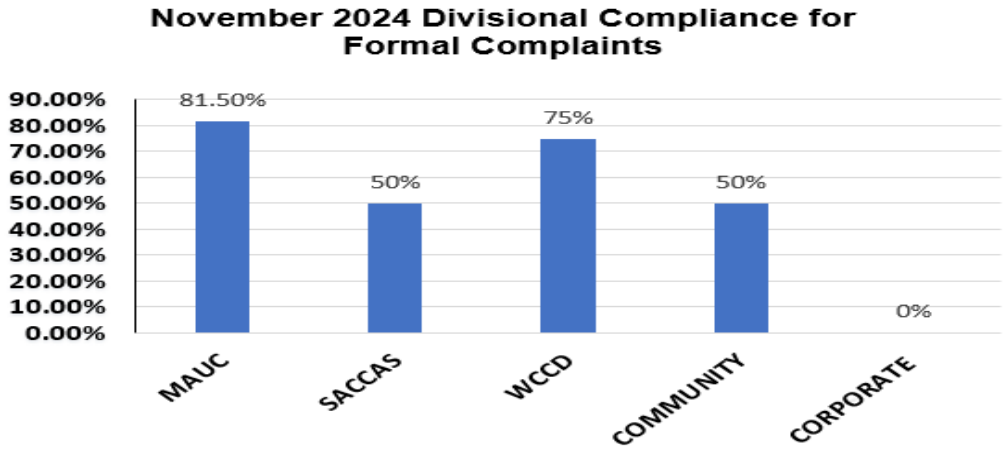
Chart 1A: complaints performance against KPIs



This graph shows the formal complaints compliance trend from December 2021 to November 2024 [Final data to be confirmed], measured against the KPI target (blue line). The compliance rate for November 2024 is highlighted as the most recent data point, with a compliance rate of 64.5%.

The compliance trend demonstrates variability, with some months exceeding the KPI target and others falling below the average benchmark. From July 2024 to November 2024 [Final data to be confirmed], compliance shows an overall improvement compared to earlier periods, with a consistent increase above the average benchmark. However, November 2024 saw a slight decline, bringing the compliance rate back to the average benchmark.

Chart 1B: Divisional compliance for formal complaints



This bar graph represents the compliance rates for formal complaints across all divisions in November 2024. MAUC achieved the highest compliance rate at 81.5%, SACCAS and Community compliance rate stands at 50%, WCCD reached a compliance rate of 75%, and Corporate recorded a compliance rate of 0%, indicating no compliance, with two complaints breaching their due date during the month.

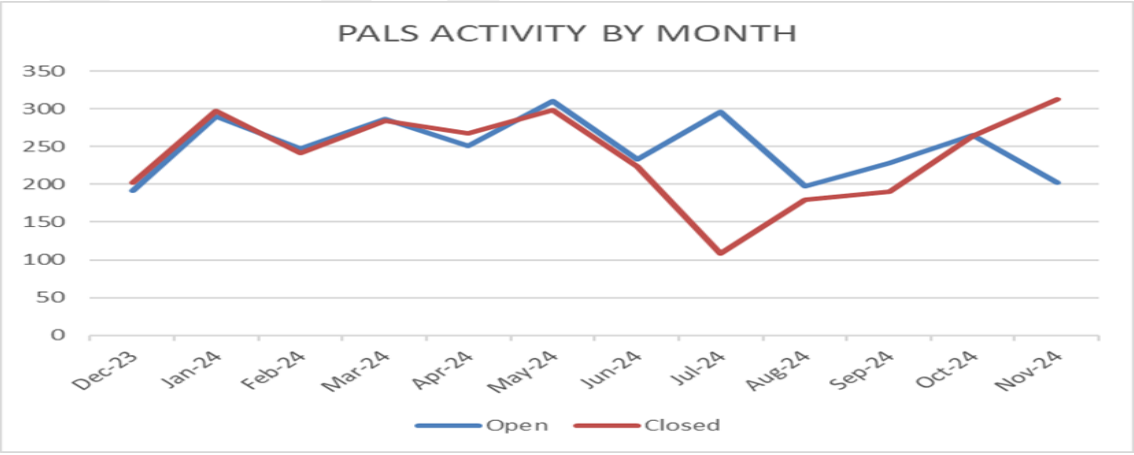
The graph highlights variations in compliance levels across the divisions, with MAUC leading and Corporate performing the lowest.

Formal Complaints Measures for Improvement

The trust's average complaints response rate over the last three months (September to November) is 75%. To improve this, drafting complaint response letter sessions have supported investigators in addressing concerns and identifying actions since July 2023. An A3 project with Maternity Services aims to enhance consistency, while a review of the MAUC A3 project seeks process improvements. Complaints officers continue to encourage timely resolution of non-clinical concerns through phone calls or appointments.

Patient Advice and Liaison Service (PALS)

Chart 1C: PALS Activity



Between 1st November and 29th November 2024, PALS recorded 202 queries, bringing the total for the year to 2,807. In November, 51% of queries (104) were closed on time.

Patient First methodology used to improve triage and timely notification of divisions. Urgent concerns are logged daily to ensure responses within 24 hours, with an acknowledgement rate of 81% last month.

Data analysis, for September to November 2024 [Final data to be confirmed], reveals the following PALS themes:

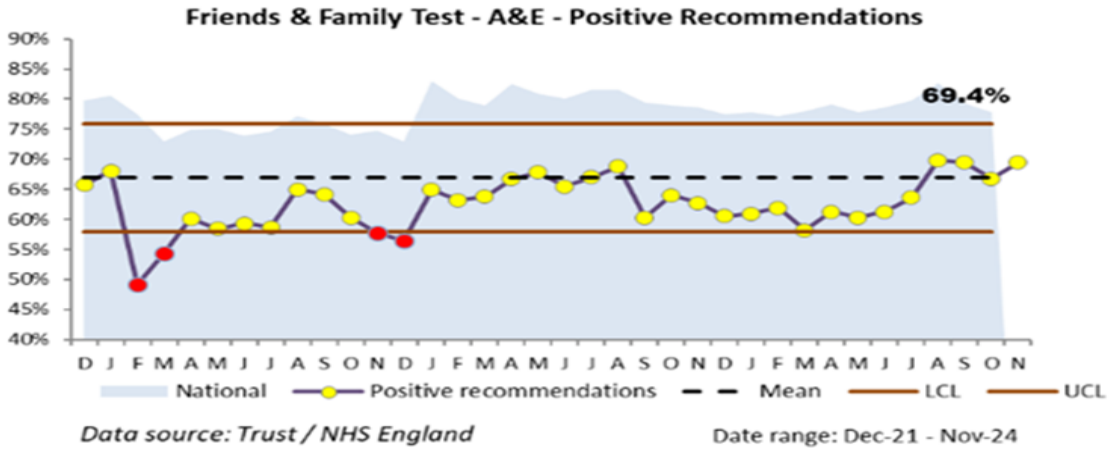
- Appointments – 212
- Communications -229
- Values & Behaviours (staff) - 137

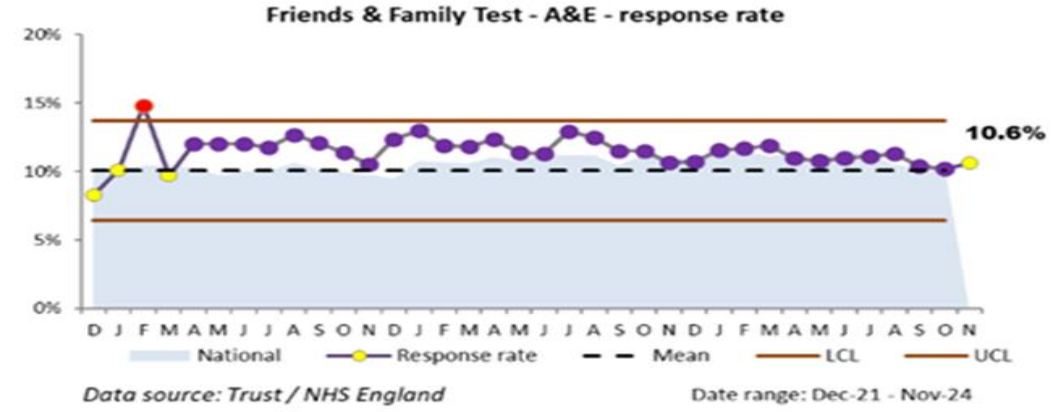
PALS Measures for Improvement

From September to November 2024[Final data to be confirmed], 74% of new PALS were acknowledged on time, with an average 45.6% response rate for cases closed in time. Measures to improve performance include reallocating staff between Complaints and PALS to manage new cases and the backlog (from September 2024). Daily triage of incoming concerns based on severity has improved acknowledgement rates to 81% in November. Additionally, MAUC caseload tracking and targeted progression began in September, supported by two PALS officers.

Friends and Family Test-A&E

Chart 1C: Friends and Family Test – A&E – positive recommendations and response rate



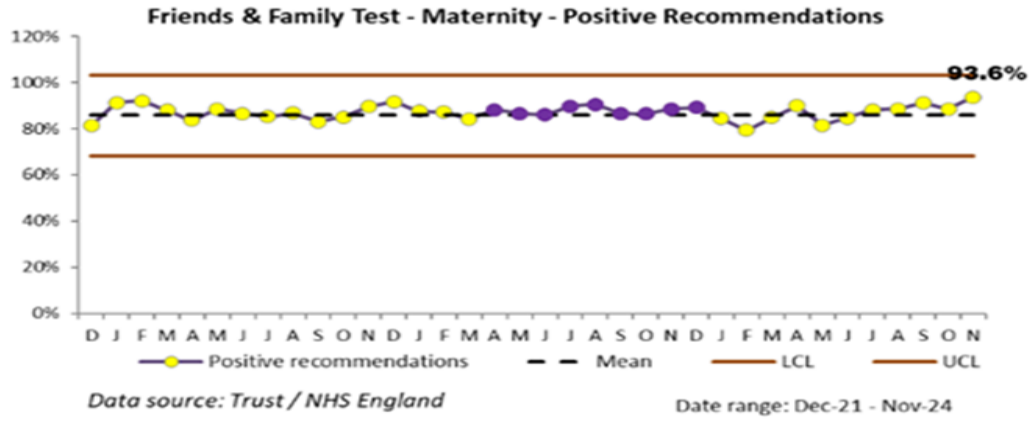


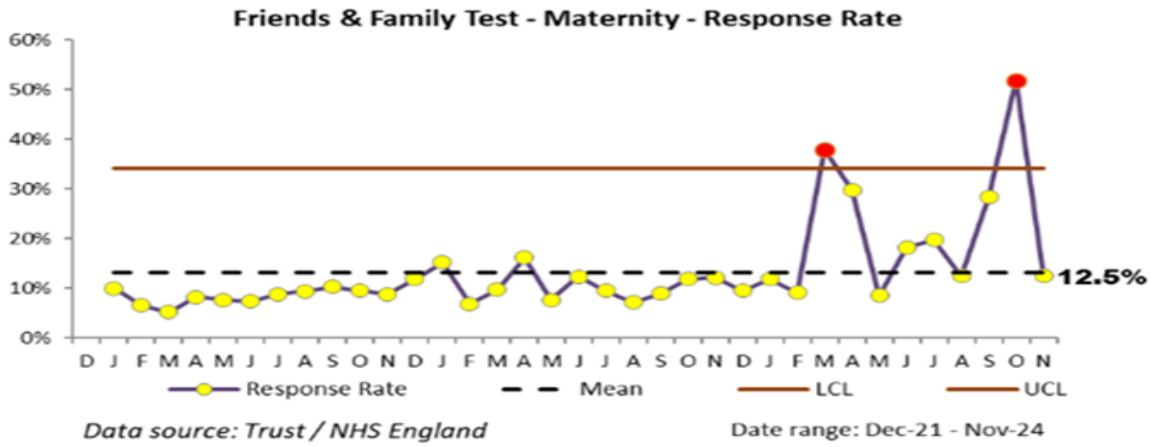
The positive recommendations rate was maintained at 69.4% in September to November 2024. Response rates increased from 10.2% in October and 10.6% in November 2024[Final data to be confirmed]. Volunteers are actively supporting with collecting feedback from patients and visitors as well as ensuring patients' experience is managed positively. ED teams are working collaboratively with the ambulance crew and other departments to manage patient flow and waiting times resulting in the gradual improved patient experiences.

Actions:

- The Volunteer Lead will collaborate with the ED senior team to review the roles of volunteers in the ED and develop strategies to increase volunteer recruitment in this area by January 2025.
- The ED senior team and Volunteer Lead will review locations for collecting feedback and identify the most appropriate and visible spots to place posters with QR codes. These will be designed to capture the attention of patients, visitors, and carers, encouraging them to provide feedback by January 2025
- The senior team will reiterate to all staff, including housekeepers, the importance of promoting the Friends and Family Test (FFT) to improve the response rate by January 2025
- Training to be arranged with emergency department team to offer volunteers who are interested in ED experience to support patient feedback collection and improve patient experience by March 2025.

Friends and Family Test-Maternity
Chart 1D: Friends and Family Test – Maternity– positive recommendations and response rate





Positive recommendations show an incline from 88.6% in October to 93.6% in November 2024. The response rate shows a decline from 51.7% in October to 12.5% in October 2024[Final data to be confirmed].

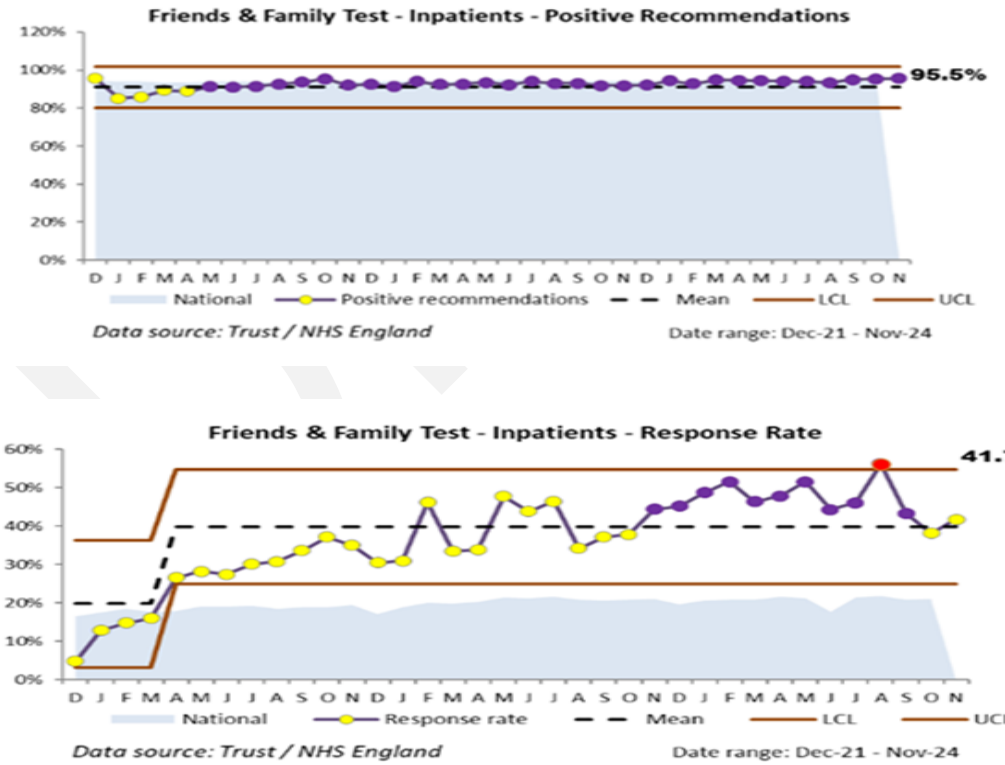
Feedback cards are the primary method regularly used by volunteers and staff to gather input from patients transferred from the labour ward and birthing unit. Ongoing issues with the iPads not showing the landing page with the different touchpoints were escalated and currently working with the provider to address the problems.

Actions:

- The volunteer lead to work with the service provider, Healthcare Communication (HCC), to resolve the issue of iPads not displaying the landing page by January 2025.
- The volunteer lead, in collaboration with maternity leads, will conduct bi-weekly checks of the iPads after the issue is resolved to ensure they are functioning properly, to prevent recurrence and to be reported at monthly patient experience committee.
- The volunteer lead will train staff and volunteers on how to effectively assist patients and families in using alternative feedback methods during the iPad downtime.
- The volunteer lead will liaise with maternity leads to provide weekly progress updates to stakeholders on the status of the iPad issue and the continued use of alternative feedback methods.

  Action timeframe: To be completed by Jan 2025

Friends and Family Test–Inpatients
Chart 1E: Friends and Family Test – Inpatients– positive recommendations and response rate



Positive recommendations figures have remained at mid-90's since March 2024. October shows slightly improved figures of 95.4% compared to September's 95%. Since October 2022, they have remained above 92% and at the national level. The response rate dropped further from 43.3% in September to 38.1% in October 2024 [Final data to be confirmed].

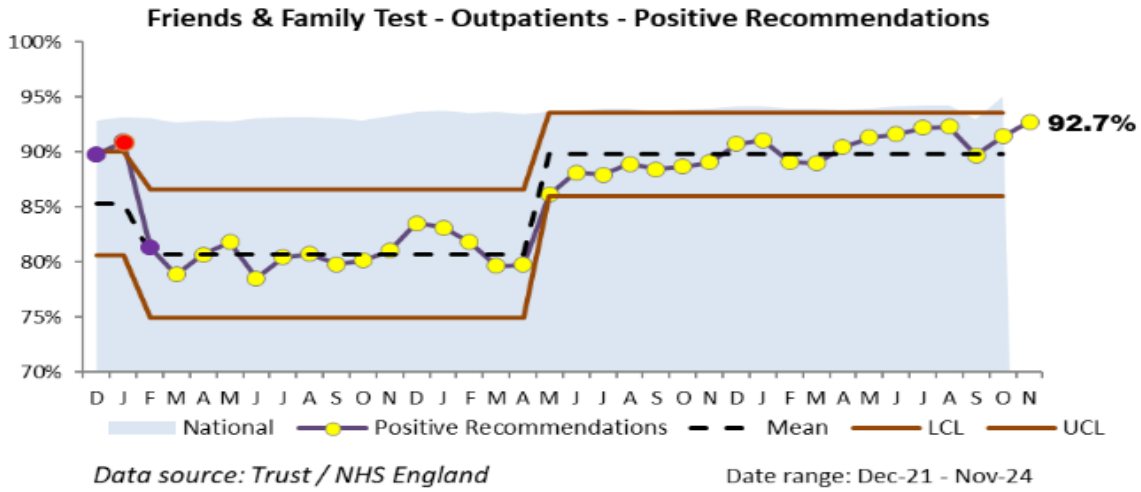
Multiple locations have reported issues with the survey app that have required to be reset multiple times by the IT team. The issues are yet to be resolved. Staff continue to use iPad, feedback cards and QR codes to collect feedback. Volunteers are tasked to support the wards with collecting feedback using different methods.

Actions:

- The Volunteer Lead and HCC to collaborate with the trust's IT team to resolve the issue of iPads not displaying the landing page by January 2025.
- Departmental managers to reiterate to staff the importance of immediately reporting any issues or concerns related to iPads or feedback cards as soon as they are identified by January 2025
- The Volunteer Lead to liaise with managers to provide regular updates on the status of the iPad issue and the continued use of alternative feedback methods by January 2025.

Friends and Family Test-Outpatients

Chart 1F: Friends and Family Test–Outpatients– positive recommendations and response rate



Variation:

Positive recommendations improved from 92.7% in October to 92.7% in November 2024 [Final data to be confirmed].

There is no notable reason for the variation. The upgraded self-check kiosk systems and volunteer support to signpost patients to clinics continue to improve the patient experience.

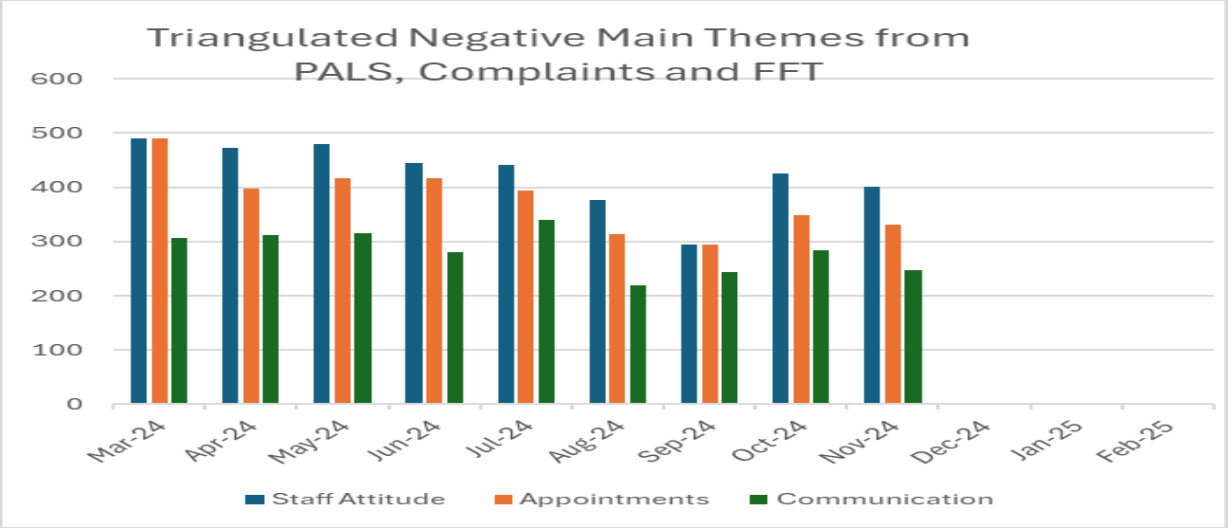
Actions:

- Volunteers and reception staff to continue to report issues and difficulties encountered when helping patients and visitors with their appointments to the outpatients' leadership team and to find solutions in a timely matter to improve future experiences.

- Reception staff and volunteers are to be kept updated on new clinics or name or location changes to guide patients and visitors.

Triangulation of Feedback (FFTs, PALs and Complaints) [Final data to be confirmed]

Chart 1G: Triangulation of Feeback



	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Staff Attitude	490	473	479	444	441	377	294	425	401
Appointments	491	398	417	417	394	313	294	349	331
Communication	306	311	315	281	340	220	244	284	248

The trust's top three areas of negative feedback show a steady decline from March to September, with the most significant drop seen in Appointments and Communication by August and September. However, October and November show an increase in all feedback categories.

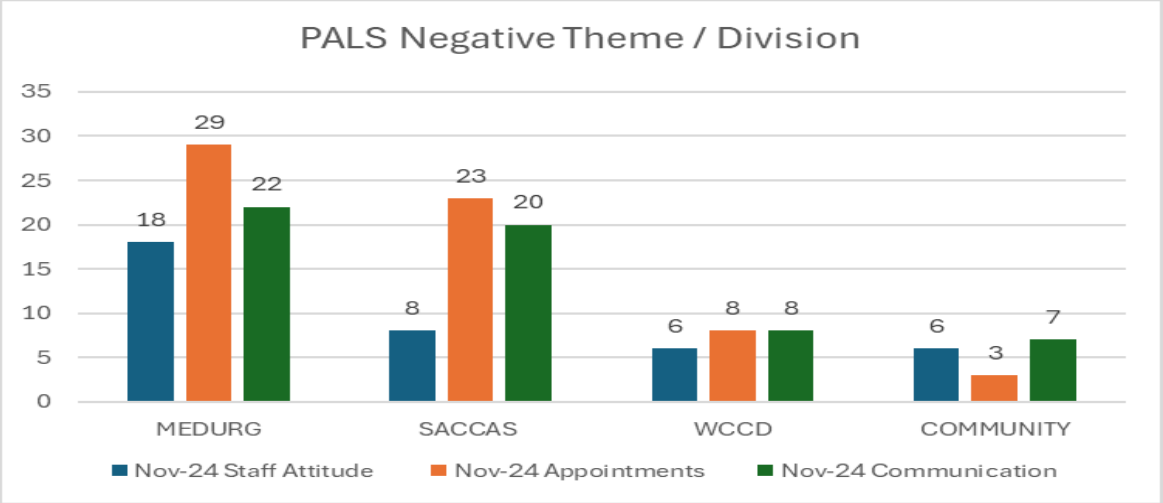
Ongoing Improvement Work

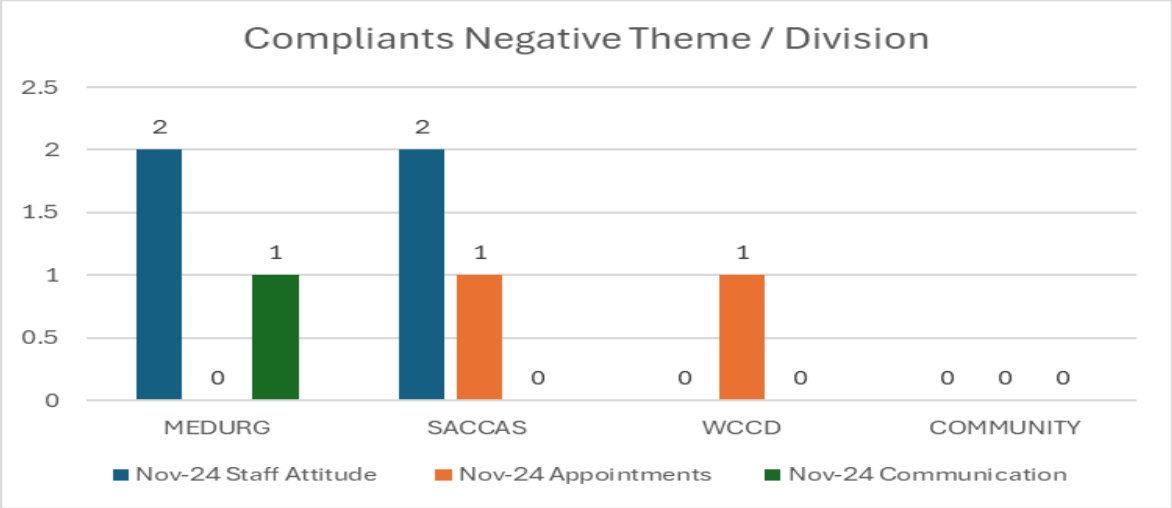
Staff Attitude: Patient Experience Learning Forum (PELF) and peer review Observation of care across the trust. On 2nd December 2024, staff from across the trust attended the Staff Customer Care Train-the-Trainer course. The next step is for attendees from each division to begin training others within their divisions.

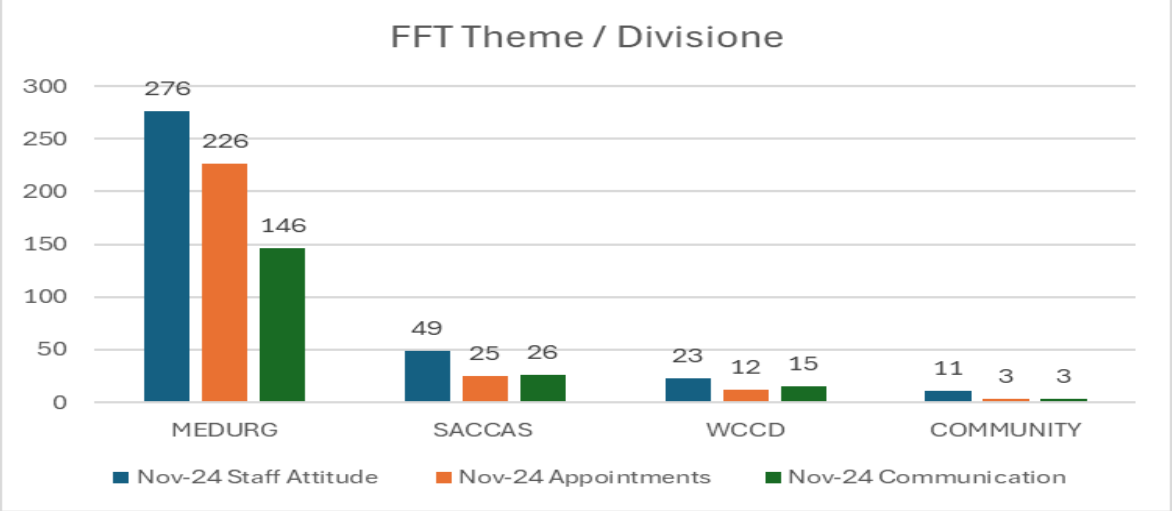
Appointments: Accessibility steering group.

Communication: Continued PELF and Peer review Observation of care.

Monitoring the Top Three Negative Feedback Themes/ Division
Chart H: Negative







MEDURG: recorded the highest feedback overall, with Staff Attitude being the most frequently mentioned theme, followed by Appointment related feedback in November 2024.

SACCAS: recorded Appointments as the most frequent theme, with Staff Attitude as the second most mentioned theme in November 2024.

WCCD: Feedback focused mainly on Appointments and communication related in November 2024.
Community: Had fewer cases across all triangulation sources, but Communication is the most frequently mentioned theme.

Ongoing improvement plan across divisions with Patient Experience Learning forum (PELF) and peer review observation of care.

CQC National Surveys

The surveys allow the NHS to hear directly from patients, offering insights into their experiences, needs, and expectations. This helps the NHS shape policies and services that are more in tune with what matters to patients, ensuring that care is truly patient-centred.

The data from these surveys highlight areas where care is exemplary and where improvements are needed. By identifying gaps in care, we can target specific areas for development, such as

communication, waiting times, or the cleanliness of facilities. Continuous feedback drives better outcomes.

We compare our performance with national benchmarks and other trusts. This helps to foster competition in terms of quality improvement, encouraging trusts to strive for excellence in patient care by learning from the best performers.

National Surveys Results Publication dates

2023/24	Sample month(s)	Trust Submit sample to PP	Fieldwork	Patient Perspective (PP) Report	CQC Report
Adult Inpatient (NIP23)	Nov-23	Dec-23	Jan-Apr24	May-24	Aug-24
Urgent and Emergency Care (UEC24)	Feb-24	Mar-24	Apr -Jul24	Aug-24	21 Nov 2024
Maternity (MAT24)	Feb-24	Mar-24	Apr -Jul24	Aug-24	28 Nov 2024
Children & Young Peoples IP/DC (CYP24)	Apr&May24	Jun (Aug)-24	Jul (Aug)-Dec24	Feb-25	Mar-25
Adult Inpatient (NIP24)	Nov-24	Dec-24	Jan-Apr25	Jun-25	Aug-25
National Cancer Patient Experience Survey (NCPES24)	September Sept - 24	N/A	Nov 24 – Jan 25	N/A	Early summer 2025
2025					
Maternity (MAT25)	Feb-25	Mar-25	Apr -Jul25	Aug-25	Nov-25
Adult Inpatient (NIP25)	Nov-25	Dec-25	Jan-Apr26	Jun-26	Aug-26

Urgent and Emergency Care (UEC24) - Type 1 Result

Top 5 Themes	Bottom 5 Themes
Care and treatment: Staff helping **patients** take medication for pre-existing medical conditions.	**Hospital environment:** Patients able to get food or drinks whilst in A&E.
Care and treatment: Staff helping to control patients' pain.	**Hospital environment:** Patients feeling safe around other patients or visitors while in A&E.
Communication and compassion: Doctor or nurse discussing **patients' anxieties or fears with them.**	**Care after leaving A&E:** Staff discussing further health or social services patient may need after leaving A&E.
Waiting: After the first assessment, patients being told **what would happen next.**	**Overall experience:** Patients' overall experience while in A&E.
Information: Patients given information **about new medications to be taken at home.**	**Respect and dignity:** Patients feeling they were treated with respect and dignity while in A&E.

Urgent and Emergency Care (UEC24) - Type 3 Result

Top 5 Themes	Bottom 5 Themes
Waiting: Patients being kept updated on waiting times to be examined or treated	**Communication & compassion:** Health professionals explaining conditions/treatments in a way that can be understood.
Care and treatment: Staff helping to control patients' pain.	**Care after leaving the UTC:** Staff discussing further health or social services patient may need after leaving UTC.
Care after leaving the UTC: Patients told who to contact if they have concerns after leaving UTC.	**Communication about tests:** Staff explaining test results in a way patients understand.
Privacy: Patients being given enough privacy when discussing their condition with the receptionist.	**Waiting:** Staff providing help with patients' conditions or symptoms while waiting.
Waiting: After the first assessment, patients being told what would happen next.	**Communication & compassion:** Patients having confidence and trust in the health professionals treating them

NHS Adult Inpatient Survey 2023 Result

Top 5 Themes	Bottom 5 Themes
Provide views on care: Patients being given the opportunity to give views on the quality of their care while at hospital	**Food: Patients** being able to get hospital food outside of set meal times
Sleeping: Patients being prevented from sleeping at night due to room temperature	**Wait to get a bed:** The wait to get a bed on a ward after arrival
Sleeping: Patients being prevented from sleeping at night due to noise from staff	**Food:** Patients being offered food that met any dietary needs or requirements they had
Information about virtual wards: Patients getting information about risks & benefits of continuing treatment on virtual wards	**Information while on waiting list:** Quality of information given while on waiting list
Sleeping: Patients not being prevented from sleeping at night	**Explaining change of wards:** Patients explained reasons for changing wards during the night in a way they can understand

Maternity Survey 2024 Result

Top 5 Themes	Bottom 5 Themes
Postnatal Care on the Ward: Partner or someone close to the service user was able to stay as much as the service user wanted.	**Labour and Birth:** Being sent home when they were worried about themselves or their baby.
Care after birth: Being given information about physical recovery after birth.	**Care after birth:** Frequency of seeing or speaking to a midwife.
Postnatal care on the ward after birth: Health Care professionals doing everything they could to manage service users pain.	**Care after birth:** Being told who to contact if advice needed about potential changes to mental health after birth.
Feeding your Baby: Midwives giving enough support and advice to feed their baby.	**Postnatal Care in the ward after birth:** Delays to discharge on the day of leaving hospital.
Labour and Birth: Service users giving appropriate information and advice on the associated risks with induction.	**Labour and Birth:** Feeling that they were given appropriate advice and support when they contacted a midwife or the hospital.

National Cancer Patient Experience Survey (NCPES)

Top 5 Themes	Bottom 5 Themes
Patients were told they could have a family member, carer or friend with them when told their diagnosis.	Diagnostic tests: staff did not appear to have all the information they needed about the patient.
Family and/or Carers were definitely involved as much as the patient wanted them to be in decisions about their treatment options.	Diagnostic test results were not explained in a way the patient could completely understand.
Beforehand patients completely had enough understandable information about surgery.	Patients were not always able to have a discussion about their needs or concerns prior to treatment.
Beforehand patients completely had enough understandable information about hormone therapy.	Patients were not offered information about how to get financial help or benefits.
Patients completely had enough understandable information about their response to surgery.	Patients did not have confidence and trust in all of the team looking after them during their stay in hospital.

National Surveys- Improvement Initiatives in the Divisions

UEC24 Type 1 &Type 3: The Emergency Department have implemented an ED Charter to ensure patient safety and for patients to have a more positive experience in ED. Proposed Tendable Audit to assess the compliance with the charter.

Inpatient Survey: Patient flow, standard work and Patient Exchange. Ongoing PELF and observation of Care. Nutrition and Hydration steering group/Gemba walk.

Maternity: Mycelium training for Building Resilient Teams – August 2024. Build upon trauma-informed care training for all staff – August 2024. Birth reflections are now facilitated by trauma practitioners. Daily breastfeeding teaching sessions (for parents) on Maternity ward include a video (safe sleeping, SIDS, thermoregulation etc) bay by bay. This will be run by the HCAs supported by infant feeding team. Bank midwife started, offering one2one support on bedside and drop-in sessions in breastfeeding room. New KMBT guideline (keeping mother and baby together). BF & Formula feeding folder in Mat ward now (leaflets are in different languages). Daily breastfeeding drop-in session on Mat ward from 2-4pm.

NCPES. Increased the number of cancer support workers from 2 to 5 (in total 4 substantive) since March 2024. Filled 4 CNS vacancies and about to advertise for a CUP CNS. Bid from the alliance for 2 days specifically for Health & Well Being agenda. Full time MISM in post. Have a substantive Personalised Cancer Care Manager in post since October 2023. Increased CAB from 1 day to 2 days per week. Macmillan Support Information booklet developed and printed for all patients with a diagnosis of cancer. Let's Talk Cancer on the Trust Induction 2024. Participation in UCL Partners review of HNA assessments & support provided

Key successes and celebrations – "North Mid Loves our Patients" -

You said We did" Events - November 2024.

Patient Flow and Length of Stay
We did: Implemented Ward Standard Work protocols in T6, T7, and T8 for Medicine and Urgent Care.

Nutrition and Hydration
We did: Strengthened compliance with the Protected Mealtime Policy in the Acute Stroke Unit (ASU) for Medicine and Urgent Care.

Frailty Pathway
We did: Established a rapid assessment and tailored care process for patients aged 65+ admitted to the Amber Unit, improving individualized support.

Infant Feeding Support
We did: Launched the "Breastfeeding Together @NorthMid" initiative, including a Padlet link accessible to both mothers and staff for breastfeeding resources (Maternity, WCCD).

Parental Involvement in Baby Care
We did: Introduced Parent-Led Ward Rounds to support family-integrated care, empowering parents in the decision-making process.

"North Mid Loves our Patients: You said, We did" Celebration

Trust Wide Continuous Improvement plan

Key Themes	In progress	Actions: Trust & Divisional	Leads/ Steering Group	Time Frame
Nutrition and hydration	Protected Mealtimes Poster (June 2024) Drink times (June 2024)	• Monthly Nutrition and Hydration Sub-Group to consider issues raised in the report and develop an action plan to address the issues and make improvements. The Nutrition and Hydration Subgroup feeds into (PEC Monthly). • Gemba Walk • Monthly Nutrition and hydration group meeting • Ward Entrance Poster	Nutrition and Hydration Sub-Group / Divisional Leads Estate and facilities. Monthly PELF - Divisional leads Lead Nurse for Patient Experience	In progress March 2025
Communication	Peer review Observation of care (March 2024) Patient Experience Learning Forum (PELF) Accessibility steering group	• Customer Service Training • Sage & Thyme training • Monthly Accessibility Steering Group Meeting • Patient Experience Learning Forum (PELF) • Peer review observation of care • Divisions to implement action plan to ensure safety netting advise is consistently given to patients.	Accessibility steering group/ Divisional Leads Monthly PELF - Divisional leads Lead Nurse for Patient Experience	In progress March 2025
Staff Attitude	Customer service Training for all staff	• Peer Review Observation of Care. • Patient Experience Learning Forum (PELF)	Monthly PELF - Divisional leads Lead Nurse for Patient Experience	In progress March 2025
Appointment and Waiting Time	Letter templates reviewed Patient Flow The new Delays management process.	• Monthly Accessibility Steering Group Meeting • Divisional review of pathways/policies to ensure improvements are made to waiting times.	Accessibility steering group/ Divisional Leads Monthly PELF - Divisional leads Lead Nurse for Patient Experience	In progress March 2025
Environmental cleanliness	Monthly Cleaning Audit, IPC, and Estate facilities Manager/matron	• Monthly Cleaning Group, Division, Estates & Facilities and IPC to address issues raised in the report.	Estate and Facilities IPC Divisional Leads	In progress March 2025
Care and Treatment	PELF Observation of care	• Privacy and Dignity policy to be reviewed by all divisions ensuring it is adhered to at all times. •	Monthly PELF - Divisional leads Lead Nurse for Patient Experience	In progress March 2025

Annex 2: Statements from local Healthwatch organisations, health and care scrutiny committees, integrated care boards and Council of Governors

To follow in the final report

Annex 3: Statement of director's responsibilities for the quality report

To follow in the final report

Appendix A: Changes made to the quality report

To follow in the final report

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

Acronym/Term	Explanation
Artificial Rupture of Membranes (ARM)	This is a procedure where the amniotic sac is deliberately broken to induce or accelerate labour.
Avoiding Term Admissions Into Neonatal Units (ATTAIN)	This program aims to reduce the number of full-term babies admitted to neonatal units by improving care practices.
Better Care Fund (BCF)	This program supports the integration of health, housing, and social care to provide person-centered care and improve outcomes for people and carers.
Birmingham Symptom-specific Obstetric Triage System (BSOTS)	This is a standardized triage system used in maternity care. It was developed to improve the safety and management of mothers and babies by providing a prompt and brief assessment of women presenting with unexpected pregnancy-related problems or concerns.
British Cardiovascular Intervention Society (BCIS)	This organization promotes excellence in interventional cardiovascular care in the UK, focusing on education, research, and clinical practice advancements.
Care Quality Commission (CQC)	The main independent regulator of all health and social care services in England.
Central Venous Catheter (CVC)	This is a flexible tube inserted into a large vein, typically in the neck, chest, or groin.
Clinical Practice Group (CPG)	Permanent structures which the trust has established to address unwarranted variation in care.
Clostridium difficile (C. diff)	A type of bacterial infection that can affect the digestive system.
Commissioning for Quality and Innovation (CQUIN)	CQUIN is a payment framework that allows commissioners to agree payments to hospitals based on agreed improvement work.
Computerised Tomography (CT)	A CT scan uses X-rays to create detailed images of the inside of the body, helping to diagnose conditions or monitor treatment effectiveness.
Continuous positive airway pressure (CPAP)	Continuous positive airway pressure (CPAP) is a form of positive airway pressure ventilator, which applies mild air pressure on a continuous basis to keep the airways continuously open in people who are not able to breathe spontaneously on their own.
Cystic Fibrosis (CF)	This is a genetic condition that affects the lungs and digestive system, causing thick, sticky mucus to build up and leading to various health issues.
Daily Living Activities (DLA)	This term is often used in healthcare to refer to the routine activities that individuals perform every day, such as eating, bathing, dressing, and mobility.
Decision to Admit (DTA)	It refers to the point at which a decision is made to admit a patient to the hospital.
DNACPR	Do not attempt cardiopulmonary resuscitation. It means that if a person has a cardiac arrest or dies suddenly, there will be guidance on what action should or shouldn't be taken by a healthcare professional, including not performing CPR on the person.

Electrocardiogram (ECGs)	An ECG is a test that records the electrical activity of the heart, including its rate and rhythm.
Electronic Patient Record (EPR)	This is a digital system that consolidates all patient information, including medical history, treatments, and medications, into one accessible platform
Electronic Prescribing and Medicines Administration (EPMA)	It is a digital system used in healthcare to manage the prescribing and administration of medications.
Enhanced Recovery After Surgery (ERAS)	This is a program designed to help patients recover more quickly after surgery by using evidence-based practices to improve outcomes and reduce recovery times.
Equipment Development Grade Evaluation (EDGE)	Refers to a specific evaluation process for equipment development within research projects.
Ethylenediaminetetraacetic Acid (EDTA)	In medical testing, EDTA is used as an anticoagulant in blood samples to prevent clotting.
Freedom to Speak Up (FTSU)	This is an initiative within the NHS designed to create an open and transparent culture where staff feel safe and confident to raise concerns about patient care, safety, or any other issues without fear of retribution.
Health and Social Care Information Centre (HSCIS)	This organization was responsible for collecting, analyzing, and presenting national health and social care data. It has since been renamed NHS Digital.
Health Services Safety Investigation Branch (HSSIB)	It is an independent organization in England that conducts investigations into patient safety incidents within the NHS.
Healthcare-Associated Infection (HCAI)	These infections can develop as a direct result of healthcare interventions, such as medical or surgical treatment, or from being in contact with a healthcare setting
High-Incidence Cohort Group (HICG)	This term is used to categorize patients who are at higher risk of HIV infection.
Hospital Episode Statistics (HES)	This is a curated data product containing details about admissions, outpatient appointments, and accident and emergency attendances at NHS hospitals in England.
Hospital Episode Statistics (HES)	A database containing details of all admissions, A&E attendances and outpatient appointments at NHS hospitals.
Immediate and Essential Actions (IEA)	These actions are typically derived from reports or reviews, such as the Ockenden Report, which outlines critical steps to improve maternity services and ensure patient safety.
Induction of Labour (IOL)	This is an obstetric procedure used to stimulate uterine contractions before spontaneous labour begins.
Infection Prevention and Control Team. (IIPCT)	This specialist multidisciplinary team provides practical and clinical advice on infection prevention and control (IPC) issues
Intensive Therapy Unit (ITU)	This is also known as the Intensive Care Unit (ICU), where critically ill patients receive specialized care.
Learning from Deaths (LfD)	National guidance for NHS trusts on how they should support, communicate and engage with bereaved families and carers following a death of someone in their care.

Local Maternity and Neonatal System (LMNS)	These are regional networks in the UK designed to coordinate and improve maternity and neonatal care services.
Local Maternity and Neonatal System (LMNSI)	These systems are regional networks in the UK designed to bring together all the organizations involved in providing and commissioning maternity and neonatal care.
Maternity and Neonatal Voices Partnership (MNVP)	This is a collaborative initiative that involves service users, including women and birthing people, in the development and improvement of maternity and neonatal services.
Maternity and Newborn Safety Investigations (MNSI)	This initiative conducts independent investigations into maternity and newborn safety incidents to identify areas for improvement and enhance overall safety in maternity care.
Modified Early Obstetric Warning System (MEOWS)	This is a physiological scoring system used to monitor pregnant women and identify those at risk of deterioration.
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE)	This program conducts national audits and confidential enquiries into maternal and perinatal deaths to identify areas for improvement and enhance the quality of maternity care.
Multi-disciplinary team (MDT)	A team consisting of staff from various professional groups i.e., nurses, therapist, doctors etc.
National Institute for Healthcare Research (NIHR)	A central part of the UK research landscape, collaborating in national activities to improve research and supporting NHS research performance.
National Institute of Clinical Excellence (NICE)	An independent organisation that produces clinical guidelines and quality standards on specific diseases and the recommended treatment for our patients. The guidelines are based on evidence and support our drive to provide effective care.
NatSSIPPs	National safety standards for invasive procedures are standards to help NHS organisations provide safer care and to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events can occur.
Neonatal Meningitis Escherichia coli (NMEC)	This term refers to a specific type of bacterial infection caused by Escherichia coli, which can lead to meningitis in newborn infants.
Neonatal Transitional Care (NTC)	NTC provides care for babies who need more support than can be provided in a regular postnatal ward but do not require intensive care.
Never event	Never events are extremely serious and largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place.
Newborn Early Warning Track and Trigger (NEWTT2s)	It is a framework designed to monitor newborns for signs of deterioration. The system includes a chart that tracks vital signs and other clinical parameters, helping healthcare professionals identify at-risk infants and intervene promptly.
NHS Improvement (NHSI)	It is an organization that supports healthcare providers in England to deliver high-quality care.
NHS NCL	NHS north central London clinical network.
NHS Resolution (NHSR)	This is an organization that provides expertise to the NHS on resolving concerns and claims related to patient safety and healthcare delivery.
Obstetric Anal Sphincter Injury (OASI)	This refers to severe perineal tearing that can occur during vaginal birth, including third- and fourth-degree tear.

Occupational Therapy (OT)	Occupational therapists help people improve their ability to perform everyday tasks, especially if they are recovering from illness or surgery, or have physical or mental health challenges.
Out-of-Hours (OOH)	In healthcare, this term refers to services provided outside of regular operating hours, typically during evenings, nights, weekends, and holidays.
Patient At Risk and Resuscitation Team (PARRT)	This team provides additional support for deteriorating patients, offering advice and assistance to clinical teams outside of Critical Care.
Patient Group Direction (PGD)	This is a written instruction for the supply and/or administration of a licensed medicine (or medicines) in an identified clinical situation, signed by a doctor or dentist and a pharmacist.
Patient Reported Outcome Measures (PROMs)	Measure of health gain in patients undergoing hip replacement, knee replacement (and up to September 2017, varicose vein and groin hernia surgery) based on responses to questionnaires before and after surgery.
Perinatal Mortality Review Tool (PMRT)	It is used to review and learn from perinatal deaths, aiming to improve the quality of care and prevent future incidents.
Personal Protective Equipment (PPE)	This includes items such as gloves, masks, gowns, and eye protection, which are used to protect healthcare workers and patients from infections and other hazards.
Plan-Do-Study-Act (PDSA)	It is a cyclical, iterative method used in quality improvement to test changes and implement improvements in processes.
Royal College of Obstetricians and Gynaecologists (RCOG)	This is a professional association based in the UK that provides guidance and recommendations to improve women's health care.
Safety, Communication, Operational Reliability, and Engagement. (SCORE)	It is a tool used in healthcare to assess the safety culture within an organization.
Saving Babies' Lives Care Bundle Version 3 (SBLCV3)	This is an evidence-based care bundle aimed at reducing perinatal mortality by implementing best practices in maternity care.
Situation, Background, Assessment, and Recommendation (SBAR)	It is a structured communication tool used in healthcare to facilitate clear and concise information exchange among team members.
Specialist Registrars (SpRs)	These are doctors in training who are pursuing advanced training in a specific medical specialty.
Specific, Measurable, Achievable, Relevant, and Time-bound (SMART)	It's a framework used to set clear and attainable goals.
Standard Operating Procedure (SOP)	This is a detailed written set of instructions designed to achieve uniformity in the performance of a specific function.
Summary hospital level mortality indicator (SHMI)	The SHMI is an indicator which reports on mortality at trust level across the NHS in England using a defined methodology. It compares the expected mortality of patients against actual mortality.
Tendable	Tendable is a digital platform designed to improve quality assurance in health and social care settings. It provides real-time inspection and reporting tools that help healthcare teams conduct digital audits, track compliance, and gain actionable insights to enhance patient care

Turnaround Time (TAT)	This refers to the time taken to complete a process, such as the interval between collecting a sample and reporting the results.
Twinkle Paediatric Diabetes Patient Management System (TWINKLE)	This is a web-based application designed to help manage paediatric patients with diabetes. It facilitates paperless and integrated care, robust reporting, and supports the collection of data for the National Paediatric Diabetes Audit (NPDA).
UK Health Security Agency (UKHSA)	This agency is responsible for protecting public health by preventing, preparing for, and responding to infectious diseases and environmental hazards.
Vaginal Birth After Caesarean (VBAC)	This term is used when a woman gives birth vaginally after having had a previous caesarean section.
Venous thromboembolism (VTE)	A blood clot that occurs in the vein.
Women and Children's Clinical Division (WCCD)	This division focuses on providing healthcare services related to maternity, paediatrics, and women's health.

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Draft Quality Account Priorities 2025 – 2026

JOSC meeting 5th June 2025

Sarah Wilding Chief Nurse and Directors of AHP
Nicola Sands Deputy Chief Nurse

Quality Account 2024/25

The quality priorities are aligned to the Trust's Corporate Objective to "Deliver outstanding safe and compassionate care in partnership with patients". The 2024 – 2025 quality priorities were;

- Ensuring patients are seen by the right person in the right place at the right time and deliver outstanding safe and compassionate care in partnership with patients.
- Access and attendance
- Reducing health inequalities in our local population
- Improving the Trust Environment to improve Patient Experience

Key achievements from 2024/25

- Birmingham Symptom Specific Obstetric Triage System (BSOTS) has been implemented in Maternity Triage.
- 75% of Trust staff have had Oliver McGowan training delivered.
- The transformation team have been reviewing outpatient letters to ensure that clinic and ward locations match hospital signage. Outpatient letters fully updated in Urology, Gynaecology and elderly care.
- The Virtual ward and rapid response urgent response 2hr/4hr/24hour targets to ensure timely patient care and admission avoidance are being met.
- The new codesigned NCL Community Red Cell (sickle cell) Service with partners and patients in NMUH and UCLH is up and running.
- Providing accessible information to those patients with learning disabilities has been achieved and the Trust webpage is live and is being used
- Virtual ward beds are being fully utilised. There are currently 44 beds at WH (20 acute split between Haringey and Islington), 16 remote monitoring beds, 8 Islington Complex VW beds.
- In conjunction with our Mental Health partners at the North London NHS Foundation Trust violence reduction team, training is being provided to all staff to support mental health patients waiting for a mental health bed.
- Training sessions on the use of restrictive practice and de-escalation techniques for adults have been provided to date.

Draft Quality Priorities 2025/26

- Ensuring patients receive safe and effective care that is delivered with kindness, compassion and in collaboration with patients and carers
- Improving the Trust Environment to enhance Patient Experience
- Reducing health inequalities in our local population by ensuring that when patients need to access our services, they have clear guidance, accessible routes and supported and listened to throughout
- We will continue to develop services to meet the needs of our population

Priority 1 Goals

Ensuring patients receive safe and effective care that is delivered with kindness, compassion and in collaboration with patients and carers

- Develop a suite of ‘What matters to me’ quotes to include pictures to educate staff these will be on screen savers and posters
- Promote the attendance of staff to the Ops School which provides a comprehensive programme of learning and development for staff working on acute pathways
- To continued work in line with Patient Flow Board objectives
- Improve the FFT scores to ensure all areas are above the NHS benchmark of 85%
- Implement systems to ensure learning and service improvement from complaints
- Meet national Standards for cleaning and see a reduction in hospital acquired infections

Priority 2 Goals

Improving the Trust Environment to enhance Patient Experience

- Continue to improve PLACE outcomes
- Monitor the patient experience through FFT, complaints and PALS feedback to improve demonstrating the positive work to improve environment
- Clearer signage and access routes through Trust premises

Priority 3 Goals

Reducing health inequalities in our local population by ensuring that when patients need to access our services, they have clear guidance, accessible routes and supported and listened to throughout

- To reduce outpatient letters from 891
- Create clinical pathways that incorporate one – stop shop models reducing the number of attendances and comprehensive diagnosis and treatment plans for patients
- Addressing Long waits for ASD/ADHD
- Improving the care we provide to people with mental health needs through additional staff education

Priority 4 Goals

We will continue to develop services to meet the needs of our population

- Promote self-management and prevention to keep patients well at home
- Expand community-based care, early discharge, and rehabilitation services.
- Reduce long waits in the community
- Continue implementing the Start Well programme to support mothers through pregnancy
- Delivery of MIS

Comments and Questions

Thank you

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