NOTICE OF MEETING

NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE – BARNET, ENFIELD AND HARINGEY SUB GROUP

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Friday 13 May 2016 at 10:00 a.m.
Enfield Civic Centre,
Silver Street, Enfield
EN1 3ES

Councillors: Alison Cornelius and Graham Old (L.B.Barnet), Abdul Abdullahi and Anne Marie Pearce (L.B.Enfield), Pippa Connor and Charles Wright (L.B.Haringey)

AGENDA

1. FILMING AT MEETINGS

Please note that this meeting may be filmed or recorded by the host Council for live or subsequent broadcast or by anyone attending the meeting using any communication method. Although we ask members of the public recording, filming or reporting on the meeting not to include the public seating areas, members of the public attending the meeting should be aware that we cannot guarantee that they will not be filmed or recorded by others attending the meeting. 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 and using the public seating area, you are consenting to being filmed and to the possible use of those images and sound recordings.

2. APOLOGIES FOR ABSENCE

3. ELECTION OF SUB GROUP CHAIR

4. DECLARATIONS OF INTEREST

Members of the Committee are invited to identify any disclosable pecuniary or prejudicial interests relevant to items on the agenda. A member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting at which a 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 their borough's Register of Members' Interests or the subject of a pending disclosure must notify their Monitoring Officer of the interest within 28 days of the disclosure.

5. MINUTES (PAGES 1 - 12)

To approve the minutes of the meeting held on 19 May 2015 – attached.

6. BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST - UPDATE (PAGES 13 - 24)

To receive an update from Maria Kane, Chief Executive, Barnet, Enfield and Haringey Mental Health NHS Trust – attached.

7. CONTRACTING AND FUNDING ARRANGEMENTS - MENTAL HEALTH UPDATE (PAGES 25 - 26)

To receive an update on the contracting and funding arrangements between the commissioning Clinical Commissioning Groups (CCGs) and Barnet, Enfield and Haringey Mental Health NHS Trust for 2016/17.

Interviews with:

- Graham MacDougall, Director of Strategy and Partnerships, Enfield CCG
- Jill Shattock, Director of Commissioning, Haringey CCG
- A representative from Barnet CCG will also be in attendance.

A short briefing paper prepared by Graham MacDougall, on behalf of the CCGs, is attached.

8. DRAFT QUALITY ACCOUNT (2015/16) FOR BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST (PAGES 27 - 82)

To consider the draft Quality Account (2015/16) for Barnet, Enfield and Haringey Mental Health NHS Trust – attached.

9. DRAFT QUALITY ACCOUNT (2015/16) FOR NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST (PAGES 83 - 158)

To consider the draft Quality Account (2015/16) for North Middlesex University Hospital NHS Trust – attached.

To help set the scene, the Trust's response to recommendations contained in the CQC Quality Report (August 2014) is included as background information. The 2014 CQC inspection report can be viewed in full via www.cqc.org.uk/location/RAPNM.

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MINUTES OF THE MEETING OF THE NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - BARNET, ENFIELD AND HARINGEY SUB GROUP - HELD ON TUESDAY 19 MAY 2015

MEMBERS: Councillors Abdul Abdullahi and Anne-Marie Pearce (LB Enfield), Alison Cornelius and Graham Old (LB Barnet), Charles Wright and Pippa Connor (LB Haringey)

Officers: Andy Ellis, Jane Juby (LB Enfield), Christian Scade (LB Haringey)

Also Attending: Andrew Wright (Director of Strategic Development, BEH Mental Health NHS Trust), Mary Sexton (Director of Nursing, Safety and Quality, BEH Mental Health NHS Trust), Maria Kane (Chief Executive, BEH Mental Health NHS Trust), Graham MacDougall (Director of Strategy and Partnerships, Enfield CCG), Jill Shattock (Director of Commissioning, Haringey CCG), Maria O'Dwyer (Barnet CCG)

2 members of the public. Deborah Fowler (Healthwatch Enfield)

1. WELCOME

Attendees were welcomed to the meeting.

Attendees were reminded of the policy for filming or recording the meeting as follows:

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2. APOLOGIES FOR ABSENCE

No apologies were received.

3. ELECTION OF SUB GROUP CHAIR

Cllr Old nominated Cllr Pearce as Chair. This was seconded by Cllr Connor.

Cllr Pearce was duly **ELECTED** as Chair, **for the duration of the meeting only**.

4. DECLARATIONS OF INTEREST

Cllr Connor declared a personal interest – her sister was currently working at a GP practice in Tottenham.

There were no disclosable pecuniary or prejudicial interests declared by members.

5. MINUTES

Page 1 - Cllr Connor commented that her sister continued to work in a GP practice in Tottenham; the Minutes implied that this was no longer the case.

Cllr Old asked if the redevelopment of St Ann's Hospital was still on schedule, as outlined in the Minutes. Andrew Wright confirmed that it was.

Subject to the above, the Minutes of the meeting Monday 23 March 2015 were duly **AGREED.**

6. DRAFT QUALITY ACCOUNT (2014/15) FOR BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST

Mary Sexton, Director of Nursing BEH Mental Health NHS Trust, introduced the Draft Quality Account 2014/15 as follows:

- The Account was an annual statutory document, required by all NHS service providers.
- The document's format and content was determined to a certain extent by guidance.
- This year's Account would, however, incorporate a more user friendly, visual format with additional information as a result of feedback on the previous year's document.
- The priorities for 2014/15 and 15/16 had been agreed via a number of stakeholder events; this ensured that they were meaningful to those involved.

- The final Account would include a summary document to make it more accessible to service users.
- Data within the Account incorporated both local statistics and national benchmarking. All data would be subject to external audit and a statement would be included in the final Account to this effect.
- The Account sought to develop and build on last year's priorities and work which were being taken forward by groups such as the Clinical Quality Review Group.
- The Trust was also working closely with the Patient Experience Committee to ensure that previous work continued to be developed.
- A number of challenges remained; for example, improving GP engagement.
- The Account would be taken to the Public Trust Board on 29 June for final sign off and would be published via the Trust's website on 30 June.

The following questions and comments were then taken:

Q: There is a lot of very positive work and information within the Account, which is to be commended. Communications with GPs seem to have improved significantly and this should be maintained. Please could you, however, expand on the position regarding the continued funding of the Primary Care Academy (page 22)?

A: Discussions around the continued funding of the Academy are still in progress. We will be keeping the situation under close review.

Q: Page 32 refers to a 90% service satisfaction level in the Service User Experience Survey. However, there seems to have been a decline in satisfaction during February and March. Were there any particular reasons for this?

A: This has been noted. A number of factors have contributed to this; in particular occupancy pressures.

Q: (Page 35) Would you say the Staff Engagement Task Force remains an effective group?

A: It is a relatively new initiative but we believe it is starting to make inroads into improving staff engagement and satisfaction. Staff satisfaction is a fluid issue; during January to March the Trust undertook a staff restructure and this kind of activity can impact upon results. We believe, however, that staff feel well supported and that their voices are heard.

Q: (Page 45) The use of CORE by the Complex Care Teams seems to show declining clinical improvement between 2010/11 and the present. Is there any explanation for this?

A: It is an accurate picture; however, it is difficult to compare year on year data and so identify any particular trends. We are aware of the situation and are closely monitoring it.

Q: What sort of engagement does the Trust undertake with CCGs?

A: There are a number of formal mechanisms including, for example, the Clinical Quality Review Group. 'Focus on Sessions' help the Trust and CCGs collectively look at particular issues and areas for improvement. We have a very positive relationship with the CCGs.

Q: (Page 8) On average, how long did it take for those complaints acknowledged outside of the 3 day target to be acknowledged?

A: The longest time taken to acknowledge a complaint was 5 days. During the last two quarters the Trust has met its target of acknowledging within 48 hours.

Q: (Page 8) On average, how long did it take to investigate those complaints not investigated within the target timescale?

A: The timescale for investigation is 25 days. No complaint took longer than 30 days to investigate. Any complaints investigated out of timescale only occurred during the year's first quarter.

Q: The Account refers to a move to individual service lines, rather than one service line across all 3 Boroughs. What was the reason for this change?

A: There are a number of reasons, the primary one being that CCGs are borough based and too much time was spent de-aggregating data for their use. Also, GPs wished for a single point of contact within their Borough and patients requested it; they wanted to be known as a 'Haringey patient', for example, rather than a 'dementia patient'. It made them feel less stigmatised and more a participant in their communities.

Q: Has the Trust now moved to a 'payment by results' contract?

A: No, but we are working towards an 'activity based' contract.

Q: Could there have been greater continuity from last year's priorities to the priorities in this year's Account?

A: The selection of this year's priorities was determined by the stakeholder events we held; the priorities therefore reflect what people wanted. However, some of the work/priorities undertaken in 14/15 have now become embedded in core learning; so this work has not been lost.

Q: What is the timeline for sending letters of discharge to GPs?

A: This varies. Some take 2-3 weeks. The target of sending assessment, review and discharge letters to GPs within 24 hours of a service user being seen in our mental health services remains a challenge and particularly difficult in some circumstances, for example, for staff who undertake visits and are therefore often out of the office. Consequently, we are in the process of agreeing more specific timelines for different working practices.

Q: Would the use of email speed up the process?

A: Yes, however, we have found that not all GPs are enabled to receive emails; we are working to improve this.

Q: Why is the level of compliance for mandatory staff training only 84%? Should it not be 100%?

A: There are quite a number of courses that are mandatory and it is sometimes a challenge to be able to release staff to attend them, given current occupancy pressures. We are aiming for full compliance and to this end, are looking at blended learning styles which may help staff meet requirements.

Q: Why do there appear to be low satisfaction levels for the National Staff Survey and the Service User Experience Survey?

A: The Patient Survey is undertaken annually and samples the experience of 800 patients. We have found, however, that the results of this survey often differ from the real time feedback we gather at a local level, which tends to be more positive. Patient experience is very individual and our staff are very aware of that. Patient feedback can also change over time once a patient leaves the service.

With regard to the Staff Survey; again this is an annual exercise. Media coverage, changes within the organisation and high levels of ward occupancy may have affected results. However, the Trust has made some real improvements in particular areas. For example, in respect of the 'would you recommend the Trust' indicator; we discovered that staff felt that they would recommend their team, but did not know enough about other teams to recommend the Trust as a whole. As a result, we are working to improve staff knowledge and experience of other areas of the Trust. The Task Group is also looking at other issues, including where responses seem 'disconnected' for example, staff may feel supported but may not feel there are enough development opportunities.

In respect of bullying and harassment, the Trust is working to understand these issues and to be clear about the standards it expects.

It was commented that staff should feel they have somewhere 'safe' to go to report any concerns and it was suggested that an explanation of the statistics and the things being done to address lower survey scores should be added to the Account. It was also requested that comparative data with other London Boroughs be added. **ACTION: Mary Sexton.**

Q: (Page 22) Referring to the levels of communication with GPs for those over 75, what are the actual numbers behind the percentages?

A: This will need to be checked **ACTION: Mary Sexton.**

Q: (Page 23) Referring to levels of attendance at Primary Care Academy training sessions, could GP CPD sessions be utilised to improve attendance?

A: We do try to do this where possible and we do have higher levels of attendance when we do. However, it is a challenge to fit them into an often busy programme.

Q: (Page 23) The usage of the GP advice line seems low, are GPs aware of it?

A: The advice line was actually implemented at the request of GPs, so they are aware of it. However, usage has been lower than we might have expected. We are committed to continuing to provide the advice line at the moment but we may review this in the future.

Q: (Page 24) Are the results of Physical Health Checks passed to GPs and what is the timescale for doing so?

A: Health checks for patients with enduring mental illness are undertaken every 12 months. Some patients may need health checks more often. Communication with GPs regarding health checks occurs, in the case of community patients, only if there is any significant change to a patient's circumstances or there are any concerns and in the case of a hospital patient, on the point of discharge.

Q: (Page 27) Referring to incident reporting, how was the target of increasing this by 10% determined?

A: It was felt there should be some sort of starting point and that this should be immediately achievable. The target will be reviewed after 6 months.

Q: (Page 28) Can you explain why there were significant increases in the numbers of serious incidents reported in May and September?

A: There are no particular factors which could explain this; serious incidents tend to be quite random in nature. There was no commonality between them.

Q: (Page 29) Are the Trust's levels of follow up contact with patients within 7 days below national average?

A: No, 98% is the national average.

Q: If no contact is established after 7 days, what action is taken?

A: A variety of actions are undertaken including welfare checks which may involve the Police visiting the home address.

Q: Are there may instances of this happening?

A: Not many. It is a small percentage.

Q: Do you take the opportunity to obtain patient feedback when contacting patients after discharge?

A: We have not done this to date but may well look at that. We acknowledge that doing so may provide more reflective feedback.

Q: (Page 34) Are the 6 questions listed in the Account for the Carer Experience Survey the total number of questions that were asked?

A: I believe these were all of the questions asked but will check this **ACTION: Mary Sexton.**

Q: (Page 39) It may be more useful to have population figures for those who use the Trust, rather than by London Borough with regard to the number of complaints?

A: It may be a statutory requirement to provide population statistics by London Borough, but I will check this **ACTION: Mary Sexton.**

It was proposed that if this was a statutory requirement, that information be added on the numbers of residents in Barnet, Enfield and Haringey who access the Trust's services **ACTION: Mary Sexton.**

Q: (Page 44) What would be a 'placebo' statistic for EQ-5D?

A: The scale would need to be checked. It should be noted that these are, however, patient reported.

It was suggested that the addition of benchmark figures from other Trusts would be helpful **ACTION: Mary Sexton.**

Q: (Page 46) Are the levels of reliable improvement during treatment within the Complex Care Teams going down and what are the reasons for this?

A: Yes, it is going down. It is a patient reported measure and it is difficult to compare year on year due to the fact that the patient group changes. Levels of occupancy on wards and higher sectioning levels may have affected results. It is sometimes difficult to achieve positive perceptions with patients who often have very complex needs and challenges.

Q: (Page 49) Why did the Trust not participate in the audit for prescribing for substance misuse (alcohol detoxification)?

A: The resources were not available at the time to participate in the audit; however, that will not be the case this year.

Q: (Page 52) Could the Trust indicate the timescale for resolving the IT coding issues?

A: The Trust has just gone live on a new upgrade for the RiO system which will address this.

Q: (Page 53) How many young people have been placed in employment support in partnership with Twinings?

A: I will need to obtain these figures after the meeting **ACTION: Mary Sexton**

It was requested that details of placements in Enfield and Haringey, as well as Barnet, be included in the Account **ACTION: Mary Sexton**

It was **AGREED** that a letter be drafted from the Sub-Group summarising all of the comments made and that this be sent to Mary Sexton by 20 June. It

was **AGREED** that comments provided for last year's Account also be included in this letter.

7. CONTRACTING AND FUNDING ARRANGEMENTS UPDATE

Graham MacDougall, Enfield CCG, gave the following update:

- No signed contract was yet in place.
- An agreed activity and finance schedule had, however, been submitted to NHS England.
- Areas of in year/long stop activity were still to be agreed and were currently under negotiation.
- It had been a significant year for the Trust, which was working closely with the CCG to agree levels of activity, efficiency of delivery and readiness to prepare and transform services. An independent company, Carnall Farrar, had been commissioned to look in more detail at the Trust's financial position.
- The Trust had operated against a deficit of £4.7m in the previous year, which would rise to £10m in the current year.
- Stabilisation of the Trust's financial position was a key area of discussion with CCGs. The Trust also wished to discuss further the sharing of risk around the deficit.
- It was acknowledged that the deficit position would impact upon staff recruitment and retention.

The following questions and comments were then taken:

Q: Is the Trust the only one in London at present to be operating with a deficit?

A: During 15/16 there will be 2-3 other Trusts in London that will be operating with a deficit.

Q: Are there any other sources or pools of funding available to the Trust to mitigate the deficit? There is a concern that service quality will drop as a result of financial instability.

A: The previous Government had committed funding over 5 years for mental health services, but this was specifically targeted at children's mental health. There was also additional money provided over the last quarter to support the Crisis Concordat. In 14/15 CCGs and the Trust did write to NHS England to request transformation funding, but this request was refused. The Trust will, however, continue to seek funding from NHS England and other sources if available. It should be noted that CCGs are also in a challenging place financially. The work of Carnell Farrar is quite extensive and will be a good source of information for future transformation programmes. It will also be key in helping the Trust and CCGs focus more on preventative work. Barnet CCG has received Parity of Esteem funding but has been mandated to target this principally at primary care.

Q: Of the four service areas the Trust operates, which is currently experiencing the biggest pressures?

A: Probably inpatient services. Occupancy levels are at 100% and an extra ward has been temporarily opened, in addition to private sector beds being used.

Q: What is the percentage of CCG budgets that is currently spent on adult mental health?

A: I would need to check this **ACTION: Graham MacDougall**

Q: What particular factors for mental health are contributing to the rising pressure on services?

A: There are a variety of factors. Changes to benefit payments have led to an increased migration of people from inner to outer London boroughs. In addition, a reduction in social care provision (for example, day services, voluntary sector community services) which might support people outside of hospital has also led to increased demand. Lastly, the increased use of legal highs, and higher levels of dementia diagnoses have contributed to increased pressure on mental health services.

Q: Are there any plans to merge/share services with other organisations in the longer term?

A: There are none apparent yet. The Trust is looking at a range of options which may include partnership working with other organisations such as Housing Associations. Under the 5 Year Forward View and the Dalton Review, the Trust is being encouraged to look at more creative partnerships. Increasing preventative work and early interventions may also help to increase self-care and management and therefore reduce demand on in hospital services. Use of new technologies will be key in helping to reach people. Such measures will, however, require a significant transformation programme and investment.

Q: What is the current, immediate position regarding mental health services and funding? Has all of the funding passed to CCGs been transferred through to the Trust?

A: Different CCGs are in different positions. Enfield has invested 5% of the 7.1% uplift in Parity of Esteem funding received; it has also invested in community services. Enfield CCG currently has a deficit of £14.4m and a savings plan of £12m; it has therefore not been possible for the CCG to invest in the Trust at a higher level. The uplift is not ring-fenced.

Barnet CCG is in a similar position and has operated under a deficit for a number of years. It has invested both in the Trust and in the IAPT service. Barnet has received an uplift of 4% for Parity of Esteem. 3.8% of the total amount has been invested in mental health services as a whole (i.e. some investment has been made outside of the Trust).

Haringey CCG has received an uplift of 3.4-5% for Parity of Esteem. Again, investment has been in a basket of services. It has invested 5% of Parity of Esteem, so has exceeded the uplift.

It was noted that all of the above information would be included in the report to be produced by Carnall Farrar.

The Group requested that the proportions of investment by CCGs in the Trust by each Borough be provided **ACTION: Graham MacDougall, Maria O'Dwyer, Jill Shattock.**

Q: Will the Carnall Farrar Report be a public document?
A: I will need to check **ACTION: Graham MacDougall.**

Q: What is the Trust doing to address the issue of patients travelling long distances to access a bed?
A: A lot of work has gone into addressing this issue. We are working with local authorities to streamline patient pathways. However, 11 days ago the Trust experienced an unpredicted large 'spike' in demand; as a consequence we have had to open a temporary extra ward.

A Commission has been set up to look at the provision of acute inpatient psychiatric beds. This review is ongoing and will be reporting in September.

Distances travelled by patients for beds have reduced recently, most are now found within the London area. However, it should be noted that many private beds are more difficult to access, as private operators are more selective.

Q: Is the Trust's financial position sustainable for the next year and the year after that? The Sub-Group should be made aware of any potential significant downturn of services or other issues that may be as a result of the Trust's position.
A: The Trust's financial position is a matter of ongoing negotiations with commissioners. The Trust has a number of expectations that it has planned for over the coming year which are positive and deliverable. I don't envisage services ceasing but it will be a very challenging year. There will, as mentioned previously, no doubt be an impact on our ability to recruit and retain staff and the Trust is doing all it can to support them.

Q: Should there be any cause for concern over the sustainability of running the St Ann's development once complete, given the deficit?
A: There is an in year and a long term situation to bear in mind. We have a transformation plan that will help address the position in the longer term which will require investment. The new facilities at St Ann's will actually help reduce the Trust's costs in running these services.

Q: What is the Trust's annual budget?

A: £190m.

Q: A forecast deficit for this year of £14.3m has previously been given, how has this now been reduced to £10m?

A: There may have been a transformation component to this. There has also been an increase in performance against our own internal Cost Improvement Targets.

Date of Next Meeting

It was **AGREED** that a September date be set for the next Sub-Group meeting at the Joint Health Overview & Scrutiny Committee meeting to be held in June. This would align with the publication of the Carnall Farrar Report.

The meeting ended at 12pm.

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Update from Barnet, Enfield and Haringey Mental Health NHS Trust

BEH JHOSC – 13 May 2016

Maria Kane
Chief Executive

Introduction

Update on key issues following last meeting on 26 February :

- Sustainability and Transformation Plan (STP)
- CQC Action Plan
- Contract position
- Enablement
- Estates
- Enfield Community Services
- To receive feedback on Trust's Quality Account for 2016/17

Sustainability and Transformation Plan

- NHS providers, commissioners and local authorities across NCL together developing five year Transformation and Sustainability Plan by 30 June
- STP will outline how the system will address three key ‘gaps’:
  - Health inequalities
  - Care quality
  - Financial sustainability
- Latest projection of financial gap across NHS in NCL by 2020/21 is £519m, assuming providers and CCGs achieve 1% CIPs annually
- Process led by David Sloman (RFL CEO), with Dorothy Blundell (CCCG CO) as CCG lead and Mike Cooke (LB Camden CEO) as LA lead
- Small central NCL Programme Team, with a series of workstreams, including urgent care, primary care, mental health, estate and workforce
- Two stakeholder workshops around mental health – one in January and second one on 12 May

Sustainability and Transformation Plan

- Overall theme of STP is about reducing numbers of people needing care in hospitals (both physical and mental healthcare)
- Target is to transfer care currently taking place in hospitals into community / primary care settings
- Mental health has a major role to play in this. Key themes of STP mental health work are:
  - Developing mental healthcare in primary care settings
  - Transforming mental health acute and recovery pathway, through greater enablement and self-care
  - Investing in improved mental health care within acute hospitals
  - Transforming CAMHS
  - Implementing the NCL Perinatal Strategy
  - Establishing an NCL female PICU

CQC Action Plan

- Trust found CQC Inspection a helpful and positive process
- CQC's report widely circulated to stakeholders. Overall rating was 'Requires Improvement' but rating of 'Good' for Caring in all services
  Full CQC report available at: http://www.cqc.org.uk/provider/RRP
- Quality Summit with CQC and stakeholders on 27 April reviewed CQC's main findings and Trust's response in Quality Improvement Plan
- CQC highlighted very positive feedback from Trust staff, highest staff morale of any London mental health provider and only Forensic service to be rated as 'Excellent'
- Trust was already working on the key issues and highlighted them to the CQC in advance, which CQC acknowledged as demonstrating insight
- Trust has developed a Quality Improvement Plan, which will be shared with stakeholders soon and will be rigorously monitored

CQC Action Plan

- Trust's Quality Improvement Plan is focused on four themes:
  - Staffing
  - Patient-centred care
  - Leadership and management
  - Premises and equipment
- Quality Improvement Plan will be a key part of Trust's overall Quality Improvement Programme now being established:
  - Dedicated Improvement Director
  - Improvement Partner
- Trust staff are fully engaged and committed to quality improvement. CQC found that Trust staff are "very caring, professional and work tirelessly to support patients"
- Trust will do everything it can to address the issues raised, but some require support from others, e.g. addressing underlying funding issues

Contract position

- Trust currently forecasting £12.9m planned deficit for 2016/17, which includes Trust making substantial cost savings
- Trust is currently reviewing further potential cost savings to move closer to proposed Control Total of £9.1m deficit
- Contract negotiations still continuing, seeking to avoid formal arbitration – latest position will be reported at the meeting
- Some movement on funding for demographic and non-demographic growth, but CCGs unable to address the increased investment recommended in the Carnall Farrar report in 2016/17
- Trust's underlying funding issue now part of NCL STP

Enablement

Trust's priorities for development of Enablement over this year are:

- 100 more service users in employment
- Ensuring staff provide an improved experience through Enablement training – measured by increased patient experience scores
- Ensuring staff provide a different 'offer' through clear alternatives to secondary care – measured by reduced reliance on secondary care
- Increasing the number of 'experts by experience' that we employ – first group of new Peer Support Workers just started
- Evaluating the programme and learning from service users and staff – series of events in each borough
- Enablement being developed with partners - useful to have an update on local authorities' position on CAMHS and Social Workers, as discussed at the last meeting

Estates

- Trust is closely involved in development of NCL STP Estates Plan
- Priority for the Trust is redevelopment of St Ann's Hospital. CQC confirmed that the ward environment at St Ann's is "the worst they have seen"
- Potential for greater consolidation of services in a larger redevelopment at St Ann's
- Trust working with NHS Improvement to ensure St Ann's approval is prioritised, once NCL Estates Plan is agreed
- Letter sent from JHOSC to NHS Improvement on this – thank you!

Enfield Community Services

- Trust continues to work with Enfield CCG to explore current funding shortfall for ECS identified by Carnall Farrar report
- Now part of a wider piece of work looking at developing a fully integrated ‘Enfield Health’ place-based model, bringing together health and care services in Enfield to improve care and cost effectiveness
- Still at early stage, but local support across organisations for further exploration

Trust Quality Account for 2016/17

- Trust's draft Quality Account, setting out proposed quality priorities for the year ahead, has been widely circulated for comments
- Series of events with stakeholders to get feedback and useful input as it has been developed
- Opportunity today to get feedback from Councillors on the draft, before it is agreed by Trust Board on 31 May and published on 30 June

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NHS Enfield Clinical Commissioning Group

UPDATE BRIEFING FROM BEH CCGS FOR BEH JHOSC – 13 MAY 2016

1. **Introduction**
   This short paper updates the Barnet, Enfield and Haringey JHOSC on the contracting and funding arrangements between the commissioning CCGs and BEHMHT for 2016/17.

2. **2016/17 Contract with Barnet, Enfield and Haringey CCGs**
   Enfield CCG, as lead commissioner CCG, has worked with the Trust over the past few months to try and agree a mental health contract for 2016/17. A number of agreements have been reached

   a) Activity outturn position for 2015/16
   b) Activity plan for 2016/17 with no growth assumed for 2016/17
   c) £2.6m recurrent commissioner support in line with Carnall-Farrar
   d) Contract schedules agreed with minor areas outstanding
   e) Contract documentation has been prepared for signing

   The commissioners view the offer as fair given that all increased investment for 2016/17 is against underfunding outlined in the Carnall-Farrar report. The Trust has not been able to accept the offer and sign the contract. There remains a financial gap between the £12.6m deficit positon and the £9.1m deficit control total issued by NHSI.

   Both Enfield CCG and the Trust have had two contract alignment meetings with NHSE and NHSI at which the above were agreed. All contracts nationally were due to be signed on Monday 25 April 2016 otherwise there would be a need for arbitration. It was agreed that the Trust and the CCGs would develop and agree a high level 5 Year Recovery Plan which would aim to substantially reduce the deficit as an alternative to arbitration. The Recovery Plan is still in the development and both parties are looking to have this agreed by 6 May at the latest.

   A verbal update will be given to the JHOSC on 13May 2016.

3. **Trust's Ongoing Deficit**
   The Recovery Plan aims to address as much of the deficit as possible over the next 5 years, though new business, Cost Improvement Programmes including estates, commissioner investment and activity shifts via Enablement and enhanced primary care. It is unlikely that this in itself will wipe out the deficit. The Trust are involved in the Mental Health component of the Sustainability and Transformation Plan which needs to address commissioner and provider deficits as part of NCL financial recovery and at the same time meet the health and wellbeing gap and the care and quality gap.

The Mental Health STP Steering Group met recently and has agreed the following priorities:

a) Primary care: enhanced mental health support to primary care, developing enhanced primary care models for mental health, enabling patients to be stepped down from secondary mental health services – potentially 15%
b) Acute mental health pathway with particular focus on inpatient pathways, rehabilitation pathways and admissions avoidance pathways
c) CAMHS with particular focus on implementing the Thrive model of care
d) Mental health estates

The activity and financial modelling is currently being undertaken for the above work streams. It has been agreed that this work needs to align with provider Cost Improvement Programmes to enable providers to take costs out of the system. It is unclear at the moment what additional financial support will be available to BEHMHT via the STP process.

Graham MacDougall
May 2016

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

A University Teaching Trust

Draft Quality Account 2015-2016

To be developed further following stakeholder input, including from BEH JHOSC on 13 May

Contents:

Part 1

Statement on Quality from Maria Kane, Chief Executive

Our Quality highlights from the past year include:

Statement on Quality from Mary Sexton, Executive Director of Nursing, Quality and Governance.

What is a Quality Account and why it is important

The Quality Account is an annual report that provides an opportunity to reflect and report on the quality of the services that are being delivered to our local communities and our stakeholders. It is a process in which engagement with patients, stakeholders and staff in an open and transparent way allows us to review the quality and demonstrate improvements in the services we provide. This affords us the opportunity to identify areas and agree our priorities for improvement with our stakeholder in the delivery of the services we provide.

All NHS providers strive to achieve high quality care for all, and the quality report gives the Trust an opportunity to demonstrate our commitment to quality improvement and the progress we have made in 2015-16 against the priorities identified. We will outline our key priorities against the three domains of quality to which we work to, Patient Safety; Patient Experience and Effectiveness.

Quality Account Governance Structure

The Executive Director of Nursing, Quality and Governance is the Executive Director with responsibility for the development of the Quality Account. Working with Clinical Directors and their teams to help shape the content of the Quality Account by working with our patients and staff to shape improvement indicators in line with our priorities identified through our engagement with them.

The Quality Account is reported on in Borough and Service dashboards which update teams on the progress made against each quality indicator. Quarterly progress reports are provided to the executive management team who then report to the Board.

Development of our Quality Priorities for 2016-2017

The Trust seeks to identify quality indicators that can be monitored and reported in a meaningful and beneficial way. To produce the quality priorities for 2016-17 we engaged with local stakeholders including up of patients, carers, staff, Clinical Commissioning Groups, Healthwatch, Overview and Scrutiny Committee members and members of the local communities we serve.

How to provide feedback

We hope that you find this report helpful and informative. We consider the feedback we receive from stakeholders as invaluable to our organisation in helping to shape and direct our quality improvement programme. We welcome your comments on this report and any suggestions on how we may improve future Quality Account reports should be sent to the Communications Department.

Email: communications@beh-mht.nhs.uk
Tel: 020 8702 3599

Address: Communications Department
Barnet, Enfield & Haringey Mental Health NHS Trust
Trust Headquarters, Orchard House
St Ann's Hospital
London N15 3TH

Additionally, you can keep up with the latest Trust news on our website Trust website: www.beh-mht.nhs.uk

Or through social media:

Follow us on Twitter @BEHMHTNHS
Like us on Facebook: www.fb.com/behmht

1.3 About BEH-MHT

Barnet Enfield & Haringey Mental Health NHS Trust (BEH) employs 2,900 staff providing inpatient and community care for children, young people and adults across Barnet, Enfield and Haringey, Community Health Services in Enfield and Specialist Services. Our annual income in 2015-2016 was £190 million. We serve a community of just over a million people and 155,000 accessed our services during the financial year.

The trust has 514 inpatient beds located on five main sites, St Ann's Hospital in Haringey, Chase Farm Hospital and St Michael's in Enfield, Edgware Community Hospital and Barnet Hospital in Barnet. Psychiatric liaison services are provided at Barnet Hospital and North Middlesex University Hospital.

The services provided by us are organised into three borough based directorates and one specialist directorate, each with a clinical director and service managers.

Our vision

To be the lead provider, coordinator and commissioner of integrated care services to improve the health and wellbeing of the people of north London and beyond.

Our values

The Trust's values are to:

- Put the needs of our patients and their carers first, and involve them fully in their care
- Show kindness and compassion in all aspects of the care we provide
- Behave with honesty, integrity and openness
- Create a safe, friendly and caring environment, where people are treated with respect, courtesy and dignity
- Strive for excellence, recognising achievements and valuing hard work
- Support our staff to be the best that they can be

Our Objectives for 2015/16 were to:

1. Provide excellent services for patients

- Provide excellent clinical services using the principles of enablement ("Live, Love, Do"), delivered with care and compassion

2. Develop our staff

- Enable our staff to be the best they can be, to deliver excellent patient care

3. Be clinically and financially sustainable.

- Develop a long term sustainability plan with our partners

1.4 Systems in place to ensure quality at the highest level

We aspire to provide care of the highest quality, in collaboration with those who use our services. BEH is an organisation that embraces continuous improvement and learning.

The Board of Directors ensures proactively that we focus not only on national targets and financial balance, but continue to place significant emphasis on the achievement of quality in our local services.

Our robust quality governance systems support the arrangements in place to provide the Board of Directors with assurances on the quality of BEH's services and to safeguard patient safety. We produce a comprehensive quality (including safety, experience and effectiveness) and performance dashboard on a monthly basis; we undertake compliance checks that mirror the Care Quality Commission's (CQC) reviews; we have an active national and local clinical audit programme; we monitor patient experience and complaints and have a robust risk management and escalation framework in place.

The quality governance system, quality performance and assurance on the arrangements in place are overseen by sub-committees of the Trust Board.

1.5 Care Quality Commission Comprehensive Inspection

The report of the inspection was published on 24th March 2016 with our Trust being given an overall rating of 'Requires Improvement'

The CQC inspected eleven of our core services and gave them each a rating.

Six of our services were rated as 'good' or 'outstanding'. Five were rated as 'requires improvement' due to the way the CQC's rating system works, means our overall rating is 'requires improvement'.

The CQC inspectors reported significant positive feedback from patients about our staff being "kind, skilled and well trained", and noted that staff "were very caring, professional and worked tirelessly to support the patients using the services provided by the Trust." Based on this evidence the CQC rated all our services as good for the 'Caring' domain.

Our services were rated as follows:

Outstanding

1. Forensic inpatient wards

Good

2. Wards for older people with mental health problems
3. Community Health Services for adults
4. Community health inpatient services
5. Community health services for children, young people and families
6. Community based mental health services for older people

Requires Improvement

1. Child and adolescent mental health wards
2. Specialist community mental health services for children and young people
3. Community based mental health services for adults of working age
4. Acute wards for adults of working age and psychiatric intensive care units
5. Mental health crisis services and health-based places of safety

The CQC acknowledged that the Trust knew about the challenges it was facing and was already making improvements.

We will be working with the CQC, our Commissioning groups and our staff on continuing to improve our services. You can find the full report on the CQC website - http://www.cqc.org.uk/provider/RRP

1.5.1 Registration with the Care Quality Commission (CQC)

Barnet Enfield and Haringey Mental Health NHS Trust is required to register with the Care Quality Commission and its current registration status is that it is registered without conditions.

Part 2:

2.0 Key actions to maintain and / or improve the quality of services delivered

2.1 Quality Strategy 2016-2019

"Quality at the Heart of Every Conversation we have"

In January 2016, we launched our Quality Strategy 2016-2019.

The strategy continues the journey outlined in the 2013-2016 Quality Strategy priorities. These are:

- Ensuring patient safety is a top priority for all staff (Patient Safety)
- Ensuring patients are offered up to date care (Clinical Effectiveness)
- Ensuring a positive experience of care for service users and carers (Patient and Carer Experience)

2.1.2 Strategic Aim

- To ensure that the Trust's approach and commitment to quality and quality governance is clearly defined so that all Trust staff are clear on their role and the drive to continually improve the quality of care.
- To ensure quality governance and risk management continue to be integrated into the Trust's culture everyday management practice

2.1.3 Quality Improvement strands

The Quality Strategy brings together the quality improvement strands within our Trust:

Trust Pillars of Quality Strategy

2.1.4 Measures of Quality

- Improving Clinical effectiveness
- Improving Patient Safety
- Improving the Patient and Carer Experience
- Adopting the Sign up to Safety campaign

Achieving all of this means we will continue to think differently. We need to be innovative and give everyone, at every level the skills they need to lead change, focusing on what matters most to our service users and staff, and improving access to evidence-based care. This will make our services more effective, give more power to our staff and improve patient experience and outcomes.

3 Review of our progress made against 2015/16 quality priorities

3.1.1 The Quality Account priorities were set against each of the three domains of quality:

- Patient Safety
- Patient Experience
- Effectiveness

3.1.2 The Trust identified the following quality improvement priorities for 2015-2016:

Safety:

- To improve discharge communication from inpatient settings with our GPs and improve individuals' physical health and wellbeing through alcohol misuse screening and smoking cessation services

Experience:

- To enable young individuals through coping and self-care skills training and provide additional support to those dealing with long term conditions.

Effectiveness:

- To evaluate a sample of enablement pilots through patient reported outcome measures.

3.1.3 Progress to date.

3.1.4 The **Discharge Communication** target was 65% in Q1 and 70% in Q2 respectively and was achieved. 85% was achieved in Q3 after the introduction of electronic mailing to GPs. Compliance of 89% was achieved in Q4, just under the Q4 target of 90%.

	Q2	Target	Q2	Target	Q3	Target	Q4	Target
Discharge summaries (containing mandatory content and sent within 24 hours)- all inpatient wards	84%	65%	87%	70%	85%	85%	89%	90%

3.1.5 **Physical health and Wellbeing**
Implementation of the Fast Alcohol Screening Test (FAST) tool:

- The FAST tool was implemented from 1st October 2015.
- Nominated trainers from each team were trained to deliver alcohol misuse assessment and communications skills into their teams.
- Data from Quarter 3 provided a baseline to measure screening rates against.
- Of those screened positive, the quarter 4 target required that 95% of service users had been given brief intervention and information and 95% have had a letter sent to their GP within 24 hours. We achieved 100% for both targets.

Patients screened through FAST Tool (Q4)	**292**
Patients screened positive receiving brief intervention and information during quarter	100% (24 of 24)
Patients screened positive and registered with a GP where communication of result is sent within 24hrs	100% (24 of 24)

3.1.6 Smoking cessation targets have not been achieved. Work is ongoing to achieve targets and audits are in place and reported to Deep Dive meetings for monitoring and addressing.

	Q1	Target	Q2	Target	Q3	Target	Q4	Target
Smoking status recorded (adults)	90%	95%	92%	95%	94%	95%	94%	95%
Smoking status recorded (14 - 18 yrs. olds)	50%	baseline	47%	90%	42%	95%	56%	95%
Brief advice offered to smokers	86%	95%	93%	95%	94%	95%	92%	95%
Quit attempts (of those wishing to quit), initiation of treatment and referral - inpatients	41%	20%	85%	21%	84%	23%	94%	24%
Quit attempts (of those wishing to quit), initiation of treatment and referral - cardiac, stroke, vascular, respiratory, maternity and diabetes services	0%	25%	63%	27%	0%	29%	N/A For Q4 there were no patients wishing to quit smoking	30%

3.2 Quality Indicators & Priorities for 2016/17

This section of our Quality Account will provide an update of our priorities for improvement and statements of assurance from our Trust Board.

BEH is committed to delivering quality care and we have worked in partnership with staff, people who use our services, carers, members, commissioners, GPs and others to identify areas for improvement.

Our Quality Account gives us an opportunity to share our performance against our priority areas for 2015/16, describe our priority areas for 2016/17 and showcase notable and innovative practice that has taken place across our services this year.

Our priorities for quality in 2016/17 were produced following detailed discussions over a six month period with service users, the Executive Directors, Trust staff, our Commissioners and external partners. Two planning events were held in October 2015 and March 2016 with participation from staff, people who use our services, carers, partners, commissioners and representatives from other statutory and voluntary organisations.

3.2.1 Our Quality Priorities for 2016/17

Three Quality Priorities for 2016/17 were agreed. These build on our quality priorities for 2015/16. We believe these priorities will help deliver the improvements most often identified by our stakeholders and will lead to improved health outcomes for our partners and for people who use our services.

- Provide excellent quality of care and improve the experience for everyone who use our services
  - Priority
  - Action
  - Target
- Develop a long term plan with our partners to maximise our resources through service improvements and innovation
  - Priority
  - Action
  - Target
- Improve our communications with our primary care partners to ensure a continuity of care following changes in treatment and discharge
  - Priority
  - Action
  - Target

3.2.2 Governance arrangements:

- **Trust Board**
  The Trust Board receive reports from the Quality Safety Committee on compliance with quality improvement and risk to the quality of care and service delivery in our Trust services.

- **Quality and Safety Committee**

  Chaired by a Non-Executive Director appointed by Trust Board, the Committee provides the Trust Board with assurance concerning all aspects of quality and safety relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients and to assure the Trust Board that where there are risks and issues that may jeopardise

the Trust's ability to deliver excellent high quality safe care that these are being managed in a controlled and timely way.

- Deep Dive Committee

Each Borough has its own Deep Dive Committee meeting chaired by the Executive Director of Nursing, Quality & Governance to enable a deeper analysis and scrutiny of the Boroughs and its services. It is a process which identifies both positive practice and areas in which further developments are required. It allows for teams to discuss and learn from each other and share further their good practice and learning.

- Borough Governance meetings

Each Borough meets monthly to review their governance and quality agendas and compliance with key workstreams. The variation of the agenda across the Boroughs will continue to enable different areas to meet their priorities. The Boroughs present twice yearly a detailed governance report to the Quality &Safety Committee to ensure scrutiny.

- SIRGs - Serious Incident Review Groups

3.3 Statement of Assurance from the Board regarding the review of services

During 2015/16, Barnet, Enfield and Haringey Mental Health Trust (BEH) provided services across mental health and community NHS services. BEH has reviewed all the data available to them on the quality of care in all of these NHS services. The income generated by the NHS services reviewed in 2015/16 represents 100% of the total income generated from the provision of NHS services by BEH for 2015/16.

3.4 Participation in clinical audits and national confidential enquiries

Clinical audit is a quality improvement process undertaken by doctors, nurses, therapists and support staff that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change (NICE 2005).

Robust programmes of national and local clinical audit that result in clear actions being implemented is a key method of ensuring high quality and ever improving services. The Trust participates in the National Clinical Audit Patient Outcome Programme (NCAPOP) audit process and additional national and locally defined clinical audits identified as being important to our population of service users.

During 2015/16 eight national clinical audits and one National Confidential Inquiry covered relevant health services that BEH provides. During 2015/16 the Trust participated in 100% national clinical audits and 100% national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that BEH was eligible to participate in during 2015/16 are listed below. We reviewed reports of seven national audits in 2015/16.

Outcomes and lessons learnt from national clinical audits

National Audits – lessons learnt	
POMH-UK Topic 10c- Prescribing antipsychotics for children and adolescents	Barnet Scan Team • A systematic psychoeducation on antipsychotics with all of the patients on caseload, prior and during the time of prescribing was carried out. • Develop Paediatrics pathway to refer the Barnet SCAN clients to have bloods in an adapted environment with support (with or without sedation) • Barnet SCAN have close links with paediatricians and consult with them regarding cardiological issues. • Regular discussions with medical colleagues, families and patients the pros and the cons of carrying out bloods and ECG to balance the physical risks of antipsychotics with the risks of agitation/traumatization of carrying out such procedures as well as the actual risk to self and others. Sometimes, it is not possible to carry out baseline medical investigations in the context of severe behavioural disturbance, but every effort is made to do so.
POMH-UK Topic 12b- Prescribing for people with a personality disorder	• To improve prescribing for people with a personality disorder the Haringey Personality Disorder Service now has a non-medical prescriber who has taken over prescribing for at least 80% of personality disorder patients currently in treatment with the Stream. • To develop a prescribing protocol by March 2016. There have been a number of improvements within the service since the baseline audit carried out in April 2012. Some of these include: • An increased proportion of patients prescribed one or more antipsychotic medications, for whom the clinical reasons for prescribing the most recently initiated antipsychotic were documented. • An increased proportion of all patients with a crisis plan and involvement in its development. • A fewer proportion of patients with a PD diagnosis only (i.e. no co-morbid psychiatric diagnosis) prescribed antipsychotics for more than 4 weeks. • No patients prescribed z-drugs or benzodiazepines. • An increased proportion of patients with a review of medication prescribed for more than four weeks.
National Audit of Intermediate Care Undertaken by the Intermediate Care team (ICT) and Magnolia ward. The national Report was published in June 2015	• There is significant improvement in waiting times for Rehabilitation as all patients are now triaged at point of entry and an agreed visit set within the same day. • Staff Nurses, Physio, and OT are now completing core care plans on Rio. • Share Records is yet out of the ICT control to influence implementation but underway with CCG involvement • For winter 2015/2016 period –All referrals requiring therapy intervention to be seen within 24 hours.
National Audit of Schizophrenia audit	• RIO care plan library has been developed across different teams to support clinicians with monitoring of patients' physical health. • Physical health sections on RIO which are allocated to record history/assessment/results of physical health were reviewed • CRHTs have reviewed all the communication materials. Posters, leaflets and cards with current contact details were produced and circulated. All these actions were discussed with service users groups through different exercises • Establishment of Physical Health Steering Group
Sentinel Stroke National Audit Programme . (SSNAP)	Enfield Community Stroke Rehab Team took part in this audit. The national report was published in July 2015. RESULTS? LEARNING?

Outcomes from local priority clinical audits

Audit	Lessons Learned
Quality Assurance Audit (care planning standards)	Guidance and training provided on developing care plan goals in line with SMART principles (specific, measureable, achievable, relevant and time-bound). Training was provided to clinicians across all the Boroughs in the Trust with local monitoring of these standards completed monthly.
Peer Service Reviews	Mental Capacity Act (MCA) and safeguarding training was provided to identify clinicians requiring further development through their team's peer review in the CQC's outcome 2 (consent to care and treatment) and CQC's outcome 7 (safeguarding). Improved supervision structures were implemented within teams to ensure staff have regular access to supervision to discuss concerns and managerial issues.
GP Discharge Summaries audit	A review of discharge summaries was undertaken to ensure it is fit for purpose and covers all the required information. A local quality improvement project was developed and piloted in a selection of community teams in Barnet and Enfield. The project focused on getting correct information to the service user's GPs, recording of physical health interventions and getting appropriate information to service users on their mental health condition. In line with this piece of work, the teams continue to review their monthly quality assurance audits which monitors the quality of physical health assessments and patient experience as reported by service users and carers.
Pre-discharge plan audit	This audit saw an improvement on the Elderly wards in quarter two 2015/16 (Q1=47% , Q2=89%) in completion of pre-discharge plan within 72 hours that has specific requirements. Teams are recording all this information on the pre-discharge plan section on RIO.
Medicines on discharge from wards	This involved the use of a mini-medication tool for patients over 75 years old across all the mental health elderly and magnolia wards.
Smoking Cessation audit	Record of smoking status and offer of brief advice increased from quarter 1 and 2, 2015-16. The results of this audit were circulated to all the teams; they have action plans in place to improve these requirements.
Infection Control audits	The infection control audits continue to drive improvements for patient safety and quality of care. Findings are discussed at the monthly environmental actions operational group meetings held in each borough to address the standard of cleanliness, and estates issues. Cleaning standards which has been much debated has improved in all patient areas. The audits highlighted that community clinics were trailing behind inpatients areas. Hotel services are addressing this.
Safe & Secure handling of medicine	There has been on-going improvement in compliance with the standards, with large improvement in the areas of concerns.

3.5 Participation in Accreditation Schemes

The CQC recognise the value that participation in accreditation and quality improvement networks has for assuring the quality of care we provide. Participation demonstrates that staff members are actively engaged in quality improvement and take pride in the quality of care they deliver.

The following BEH wards and services have successfully participated in accreditation schemes, part of The Royal College of Psychiatrists' national quality improvement programme.

01 April 2015 – 31 March 2016

	Trust Participation	National Participation
Service Accreditation Programmes and Quality Improvement Networks		
Eating Disorder Inpatient Wards	1 wards	32 wards
Forensic Mental Health Units	1 services	123 services
Inpatient Child and Adolescent Wards	1 ward	108 wards
Inpatient Rehabilitation Units	0 wards	52 wards
Learning Disability Inpatient Wards	0 wards	42 wards
Mother and Baby Units	N/A units	17 units
Older Peoples' Inpatient Wards	0 wards	68 wards
Psychiatric Intensive Care Wards	0 wards	39 wards
Working Age Inpatient Wards	0 wards	146 wards
Child and Adolescent Community Mental Health Teams	0 teams	64 teams
Crisis Resolution and Home Treatment Teams	2 teams	40 teams
Electroconvulsive Therapy Clinics	1 clinic	99 clinics
Memory Clinics	3 clinics	105 clinics clinics
Perinatal Community Mental Health Teams	0 teams	17 teams
Psychiatric Liaison Teams	2 teams	52 teams

3.6 Peer Service Review Programme

3.6.1 The Trust has established a peer service review process, developed as a means of assessing team compliance with the Care Quality Commission's (CQC) Regulatory Framework. Peer review tools included local standards established by Trust policy and procedures related to each CQC outcome in the Essential Standards for Quality and Safety. Questions specific to different teams in the Trust are identified within the tool.

3.6.2 The peer review audit tool consists of four elements of information to be collected during the review process were:

- **General Inspection** – An assessment of the team environment which requires teams to have such items as information on medicines or treatment; patient satisfaction results displayed; the names of staff who can order controlled drugs; etc.
- **Patient Records Inspection** – An audit of patient records of the patients seen by the team. Reviewers are required to inspect three patient records as a snapshot of the teams compliance with Trust policy and procedure (i.e. patients having a copy of their care plan; patients being involved in their care planning; patients consent to medication documented, etc.)
- **Service User Interview** – The reviewers speak with three service users to obtain their feedback on the services provided (i.e. whether individuals have been involved in assessing and planning their care; agreed to treatment; have access to fresh air and exercise; are given an opportunity to feedback on their care plan). These interviews may not always be possible in the community teams.
- **Staff Interview** – This element requires reviewers to speak to three staff members and assess their knowledge in relation to key Trust policy and procedures (i.e. what is the process for checking controlled drugs; the procedure for monitoring service users taking high dose antipsychotics).

3.7 Quality Assurance Programme

- The Quality Assurance (QA) programme is designed to assist with embedding quality at a local level. The implementation and maintenance of high standards is for the benefit of all involved in the mental health and community services and is focussed on ensuring people who use our services receive high quality care.

- The Quality Assurance Programme is a collection of all the Trust Audit programmes such as the Pharmacy Department Audit Programme, NICE Audit Programme, National Audit and Confidential Enquiries Programme, CQUIN programme Junior Doctors and other Clinical Staff. They cover important areas including Quality Assurance Audits, Service Peer Reviews, national and local surveys and audits, monitoring of outcome measurements, patient safety, safeguarding and service user and carer experience. Together these assessments combine to give a total of over 100 audits, surveys and quality projects undertaken a year.

- The Quality Assurance Programme provides teams, services and the Trust Board with timely data to be assured that the quality agenda is being appropriately monitored and clinical quality risks are identified and addressed at every level of the organisation.

- The QA programme includes spot checks to provide assurance to management over the accuracy of data used to audit wards and community services.

3.8 Trust arrangements for learning from Clinical Audit:

To ensure lessons are learnt and to share good practice, we have put in place the following arrangements:

- Reporting of the outcomes of clinical audit. Ensuring that audit activity and in particular recommendations and learning from audits, are widely disseminated and implemented. Lessons learned from clinical audit activity in one Borough are shared with the other Boroughs wherever relevant to ensure that common themes are identified and steps are taken to improve services where necessary.

- Early involvement of managers in the clinical audit process ensuring commitment where any identified changes raise resource implications.

- Evidence of safe and effective care through participation in all relevant audits within the National Clinical Audit and Patient Outcomes Programme.

- Increased engagement and strengthened links with clinical directors, senior nurses and department leads about the Clinical Audit agenda.

- Improved action planning to address variation with re-audit where indicated so that organisational learning takes place.

- Ensure that all clinical audit activity is centrally registered, coordinated, monitored and reported on systematically and effectively so as to maximize the potential for improvement and learning.

- Ensuring robust local processes for the sharing of learning from local clinical audits across the Trust so as to maximize the

potential for learning and quality improvement across the widest possible clinical audience.

- Align clinical audit activity to the Trust's quality and safety priorities. The Clinical Audit Programme links to the Trust's Quality Strategy and Quality Aims.

3.9 Patient Reported Outcome Measures (PROMS)

The Trust currently uses PROMs in a range of services. Different software and systems that meets the individual service's needs are utilised for collecting, analysing and sharing of data.
AM to provide update

3.9.1 Implementation of PROMs

The PROMs reporting process will be reviewed so that adequate information is available to clinicians, people who use our services and commissioners where it is relevant. A system for monitoring and reporting of patient outcome information to governance committees will be established.

Add data.

3.10 Participation in Clinical Research

- The National Institute of Health Research (NIHR) distributes £280m a year of research funding via 15 Clinical Research Networks (CRNs), the local one being the North Thames CRN (NT CRN). Research support services (including research governance) are also provided through local structures, the one for north, east and central London being called 'NoCLOR' (www.noclor.nhs.uk), which supports the Trusts Research and Development Committee R&D committee and provides training and support for research staff. Studies which receive external funding through competitive bids can apply to be on the NIHR portfolio through the local Clinical Research Network (CRN).

- The target for the recruitment of participants in research for our Trust in 2015/2016 was set at 302, an increase of 13.5% on the recruitment figure achieved 2014/15 of 266. The number of patients receiving NHS services provided or sub-contracted by BEH in 2015/16 that were recruited to participate in research approved by a research ethics committee was 343, 13.5% more than expected.

- Throughout the year, the Trust has been involved in 31 studies; 23 were NIHR funded, and 8 were unfunded. There were no commercial trials.

- Over the past year researchers associated with the Trust have published 40 articles in peer reviewed journals.

- The Trust's research partners are NIHR through local CRN, NoCLOR, University College London, and Middlesex University.

An example of studies where people who use BEH service have been recruited during 2015/16:

Dementia and neuro-degenerative studies conducted:

The PrOVIDe study	The aim of this study was to establish the prevalence

	of a range of vision problems among people with dementia.
Preferences for End of Life Care	This was a local PhD study, asking the question: How well do people with dementia and memory problems, and their carers, agree of preferences for life sustaining treatment(s) at end of life and which factors influence this?
Patient Recorded Outcome Measures (PROMs)	This was a questionnaire-based study to evaluate health-related quality of life, (HRQL) of patients and carers attending first Memory Clinic appointments at Enfield Memory Service.

Mental Health Research Network (MHRN) studies conducted in 2015/16

Domestic violence and women with learning disabilities	The overall aim is to learn through in-depth, one-to-one interviews, more about the experiences of domestic violence by women with learning disabilities to identify ways of improving the support available to them.
DNA variation in adults with learning disability	The study analyses genetic differences in those over 18 with learning disabilities and mental health problems. The study aims to identify genes which influence treatment response and prognosis.
EQUIP: Training to promote user involvement in care planning	The main purpose of this research was to develop a user/carer-led training package for mental health professionals to enhance user/carer involvement in their care planning.
Homicide by patients with schizophrenia: a case-control study	This study aims to examine socio-demographic, criminological and clinical characteristics and clinical care of people with schizophrenia who commit homicide compared with control cases with schizophrenia who do not commit homicide.
IMPACT-ME	Qualitative study aiming to explore the process of overcoming severe depression as experienced by adolescents and their families receiving psychological therapies.
LonDownS cohort	An integrated study of cognition and risk for Alzheimer's Disease in Down Syndrome. The aim of this study was to investigate the variations in the development of AD and their developmental origins.
Validation of risk assessments for patients from MSS (VoRAMSS)	The validation of new risk assessment instruments for use with patients discharged from medium secure services.

3.11 Commissioning for Quality and Innovation (CQUINS)

3.11.1 Goals agreed with commissioners for 2015/16

The CQUIN (Commissioning for Quality and Innovation) payment framework aims to support the cultural shift towards making quality the organising principle of NHS services, by embedding quality at the heart of commissioner-provider discussions. It continues to be an important lever, supplementing Quality Accounts, to ensure that local quality improvement priorities are discussed and agreed at Board level within and between organisations.

Following negotiation with commissioners, BEH launched a broad range of quality initiatives under the CQUIN scheme during 2015/16 to increase the quality of care and experience for people who use our services.

We implemented five national CQUIN schemes across the organisation and twelve local schemes following discussions with the Clinical Commissioning Groups based on local priorities. Additionally, five CQUINS schemes specific to Specialist Services were implemented.

Nationally applicable CQUINS:

- Cardio Metabolic Assessment and Treatment for Patients with Psychoses.
- GP Communications
- (Enfield Community Services) Dementia and Delirium – Find, Assess, Investigate, Refer and Inform (FAIRI):
- (Enfield Community Services) Dementia and Delirium – Staff Training
- (Enfield Community Services) Dementia and Delirium – Supporting Carers

A selection of the projects negotiated locally included initiatives aimed at:

- Prevention – Smoking Cessation:
    - To offer brief smoking advice and treatment to inpatients
    - pro-active promotion of stop smoking service (in-house or local)
    - offer of Nicotine Replacement Therapy
    - referral to appropriate physical health specialities
    - identify a smoking cessation clinical champion.
- Prevention – Alcohol Misuse:
    - Evidence-based screening and brief advice tool to identify increasing (hazardous) and high risk (harmful) alcohol consumption
    - Brief intervention and information on sensible/safer drinking for positive screens. Communication to GP and appropriate referrals to alcohol liaison
    - frontline staff trained to screen and provide information and refer where indicated.
- Prevention – Domestic Violence (DV):
    - Develop measure to identify, assess and advise patients where there is evidence of domestic violence
    - encourage provision of specialist advice, information and support services
    - further referral where DV identified.
- Safe and timely discharge
    - Effective discharge arrangements - avoiding risk of unnecessarily long lengths of stay, minimising risk of readmission and ensuring safety on discharge.
    - Medicines on Discharge: discharge plan in place within 24 hours.
    - Discharge information for GPs: summaries to GPs within 24 hours.

3.11.2 Specialist Services CQUINs for 2015-16:

- Secure Service Users Active Engagement Programme: Q2 - Audit of nature and extent of service user involvement in risk assessment and safety management plans.

- Mental Health Carer Involvement Strategies: Builds on the carer involvement strategies developed during 2014/15 and requires providers to evaluate the effectiveness of these strategies and further develop ways to involve carers, family and friends at a local and regional level.

- Assuring the Appropriateness of Unplanned CAMHS Admissions.

- Improving Physical Healthcare to Reduce Premature Mortality in MH: To demonstrate full implementation of appropriate processes for assessing, documenting and acting on cardio metabolic risk factors in inpatients with psychoses and community patients.
  Add if achieved or not.

3.12 Data Quality

The ability of the Trust to have timely and effective monitoring reports using complete data, is recognised as a fundamental requirement in order for the Trust to deliver safe, high quality care. The Trust Board strongly believes that all decisions, whether clinical, managerial or financial, need to be based on information which is accurate, timely, complete and consistent. A high level of data quality also allows the Trust to undertake meaningful planning and enables services to be alerted of deviation from expected trends.

Significant improvements have been made during 2015/16 in terms of data quality and reporting. The following key developments have been made:

• Introduction of monthly dashboards allowing the Trust to display validated data against key performance indicators, track compliance and allow data quality issues to be clearly identified;

• Introduction of a borough specific report in the same layout as the report to Trust Board. This has improved consistency of reporting.

3.13 National Mandated Indicators of Quality

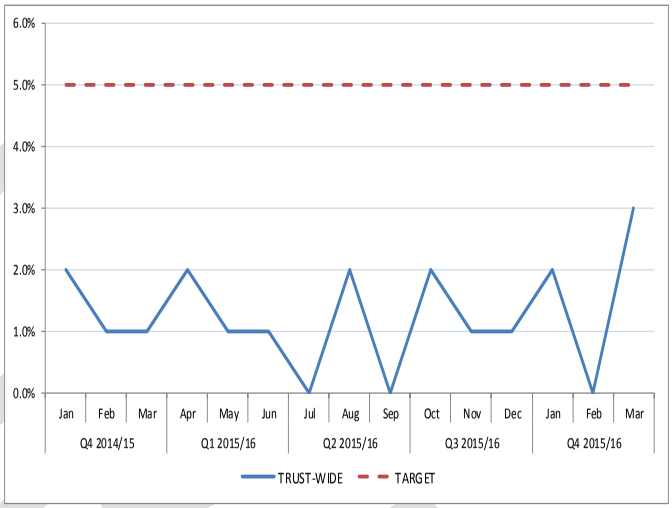
We are required to report against a core set of national quality indicators to provide an overview of performance in 2015/16.

% OF ADMISSIONS THAT ARE EMERGENCY READMISSIONS WITHIN 28 DAYS OF DISCHARGE

This indicator shows the % of all Admissions that are Emergency Readmissions within 28 days of discharge.
The target established by Monitor is less than 5% of all Admissions should be Emergency Readmissions.

Barnet, Enfield & Haringey NHS Mental Health Trust have over-performed against this target, with an average of 1.3% of all Admissions being Emergency Readmissions within 28 days.

	Q4 2014/15			Q1 2015/16			Q2 2015/16			Q3 2015/16			Q4 2015/16		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
TRUST-WIDE	2.0%	1.0%	1.0%	2.0%	1.0%	1.0%	0.0%	2.0%	0.0%	2.0%	1.0%	1.0%	2.0%	0.0%	3.0%
TARGET	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%

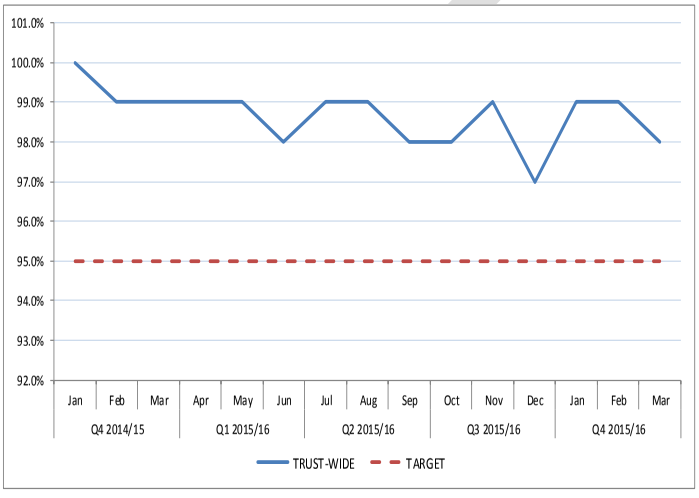


IAPT - % OF PEOPLE TREATED WITHIN 18 WEEKS OF REFERRAL

This indicator shows the % of IAPT referrals that finish a course of treatment, who received their first treatment appointment within 18 weeks of referral.
The target set by Monitor of 95% provides for tolerance for factors outside of the control of the Trust which may prevent an individual being treated within 18 weeks.

Barnet, Enfield & Haringey NHS Mental Health Trust have performed well against this target, with an average of 98.7% ofpatients treated within the target in the last 15 months available.

	Q4 2014/15			Q1 2015/16			Q2 2015/16			Q3 2015/16			Q4 2015/16		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
TRUST-WIDE	100.0%	99.0%	99.0%	99.0%	99.0%	98.0%	99.0%	99.0%	98.0%	98.0%	99.0%	97.0%	99.0%	99.0%	98.0%
TARGET	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

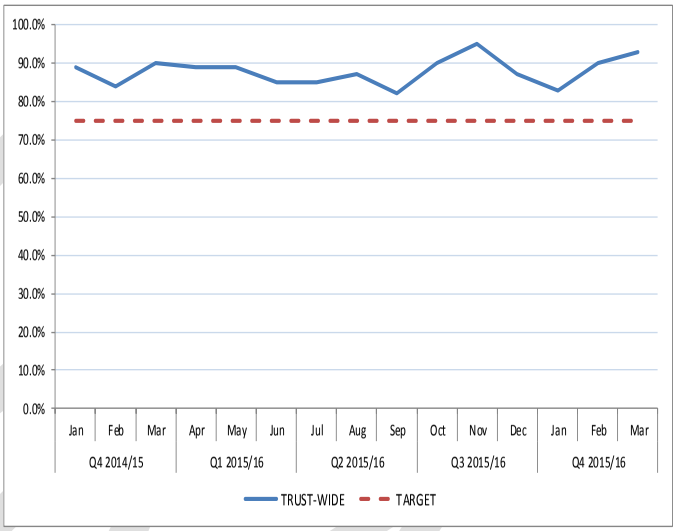


IAPT - % OF PEOPLE TREATED WITHIN 6 WEEKS OF REFERRAL

This indicator shows the % of IAPT referrals that finish a course of treatment, who received their first treatment appointment within 6 weeks of referral.
The target set by Monitor of 95% provides for tolerance for factors outside of the control of the Trust which may prevent an individual being treated within 6 weeks.

Barnet, Enfield & Haringey NHS Mental Health Trust have performed well against this target, with an average of 87.9% of patients treated within the target in the last 12 months available.

	Q4 2014/15			Q1 2015/16			Q2 2015/16			Q3 2015/16			Q4 2015/16		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
TRUST-WIDE	89.0%	84.0%	90.0%	89.0%	89.0%	85.0%	85.0%	87.0%	82.0%	90.0%	95.0%	87.0%	83.0%	90.0%	93.0%
TARGET	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%

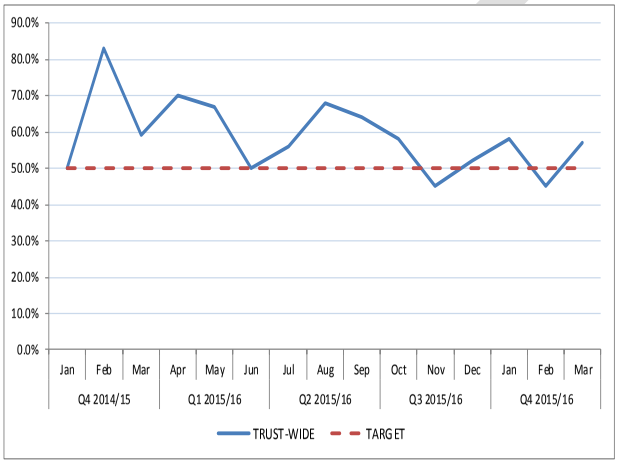


EIP - % OF PEOPLE TREATED WITHIN 2 WEEKS OF REFERRAL

This indicator shows the % of EIP referrals that have been placed on a NICE concordant course of treatment, who received their first treatment appointment within 2 weeks of referral.
The target set by Monitor of 50% provides for tolerance for factors outside of the control of the Trust which may prevent an individual being treated within 2 weeks.

Barnet, Enfield & Haringey NHS Mental Health Trust have performed well against this target, with an average of 58.8% of patients treated within the target in the last 15 months available.

	Q4 2014/15			Q1 2015/16			Q2 2015/16			Q3 2015/16			Q4 2015/16		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
TRUST-WIDE	50.0%	83.0%	59.0%	70.0%	67.0%	50.0%	56.0%	68.0%	64.0%	58.0%	45.0%	52.0%	58.0%	45.0%	57.0%
TARGET	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%

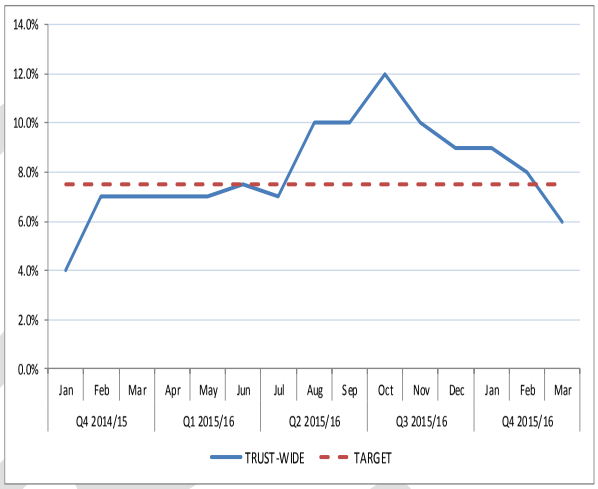


% OF OCCUPIED BED-DAYS DUE TO DELAYED TRANSFERS OF CARE

This indicator is calculated as the % of In-Patient bed-days lost to DTOC's due to either NHS or Social Care related issues for Mental Health services.
The target established by Monitor is less than 7.5% of patient bed-days should be DTOC.

Barnet, Enfield & Haringey NHS Mental Health Trust have under-performed against this target, with an average of 8.0% of bed-days being DTOC in the last 15 months available.
44% of the delays have been the responsibility of the NHS, 41% the responsibility of Local Authorities and 15% have been Joint responsibility.

	Q4 2014/15			Q1 2015/16			Q2 2015/16			Q3 2015/16			Q4 2015/16		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
TRUST-WIDE	4.0%	7.0%	7.0%	7.0%	7.0%	7.5%	7.0%	10.0%	10.0%	12.0%	10.0%	9.0%	9.0%	8.0%	6.0%
TARGET	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%

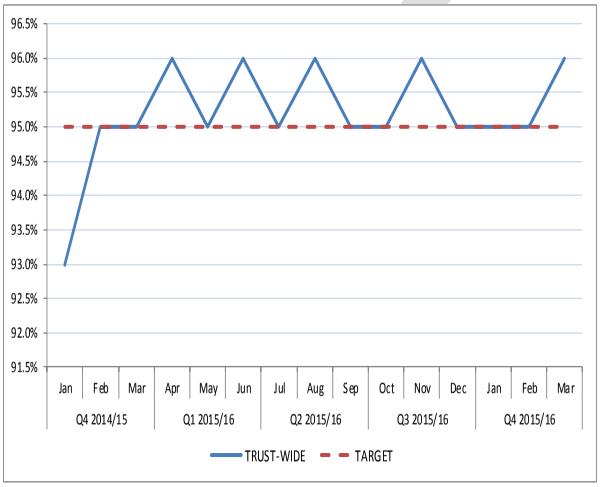


CARE PROGRAMME APPROACH - % OF PATIENTS REVIEWED IN THE LAST 12 MONTHS

This indicator applies to adults who have been on the Care Programme Approach for at least 12 months.
The target set by Monitor of 95% provides for tolerance for factors outside of the control of the Trust which may prevent a review being completed for all patients every 12 months.

Barnet, Enfield & Haringey NHS Mental Health Trust have performed well against this target, with an average of 95.2% of patients reviewed in the last 15 months available.

	Q4 2014/15			Q1 2015/16			Q2 2015/16			Q3 2015/16			Q4 2015/16		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
TRUST-WIDE	93.0%	95.0%	95.0%	96.0%	95.0%	96.0%	95.0%	96.0%	95.0%	95.0%	96.0%	95.0%	95.0%	95.0%	96.0%
TARGET	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%



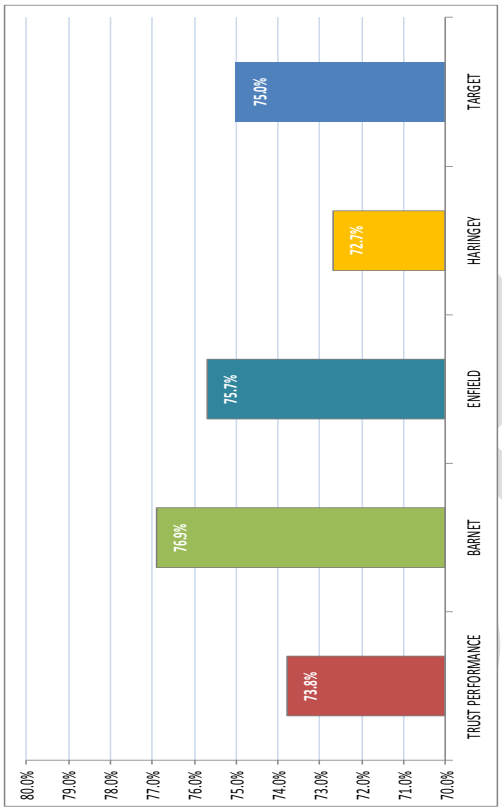
Local Data Quality Priorities

% OF CLIENTS WITH A RISK ASSESSMENT RECORDED IN PREVIOUS 12 MONTHS

This measures the % of open clients with a Risk Assessment Recorded within the last 12 months.
The local target set is 75%.

Barnet, Enfield & Haringey NHS Mental Health Trust have under-performed against this target, with an average of 73.8% of open clients with a Risk Assessment Recorded within the last 12 months, recorded in 2015/16.

INDICATOR	TRUST PERFORMANCE	BARNET	ENFIELD	HARINGEY	TARGET
	73.8%	76.9%	75.7%	72.7%	75.0%



3.14 Trustwide Quality Indicators

As well as progress with implementing the quality priorities identified in our Quality Account last year, the Trust is required to provide an overview of the quality of care provided during 2015/16 based on our performance against selected quality indicators. The Trust has selected the following indicators which have been regularly monitored by the organisation, and cover a range of different services.

Safety		2012-2013	2013-2014	2014-2015	2015-2016	National Benchmark (NB)/ Internal Trust Targets (ITT)
GP Communications	Assessment, review and discharge letters sent within 24 hours based on sample of 200 records audited in Q1, Q2, Q3 and Q4.	n/a	65%	62%	**Q1-Q3 : 85% Q4 : 89%**	**Staged target Q1 - 65% Q2 = 70% Q3 = 85 Q4 = 90% (ITT)**
Patient Safety Incidents	Number of incidents reported monthly (pcm)	472 pcm	583 pcm	514 pcm	**582 pcm**	**10% increase in reporting (ITT)**
	Percentage of patient safety incidents of which were severe or death	0.2% Severe or Death	1.19% Severe or Death	2.53% Severe or Death	**1.02% Severe or Death**	**2014-2015 average 1.03% (NB - NRLS)**
Improved Physical Heatlh		99%	99%	99%	**94%**	**90% (ITT)**
7-day follow up after discharge from inpatient care		99%	99%	99%	**99%**	**96.90 (NB)**

Effectiveness	2012-2013	2013-2014	2014-2015	2015-2016	National Benchmark (NB)/ Internal Trust Targets (ITT)
Evaluation of Enablement Projects	n/a	n/a	n/a	Ongoing	**ITT**
Patient identified care goals - indicating development of patient identified goals and involvement in care planning	94%	96%	96%	92%	**90% (ITT)**
Emergency Readmissions	1.70%	2.77%	2.33%	**1.30%**	**<5% (NB)**

Effectiveness	2012-2013	2013-2014	2014-2015	2015-2016	National Benchmark (NB)/ Internal Trust Targets (ITT)
Evaluation of Enablement Projects	n/a	n/a	n/a	Ongoing	ITT
Patient identified care goals - indicating development of patient identified goals and involvement in care planning	94%	96%	96%	92%	90% (ITT)
Emergency Readmissions	1.70%	2.77%	2.33%	1.30%	<5% (NB)

3.15 Information Governance Toolkit

Barnet Enfield and Haringey Mental Health NHS Trust's 2015/16 compliance for Information Quality and Records Management was assessed using the Information Governance Toolkit. The Trust met level 2 criteria. An improvement of our overall 'score' from 77% to 78% was achieved. The Trust commissioned an independent internal audit which confirmed that the Trust's procedures for managing its Information Governance Toolkit improvement plans including monitoring and reporting were robust, reduce the risk of failure or delay in implementing improvements to the Trust's submissions and the achievement of target levels in respect of Toolkit compliance. The report confirmed that the Trust's procedures for managing compliance with mandatory information governance training targets were robust, reducing the risk of breaches in Trust-managed confidential information due to members of staff who are not appropriately trained.

3.16 GP Advice Line

In agreement with our GP colleagues an advice line was introduced in 2013. The advice line continues to provide GPs with access to generic clinical advice through telephone conferences with psychiatrists within working hours to assist the GP in supporting their patients.

Analysis of the 234 GP advice calls received in 2015/2016 show that the majority of calls related to medication queries. The remaining calls were general patient management queries.

3.17 GP Hub Questionnaire

The Trust seeks the views of GPs who use our services to partly ensure we are providing a good service to our colleagues

The two questions asked in this online GP survey were:
Q1 - Was your call answered promptly?
Q2 - Are you happy with the outcome?

Feedback from the survey has been positive. Of the 212 GPs surveyed, 99.5% said their call was answered promptly and 98% said they were happy with the outcome.

3.18 PATIENT EXPERIENCE

There are lots of ways that people using services and their family and carers can give feedback about services the Trust provides. This information is vital in terms of knowing whether we are getting things right and allows us to make improvements and to celebrate and learn from good practice.

3.18.1 The Friends and Family Test

The Friends and Family Test (FFT) is an important feedback tool widely used across NHS organisations to measure patient experience. The test asks people who use our services if they would recommend services to friends or family and offers an opportunity to explain why.

The Trust launched the FFT in December 2014 and all services continue to offer the survey across the Trust. At present, data is collected using paper surveys and electronic submission via the Trust website.

The FFT is a tool that gives all patients the opportunity to provide continuous, near real-time feedback about their experience of the NHS care and treatment they have just received. The response options are: Extremely likely, Likely, Neither, Unlikely, Extremely Unlikely, Don't know.

The FFT question asks people if they would recommend the services they have used and forms Questions 1) and 2) of the Patient and Carer survey used by the Trust. The previous questionnaire did not include the follow up question:

"What was good about your visit" or "Can you tell us why you gave that response"?

From 1 January 2015 the follow up question has been included.

The table below shows the Trust monthly performance against the Trust benchmark satisfaction rate of 80%. The benchmark for mental health services is 80% and 90% for Enfield Community Services.

Area	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
	%	%	%	%	%	%	%	%	%	%	%	%
Trust Overall	89	89	85	89	88	86	86	86	87	86	86	90
FFT ECS	98	98	95	98	98	98	98	99	98	96	99	99
FFT All MH	84	85	81	86	84	82	81	82	81	81	79	86

From April 2015 to March 2016, 12,420 FFT questionnaires have been completed with an overall positive 87% rate for people recommending services to their friends and family.

This equates to a 9% response rate in mental health services and 3% response rate for community services against all activity within the Trust. There are a number of initiatives in each borough and service to support increasing the response rate.

3.18.2 Patient and Carer Surveys

All people using services and their family and carers are offered the opportunity to complete the Patient and Carer Survey which consists of a range of questions asking about people's individual experiences of the Trust as well as a free text section for additional comments. The 12 questions are split into three sections covering Information, Involvement and Dignity and Respect and include two additional questions related to the Friends and Family Test with a Trust benchmark satisfaction rate of 80%.

From April 2015 to March 2016 the trust gathered 12,035 surveys with an 89% satisfaction rate.

Survey group	Domain	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	2015-16 to date	2014-15
		%	%	%	%	%	%	%	%	%	%	%	%		
Service User	Information	89	86	87	88	86	87	88	86	89	88	85	88	87	88
	Involvement	90	86	87	88	87	86	88	85	89	88	85	88	87	90
	Dignity & Respect	95	93	93	94	94	93	94	92	94	94	91	93	93	95
	Overall Score	90	87	88	89	87	87	88	86	89	89	86	88	88	90
	No of Responses	1,075	886	983	1,007	945	798	1,055	831	826	670	757	687	10,520	13,112
Carer	Information	84	88	88	89	91	90	87	91	91	90	81	89	88	94
	Involvement	90	91	91	94	95	91	89	93	96	92	82	90	91	95
	Dignity & Respect	96	97	94	99	97	98	95	96	99	96	93	96	96	99
	Overall Score	88	90	90	92	94	92	89	92	94	92	83	90	91	95
	No of Responses	166	147	157	138	172	136	113	130	100	84	113	160	1,616	3,553
Service User & Carer	Information	89	86	87	88	87	87	88	86	89	88	85	88	87	90
	Involvement	90	86	87	88	87	87	88	86	89	88	85	88	88	90
	Dignity & Respect	95	94	93	95	94	94	94	93	95	94	91	94	94	96
	Overall Score	90	87	88	89	88	88	88	87	90	89	85	88	88	91
	No of Responses	1,241	1,033	1,140	1,145	1,117	934	1,168	961	926	754	870	847	12,136	16,668

3 Overall the highest and lowest performing areas relate to the questions in the survey that are designed for carers:

4 Q14. Do staff treat the person you care for with respect? 96% satisfaction rate (Dignity and Respect section)

5 Q7. Are you given information about resources and support available for carers? 84% satisfaction rate (Information section).

6 

7 In relation to this the Trust is undertaking work to gain The Triangle of Care accreditation. This is an audit process that looks at all aspects of carers being involved as part of the recovery process as well as ensuring that all services review and improve the information and resources made available to carers as well as signpost to the excellent local carer groups in each borough.

8 The additional comments section of the Patient and Carer survey provides excellent feedback services. Below is a small selection of the thousands of positive comments provided over the last 12 months:

9 "In our experience we have always been treated fairly and kindly. Everyone is very helpful and our needs have always been met" Enfield Wheelchair Service (Feb 2016)

10 “I am happy with the care received at Wellbeing” Haringey Wellbeing Team (April 2015)

11 “I think this is the best ward I have ever been on. The staff are helpful and I am looking forward to discharge” Devon Ward (September 2015)

12 “I was very comfortable on Thames (ward). The staff and medical staff were lovely. I work in the health service so I know a good team when I see it” Thames Ward (July 2015)

13 “The service we received was very good and informative” Haringey Memory Service (May 2015)

14 “Always welcomed by staff” Sussex Ward (June 2015)

15 “Excellent care and a great atmosphere on the ward” Cornwall Villa (March 2016)

16 “Helpful, efficient, friendly” Barnet Community Rehabilitation Team (June 2015)

17 “Nice and helpful staff. Information received was clear, sufficient and well delivered” Barnet Assessment Service (May 2015).

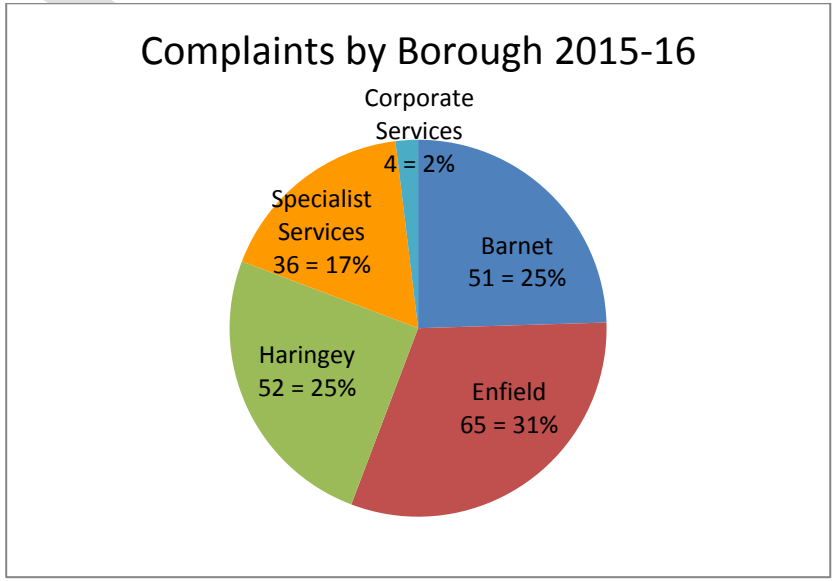
3.18.3 Complaints

4 Comments and complaints about services are taken very seriously. All complaints are treated in confidence and the Trust aims to respond within 25 working days of receiving a complaint.

5 From April 2015 to March 2016 the Trust achieved a 93% three day acknowledgement to formal complaints compliance and a 25 day response rate to formal complaints of 74%. Both are areas for improvement with on-going work on ensuring that people who raise concerns receive an apology, explanation of any learning and inform future service provision.

6 The Patient Experience Team continue to run ‘Effective Complaints’ training for staff working at all levels. The Patient Experience Team have reviewed the training package on offer following feedback from staff and from talking to people who have made complaints and asking what is important to them when they contact the Trust. The training is underpinned by person centred working and discussion around the practicalities of overseeing a administrative process with the person making the complaint feeling supported and that their concerns are properly understood and investigated with a fair and pro-active response.

7 In 2015/16, between 1st April 2015 and 31st March 2016 the Trust received 208 complaints which reflect a general decrease in complaints received from the previous year when 258 complaints were received within the same time period.



26 Complaints subjects for the year 1st April 2015 – 29th March 2016 are:

Complaint Subject	Number
All aspects of Clinical Care and Treatment	100
Communication/information to patients	34
Attitude of staff	32
Medication	10
Other	9
Discharge arrangements	6
Admissions	4
Medical Records	3
Patients' property issues	3
Accommodation	2
Security	2
Waiting times / delays	2
Car parking	1

3.18.4 Compliments

In 2015/16, between 1st April 2015 and 31st March 2016, 477 compliments related to the care and services provided by our Trust were recorded on Datix, our patient safety and risk management system:

Area of compliment	Number of compliments
Attitude	160
Clinical Care	280
Communication/information	13
Other	24
Total	477

3.19 Patient Safety

Protecting patients from avoidable harm is something to which there is universal agreement and the Trust has clearly defined processes and procedures to help avoid these events occurring.

The Trust has a number of initiatives in place to promote and monitor patient safety.

3.19.1 Patient Safety Conference, January 2016
The Trust held its first Patient Safety Conference in January 2016. This was a very successful event attended by over 200 delegates. Speakers included

- Kevin Cleary, Medical Director of East London Foundation Trust, formerly of the
- National Patient Safety Agency
- Catherine Ede, Regional Lead for London, Sign up to Safety
- Michelle Anstiss, Safety & Learning Lead, NHS Litigation Authority

Comms to provide photos

3.19.2 Training for staff

The Trust, via an external provider has provided three two-day Root Cause Analysis training courses for staff across all professional groups. The training has been crucial in developing investigative skills for staff which has led to improvements in the quality of incident investigations. Through undertaking investigations, staff have become more aware of any gaps in their own or team's delivery of care and services.

3.19.3 The Patient Safety Team has facilitated monthly 'Pop up' training sessions on incident reporting, risk registers and Duty of Candour. This

informal arrangement has allowed Trust staff to drop in to sessions for information, advise and support in these areas.

3.20 Safety Thermometer (Harm free care)

The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.

It allows teams to measure harm and the proportion of patients that are 'harm free' during their working day.

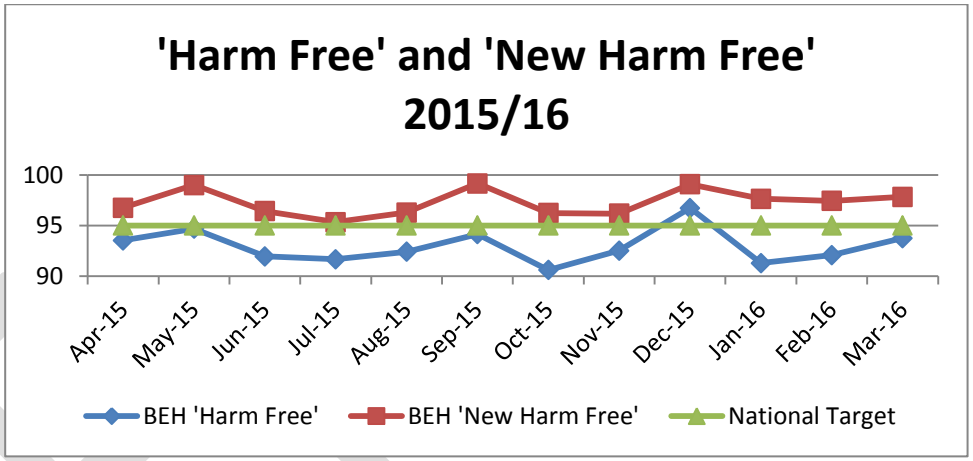
3.20.1 Classic Safety Thermometer

The Classic safety thermometer is a monthly census which measures the proportion of patients that are 'harm free' from pressure ulcers, falls, urine infections, and venous thromboembolism. It is carried out on a specified day each month by the teams that work with patients that are considered to be high risk for these kinds of harms.

BEH has reviewed the list of participating teams to ensure the tool is only being used in appropriate areas and we audit the data provided by teams against patient records and incident reports in order to ensure its accuracy.

The results are reported back to teams via our monthly Heat Maps (ward level dashboards) and any issues are highlighted via Borough level reports.

The graph below shows the proportion of patients included in the data collection that were either 'harm free' or 'new harm free'. Although BEH is below the national target for 'Harm Free', we are above it for 'New Harms'.



☒ **Issues** Data quality; a number of teams have been misinterpreting definitions and, as a result, have been reporting inaccurately.

☑ **Achievements** Response to data quality issues; Auditing of falls data against patient records and incident reports to ensure data accuracy and appropriate documentation and reporting.

Planned improvements for 2016/17 To address data quality issues through training, guidance, and further auditing of data.

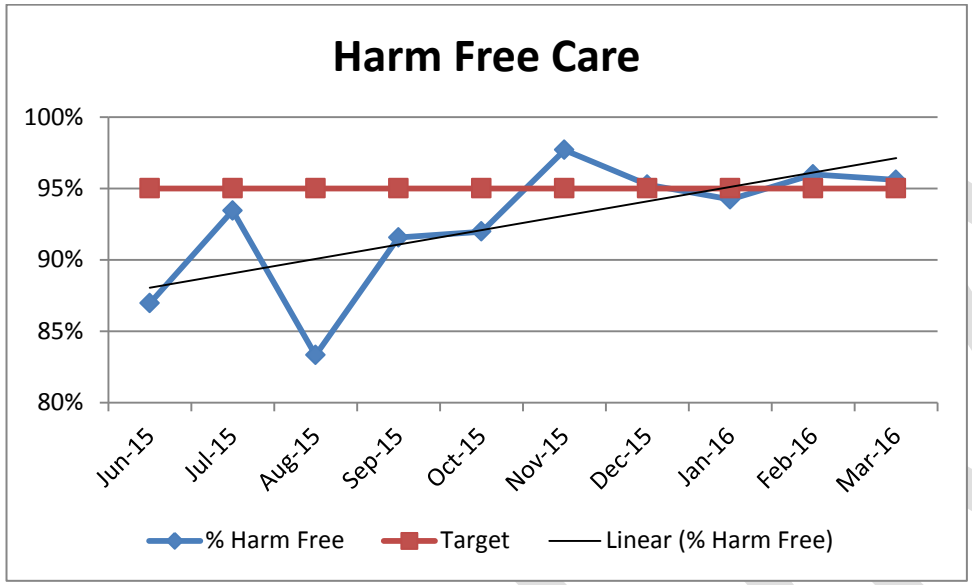
3.20.2 Mental Health Safety Thermometer

The Mental Health Safety Thermometer is a national tool that measures the proportion of patients that have experienced harms that are common

to patients engaged with mental health services; self-harm, psychological safety, violence and aggression, medication omissions, and restraint.

BEH began implementing the Mental Health Safety Thermometer in June 2015 and the tool is now being completed by all inpatient mental health units.

The chart below shows the proportion of patients included in the data collection that experience 'harm free care'.



☒Issues Data quality; a small number of teams have misinterpreted the guidance and, as a result, have collected and reported inaccurate/inappropriate data.

☑Achievements Implementation of tool across all appropriate inpatient units (28 wards)
Auditing of Self harm, violence and aggression, and restraint against patient records and incident reports to ensure data accuracy and appropriate documentation and reporting.

Planned Improvements for 2016/17 To address data quality issues through training, guidance, and auditing of data.

3.20.3 Heat Maps

BEH introduced 'Heat Map' ward level dashboards in June 2015. They are produced monthly for all inpatient teams across the trust. The purpose of the Heat Maps is to give teams' easy access to a broad range of interrelated data on a single page allowing them to identify on one page, themes and issues so that teams can consider and take action and learn from each other and find shared solutions.

Heat maps provide teams with a month by month breakdown of their progress across a wide variety of indicators including patient surveys and complaints, records audit, incidents, staffing levels, safety thermometers, infection control, and claims. Where appropriate, the data is RAG rated to show compliance with Trust or national standards/targets. The layout is flexible and teams were regularly invited to request the inclusion of additional information.

Heat Maps have been distributed to team managers and senior management and reported at several governance meetings within the Trust.

Thames														Trust Target	2015-16	2014-2015	2013-2014	2012-2013
Quality Indicator	2015-16 Data																	
Patient and Carer Survey	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**						
FFT Responses	17	41	30	25	25	8	31	17	15	20	12	11	No target	252	510	N/A	N/A
FFT Recommend Responses	16	39	28	25	23	8	31	16	14	20	12	11		243	491	N/A	N/A
FFT Score (Recommend %)	**94**	**95**	**93**	**100**	**92**	**100**	**100**	**94**	**93**	**100**	**100**	**100**		**96**	**96**	**N/A**	**N/A**
Information	88	84	80	89	83	88	81	78	93	86	90	84	80%	84	93	89	82
Involvement	95	85	78	90	84	92	84	86	99	88	89	86		87	94	89	84
Dignity & Respect	100	94	90	100	92	94	94	94	100	93	96	100		95	98	97	94
Overall	**92**	**86**	**81**	**90**	**84**	**90**	**83**	**82**	**96**	**87**	**90**	**86**		**86**	**94**	**90**	**84**
No of Returns	17	41	30	25	25	8	31	17	15	20	12	11	6.7pcm	252	510	601	509
Trust QA Audit	**Apr-15**	**May**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**						
Assessment	100	100	100	100	100	80	88	98	100	100	97	100	90%	97	100	100	N/A
Care Co-ordination	100	100	100	100	100	100	100	100	100	100	100	100		100	86	94	N/A
Care Plan	100	100	100	91	100	100	100	98	100	100	95	100		99	95	97	N/A
Carers	100	100	25	98	75	33	80	66	98	78	99	100	80%	87	88	74	N/A
GP Communication	100	100	100	100	100	100	100	100	100	100	100	100		100	99	100	N/A
Information	100	100	100	100	100	100	100	100	100	100	100	100		100	99	100	N/A
Involvement	100	100	100	97	100	100	100	98	100	100	92	100	90%	99	97	98	N/A
Outcomes	100	100	100	100	100	100	100	100	100	100	100	100		100	100	99	N/A
Physical Health check	100	100	100	100	100	100	86	100	100	100	100	100		99	100	100	N/A
Risk	100	100	100	100	100	100	100	100	100	100	100	100		100	99	98	N/A
Smoking	100	100	100	100	100	100	100	100	100	100	100	100	90%	100	99	85	N/A
Overall	**100**	**100**	**100**	**98**	**100**	**96**	**97**	**99**	**100**	**99**	**98**	**100**	90%	**99**	**97**	**97**	**N/A**
No of Returns	8	9	6	7	5	8	7	14	7	9	6	8	6.7pcm	94	91	98	N/A
Spot Check % Difference	N/A	N/A	N/A	N/A	N/A	-3	N/A	N/A	N/A	N/A	N/A	N/A	≤5%	N/A	N/A	N/A	N/A
Spot Check No. of Records	0	0	0	0	0	5	0	0	0	0	0	0	N/A	N/A	N/A	N/A	N/A
Incidents & Complaints	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**						
Moderate Incidents	0	0	0	1	0	0	0	0	0	0	0	0	N/A	N/A	N/A	N/A	N/A
Serious Incidents	1	0	0	0	1	1	0	0	0	0	0	1	N/A	N/A	N/A	N/A	N/A
Total No. Incidents	21	11	21	33	17	19	18	20	12	17	20	27		N/A	N/A	N/A	N/A
Formal Complaints	0	0	0	0	0	0	0	0	0	1	1	1	N/A	N/A	N/A	N/A	N/A
Informal Complaints	1	0	0	0	0	1	0	0	0	0	1	0		N/A	N/A	N/A	N/A
Total No. Complaints	1	0	0	0	0	1	0	0	0	1	2	1		N/A	N/A	N/A	N/A

☑ Achievements

Implementation of monthly ward level heat maps across all 29 inpatient teams and all 3 Crisis Resolution Home Treatment Teams.

Planned Improvements for 2016/17

Where resources allow, extend heat maps to include high priority community teams.

3.21.1 Patient Safety – Serious Incidents

The management of Serious Incidents includes not only the identification, reporting and investigation of each incident but also the implementation of any recommendations following investigation, assurance that implementation has led to improvements in care and dissemination of learning to prevent recurrence.

- The Trust's Management of Incidents Policy was agreed in May 2015. It's based on NHS England's National Serious Incident Framework 2015 and therefore aims to provide a balanced response to all incidents and deaths.
    - The Trust Boroughs and Specialist Services have established Serious Incident Review Groups (SIRG) that has an overview of all serious incident investigations, trends, themes and identified learning in their Borough.
    - The Trust Board receives regular Serious Incident reports which includes details of numbers of incidents, inclusive of deaths, comparisons of previous quarters and trends so that Trust Board can be assured that learning has been identified and is embedded in the organisation.

- The Trust works closely with the Her Majesty's Coroner for the Northern District of Greater London with regards to any deaths reported.

- All investigation reports use a Root Cause Analysis (RCA) methodology of investigation and are reviewed and approved by the Clinical Director for the Borough, and then signed off by the Medical Director.

- The Trust takes seriously its responsibilities to be open and honest with its patients and service users and has carried out training and implemented robust processes to ensure that the Trust complies with the Duty of Candour legislation.

- Duty of Candour compliance is reported regularly to Trust Board, Quality & Safety Committee and the Commissioners and we are pleased that we have achieved 96% compliance.

- The issues and learning from each investigation is discussed at Borough Governance meetings. Key learning points are included in the monthly Quality Bulletin sent to all staff.

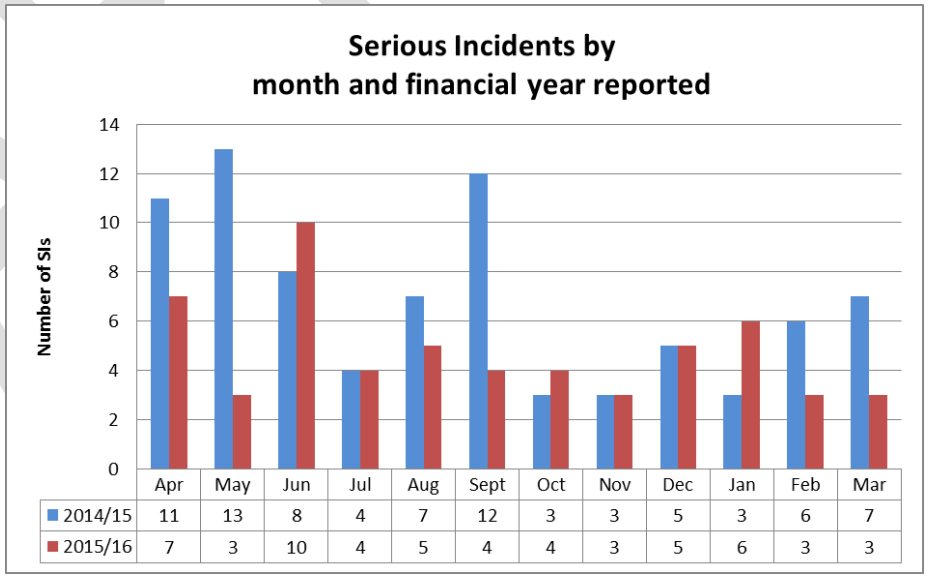
- A Berwick Learning Events programme led by the Medical Director is in place. The events cover a range of topics inclusive of learning from serious incidents.

- Sharing lessons learnt
  The Trust is focused on providing the appropriate resources that will facilitate learning from incident themes and investigations

3.21.1 Number of Serious Incidents (SIs)

During 2015/16, in accordance with the national Serious Incident Framework 2015 and categorisation of serious incident cases, the Trust reported 57 Serious Incidents, a reduction from the previous year. Five serious incidents were de-escalated upon the completion of the investigation when it was found that the serious incident was not caused by the care provided or service delivered by the Trust.

The chart below shows the SIs reported monthly and the comparison of SIs reported the previous year.



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	11	13	8	4	7	12	3	3	5	3	6	7
2015/16	7	3	10	4	5	4	4	3	5	6	3	3

3.21.2 Reporting within two working days

NHS England Serious Incident Framework 2015 states that timely reporting is essential and serious incidents must be recorded on STEIS within two working days of being identified. 98% of SIs were reported to Strategic Executive Information System (*STEIS*) within two days.

3.21.3 Never Events

'Never Events' are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been implemented by the Trust. We are pleased to say the Trust had no 'Never Events' in 2015/16.

3.22 Implementation of Duty of Candour

Duty of Candour

3.22.1 The Duty of Candour is a legal duty on us to inform and apologise to people who use our services if there have been mistakes in their care that have led to significant harm.

3.22.2 The Trust takes seriously its responsibilities to be open and honest with its patients and service users and has implemented a Trust wide training programme and implemented robust processes to ensure that the Trust complies with the Duty of Candour legislation.

3.22.3 Our compliance with Duty of Candour for 2015/2016 was 96%, that is, the Trust informed the relevant person in person as soon as reasonably practicable after becoming aware that a safety incident had occurred, and provided support to them in relation to the incident within 10 days on the incident being identified.

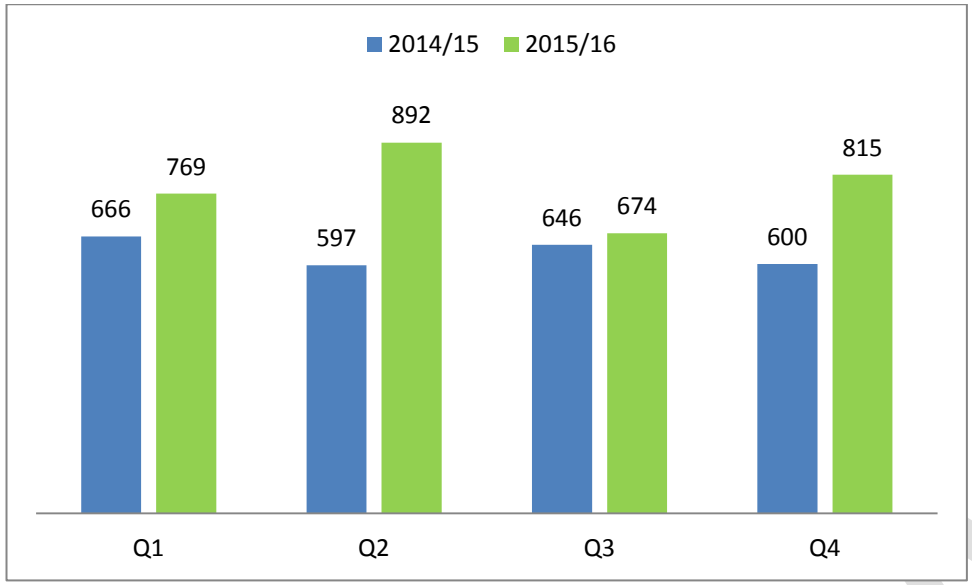
3.23 Patient Safety Incidents

Datix is the Trust's incident reporting and management system. Datix coding was updated in April 2015 to allow for a more accurate coding of incidents. New processes were put in place to enable more accurate capture of patient safety incidents. In October 2015, a new, simplified form was introduced to assist with the reporting of incidents and to aide managers when reviewing incidents.

These improvements have resulted in:

- Improved reporting to the National Reporting and Learning System (NRLS) - reporting increased by 30% when compared to the same period last year.
- Reporting increased overall by 13%
- Reporting increased by 16% since new form design.

Patient Safety Incidents reported in 2014/15 and 2015/16:



The number of patient safety incidents reported to NRLS in 2015/16 was 3150**.**

Datix Improvements 2015/16

- The Trust's risk registers have been streamlined to allow teams to add risks to their registers with ease. Due to the risk registers being 'live', teams have been able to review their risks and update in real time.

Planned improvements for 2016/17

- Safety Alert Broadcasting System (SABS)
  Work is currently underway to roll out the distribution of SABS through Datix. This final phase will bring all aspects of risk management together under one risk management system and will enable correlation to be made between the different aspects of risk management.
- Dashboards
  The Trust is in the process of making Dashboards available on Datix for all managers. The Dashboard page will display a set of reports, providing managers with an overview of records / trends for their teams.

3.22 Infection Prevention and Control

The Trust is committed to minimising healthcare associated infections in its managed services, and providing a safe clean environment for people who use our services. Assurance is provided by regularly auditing clinical areas for compliance against infection control best practice guidelines. The infection control audit looks at hand hygiene practice, and infection prevention and control measures in place in the clinical environment using an audit tool based on national guidance.

	Clostridium Difficile	MRSA bacteraemias.
Number of occurrences in 2015/16	1 (October 2015)	0

3.23 Infection Prevention and Control Training

3.23.1 Infection prevention and control training is part of the Trust mandatory training programme for all staff.

3.23.2 In 2015/16, 87% of staff had completed the training compared to 85.4% in 2014/2015.

3.24 Patient-led Assessment of the Care Environment (PLACE)

3.24.1 Patient-led Assessment of the Care Environment (PLACE) inspections are voluntary self-assessments of a range of non-clinical services which contribute to the environment in which healthcare is delivered.

3.24.2 The PLACE assessment provided a snapshot of how we have performed against a range of non-clinical activities which impact on our patients' experience of care.

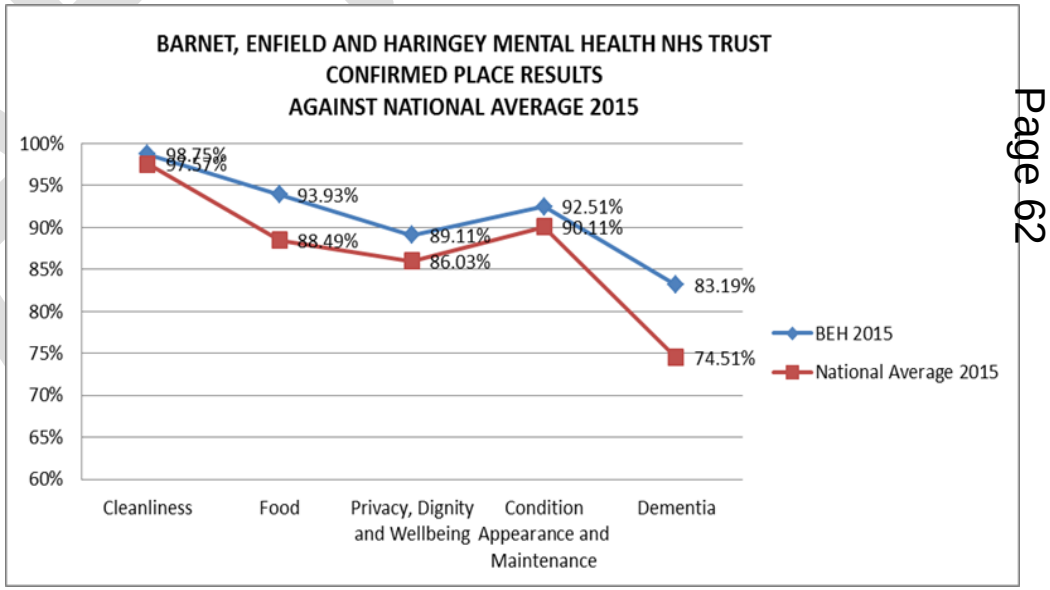
3.24.3 The Trust was assessed on five main categories

- cleanliness
- food
- privacy, dignity and wellbeing
- condition appearance and maintenance of building facilities
- dementia.

3.24.4 The 2015 assessment was completed in June 2015 and was submitted to the Health and Social Care Information Centre.

3.24.5 Our overall scores in each category assessed in 2015 were above the national average scores in all of the five PLACE domains assessed.

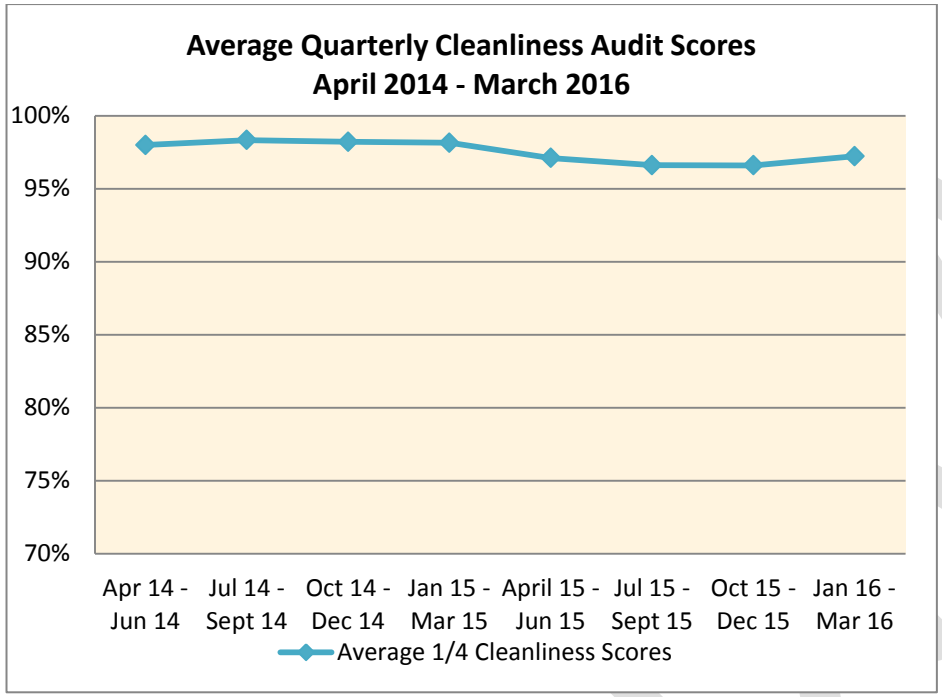
	Cleanliness	Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia
BEHMHT	98.75%	93.93%	89.11%	92.51%	83.19%
National Average	97.57%	88.49%	86.03%	90.11%	74.51%



3.24 Environmental cleaning

Environmental cleaning audits of all inpatient areas were undertaken as part of our programme of infection control audits. The audit tool is based on the 49 elements of the National Specifications for Cleanliness in the NHS (2007).

The Trust scored consistently above the 95% compliance rate.



3.25 Sign up to Safety

The Trust has signed up to the Sign up to Safety campaign, a national patient safety campaign designed to help make the NHS the safest healthcare system in the world by creating a system devoted to continuous learning and improvement.

By adopting the Sign up to Safety campaign, which aims to deliver harm free care for every patient, every time, everywhere, we will champion openness and honesty and support everyone to improve the safety of patients.

As a result of adopting the pledges in the Sign up to Safety campaign we will ensure that we will put safety first, continually learn, work and communicate with honesty and integrity, collaborate and be supportive.

3.26 SafeCare Module Implementation Update

- SafeCare is a software package that captures and reports on safe staffing to support every stage of healthcare workforce planning and delivery; from agreeing establishments to planning rosters, making just-in-time changes on the ground and through to Board assurance. With HealthRoster and SafeCare service managers can compare staffing levels across wards and departments, allowing them to maintain safe and compliant patient care based on individual patient acuity and dependency.

- Using the SafeCare module will support the identification of best practice and risk areas with inter-trust benchmarking on staffing metrics, allowing us to strengthen and improve our practice. This will allow ward managers to understand how actual patient numbers, acuity and dependency impacts on planned rosters and will enable ward managers to make alterations as needed.

- Through its multiple reporting capabilities SafeCare can provide clear visibility of staffing issues in in-patient wards. It is planned that SafeCare will provide staffing display and establishment reports as well as monthly Established Versus Planned Staffing Board Reports.

- The SafeCare system for the first four early adopter wards (Finsbury Ward, The Magnolia Unit, The Oaks and Thames Ward) went live in February 2016. The early adopter wards have been successful in implementing the system. Further work is needed to ensure wards fully meet the census requirements (data inputting that ensures clinical acuity is accurately reflected within the SafeCare system) and on-going monitoring are being established to ensure the safe staffing multipliers used continue to be appropriate for the different clinical settings and to support the adaptation of multipliers to ensure clinical relevance.

- A further four wards have been identified to implement SafeCare. The early adopter ward managers are trained trainers for SafeCare and will provide training and support to the next cohort of ward managers. This phased implementation allows for continuous learning that is shared across all the adopter wards. A phased approach to implementation will continue until SafeCare is live on all inpatient wards.

- The Nursing and Workforce Directorates are working closely to ensure the full and timely implementation of SafeCare across all inpatient wards.

STAFF EXPERIENCE

Staff survey 2015/16

We participate in the annual NHS staff survey which provides valuable insight into staff morale and staff impressions of working at the Trust. We aimed to address the core issues highlighted in the staff survey results and the latest results have shown improvements in most areas, including staff engagement and wellbeing.

Achievements over the past year have included:

- Continuing engagement activities such as CEO forums, executive director visits, communications initiatives such as take 2 and the CEO blog – all building on the "Listening into Action" work undertaken previously

- Active promotion of the Raising Concerns at Work policy and training for staff and managers

- Production of flowchart based guidance on the appropriate use of whistleblowing and other ways to raise concerns (posters, pocket cards)

- Refinement of the Trust's learning zone on the intranet as a portal to e-learning and wider development opportunities

- Promotion of the employee assistance programme

- Support for, and development of the staff wellbeing forum and equalities forum

Enablement 2014/15 Key Priority

The Enablement Programme is a key priority for the Trust. We have taken steps over the last 12 months in our aim to deliver services that are needs led.

The Trust is helping people who use our services to 'Live, Love and Do'. This means:

- A focus on life beyond their diagnosis.
- Strengths based approach
- Collaborative working towards service user defined goals

We officially launched the Enablement Programme in April 2015. In the past year we have made significant changes to transform the thinking, culture and practice within the organisation. Integrated enablement work streams have been initiated with a clear focus on the development of external partnerships. We will be celebrating the success of the first year with an enablement "one-year on" event in May.

Enablement Summary:

- Working with Clinical Commissioning Groups and Local Authorities to form a new integrated access point in each borough for mental health referrals
- Recruiting people with lived experience (community engagement workers)
- Formulating meaningful enablement outcomes
- Connecting with voluntary sector organisations and service user groups for joint service improvement
- Enablement training has started
- Enablement team assessments are being facilitated for adult 'front door services', leading to actions.
- Learning and sharing events are planned in each borough with voluntary sector organisations

Projects:

- Enfield peer support project

Working in partnership with the Enfield Mental Health users (EMU) group to provide peer support workers. These new workers have a core aim of promoting recovery, sharing lived experience of local resources and forming personalised goals with service users. All service users selected are currently living with high level supported accommodation with an aim to step down the level of reliance on services and to promote self-independence and resilience.

- Community engagement workers

People with lived experience employed by BEH to promote community resources and alternative enablement options. We have recruited eight new staff members who will work in our assessment services.

- Beacon Centre ‘My Star’

The introduction of the *My Star* (the outcome star for children and young people) to the Beacon Centre will aim to engage the young people to reflect on their experiences, develop insight and consider future plans around eight parts of life that are important to children and young people. The *My Star* is a collaborative strengths based recovery tool designed to assist the change process and the interventions will be based on hope, wellness and empowerment. The group programme is currently being developed and will be rolled out during 2016.

- Forensic Sensory Project

The Forensic Learning Disability Service is developing a sensory room. The aim of this project is to create and enable the use of a sensory room in order to help to create a safe space, promote resilience, recovery and enable service users to develop alternative coping skills based on their sensory need. The service users have been and will continue to be involved in the design of the sensory room in order to encourage them to take responsibility and ownership of the room.

Plans for 2016/17:

- Finalise integrated models of service provision underpinned by enablement principles

- Encourage new creative enablement projects

- Enablement focus towards older adults and children’s services

- Review and expand the role of community engagement workers

- Sharing enablement outcomes locally and nationally

- Build new voluntary sector partners and enablement options in the community

Clinical Networks

The Trust has undergone restructuring to provide borough based services, in line with these changes the structure and remit of Clinical Focus Groups / Clinical Council were revised and Clinical Networks were established. One of the remits of these networks is to lead and coordinate on the implementation and monitoring of NICE and other national guidance.

The following Clinical Networks/ forums have been established and meet regularly:

- Complex Care Clinical Network
- Psychosis Clinical Network
- Learning Disability Clinical Network
- CAMHS Clinical Network
- Pressure Ulcer Forum
- Physical Health Steering Group

- Acute Care Clinical Network

In addition to the Clinical Networks, there are different arrangements in place to monitor compliance with NICE Guidance across the borough based structure.

New Safeguarding Inbox 

The Trust is committed to safeguarding people who use our services.. In order to have an improved overview of safeguarding activity we have set up a safeguarding inbox. The Trust safeguarding team now require copies of all safeguarding referrals/alerts made for children and adults to be sent to the new inbox. Access to the inbox is strictly limited to the safeguarding team and will allow us to view referrals, and give feedback and further support if required.

Message from the Workforce directorate

In 2015/16, the Workforce Directorate has focussed on two major themes – getting the basics right and improving the level of staff engagement in the Trust by building on the “Listening into Action” work carried out previously. To achieve this, we have improved processes, introduced new systems and sought to improve the Trust’s mandatory training compliance level.

Equality and Organisational Development

In 2015-16 a key theme of both equality and organisational development work has been embedding and mainstreaming improvements and good practice - promoting our Trust as the place to be, an employer of choice and a Trust which staff would readily recommend as a place to work or receive care. Taking evidence from the national staff survey and the Staff Friends and Family Test, we are supporting work in partnership with staff side and colleagues across the Trust, to build on the improvements in staff engagement brought through the Listening into Action programme.

The Trust does well on many aspects of the working environment and staff perceptions. This was recognised by the Trust making it into the HSJ Best 100 places to work.

Nursing Recruitment of Students

BEH held a coffee morning recruitment event on the 10th February 2016 for final year student nurses that have been on placement at the Trust as well as a recruitment event at Middlesex University on Friday 18th March 2016. At the events students had the opportunity to hear from and speak to a number of BEH staff. Details of the Trust preceptorship programme and development opportunities were provided and the students were informed of the option to take up a conditional offer of employment at BEH.

Student nurses attending the events have been extremely positive about the recruitment intentions of the Trust.

A recruitment pro-forma was issued at the events to enable students wishing to work at BEH to tell us which areas they would like to work in and if rotation was important to them. As of the 18th March 2016 a total of 40 recruitment pro-forma have been received with students expressing interest in working within various teams/services across the Trust.

The Nursing Directorate, Workforce and Borough/Service Line Assistant Directors are working together to align individuals to the appropriate vacancies and ensure eligible students are able to transition smoothly into role.

Staff survey 2015/16 results

The final results of our Staff Survey 2015 were published in February 2016.

We are delighted to say much of it is positive, better than last year, and with notable improvements in some important areas. There has been a large 9% jump in the number of staff recognising that care of patients is considered BEH's top priority, *and* we have seen a 6% increase in staff recommending BEH as an organisation to work or receive treatment. We have also seen a similar rise in staff who would recommend BEH as a place to work. This is excellent to know as we are about to embark on a major local, regional, national and international recruitment campaign.

Overall the survey reveals a growth in the numbers of staff who are feeling more engaged with the Trust. We have seen a good increase in staff motivation at work, which is better than the national average, and we score consistently high with the numbers of staff who feel they are able to make positive contributions to improve their team or show initiative in their role.

Some of our best ranking scores were in areas of: flexible working; staff satisfaction in being able to provide quality patient care; and, effective use of service user feedback

Of course, the survey highlights areas where we have to do better. There has been a rise in the number of colleagues reporting a recent experience of harassment, bullying or abuse. And, we have to demonstrate as an organisation that we are committed to taking action on health and wellbeing.

There is much to be proud about in this report and there are areas we need to concentrate on. Over the coming months, workforce directorate teams, supported by Communications, will be working with local service leads to identify ways to improve engagement and help strengthen areas where currently we can do better.

Staff Engagement

Staff engagement = made up of key findings for:

- ability to contribute to improvements
- recommend the Trust as a place to work or receive treatment
- motivated and engaged in their work

BEH 2015	BEH 2014	Average
3.83	3.69	3.81

Barnet, Enfield and Haringey NHS

Staff recommendation of the Trust as a place to work/receive treatment

Staff recommendation = made up of key findings for:

- care of patients/service users is Trust's top priority (74%)
- "I would recommend my Trust as a place to work" (55%)
- "If a friend/relative needed treatment, I would be happy with the standard of care provided by this Trust" (56%)

BEH 2015	BEH 2014	Average
3.64	3.44	3.71

Barnet, Enfield and Haringey NHS

Top five ranking scores

	2015	Average
% feeling pressure to attend work in last three months when feeling unwell	50%	60%
Effective use of patient/service user feedback	3.83	3.69
% satisfied with opportunities for flexible working patterns	62%	56%
Staff satisfaction with quality of work/patient care they are able to deliver	4.00	3.89
% reporting most recent experience of violence	82%	74%

Barnet, Enfield and Haringey NHS

Bottom five ranking scores

	2015	Average
% believing Trust provides equal opportunities for career progression or promotion	78%	89%
% experiencing physical violence from staff in last 12 months	4%	2%
% experiencing discrimination at work in last 12 months	17%	10%
% experiencing harassment/bullying/abuse from staff in last 12 months	24%	21%
Trust and management interest in/action on health and wellbeing	3.62	3.69

Where staff experience has improved

	2015	2014
Staff confidence and security in reporting unsafe clinical practice	3.70	3.54
% experiencing physical violence from staff in last 12 months	4%	6%
Staff motivation at work	4.01	3.89
% witnessing potentially harmful errors, near misses or incidents in last month	23%	27%
Staff recommendation of Trust as a place to work/receive treatment	3.65	3.45

Where staff experience has deteriorated

	2015	2014
% reporting most recent experience of harassment, bullying or abuse	49%	56%

Barnet, Enfield and Haringey NHS

Staff training

The Trust has seen a steady increase in training compliance this year which, together with progress around streamlining requirements and improving training quality, is providing a safe environment for the people who use our services as well as our staff.

Statutory and mandatory training compliance as at 18 February 2016

Topic	Number of staff who	% of staff co
Breakaway	1,085	73.18%
Conflict Resolution	548	79.01%
CPA and CRA	1,222	74.63%
Equality and Diversity	2,808	87.96%
Fire Safety	2,808	88.35%
Health and Safety	2,808	88.21%
Infection Control	2,808	88.14%
Information Governance	2,808	84.05%
Moving and Handling High Risk	263	79.09%
Moving and Handling Medium Risk	136	55.88%
PMVA	464	86.64%
PMVA Older People	104	70.19%
Resuscitation Level 2 - Adult and Paed BLS and AED	362	74.59%
Resuscitation Level 2 - Adult BLS and AED	1,293	72.54%
Resuscitation Level 3 - Immediate Life Support	502	71.71%
Safeguarding Adults Level 1 & 2	2,808	87.82%
Safeguarding Children Level 1 & 2	2,808	90.78%
Safeguarding Children Level 3	474	76.37%
Safeguarding Children Level 4	5	100%

Borough achievements

Barnet:

Education in Primary Care

Consultant Psychiatrists in Barnet have taken an active role in the delivery of a Community Education Providers Network (CEPN) programme of multi-professional learning. Through the Primary Care Academy we have provided a total of 18 sessions of practice based learning for GPs, practice nurses and community pharmacists on two topics: Long term mental health conditions, and medically unexplained symptoms.

Liaison Services:

Our Mental Health Liaison Services at both North Middlesex University Hospital and Barnet Hospital have received accreditation under the Royal College of Psychiatrists PLAN (Psychiatric Liaison Accreditation Network) scheme. This is a considerable achievement for relatively newly established teams, operating under uncertain long-term commissioning arrangements and is a testament to the hard work and dedication of the clinicians and managers of these teams.

Individual Placement and Support (IPS)

This employment support scheme in partnership with Twining enterprise continues to deliver successful outcomes. In the latest quarter 3, 11 people were supported back into employment from the Community Mental Health teams in Barnet. Roles secured include Business Analyst, General Assistant at a Mail Company, Care Assistant, Spa Receptionist and Medical Secretary. The service has now been successful in achieving an IPS Centre for Excellence accreditation.

Coffee with the Consultant

An open invitation to all patients to attend ‘Coffee with the Consultant’ Every Tuesday on Thames Ward has been well received by patients. Based on Trusts’ value & visions of Recovery & Enablement, ward Consultant Psychiatrist Dr Aziz has been running this well attended group forum for over a year where patients’ choose a topic within light informal setting to discuss as well as supports creating better social integration on the ward and life beyond discharge.

Plans for 16/17:

The Borough Clinical Director and Psychological Therapies lead are developing a regular series of bi-monthly multi-professional learning events. The focus of these is to be on sharing learning from innovative team-level projects as well as reflecting on and sharing the learning untoward events.

Teams affected by incidents will be able to share their experience - the learning and how practice changed - alongside space for teams to

present service improvement work and projects they have been involved in. The first event is scheduled for mid-April.

Haringey:

Patient Safety.

- We have learnt from serious incidences:

- We have improved the staffing and management of the section 136 Suite at St Ann's Hospital.

- We have improved support for staff who have been involved in violent incidences

- We have introduced a ward staff development programme

- Improvements made to Privacy and Dignity on Haringey Assessment Ward.

Patient Experience:

- Following on from the delivery of the Taking the Lead training developed by young people who have been involved with BEH services (both CAMHS and Adult) and facilitated by deep black, the local CCG commissioner has embedded within the CAMHS transformation plan a project to develop a Creative Life Skills course. This will be for young people (14 years +) who are looking to move away from involvement with CYP mental health services, but need a "step-down" provision to enable this to happen. It is also seeking to help young people feel that they may no longer need to be passed from CAMHS to adult services – but can use this course to step away.

The course will be developed through consultation with young people – starting in April – which will then be followed by four co-create workshops.

The programme will be rolled out later in the year – with a view to evaluating the impact of the course, so that it can become a more sustainable offer to young people.

- Peer support work – developing a peer mentoring programme and peer support package for young people within the community with local partners – Haringey Play. Looking to enhance this support with the use of the Silent Secret App for those young people that would prefer a digital platform to be able to access support.

- Recruitment of three employment workers through Twinings to support people who use our services into employment/training within the EIS service, CCT and the Recovery Enablement Stream.

Effectiveness:

- CAMHS AOT project Time to Talk awarded a HSJ award

- Haringey Memory Services Accredited as Excellent by MSNAP

- Haringey Enablement Learning Events have been arranged to share areas of good practice in innovative and enabling services.

Challenges

- Recruitment and retention of staff
- Waiting times
- Demand for inpatient beds

Priorities for 2016/2017:

- Increase Service User involvement
- Focus on quality (Nice Guidelines) and patient safety
- Achieve KPI's
- Transformation of Adult Pathway along enablement principles
- Change Ward Shift Programme
- Develop a culture of Continuous Improvement
- Improve Sharing of Learning from incidents within the Borough and across the Boroughs
- Engage in innovative recruitment practices

A new pub has opened – inside an Enfield hospital's dementia ward.

Staff have created a non-alcoholic drinks pub in the Cornwall Villa ward at Chase Farm Hospital.

It is hoped creating a friendlier and more familiar environment will encourage patients into conversation and build social interaction and relationships with each other, friends and family.

Ward manager Mounir Benbassou said: "We're delighted to be opening up this pub on site and believe it will have real benefits for the people we

care for. We try to create a homely and familiar environment to help with stimulation.

"Keeping people engaged has been known to bring about memories, help foster emotional connections with others and encourage self-expression – this is exactly the kind of behaviours we want to promote.

"We hope the pub will create another opportunity for family to visit their relatives, and will also give them the opportunity to engage with staff more, which can make the delivery of care much more cohesive.

"We've talked to our patients' loved ones and they have been really keen on the idea and hope it will trigger fond memories of pub lunches and summer evenings enjoying drinks."

The venue will also run activities throughout the day, including playing cards, dominoes, music and dance which people can get involved with.

Blue Nile House Self Catering Project

BEH provides a self-catering initiative at Blue Nile House, a male low secure unit with patients who have been involved with the criminal justice system. On admission to forensic services users can quickly become de-skilled due to the decreased opportunity to practice previously learnt skills, such as cooking. When they are discharged service users are expected to shop, budget and cook all their meals independently and have found this challenging. Especially as they are also dealing with moving to a new, and often less supported environment in the community. Our project enables them to practise these skills prior to leaving hospital.

Outcomes:

Benefits for patients:

- Strong enablement focus on self-sufficiency and independence
- Develop budgeting skills by enabling them to plan their weekly shop
- Develop or maintain their cooking skills by enabling them to cook low level meals progressing to higher complex meals.
- Develop skills in a positive and safe environment
- Gain confidence in order to transfer these essential skills to community living once discharged
- Greater choice and control in an environment that can be restrictive
- Positive experience of care and support through working collaboratively
- Enables service users to take greater control of their diet and make healthy lifestyle choices
- Teaches those with physical health problems such as diabetes how to manage their condition as independently as possible
- Enhances patient choice. Patients in hospital come from culturally diverse backgrounds, the self-catering programme enables patients to cook food from their own culture which others on the ward are able to try and learn from.
- Creates a sociable environment and helps build relationships. We have found they often discuss their meals and take tips from one another.
- Through sessions and teaching on physical health conditions, patients are able to put their learning into practice and improve their healthy choices and health outcomes.

BEHMHT NUTRITION AND DIETETIC SERVICE

In 2015-2016 the ECS dieticians started to deliver “Conversation Map” training. This is a new, interactive, evidence based method of group education for diabetic patients, tailored to their needs and individual requirements.

The primary care clinics in Enfield have been restructured, with dedicated paediatric clinics and a new post established for primary care clinics.

The dietetic service now has specialist “Low FODMAP” clinics which use innovative dietary changes to treat Irritable Bowel Syndrome. Patient feedback has been very positive and an audit is planned for the new financial year.

In conjunction with the medicines management team , the new Medicines Management Dietician has developed a formulary for ONS (Oral Nutritional Supplements). She has completed practice audits, GP and health professional training. The resulting appropriate prescribing has resulted in significant cost savings whilst meeting the nutritional needs of patients. After a one year pilot project, the post is now substantive.

The Home Enteral Feeding service has expanded, with the appointment of another full-time dietician for tube-fed patients. We are currently participating in a tender process with other London NHS Trusts for tube feeds and plastics to achieve a high quality, cost effective service.

Within the last year, the whole dietetic team has been trained to take undergraduate/postgraduate student dieticians. The first student is currently on placement with us and more placements are planned for the new financial year.

CHAT

During 2015/16 Care Homes Assessment Team (CHAT) increased from covering 31 care homes to 45, which is all the older people residential and nursing homes in the borough of Enfield.

CHAT continue to work in an integrated way with our community services in Enfield , North Middlesex University Hospital, older peoples mental health team, the voluntary sector, GPs, social services, the local authority and care homes for the benefit of the residents.

Supporting residents in care homes to a comfortable and dignified death in their preferred place has been a huge success of the CHAT team. In 2013/2014 the team achieved 95% deaths in preferred place and during 2014/15 achieved 99%. 2015/16 CHAT maintained this excellent statistic with 99% of residents from Enfield CHAT covered care homes dying in their preferred place.

Falls requiring attendance at A&E have continued to decline from CHAT covered care homes. In 2013/14 20% of falls resulted in an A&E attendance, in 2014/15 15% and in 2015/16 14%. The number of falls have continued to decline. CHAT monitor the number of falls per registered bed to enable comparison of larger homes with smaller homes. In 2014/15 CHAT had 88% falls per registered bed for the whole year and this decreased to 80% during 2015/16.

During 2015/16 CHAT have developed increased opportunities for training within the care homes. Either delivered directly or facilitated training through Enfield Community Services (ECS)specialist nurses, therapists or other organisations such as North London Hospice has increased during 2015/16. CHAT has been working on assisting nursing homes with preparation for revalidation, clinical supervision, career development and mentoring. In 2014/15 CHAT trained 321 members of staff and in 2015/16 CHAT trained 811 members of staff thereby increasing training by 153%.

CHAT are very proud to have been shortlisted for a Patient Safety Award for enhancing the care of older people and a Nursing Times Award for enhancing dignity in care. Whilst CHAT didn't win, it was an honour to be shortlisted and to get the opportunity to attend the awards, network and spread the word about CHAT and its successes.

Trust's Board Assurance Framework, which was accepted for inclusion in "The Foundations of Good Governance – A Compendium of Good Practice". It replaces a copy of Oxford University Hospital Trust's Board Assurance Framework

The document will be launched at NHS Providers Governance Conference which takes place on 7 July 2016.

Diabetes Service

On addition to our clinical commitments over the last year the diabetes team have continued to work with GP practice teams to enhance knowledge and skills about diabetes and its management. This has been done by providing clinically supported sessions that have been well evaluated, as well as visiting practices to

do case note reviews for more complex patients. This project also included bespoke training packages, for example, insulin management and foot assessment.

The team are currently undertaking further work with our partners in the CCG as well as the acute sector to ensure that our diabetes guidelines are in line with recent NICE guidance (NG 28, issued December 2015). This will continue to ensure that all people with diabetes in Enfield will have access to the most up to date advice.

We are continuing to support people with diabetes who have had recent admissions to hospital for hypoglycaemia (low blood glucose levels) and to offer assessment and advice that will prevent further admission.

We continue to prioritise our work with vulnerable groups and to ensure that relevant information is given at the appropriate time to raise awareness of diabetes and so prevent the onset of diabetes. We have links to our local Diabetes UK support group and work closely with them to support people with diabetes in the locality."

Community Crisis Response Team - Rapid Response Service

The aim of The Community Crisis Response Team (CCRT) which works across Enfield and Barnet is to provide a rapid assessment and immediate treatment/care for patients within their own homes. It will ensure that patients have access to an alternative to hospital admission where it is clinically appropriate and to prevent unnecessary hospital admissions.

The service started on 18th January 2016. It will cover unscheduled and/or enhanced care needs between the hours of 17:00 and 2:00 Monday to Sunday 365 days a year.

Response will be initiated within 20 minutes to two hours (depending on triage) of the referral being made by LAS, Barndoc, NHS 111, the patient's GP, Social Services, community matrons, NHS Trusts or other health care professionals. Programmes of support or treatment will be carried out for the acute phase of care, involving other support agencies as soon as clinically appropriate. The service will focus on preventing avoidable admissions to hospital, or preventing patients who have been recently discharged from having a re-admission due to a crisis.

Allied Health Professionals Services

"Grabbing the opportunities: There is nothing occupational therapists' can't do!"- the non-traditional areas that Occupational Therapy (OT) has been promoted within the Forensic Service.

The North London Forensic Service (NLFS) has developed considerably in the last 10 years:

- 198 inpatient beds and a number of community services
- provides mental health input into HMP Pentonville, HMYOI Feltham, and HMP Brixton and recently successfully bid, alongside Care UK, to provide these services into HMP Wormwood Scrubbs, HMPYOI Aylesbury , HMP Grendon Underwood and HMP Springhill.
- Provide Liaison and Diversion Services to eight boroughs, as well as at Highbury and Hendon Magistrates Court.

Provide the liaison and diversion service into the two main London British Transport Police custody suites and in partnership with them deliver a suicide prevention and mental health liaison team that covers the entire London Underground and Network Rail South East England.

- NLFS is one of four London Trusts that together comprise the London Pathways Partnership (LPP). LPP provides the offender personality disorder service provision into all National Probation Service offices in London plus a progression unit at HMP Brixton, PIPE at HMP Swaleside and treatment services in HMP Pentonville and HMYOI Aylesbury.

- Jointly provide the Fixated Threat Assessment Centre with the Metropolitan Police Service (MPS) whose function is the assessment and management of inappropriate and threatening communications and approaches to the Royal Family, other prominent people (e.g. Prime Minister), Members of Parliament and protected sites.

- The service has developed a National Stalking Clinic, which provides assessment and treatment of stalkers and training regarding stalkers for probation and other organizations. The service works closely with other health, social services and criminal justice agencies to reduce and manage the risk posed to others by the service user group.

- The service has a specialist placement service which monitors out of area secure placements. All service users placed in secure placements out of area are monitored and the service has been able to observe the models of care, which work well for each client group.

- Since the service was established occupational therapy has been a core part of service provision but has grown exponentially as service needs and the commissioning landscape as developed (Heath and Social Care Act 2013).

- Over the past eight years the OT department has been restructured significantly through continual skill mix reviews.

- Following a period of building a solid foundation for the core of the OT work across services, leaders have had a long term vision to develop the remit of OT in forensic services in non-traditional areas. At the heart of this is the belief that OT has a unique contribution to make in all areas of mental health practice.

- Key Performance Indicators
Commissioning for Quality and Innovation

- KPIs and CQUINS that were given by the commissioners in forensic services did not state that OT involvement was needed, however we used these as an opportunity to promote work OTs were already doing and to develop services whilst expanding the OT role.

- Payment Framework to encourage care providers to continually improve how care is delivered.

- New opportunities for OT's were sought out through involvement in achieving KPIs and CQUIN, bidding for new services and creating innovative practice models. This reflects the current drive in the NHS, with non-traditional roles, teams and structures being championed (NHS: Five year forward view 2015).

- Recovery assessment – SU recovery tool, Recovery Star, Recovery performance indicator which we report on every six months.

- User led recovery goals – naturally fell to OT as two SU goals came out of the recovery Star and led to two SU care plans being written in the first person
- Numeracy and literacy – Increase provision by 40% by utilising resources differently – Bart College, Laptops, online course, Internet provision, OT/ TI skills
- CPA – transforming CPA process so service users are at the centre – including opportunities for SU to chair their own meetings. Also designing workshops with
- SU – how to get the best of you CPA and include the CPA process, skills for chairing – assertive and role play.
-

Innovative work

REP - Forensic recovery college , Psycho-educational courses and workshops to provide service users with self help tools to work towards their community, social and employment goals, Material and workshops Co-produced and co-facilitated by service users

National Stalking clinic - Initially run by a Psychiatrist and psychologist, involvement from OT introduced to look the functional aspects of stalking behaviour – role, identity, job, routine, motivated to engage.

OPD OT Pathway (working with personality disorders: a practitioners guide 2015)

Work experience - Long –term successful project designed to give service users valuable work experience to enhance, develop and maintain skills.

Self catering & Dragon's Den – Low secure ward, six service users independently self-catering all meals, nine services users self catering breakfast and lunch with support from staff.
Pilot project will then rolled out on all other wards, including Admission wards.

Twenty thousand pounds was received from our *Dragons' Den* initially.

Good news stories – **have small extracts throughout QA – to add.**

Include a section on awards, accreditation and QA projects.

Off the back of the success of ‘Back in the Game FC’ (based in Haringey), The Tottenham Hotspur Foundation have developed a 20 week programme in Barnet. The scheme has been arranged in conjunction with Barnet & Southgate College and BEH. The scheme welcomes people who use our services, carers, family and staff members to attend and join in.

BEH has partnered up with the Tottenham Hotspur Foundation, Haringey Council and Clarendon Recovery College to set up an adult football team for its service users, family members and staff.

The Trust awarded the organisers funding for balls, cones, bibs, football kits and the facilities for the next 10 months to get the ‘Back In The Game’ Football Club started.

Andrew Scott-Lee, Governance Facilitator, is one of the organisers. He said: “The Tottenham Hotspur Foundation started as an initial 20 week pilot as part of a community initiative to create more self-sufficient groups or teams.

“The club meet every Friday in Tottenham to train and play matches. We started with only a few attendees but we’ve grown gradually over the past six months. It’s fantastic to see the camaraderie of the players and the encouragement they give each other.

“When the 20 week pilot elapsed I was invited to pitch to the Trust Board for more funding to continue the scheme. Fortunately, It was met with enthusiasm and we received funding for another 12 months.

The scheme aims to promote mental and physical well-being and recovery and is in-line with the Trusts enablement programme, and its vision and values. It offers services users and staff the opportunity for exercise, meet other people outside of a clinical setting and helps patients during their period of recovery to connect with the community. Reports from those that attend include benefits such as “feeling part of something,” “provides something to do every week” and “gives people the chance to make friends and achieve something.”

Andrew explains: “We are encouraging those using mental health services in Barnet, Enfield and Haringey, their families, carers and staff to join us. The team have completed one season of competing in a local Power league and are due to start another season imminently. All levels are welcome.

“The great thing about it is that anyone, of any level, can slip on a pair of trainers and have a game.”

Back In The Game FC meet Fridays 11am to 1pm at Power league, Willoughby Lane, Tottenham, London, N17 0SL.

Statements from Commissioners, OSC, Healthwatch, Auditors

North Middlesex University Hospital NHS
NHS Trust

2015/16 Quality Account – Version 2

Please return comments to Dane Satterthwaite, Associate Director of Governance (dane.satterthwaite@nhs.net)

Statement on quality from the chief executive

Welcome to our quality account for the financial year 2015/16.

We hope that you enjoy finding out more about our achievements during the year and how we are working with our partners in the local community. Although it has been a challenging year, we have continued to make good progress on our 10-year journey of improvement.

In common with many other trusts, sustaining our previously strong performance in A&E waiting times and our strong financial surplus, sustained over the previous years, has not been possible. We have been open and honest with our health partners about the difficulties the year has posed since they first emerged last summer and we continue to work hard to resolve them through our "Safer, faster, better" quality improvement and transformation programme.

Notwithstanding this, we have continued to develop the new modern hospital that the last 10 years of planning, rebuilding, modernisation and growth has given us.

In 2015/16 we are delighted to have been able to further improve our patients pathways, to consolidate our established record for providing high quality clinical care, to continue to develop new services and modernise existing ones, and to grow our newly formed staff values refocusing our efforts on improved patient experience.

As ever we would like to thank our staff for their continued hard work, commitment and determination to provide excellent patient care and to our health and community partners for their involvement and support.

Introduction

North Middlesex University Hospital NHS Trust is a single site, medium-sized hospital, located in Edmonton and is the local acute hospital for the boroughs of Enfield and Haringey, which have a combined population of approximately 590,000. We provide high quality care across a full range of secondary care services and some specialist tertiary services that reflect the needs of the local population.

We provide services in collaboration with a range of partners, including local GPs, acute, mental health and community health service providers.

Each day, North Middlesex Hospital cares for:

- 500 patients in A&E
- 450 inpatients on our wards
- 50 patients undergoing major or minor surgery
- 900 outpatients attending clinics
- 200 women attending maternity clinics
- 15 babies born in our maternity unit.

In addition we provide:

- 400 X-rays and radiology tests
- 500 blood tests

We are a founder member of University College London Partners, working to adapt academic and laboratory research to enable improved clinical outcomes for our patients. We also work closely with a number of universities to provide training for doctors, nurses and other healthcare professionals as part of both undergraduate and postgraduate programmes.

We are a major local employer with, in March 2016, a headcount of over 3,000 staff, over 60% of whom live locally in Enfield and Haringey.

Our vision and strategy

The trust's vision for the next 10 years is to become the healthcare provider of choice for the diverse population we serve in north London and beyond, recognised for excellent emergency, acute, maternity and ambulatory care, delivered by excellent and compassionate staff.

The vision is underpinned by five strategic objectives. These are to:

- provide excellent clinical outcomes
- ensure positive experiences for patients and GPs
- be an employer of choice with a workforce that is excellent and compassionate and who act as ambassadors for the hospital
- provide services that are value for money for the taxpayer
- maximise the efficient use of our site through closer working with other organisations and by fostering education, teaching and research.

Our 10-year journey of improvement and growth

Our journey of improvement and growth began in 2005/06 with the start of detailed local planning for the Barnet, Enfield and Haringey (BEH) clinical strategy. It was to be London's biggest reorganisation of acute services in over a decade, involving health services across three London boroughs for half a million people.

In 2009 most of North Middlesex University Hospital's old Victorian buildings were demolished and a new £123 million modern hospital took shape which opened to patients the following year.

In September 2011, the Secretary of State for Health approved the BEH plan and the next development phase began. The trust received £80m of publicly-funded investment to build additional new facilities, to continue to modernise older facilities and to grow. Building work soon began and the new women's and children's facility finally opened in November 2013. Our accident and emergency department expanded in December 2013, becoming one of the busiest A&E departments in the capital.

The BEH modernisation continued throughout 2014/15, with older wards and departments upgraded in a massive refurbishment programme in the hospital's 1970s tower block and other areas.

When the BEH programme finally ended in March 2015, 94% of our clinical services were provided from new and modernised buildings that were less than six years old, creating a fantastic modern environment for our patients, visitors and staff.

We had also undergone unprecedented growth. Compared to 2013, before the BEH changes were implemented, we now have 25% more staff, care for 19% more A&E patients, admit 44% more patients, undertake 44% more surgical operations and procedures, see 27% more patients in outpatients, and deliver 37% more babies at the hospital.

Improved care pathways

The modernisation and growth of our services enabled the hospital to become one of the first in London to achieve the NHS London Quality Standards. It has enabled us to create new and better care pathways: patients referred directly by GPs or admitted through A&E are seen sooner by consultants; decisions about patient care are taken more quickly; we have specialty doctors available 16 hours a day, seven days a week and inpatients all reviewed by a consultant within 14 hours of admission.

Key issues and risks – new challenges in 2015/16

In 2015/16, our focus of attention moved from environmental modernisation and growth at the hospital to NHS-wide challenges, issues and risks which shape the health economy we operate in.

In common with all acute trusts, in 2015/16 North Middlesex University Hospital faced rising demand for NHS services, particularly among our ageing older population; rising agency staff costs and exacting NHS efficiency targets.

As the acute hospital for our local community, we are also trying to meet rising patient expectations: for improved hospital services, better clinical outcomes, shorter waiting times and improved patient experience.

Summary of our performance in 2015/16

Performance against key national priorities in 2015/16

The financial year 2015/16 has seen variable performance against national quality priorities. Disappointingly, the Trust has consistently failed to deliver satisfactory performance against the 4 hour A&E standard. The Trust has also failed to deliver satisfactory diagnostic waiting times and performance against some of the important cancer waiting time targets has been inconsistent throughout the year. There have, however, also been significant areas of strong quality performance. The Trust has continued to consistently deliver elective care in a timely manner across all pathways. This represents a deterioration in some aspects of the quality of care we provide at North Middlesex in comparison to 2014/15. I, my management team and all our staff at North Middlesex University Hospital are disappointed with these inconsistencies in quality and we are unequivocally committed to rectifying these aspects of inconsistent quality performance in 2016/17 and restoring the provision of uniformly high quality care across all clinical pathways.

Category	Indicator name	Benchmark	Target	Q1			Q2			Q3			Q4		
				Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
A&E	A&E All Types Monthly Performance	National	95%	94.2%	94.2%	94.8%	95.0%	92.4%	86.7%	84.3%	77.3%	71.9%	66.4%	67.2%	68.4%
Cancer	Cancer Two Week Wait Standard	National	93%	94%	95%	92%	88%	94%	96%	95%	97%	97%	94%	94%	tbc
Cancer	Cancer Breast Symptom Two Week Wait Standard	National	93%	94%	96%	91%	88%	84%	95%	96%	98%	97%	93%	95%	tbc
Cancer	Cancer 31 Day DTT to Treatment	National	96%	98%	94%	96%	99%	99%	100%	100%	100%	100%	99%	100%	tbc
Cancer	Cancer 31 Day Subsequent Drug Standard	National	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	tbc
Cancer	Cancer 31 Day Subsequent Radiotherapy Standard	National	94%	96%	97%	95%	93%	98%	99%	100%	98%	100%	100%	100%	tbc
Cancer	Cancer 31 Day Subsequent Surgery Standard	National	94%	100%	100%	0%	100%	100%	100%	100%	100%	100%	100%	n/a	tbc
Cancer	Cancer 62 Day Standard	National	85%	94%	67%	63%	87%	83%	78%	81%	79%	91%	86%	79%	tbc
Cancer	Cancer 62 Day Screening Standard	National	90%	100%	75%	100%	100%	90%	100%	100%	100%	100%	100%	100%	tbc
Diagnostics	Diagnostic waiting times	National	99%	99%	99%	96%	98%	97%	97%	95%	92%	90%	89%	93%	99%
RTT	Referral to Treatment Admitted	National	90%	93%	94%	92%	92%	92%	94%	94%	93%	93%	96%	95%	91%
RTT	Referral to Treatment Non Admitted	National	95%	97%	97%	97%	96%	96%	97%	95%	97%	97%	98%	98%	96%
RTT	Referral to Treatment Incomplete	National	92%	97%	97%	96%	96%	96%	96%	95%	96%	96%	97%	96%	96%
Standards	Patients not re-booked within 28 days of last minute cancellation	National	0	0	0	0	0	0	0	0	0	0	tbc	tbc	tbc
Infection	MRSA bacteraemia incidences	National	0	0	0	0	0	0	0	0	0	0	0	0	0
Infection	Clostridium Difficile All hospital-acquired incidences	14-15 outturn	3	1	2	2	2	3	3	3	1	6	4	6	5

A&E challenges

Until July 2015 our A&E department performed relatively well against the standard of seeing and admitting or discharging 95% of patients within four hours. In 2013/14 we had exceeded the 95% target, and dipped just below it at 93.6% in the year to 2014/15. In the first four months of 2015/16 we continued at 94% to 95%, outperforming most other London hospitals. However, in August 2015, in common with most acute trusts across the country, the waiting time performance dipped. The downturn continued until January 2016 when it reached a low of 66% and subsequently recovered slightly to above 70% but this remains significantly below our target. Across the year to 2015/16 we achieved an annual four-hour waiting time target of 82.7%.

There were a number of interconnected reasons for this substantial drop in performance. These included an increase in the numbers of elderly patients who presented with multiple comorbidities and required multiple diagnostic tests before discharge or admission. Difficulties discharging inpatients to the community at times caused a severe shortage of inpatient beds which slowed flow through A&E of patients who needed to be admitted.

Another issue was clusters of ambulances arriving together from our three ambulance service providers who cover London, Hertfordshire and Essex.

However, most significant of all was a shortage of senior consultants in the emergency department (ED) team which began to have an impact in August 2015 and which deepened to the end of the year, despite our best efforts to recruit. The issue reflects a national shortage of emergency department specialty doctors with our hospital particularly adversely affected.

Since the problems first surfaced last year, we have been open with our health partners about the challenges and have worked closely with them to tackle the many interlinked contributing factors, both internally and in the local health care system. This work is ongoing and will continue in 2016/17 through the “Safer, faster, better” programme, with the aim of achieving a sustainable improvement to waiting time performance by the end of the financial year.

It has been a challenging time, not least for our hardworking ED team. We would like to express our thanks to them for their dedication and determination to maintain the highest levels of patient care throughout this time.

Mortality rates

The table below shows the Trust’s most recent mortality rates for the past 12 months as measured by both Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital level Mortality Indicator (SHMI). The expected level of mortality is 100, with scores between 90 and 110 representing statistically normal, expected levels of mortality. Scores below 90 or above 110 represent statistically significant levels of mortality either lower (better) or higher (worse) than expected. There was a statistically significant deterioration in the Trust’s mortality between December 2014 and April 2015.

Indicator name	Benchmark	Target	Q1			Q2			Q3			Q4		
			Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16
Hospital Standardised Mortality Ratio in-month	National	100	134.5	118.5	121.3	98.5	103.3	77.0	101.9	106.8	95.5	99.6	113.1	107.9
Hospital Standardised Mortality Ratio rolling 12 months	National	100	110.6	110.7	113.1	113.6	114.2	113.2	111.8	111.0	109.6	109.4	108.1	106.1
Summary Hospital level Mortality Indicator (SHMI) - in-month	National	100	114.7	87.3	111.1	114.9	109.5	104.3	100.0	103.0	94.4	72.1	90.8	85.4
Summary Hospital level Mortality Indicator (SHMI) - rolling 12 months	National	100	93.2	93.6	95.3	96.4	97.6	97.8	99.9	100.6	101.7	101.0	100.6	99.1

As a result of this increase, the Trust received 3 mortality outlier alerts from Dr Foster which the CQC asked the trust to investigate in June 2015. These mortality outlier alerts suggested the Trust may have a significant problem with the care provided to patients attending the hospital with urinary tract infections, sepsis or acute cerebrovascular accidents. The Trust undertook a detailed case note review for the patients identified by the alerts. These casenote reviews identified that all of the patient deaths relating to urinary tract infections and acute cerebrovascular accidents were expected deaths and all of the patients received good quality of care. The casenote review for patients who attended with sepsis demonstrated that the care some of the patients identified in the alert received could be improved. The Trust has taken action in response to this learning. The casenote reviews confirmed that the higher than expected level of mortality witnessed during the period December 2014 to April 2015 was closely related to the relative ineffectiveness of the winter flu vaccine. The Office for National Statistics has published national mortality data and the Trust's mortality performance reflects this national picture. The Trust has provided the CQC with a detailed response to these three mortality alerts, and the CQC has closed the mortality outlier alerts.

In November, the Trust received another Dr Foster mortality outlier alert that the CQC has asked us to investigate. This alert related to therapeutic operations on ileum and jejunum. The investigation of this alert remains ongoing and the alert currently remains open with the CQC.

Never Event

Tragically, we had a Never Event at the Trust in February, when a patient died following a medication error which saw her receive an oral medication via a peripherally inserted central catheter (PICC) line. This incident remains under investigation to enable the Trust to identify the root causes of the incident so that lessons will be learned and robust action taken to prevent a similar incident from ever happening again at North Middlesex Hospital.

Infection control

We performed well against key safety performance indicators. There were no reported cases of hospital-acquired MRSA infection for the second consecutive year, a major achievement.

There were 37 cases of hospital-acquired Clostridium difficile infection, 3 more than our performance target. However, we routinely undertake a root cause analysis investigation whenever a patient suffers a hospital acquired clostridium difficile infection to determine whether the infection was preventable. Of the 37 patients who regrettably suffered a hospital acquired clostridium difficile infection, X of these infections were determined to preventable due to lapses in the care we provided. **(Q4 TBC)**

To summarise therefore, there have been some specific aspects of our care as outlined above, which have not met the exacting standard of care we aspire to provide each and every one of our patients. Consequently, whilst the Trust continued to provide safe, good quality care to the vast majority of our patients during 2015/16, I and my team are clear that further improvements to the quality of our services are possible and required. Our staff across the Trust are determined to deliver the necessary improvements during 2016/17 and this Quality Account outlines the Trust's top quality improvement priorities which will be delivered across this coming year.

Finally, I confirm that to the best of my knowledge, the information contained throughout this document is accurate.

Julie Lowe

Chief executive

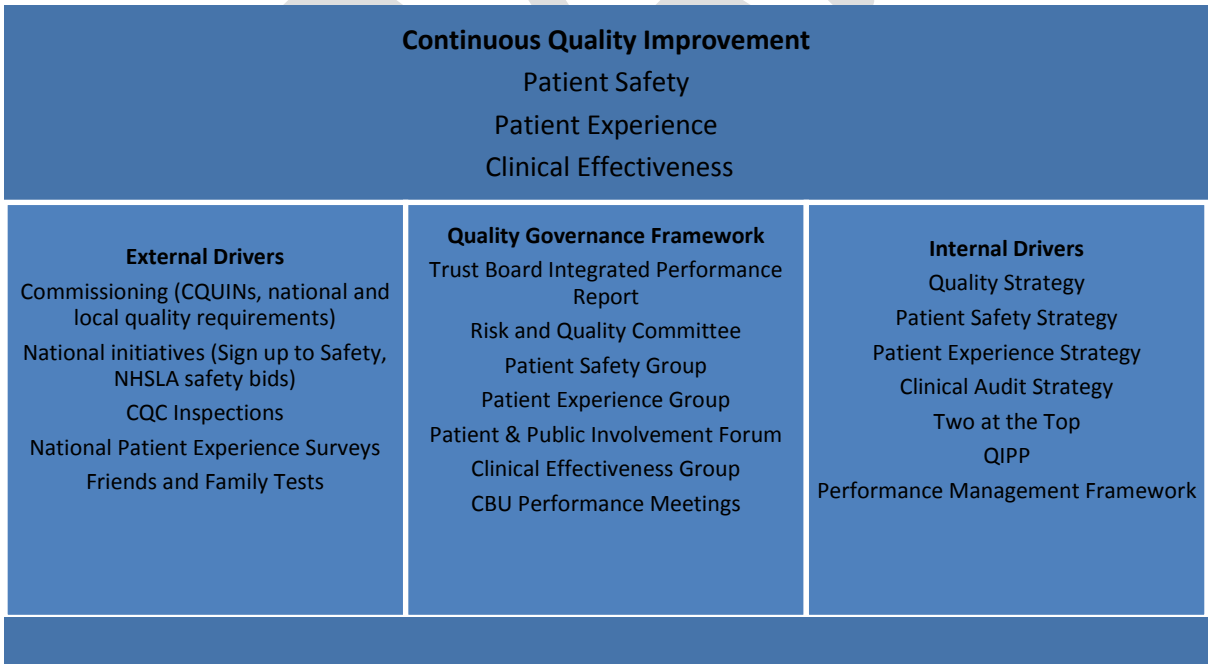
How quality is embedded in our culture at North Middlesex University Hospital

North Middlesex Hospital has embedded continuous quality improvement into the organisational culture by putting in place a structure that enables quality to be effectively measured and monitored. This framework also enables quality improvement initiatives to be effectively implemented in response to external drivers such a local commissioner initiatives or developments in national priorities.

The Trust engages with its commissioners to improve quality via contracting and the inclusion of CQUINs and quality requirements in the Trust's contract. Performance against these quality requirements is monitored by the Trust and Commissioners monthly at CQRG.

The Trust has a number of quality improvement strategies and initiatives in place to drive quality improvement across the hospital. For example the Trust is currently implementing a Two at the Top programme to enhance local ward level ownership of quality improvement interventions.

This culture is underpinned by a robust quality governance framework. Quality has been integrated into the Trust's performance management framework. This enables the Trust Board to triangulate key quality performance data alongside other performance metrics such as financial performance. Furthermore our performance management framework ensures that Clinical Business Units are held to account for the quality of the services they provide. This directorate level of scrutiny is supported by local ward level quality dashboard reporting which enables effective monitoring of ward and departmental level quality, so that ward sisters and heads of department are accountable for the quality of care provided in their areas.



Duty of Candour

This trust is committed to providing care that is safe and high quality. However, on rare occasions, patients will regrettably come to significant harm as a result of a patient safety incident. The Trust is committed to being transparent, open, honest

and accountable to patients and their families when these incidents occur. In order to ensure this takes place whenever a patient comes to significant harm, the Trust has provided duty of candour training to senior clinicians so that they can support patients who are involved in these incidents and their families in the immediate aftermath of such patient safety incidents.

The Trust understands that patient safety incidents can cause patients to lose confidence in the quality of services we provide. By being immediately open, apologetic, honest and transparent when patients come to harm, we hope to retain or regain their trust and confidence. The Trust recognises that it is necessary to provide emotional support to patients by informing them as to what went wrong and providing patients and their families with a sincere apology as well as an opportunity for them to ask any questions they may have. Depending of the specific details of the patient safety incident, some questions that the patient or their family may have will require investigation. The Trust undertakes root cause analysis investigations into all serious incidents and incidents that cause patients moderate harm or worse. Where patients or their families have questions that cannot be immediately answered by the clinical team caring for the patient, these questions are included in the investigation terms of reference. This is important as it ensures that patients and families feel that they are involved in the investigation process and feel confident that it is rigorous and addresses their concerns. In order to support these important processes, during 2015/16 the trust provided root cause analysis investigation training to 40 senior clinicians including consultants, senior nurses and managers. This two day long investigation training course included specific duty of candour training to provide these incident investigators with the specific skills and knowledge to support patients and families involved in relevant patient safety incidents with the information they are seeking regarding what happened and why they or their relative has come to harm.

Following the completion of the investigation into these incidents, the Trust routinely provides a copy of the investigation report to the patient harmed in the incident or their family and invites them to come into the trust to meet with the investigation team to go through the report together, hear what action is taken to ensure similar incidents do not happen again in the future and ask any further questions that the family may have.

The table below shows the number of relevant incidents that required duty of candour conversations to take place during 2015/16, how many of these incidents had duty of candour conversations following the incident. The Trust aims to ensure this happens within 10 days of the incident being reported.

The second table shows how many investigation reports have subsequently been shared with patients and their families.

Month	Number of incidents	Number of incidents reported to patients/ relevant person	Number of incidents not reported to patients/ relevant person	Number of reported incidents reported to patient / Relevant person within 10 days of being reported on Datix	Percentage	Number of incidents not reported to Pt or NOK within 10 days	Percentage
April	14	14	0	11	78.57	3	21.43
May	12	12	0	10	83.33	2	16.67
June	8	8	0	8	100.00	0	0.00
July	11	11	0	10	90.91	1	9.09
August	15	15	0	12	80	3	20
September	17	17	0	15	88.24	2	11.76
October	3	2	1	2	66.67	1	33.33
November	8	8	0	6	75.00	2	25.00
December	4	3	1	3	75.00	1	25.00
January	6	6	0	6	100.00	2	0.00
February	10	10	0	7	70.00	3	30.00
March	11	10	1	9	81.82	1	18.18
Total	119	116	3	99	83.19	21	16.81

N.B. Insert second table here.

Sign Up to Safety

The Trust's Patient Safety Group monitors the safety improvement initiatives across the Trust including the Trust's safety improvement plan. North Middlesex University Hospital has made the following pledges as part of its commitment to NHS England's Sign Up to Safety campaign:

Put safety first. Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally. We will:

1. Maintain our high level of incident reporting, continuing to report above average 'no harm' / near miss events.
2. Improve our management of sepsis
3. Reduce incidence of falls by 10% in 1 year, with zero tolerance for injurious falls
4. Reduce the incidence of clinically significant medication errors by 10% in 1 year
5. Healthcare associated infections: aspire to eliminate hospital acquired MRSA bacteraemias, and reduce avoidable hospital acquired C Difficile infections
6. Complete WHO surgical checklist in 95% surgical and other interventional procedures, auditing also the quality and rigour of the process on a regular basis.
7. Ensure that a Consultant reviews 95% of acutely presenting medical and surgical patients within 14 hours of arrival
8. Improve maternal and fetal monitoring - with use of 'early warning score' observation charts in mothers with medical problems, and fetal monitoring with improved heart rate tracking.

Continually learn. Make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are. We will

9. Assess our compliance with every NICE clinical guideline, within 3 months of its publication, addressing gaps in compliance in services relevant to our Trust.
10. Continue to demonstrate robust reporting of incidents, complaints and claims, with evidence of learning from them, while reducing the level of harm caused to our patients.
11. Ensure triangulation of complaints with incidents and patient feedback to improve the care we provide.
12. Complete timely Serious Incidents investigations and ensure lessons are learned to prevent future harm.
13. Improve the effectiveness of our learning, continuing to publish 'Safety Message of the week', patient safety newsletters, and holding multi-professional 'Patient Safety Conferences'.

Honesty. Be transparent with people about our progress to tackle patient safety issues ,and support staff to be candid with patients and their families if something goes wrong. We will

14. Publish our 'sign up to safety' pledges, and plan, across the Trust and report performance against our pledges and other ongoing safety initiatives for staff, patients, and public to view.

15. Develop a 'two at the top' campaign so that staff, patients and their relatives know who the accountable clinicians are in a particular clinical area, and know that they can raise concerns if there are issues with care.

16. Monitor compliance with Duty of Candour guidance across the organisation, so that when things go wrong, patients and their families understand and are offered an apology and support.

Collaborate. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use. We will

17. Engage with all stakeholders – Clinician Commissioning Groups, NHS England, Trust Development Authority, Care Quality Commission, and Monitor – working across organisational boundaries, aiming to support and share learning with one another.

18. Engage in collaborative development and research programme with academic health science partners, such as UCLP

19. Listen to our patients and their families, so that we can work in partnership to improve the safety and quality of our services.

Support . Help people understand when things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress. We will

20. Hold regular 'Schwartz Rounds' to allow staff to share and discuss their experiences of how being involved in managing difficult clinical situations has affected them.

21. Celebrate progress and staff achievement by recognition through 'staff awards'

22. Support staff to know that they are encouraged to report any patient safety concerns or incidents, and are safe to invoke the 'raising concerns' policy at any time without fear of any negative consequence

2015 Staff Awards Winners

Over 400 staff and guests attended the glittering staff awards event at Alexandra Palace in October to recognise and celebrate staff achievements. For our 2015 staff awards ceremony, 214 members of staff or teams were nominated for an award by their colleagues. A panel of judges reviewed the nominations and a shortlist of 38 finalists across the 11 award categories were identified. Our staff awards 2015 winners were:

Chair's award for lifetime achievement in the NHS

Jan Cardenas, *community midwife*

Hilary Sinclair, *consultant rheumatologist*

Gerry Brown, *data quality manager*

Clinical excellence award

Mariya Savova and Ana Monserat, *maternity support workers*

Education excellence award

Schwartz Round organisers: Frances Evans, *consultant obstetrician,* ***Matt Brown,*** *clinical psychologist,* ***Marie Powell,*** *personal assistant.*

Improvement award

Sally Utting, *ophthalmology nurse*

Patient experience and involvement award

Sue Williams, *colorectal nurse specialist*

Top quality patient care award

Fola Babsola, *surgical care nurse*

Teamwork (team) award

Cardiology nursing team

Teamwork (individual) award

Val Johnson, *trauma coordinator and fracture clinic sister*

Unsung hero award for NHS staff

Accident and Emergency reception team

Unsung hero award for partner organisation

Patient transport team

ByNorth Community Partnership award

Apprentice project team

Chief Executive's award for Leadership

Breda Cuddihy, *matron for CBU4, theatres and surgical specialties*

In addition, the trust recognised twelve members of staff who received long service awards for 25 years of dedicated service to the hospital and our patients. They are: Manjot Dhillon, Silka Paupiah, Mohammad Ben, Ashley Fuzurally, Cheryl Newell, Jayashri Patel, Janinje Avery, Kalpna Lakhani, Jennifer O'Neil, Peter Doyle, Claire Telling, Robert Luder and Jennifer Layne.

Delivery of the 2015/16 Quality Priorities

The table below summarises the Trust's performance against delivering the quality priorities we identified in last year's quality account.

	Priority	Key objective	Measure	2015/16 Performance summary
Safety	1. Healthcare associated infections and sepsis	Reduce number of healthcare associated infections and improve treatment of patients with sepsis	Process & patient outcomes	Partially Achieved
	2. Falls prevention and management	Reduce harm from patient falls	Process & patient outcomes	Achieved in full
	3. Skin care and pressure ulcer management	Reduce harm from hospital acquired pressure ulcers	Patient outcomes	Partially achieved
Experience	1. Improved patient communication and engagement	Improved patient satisfaction as measured by FFT and national CQC surveys	Process & patient outcomes	Partially achieved
	2. End of life care	Increase End of Life referrals and number of patients who die in their preferred location of choice.	Process & patient outcomes	Achieved in full
	3. Dementia care	Increase staff training and improved dementia carer satisfaction	Process & patient outcomes	Partially achieved
Clinical Effectiveness	1. Patient Reported outcome measures	Increase participation and improve outcomes reported via PROMs	Process	Partially achieved
	2. Specialty specific outcome measures	Improvements in specialty outcome measures	Process	Not achieved
	3. Anaesthetics service improvement plan	Implement anaesthetics service improvement plan	Process & patient outcomes	Achieved in full

Patient Safety Priorities for delivery in 2015/16

As part of the Trust's longstanding commitment to a continuous improvement in the safety of its services, the Trust continues to participate in Sign Up to Safety, a national campaign that aspires to make the NHS the safest healthcare system in the world. As part of this campaign, the Trust devised a Safety Improvement Plan for 2015/16 which outlined all the safety initiatives that the Trust undertook during 2015/16 to continue our journey to ever safer healthcare.

The Trust submitted the Safety Improvement Plan along with a bid for enabling funds to finance some of the interventions to the NHS Litigation Authority (NHS LA). The NHS LA received 243 such bids and North Middlesex was one of only 67 successful bids and was been awarded £130,000 to finance the introducing of a central monitoring stations for Fetal Heart Rate monitoring in Maternity that is also accessible remotely so that on-call consultants can view CTG traces from across the Trust or offsite. This new equipment was installed and commissioned in 2015/16 and is now in clinical use in the Maternity Department.

Priority 1: To reduce harm to patients by reducing and aspiring to eliminating avoidable healthcare associated bloodstream infections and improving the management of Clostridium difficile and patients with sepsis.

Why we chose this priority?

The Trust has made significant improvements in reducing hospital acquired bloodstream infections such as MRSA and E. Coli over the previous 3 years. Despite the significant increase in emergency activity following the implementation of the Barnet, Enfield and Haringey Clinical Strategy in 2013/14, 2014/15 saw the number of infections remain steady, which is indicative of a significant improvement in infection rates. The Trust wanted to build on this success and aspires to provide care in which avoidable hospital acquired bloodstream infections are eliminated.

Furthermore, the Trust's catheterisation rate as measured on the Safety Thermometer, was significantly higher than the national average, this suggested that the Trust could further reduce the risk of infection by reviewing its use of urinary catheters and bringing usage more closely in line with the national average as reported via the Safety Thermometer.

In addition to this, the risk of harm to patients caused by hospital acquired infections could be reduced by the achievement of the Trust's allocated objective for the maximum number of patients who contract hospital acquired Clostridium Difficile during 2015/16. The Trust committed to ensuring that fewer than 34 patients contracted hospital acquired Clostridium Difficile during 2015/16.

What we wanted to improve?

Our aim was to reduce mortality and improve patient outcomes by reducing hospital acquired infections through the expanded use of the 'Saving Lives' audit tools. The Trust implemented the Central line insertion and care Saving Lives bundle in Oncology. In addition, the Urinary Catheter care bundle and the care bundle to reduce the risk from Clostridium Difficile were successfully rolled out to all relevant clinical areas across the Trust. The Trust sought to expand its promotion of the Sepsis 6 bundle, and continue the provision of Sepsis trolleys in Accident and Emergency so that compliance with the Sepsis 6 bundle improves and becomes embedded in practice across the Trust.

In addition, the Trust wanted to work with external partners in the community to improve the infection prevention and control practice and standards in the local health economy. The Trust wanted to work with commissioners to participate in

whole system working in order to support community providers with the undertaking of community acquired Clostridium Difficile root cause analysis investigations as required. Furthermore, the Trust also wanted to support local commissioner initiatives to reduce infections in the community through engagement and participation. This would enable the Trust to positively contribute to the dissemination of good infection prevention and control practices in the community for our patients.

What would success look like?

Success would see a continuous reduction in infections until we have achieved our aspiration to eliminate avoidable healthcare associated MRSA, MSSA and E.Coli bloodstream infections. In addition, success would see a reduction in the use of urinary catheters until we have more closely converged towards the national average for urinary catheterisation as measured via the safety thermometer.

Successful delivery of this priority would result in fewer than 34 patients contract hospital acquired Clostridium Difficile during 2015/16.

Successful delivery of this priority would also result in improved management of patients with Sepsis, improved compliance with the sepsis six bundle and improved mortality and morbidity for patients with sepsis. Achievement of this priority would also support the Trust's achievement of the national Sepsis CQUIN targets for 2015/16.

How we monitored progress?

The implementation of the Saving Lives Care bundles and associated audits was overseen by the Infection Prevention and Control Committee which is chaired by the Director of Nursing. The results of this and the monitoring of the outcomes in terms of reduced infections were also be reported to the Patient Safety Group.

The Trust's performance regarding the management of patients with sepsis and reduction of Clostridium Difficile, was monitored internally and reported to our commissioners at the Clinical Quality Review Group meetings.

What we achieved during 2015/16

Priority 1: To reduce harm to patients by reducing and aspiring to eliminating avoidable healthcare associated bloodstream infections and improving the management of Clostridium difficile and patients with sepsis														
Reduction in the number of bloodstream infections during 2015/16	Benchmark or target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	**Annualised performance**
MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
MSSA	<4	0	0	1	0	0	1	0	1	1	1	0	1	**6**
E.Coli	<18	1	3	1	0	2	4	1	1	5	1	0	3	**22**
Fewer than 34 hospital-acquired Clostridium difficile infections during 2015/16	34	1	2	2	2	3	3	3	1	6	4	5	3	**37***
Saving Lives - Reducing the risk of CDI	>95%	No data	98.13%	99.47	98.6	98.87	99.67	99.37%	100%	99.29%	99.31%	98.80%	100%	**99.23%**
Saving Lives - Ventilated Patients bundle	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	**100%**
Saving Lives - PVC (Insertion)	>95%	96.24%	95.96%	97.31%	97.72%	98.30%	98.61%	98.00%	94.96%	89.29%	98.79%	98.74%	98.75	**98.89%**
Saving Lives - PVC (Ongoing Care)	>95%	96.00%	95.00%	95.80%	96.04%	97.91%	97.98%	96.73%	98.09%	91.91%	97.18%	99.77%	99.69%	**96.83%**
Number of central line infections and proportion attributable to lapses in care	<2 with a stretch target of 0	0	0	0	0	0	0	0	1*	1*	0	0	0	**2**
Number of ventilator acquired pneumonia attributable to lapses in care	<2 with a stretch target of 0	0	0	0	0	0	0	2*	0	0	0	0	0	2
Sepsis - % of patients who meet trust criteria for sepsis screening who were screened.	>90%	100%	100%	100%	100%	100%	100%	96.00%	97%	96%				**TBC**
Sepsis - % of patients presenting with severe sepsis, red flag sepsis or septic shock to ED and were administered IV antibiotics within one hour of arrival	>90% by end of Q4	Audit commenced Q2.			36.70%	46.70%	33.30%	**32.10%**	**37.50%**	**40.00%**				**TBC**

Priority	Objective	What we achieved	Status
Reducing harm from hospital acquired infections and improved management of patients with sepsis.	Zero hospital acquired MRSA Bacteraemia	For the second consecutive year, we achieved no hospital acquired MRSA bacteraemia infections.	Achieved
	Fewer than 34 hospital acquired Clostridium difficile infections	The Trust was set a trajectory of no more than 34 hospital acquired Clostridium difficile infections during 2015/16. We are obliged to report all hospital acquired Clostridium difficile infections, and during 2015/16 the Trust reported 37 which is in excess of our trajectory. However, each hospital acquired clostridium difficile infection is subject to a root cause analysis investigation to identify whether the infection is attributable to any lapses or shortcomings in the care provided to that patient. This investigation process is subject to external scrutiny from our commissioners in order that they be assured that our investigation is suitably rigorous and so that all lapses in care are identified. As a result of this root cause analysis process, during 2015/16, out of 37 clostridium difficile infections reported by the Trust, only 8 were identified as being the result of lapses in care provided the Trust. This is well within the trajectory set at the beginning of the year.	Mostly achieved
	Fewer than 4 hospital acquired MSSA infections	During 2015/16 the Trust reported 6 hospital acquired MSSA infections.	Not achieved
	Fewer than 18 hospital acquired E.Coli bloodstream infections	During 2015/16 the Trust reported 22 hospital acquired E.coli bloodstream infections	Not achieved
	2 or fewer Ventilator acquired pneumonia	During 2015/16 the Trust reported 2 ventilator acquired pneumonia	Partially Achieved
	1 or fewer Central line bloodstream infections in Critical Care	During 2015/16 the Trust reported 2 central line blood infections in critical care	Not achieved
	> 95% compliance with the Clostridium difficile saving lives audit bundle	The Trust achieved 99.23% compliance with the Clostridium difficile saving lives audit bundle. However, this high level of compliance did not result in the Trust achieving its trajectory of 34 or fewer hospital acquired clostridium difficile infections during 2015/16. However the root cause analysis investigations into each of these hospital acquired infections has demonstrated that only XX of these infections was due to lapses in the care we provided. Nonetheless, the Trust is going to respond to this by implementing an enhanced environmental and practice audit programme in addition to the saving lives audit bundle to ensure that the Trust continues to reduce hospital acquired infections.	Achieved
	100% compliance with the ventilated patients bundle	The Trust achieved 100% compliance with this audit bundle.	Achieved
	> 95% compliance with the PVC insertion and ongoing care saving lives audit bundles	The Trust achieved 98.89% compliance with the insertion bundle and 96.83% for ongoing care bundle.	Achieved
	> 90% of patients meeting sepsis criteria, being screened for sepsis in ED	The Trust achieved this requirement. Earlier in the year we implemented an electronic screening proforma on the electronic medical records used for our patients in the Emergency Department. This helped to ensure we met this requirement.	Achieved

	> 90% of patients presenting with severe sepsis, red flag sepsis or septic shock to ED and were administered IV antibiotics within one hour of arrival by the end of Q4	The Trust failed to achieve the requirement of ensuring that at least 90% of patients presenting with severe sepsis or septic shock to the Emergency Department were administered with IV antibiotics within one hour of arrival. In response to this, the Trust has included sepsis management for both patients in the Emergency Department, and inpatients across the hospital, in the Safer, Faster, Better transformation programme. This will see additional interventions implemented in the Emergency Department and across the hospital, to ensure the Trust meets this important requirement during 2016/17.	Not achieved

Priority 2: Reducing the harm from patient falls

Why we chose this priority?

Patient falls continue to be the most frequently reported type of incident at North Middlesex University Hospital. The falls rate had increased since the implementation of the Barnet, Enfield and Haringey Clinical Strategy as a result of the increased acute activity at the Trust which has seen the Trust care for an increasingly aged and more acutely unwell patient population. Whilst 2014/15 saw the monthly falls rate increase, the injury rate for falls that resulted in a moderate or severe injury reduced. Therefore whilst some important progress has been made at reducing the harm from patient falls, there remains work to be done that can further reduce the risk of patient harm from falling. Furthermore, the CQC Inspection report identified how the risk of patient falls in Accident and Emergency could be reduced by introducing a departmental falls risk assessment tool. Therefore the Trust continued to commit to reducing harm from patient falls as a quality priority for 2015/16.

What we wanted to improve?

In order to reduce the harm caused by patient falls, the Trust wanted to improve the falls risk assessment process so that all patients undergo suitably comprehensive falls risk assessments, and where these identify a patient as being at risk of falling, suitable falls prevention interventions are implemented. Achieving this would reduce the number of unobserved falls and increase the number of falls that are assisted by staff for example, where a patient is lowered to the floor, bed or chair. Where patients do suffer a fall, it is important that they are suitably reviewed and where a patient's condition deteriorates, they are escalated appropriately. The Trust therefore committed to improving compliance with the post falls protocol for patients who suffer a fall.

What would success look like?

Sustained reduction in the falls rate

Sustained reduction in the falls injury rate for falls that result in moderate or severe harm

Increased percentage of falls where a Falls Risk Assessment had been completed prior to the fall

Increased percentage of falls where the patient was subsequently managed in accordance with the post falls protocol.

What we achieved during 2015/16

Priority	Objective	What we achieved	Status
Reducing harm from patient falls	Increased percentage of falls where a Falls Risk Assessment had been completed prior to the fall	The Trust achieved an increase in the percentage of risk assessments that were completed for patients who subsequently suffered a fall. The baseline for 2015/16 was based on auditing performance during 2014/15 during which 87.89% of patients who fell had undergone a falls risk assessment. We audited compliance with the falls risk assessment process on a monthly basis during 2015/16 and compliance with the risk assessment processes exceeded 87.89% in 11 out of 12 months and the annualised average for 2015/16 was 91.49%.	Achieved
	Increased percentage of falls where the patient was subsequently managed in accordance with the post falls protocol.	The Trust achieved an increase in the percentage of patients who were managed in accordance with the post fall protocol whenever a patient suffered a fall. The baseline for 2015/16 was based on auditing performance during 2014/15 during which 83.42% of patients who fell were managed in accordance with the post fall protocol. We audited compliance with the post fall protocol on a monthly basis during 2015/16 and compliance with the post fall protocol exceeded 83.42 in 10 out of the 12 months and annualised performance for 2015/16 was 89.37%	Achieved
	Sustained reduction in the falls rate	The Trust achieved a reduction in the falls rate in 2015/16 in comparison to 2014/15. In 2014/15 there were 68.32 adult admissions per patient fall. In 2015/16 there were 71.11 adult admissions per patient fall.	Achieved
	Sustained reduction in the falls injury rate for falls that result in moderate or severe harm	The Trust achieved a reduction in the falls injury rate for all severity of harm. The percentage of patient falls resulting in minor harm (such as those requiring first aid or analgesia) decreased from 17.94% of falls reported during 2014/15 to 12.83% of patient falls reported during 2015/16. This means that whereas in 2014/15, there were 380.87 adult admissions per patient fall, in 2015/16 this increased to 554.30 adult admissions per patient fall. Similarly, the percentage of patient falls resulting in moderate harm decreased from 1.72% of patient falls, to 1.05% of patient falls. This means that whereas in 2014/15 there were 3975.38 adult admissions per fall resulting in moderate harm, in 2015/16 this increased to 6762.40 adult admissions per fall resulting in moderate harm. For the second consecutive year, there were no falls that resulted in permanent severe harm or a patient death.	Achieved

Priority 2: Reducing the harm from patient falls														
	Benchmark or target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Annualised performance
Reduction in proportion of falls resulting in harm	<19.66%	13.31%			15.98%			14.46			12.25%			**13.88%**
Percentage of falls reported where falls risk assessment had been completed prior to fall	>87.89%	89.74	94.85	91.57	96.77	89.93	94.37	92	87.06	91.57	91.96	90.1	88.00	**91.49%**
Percentage of falls reported where patient was subsequently managed in accordance with the post falls protocol	>83.42%	92.31	86.17	93.9	95.16	93.22	91.55	87.83	92.94	87.95	90.06	78.2	83.1	**89.37%**

Priority 3: To continue to reduce harm from pressure ulcers and aspire to eliminate avoidable hospital acquired grade 3 and grade 4 pressure ulcers

Why we chose this priority?

This priority was selected because the Trust has made continued progress with reducing the number of hospital acquired pressure ulcers. The Trust committed to continuing this reduction in hospital acquired pressure ulcers and aspires to eliminate avoidable or preventable hospital acquired grade 3 or grade 4 pressure ulcers. Furthermore, we included this priority in our Safety Improvement Plan and the 2015/16 Quality Account because reducing the risk of pressure ulcers for patients in Accident and Emergency was also highlighted by the CQC in their inspection report.

What we wanted to improve?

The aim of this project was to reduce patient harm caused by pressure ulcers by reducing the number and severity of hospital acquired pressure ulcers. This would be delivered through the early recognition of patients at risk of developing hospital acquired pressure ulcers, implementation of effective care to prevent skin deterioration and the configuration and provision of infrastructure to support patients with pressure ulcers.

The Trust has recently expanded its Tissue Viability Service and will:

Continue and improve the robust use of the SSKIN Bundle

Expanded training in pressure ulcer prevention and management

Improve access to pressure relieving equipment and effective barrier products.

Work with commissioners and community services to assist in the management of pressure ulcers in the community to aid the reduction of patients being admitted with pressure ulcers.

What would success look like?

Reduction in the number of hospital acquired grade 3 and grade 4 pressure ulcers

Reduction in the number of avoidable hospital acquired pressure ulcers

Reduction in the number of patients who have developed new pressure ulcers and number with existing pressure ulcers as measured by the Safety Thermometer

Reduction in the comparative proportion of hospital acquired pressure ulcers in comparison to community acquired pressure ulcers.

How we monitored progress?

The Safety Improvement Plan is monitored at the Patient Safety Group which is chaired by the Medical Director. In addition, each hospital acquired grade 3 or grade 4 pressure ulcer is reported to our commissioners as and subject to a root cause analysis investigation. The findings of these investigations are reported to the Trust's Risk and Quality Committee which is chaired by a non-executive director. Furthermore, the NHS Safety Thermometer provides the Trust with national comparative data which enables the Trust to benchmark its performance in reducing the number of patients who have developed new pressure ulcers and the number of patients with existing pressure ulcers.

What we achieved during 2015/16

Priority 3: To continue to reduce harm from pressure ulcers and aspire to eliminate avoidable hospital-acquired grade 3 and grade 4 pressure ulcers														**Q1 performance**	**Q4 performance**	**Annualised performance**
Number of hospital acquired, 3 and 4 pressure ulcers	<15	4			2			7			4			**N/A**	**N/A**	**16***
Number of patients surveyed who have developed new pressure ulcers, and number with existing pressure ulcers	Prevalence of all PUs = 4.66%	5.98	5.84	3.55	5.86	No ST data due to DQ issue	4.9	4.16	7.6	4.96	4.46	3.47	4.1	5.09%	4.02%	**5.31%**
	Prevalence of new PUs = 1.17%	2.76	1.52	1.25	3.04		1.02	0.89	0.82	0.38	0.56	0.61	0.68	1.82%	0.61%	**1.22%**

Priority	Objective	What we achieved	Status
To continue to reduce harm from pressure ulcers and aspire to eliminate avoidable hospital-acquired grade 3 and grade 4 pressure ulcers	Reduce the number of hospital acquired, 3 and 4 pressure ulcers to below 15 and aspire to eliminate avoidable hospital acquired pressure ulcers.	During 2015/16 16 patients developed a hospital acquired pressure ulcer. All of these have been subject to a root cause analysis investigation to determine whether the pressure ulcer was preventable. The findings from these investigations are reviewed and verified by the Pressure Ulcer Review panel. Thus far 14 out of the 16 root cause analysis investigations have been reviewed and of these 2 have been identified as being avoidable with 2 of the 16 pressure ulcers investigations to be reviewed at the pressure ulcer panel.	Partially achieved
	Reduce the number of patients surveyed who have developed new pressure ulcers	The trust achieved a reduction in the percentage of patients surveyed using the NHS Safety Thermometer with new pressure ulcers (including all grades of pressure ulcer - 2s,3s and 4s) from 1.82% in quarter 1 to 0.61% of surveyed patients in quarter 4. The annualised percentage of surveyed patients who had a new pressure ulcer rate was 1.22%.	Achieved
	Support local health partners to deliver a reduction in the number of patients surveyed who have existing pressure ulcers	There was a reduction in the percentage of patients surveyed using the NHS Safety Thermometer who had existing pressure ulcers. The percentage of patients with existing pressure ulcers in quarter 1 was 5.09% and this reduced to 4.02% in quarter 4. The annualised percentage of surveyed patients who had an existing pressure ulcer was 5.31%	Achieved

Patient Experience Priorities for delivery in 2015/16

Priority 1: To improve patient satisfaction as measured by national surveys and the Friends and Family test

Why we chose this priority?

It is well established that a positive experience of care aids and expedites our patients' recovery. In order to ensure our patients enjoy a positive and improving experience, we need to listen to them and respond to their feedback, concerns and complaints. Delivering improved patient satisfaction demonstrates that our services are caring, and well-led by clinicians and managers who are responsive to the needs of our patients.

What we wanted to improve?

Our aim was to improve overall patient satisfaction as measured by the national inpatient, outpatient and cancer surveys conducted and published by the CQC. We want to provide our patients with an ever improving experience that results in continually improving patient ratings of the overall experience of care in the national patient experience surveys. In addition to the rating of overall experience, the Trust targeted interventions where it performed worse than expected in any of the national patient experience surveys.

In addition to this, the Trust wanted to improve the experience of inpatients, patients in Accident and Emergency, and expectant mothers who use our maternity services so that they increasingly would recommend North Middlesex University ored progress?

The Trust uses a patient experience tracker to survey patient experience and provide real time feedback throughout the year. Patient experience tracker results are used at ward and department level so that ward managers and heads of department can monitor and respond to patient experience concerns in a timely manner. In addition to the patient experience tracker, the friends and family test are also monitored at ward level, including maternity and Accident and Emergency. These scores are aggregated and feed into the Trust's overarching performance management framework so that patient experience is seen as a vital key performance indicator. This data also feeds into the Trust Board Integrated Performance Report so that there is a clear line of sight on patient experience performance from the ward to the trust board. Additionally, this information was used by the Patient Experience Group which worked closely with our Patient Representative Forum prior to its reconfiguration and launch of the Patient and Public Involvement Forum.

What would success look like?

National Patient Surveys

Each year the CQC conducts the national inpatient survey. The results of this survey are benchmarked alongside the performance of all other NHS trusts and foundation trusts. As such, they enable us to accurately compare how satisfied our patients are with their care at North Middlesex Hospital, in comparison to other local trusts. Our aspiration was to achieve continuous improvement on the question which asks patients to rate their experience from 0 to 10, with 10 representing a 'very good' experience.

We also targeted those aspects of the patient experience which, according to the national surveys, we perform worse than expected. Therefore, success would see the number of questions in which the trust perform as worse than expected being continuously reduced.

Friends and family test

In addition to the national patient surveys, the trust also asks inpatients, patients who use our Accident and Emergency department, and expectant mothers who use our maternity service, whether they would recommend us to their friends and family. Our aim was to increase the percentage of patients who respond to the Friends and Family Test stating they would be 'very likely' to recommend the Trust to their friends and family. We wanted to see continuous improvement in our friends and family test scores for inpatients, accident and emergency patients and maternity users so that 90% of our patients would recommend us to their friends and family.

What we achieved during 2015/16

Priority 1: To improve patient satisfaction as measured by national surveys and the Friends and Family test														
	Benchmark or target	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**	**2015/16 performance**
The trust will improve the percentage of patients who respond to the FFT question with a response of 'very likely'	Inpatients FFT baseline – 73.3%	71.87 %	62.49 %	68.55 %	71.71 %	68.24 %	65.88 %	61.35 %	70.92 %	70.19 %	65.54 %	66.06 %	65.76 %	67.38
	A&E FFT baseline – 37.3%	38.80 %	39.58 %	43.22 %	35.13 %	38.05 %	31.66 %	29.77 %	30.13 %	30.14 %	26.62 %	22.59 %	25.43 %	32.59
	Maternity users baseline – 30%	47.09 %	69.55 %	55.05 %	50.47 %	57.47 %	68.54 %	83.73 %	74.46 %	77.25 %	80.38 %	67.75 %	69.68 %	66.81
Improve the turnaround time for formal patient complaints so that 80% of patients receive an appropriate response within target deadlines	> 40.6%	19%	26%	41%	39%	42%	46%	47%	57%	65%	69%	72%	73%	73%

Priority	Objective	What we achieved	Status
To improve patient satisfaction as measured by national surveys and the Friends and Family test	Improved performance in the CQC national inpatient survey	The Trust's performance in the annual national inpatient survey demonstrates that the Trust made significant progress in 2015. The Trust's average score across all the questions in the 2014 national inpatient survey was 68.2 and this increased to 71.3 in 2015. Furthermore, the trust improved its responses on 20 out of 60 questions by more than 5% and none of the 60 questions scored worse by 5% or more in 2015 in comparison to 2014.	Achieved
	The trust will improve the percentage of patients who respond to the FFT question with a response of 'extremely likely'	This objective was achieved in relation to increasing the percentage of maternity patients who would be extremely likely to recommend the trust to their friends and family which increased from a baseline of 30% to 67%. The percentages of inpatients and Emergency Department patients who would be extremely likely to recommend the Trust to Friends and Family decreased slightly. Inpatients who were extremely likely to recommend the trust reduced from a baseline of 73% to 67%. However this masks a consistent and continuous improvement in the overall percentage of inpatients who would recommend the Trust to their friends and family. This increased from 92% of inpatients in April 2015 to 96% of inpatients in March 2016. Emergency Department patients who were extremely likely to recommend the trust to friends and family reduced from a baseline of 37% to 33%. This was also reflected in a reduction in the total percentage of Emergency Department patients who would recommend the Trust to friends and family, which reduced from 81% in April 2015 to 49% in March 2016.	Partially achieved
	Improve the turnaround time for responding to formal patient complaints from 40% being on time so that 80% of patients receive an appropriate response within target deadlines	The Trust made significant and sustained improvement in reducing the length of time it took to respond to formal complaints. The Trust improved performance from the 2014/15 baseline of 40% and only 19% of complaints in April 2015 being responded to on time, to 73% of formal complaints being responded to on time in March 2016. This is still below the level of performance the Trust would like to see and the stretching target of 80% we set ourselves. Nonetheless, this is a significant improvement. The Trust remains committed to delivering further improvements in the time taken to provide responses to patients and families who complain to us about our services. Delivering further improvements in our response times will be included in our quality account priorities for delivery in 2016/17.	Partially achieved

Priority 2: Continued improvement to End of Life care so that North Middlesex Hospital becomes an exemplar provider

Why we chose this priority

Delivering compassionate, high quality care to patients at the End of Life is important to our patients and their loved ones. Providing such high quality care is also important to our staff, however some may find it difficult to initiate conversations with patients about their treatment preferences and their preferred location to receive their care. For example, some patients may wish to be cared for at home surrounded by their family, rather than in hospital. By having these conversations about treatment choices and making sure that all members of a patient's multidisciplinary team know the patient's care plan, we will provide good quality care that responds to the individual needs of our patients. Furthermore, we have chosen this as a priority because End of Life Care was an area that the CQC identified as requiring improvement when they inspected the Trust in June 2014.

What we wanted to improve

We wanted to expand our End of Life service so that it is accessible seven days a week. In addition, we wanted to improve End of Life care pathways with providers in the local community, so that patients approaching the End of Life can experience a seamless transition between the trust and community providers so that an increased number of patients are able to die in their preferred location. We also wanted to expand End of Life training to all relevant wards and specialties so that our staff are equipped with the knowledge and have the skills and confidence to provide patients with compassionate care that is tailored to each End of Life patient's needs.

How we monitored progress

The End of Life Group is chaired by the Director of Nursing and monitors the improvements to the End of Life service.

What would success look like?

Increased referrals to the End of Life Care Team

Increased number of referrals seen on the same or following day.

Expanded service provision to seven days a week

Increased percentage of patients who are able to die in their location of choice.

Priority 2: Continued improvement to end-of-life care so that North Middlesex University Hospital becomes an exemplar provider														Annualised performance
	Benchmark or target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	2015/16
Increase the number of patients who are referred to the end-of-life care team	>545	65	55	69	61	51	66	69	54	42	65	51	43	691
Increase the number of patients who are seen on the same or following day by the end-of-life care team	97%	94% (61 pts)	98% (54 pts)	94% (65 pts)	100% (61 pts)	96% (49 pts)	97% (64 pts)	95% (65 pts)	93% (50 pts)	95% (40 pts)	100% (65 pts)	100% (51 pts)	100% (43 pts)	97% (665 pts)
Increase the percentage of patients who are enabled to die in their preferred location of choice	Achieved = 44% Not achieved = 34% Not applicable = 22%	51% 17% 32%	54% 22% 24%	61% 20% 19%	53% 16% 31%	57% 14% 29%	50% 23% 27%	61% 10% 28%	61% 17% 20%	36% 7% 43%	55% 15% 30%	71% 21% 8%	71% 8% 21%	65% 16% 26%

Priority	Objective	What we achieved	Status
Continued improvement to end-of-life care so that North Middlesex University Hospital becomes an exemplar provider	Increase the number of patients who are referred to the end-of-life care team above the 545 who were referred for palliative care during 2014/15.	The Trust referred 691 patients to the end of life team during 2015/16. This is an increase of 146 patients during the year. This ensured that the Trust provided high quality, compassionate care to more patients who were approaching the end of their life. This also enabled the Trust to provide compassion and support to the family and loved ones of more patients than we cared for in the previous year.	Achieved
	Increase the number of patients who are seen on the same or following day by the end-of-life care team	When patients are approaching the end of their life, it is vitally important that they are referred and then reviewed by the End of Life Team in a timely manner. Of the 691 patients who were referred to the End of Life team, 665 were reviewed the same or following day. This included 100% of the patients referred to the End of Life team between January and March 2016 and averaged 97% across the entire year.	Achieved
	Increase the percentage of patients who are enabled to die in their preferred location of choice	During 2015/16 the End of Life team worked hard to increase the numbers of patients who died in their preferred location of choice. During 2014/15, the end of life team ensure that 44% of the patients they reviewed were able to die where they wanted to. In 2015/16 the End of Life team were able to increase this to 65% of the patients they reviewed.	Achieved

Priority 3: Improving care for patients with dementia

Why we chose this priority?

Patients suffering from dementia often have complex care needs and, particularly in the later stages of the disease, high levels of dependency and increased risk of morbidity and mortality. High quality dementia care recognises and promotes the human value of patients with dementia and those who care for them by recognising and preserving the patient's individuality and taking action to promote and protect their safety and well-being. Patients with dementia can often challenge the skills of carers and the capacity of service so it is essential that staff are equipped with the requisite expertise to care for patients with dementia. Furthermore, we chose this priority because the CQC identified our medical services, including care of the elderly, as one of the areas that required improvement. The quality of our dementia care was one of the aspects that contributed to this.

What we wanted to improve?

We want to enhance and expand the knowledge and skills of staff to ensure they can care for patients with dementia across the Trust. We will, however target this training on the most relevant clinical areas, which are the Care of the Elderly wards, Accident and Emergency department and the Acute Medical Unit. We will increase the number of staff who have undergone dementia training in these high risk clinical areas.

How we monitored progress?

The Trust has a Dementia Care Steering Group which will monitor the implementation of these quality improvement initiatives aimed at improving the quality of dementia care that we provide. The Trust is also participating in the UCL Partners dementia programme and the performance of the trust in terms of providing dementia training is reported through to UCLP.

What would success look like?

Increased percentage of staff in Accident and Emergency, the care of the elderly wards and the Acute Medical Unit who have received dementia training.

Increased use of the carer's passport scheme to support carers of patients with dementia.

Increased capture of abbreviated mental test score (MTS) and diagnoses of dementia on Electronic Discharge Summaries as a percentage of patients aged over 70 years.

What we achieved in 2015/16

Priority 3: Improving care for patients with dementia														Q1 performance	Q4 performance	15/16 performance
Increased capture of diagnoses of dementia on electronic discharge summaries as a percentage of patients aged over seventy years	Improvement on baseline established in Q1	93 %	88 %	88 %	80 %	92 %	84 %	84 %	96 %	96 %	92 %	92 %	96 %	89.67 %	93.33 %	90.08 %
Increased capture of MTS on electronic discharge summaries as a percentage of patients aged over seventy years	Improvement on baseline established in Q1	21 %	32 %	27 %	20 %	16 %	28 %	12 %	4%	4%	8%	24 %	4%	26.67 %	12%	17%
Increased percentage of staff who have received dementia training	Deliver Dementia training programme	21.5% trained in Q1 (640/2976)			23.2% trained in Q2 (682/2932)			11.9% trained in Q3 (348/2932)			Q4 TBC					
Increased use of the carer's passport scheme to support carers of patients with dementia	Improvement on baseline established in Q1	9%			24%			9%			Q4 TBC					

Priority	Objective	What we achieved	Status
Priority 3: Improving care for patients with dementia	Increased capture of diagnoses of dementia on electronic discharge summaries as a percentage of patients aged over seventy years	The audit of electronic discharge summaries for patients coded with dementia at any point during their admission indicated that there was an improvement in the capture of a diagnosis of dementia on the electronic discharge summary for the patient's GP. The quarter 1 baseline was 89.67% and this was improved to 93.33% by Q4.	Achieved
	Increased capture of MTS on electronic discharge summaries as a percentage of patients aged over seventy years	The audit of electronic discharge summaries for patients coded with dementia at any point during their admission indicated that there was not an improvement in the capture of MTS on the electronic discharge summary for the patient's GP. The quarter 1 baseline was 26.67% and this deteriorated to 12% in Q4 with annualised performance of 17%.	Not achieved
	Increased percentage of staff who have received dementia training	The Trust has provided a range of dementia training to various staff groups across the Trust. The Trust provided dementia training to 640 staff in Q1, 682 in Q2 and 348 in Q3. This represents 57% of the Trust's total workforce*. Q4 training figures to be finalised.	Achieved*
	Increased use of the carer's passport scheme to support carers of patients with dementia	The Trust's dementia carers audit results indicate that a slight improvement was achieved in Q2 in comparison to Q1. However there is still significant progress required to be made to bring this level up to where the Trust wants. We want all relevant patient carers to be routinely offered a carers passport and the Dementia steering group will review the dementia carer audit results to ensure action is taken to address this. *Q4 carers audit underway, awaiting responses.	Partially achieved*

Clinical Effectiveness Priorities for delivery in 2015/16

Priority 1: Improved patient participation in the Patient Reported Outcome Measures (PROMs) questionnaires

Why we chose this priority?

In last year's Quality Account we identified the need to increase patient completion of the PROMs questionnaires in response to data received from the national centre which indicated we had a low level of patient participation. In response to this, we set an ambitious stretch target of giving 95% of eligible patients the opportunity to participate in PROMs. Performance against this target during 2014/15 was mixed. We succeeded in getting 96% of patients who underwent total hip replacements to participate in PROMs. However we failed to deliver 95% participation for knee replacement patients, of whom participation increased to 86%, and groin hernia patients, of whom only 34% of patients opted to participate. This indicates a need to continue the concentration on PROMs in order to maintain the current good performance regarding knee replacement patients and to improve performance for hip replacement and groin hernia patients to the requisite level. The Trust also failed to instigate a system for capturing the details of patients who decline to participate in PROMs questionnaires.

What we wanted to improve?

We wanted to maintain the current level of good performance for hip replacement patients

We wanted to improve participation for knee replacement and groin hernia patients to 95%

The trust does not perform varicose vein surgery so we are not measured on this outcome.

How we monitor progress?

The Sister for Pre-assessment maintains a log of the number of patients who have participated in the PROMs surveys for each different type of procedure. These are cross referenced to the number of applicable patients who underwent that procedure during the month.

What would success look like?

An increase in the participation rates for each category of PROM survey with a stretch target of 95% of patients who are eligible to take part in the PROMs survey given the opportunity to complete the questionnaire and their information sent to the national team for analysis.

What we achieved during 2015/16

Improved patient participation in the patient reported outcome measures (PROMs) questionnaires							
		Q1	Q2	Q3	Q4	2015/16	Total
Increase participation in PROMS with a stretch target of 95% of eligible patients to participate in PROMs surveys	Groin hernia PROMs participation rate = 34%	63.27%	41.67%	29%	26.67%	37.01%	60.09%
	Total hip replacement PROMs participation rate = 96%	90.91%	65.71%	58.97%	69.77%	70.67%	
	Knee replacement PROMs participation rate = 86%	125.58%	91.11%	66.67%	102.04%	92.93%	

All relevant patients are invited to participate in the PROMs survey, the table above indicates the percentage of relevant patients who agree to participate and complete the initial survey at pre-assessment. The groin hernia participation rate initially improved significantly before declining in quarters 3 and 4 to return to slightly above the 2014/15 baseline of 34%, increasing marginally to 37% but a long way short of the ambitious target of 95%. Total hip replacement participation declined over the year from 96% in 2014/15 to 71% in 2015/16. The Knee replacement participation increased from 86% in 2014/15 to 93% in 2015/16. Overall, however, this failed to compensate for the deterioration in hernia and hip replacement PROMS so the Trust's overall participation was 60%. The CBU4 Surgical Specialties management team will devise an action plan to improve participation in PROMS during 2016/17.

Priority 2: Improved performance against the specialty specific clinical outcome measures

The Trust did not maintain the specialty specific outcome measures reporting mechanism during 2015/16 as such the specialty specific outcome measures objective was not achieved. During 2015/16 the Trust invested in 2 benchmarking tools to enable the Trust to analyse its performance across a suite of clinical quality indicators and compare the quality of services we provide with national and peer group benchmarks.

We have fully revised our performance management framework and the Integrated Performance Report to Trust Board so that both of these benchmarking tools feed into our performance reporting. The first tool is CHKS analytics which enables to trust to analyse its mortality data and other clinical quality measures and compare them to national and peer group benchmarks. Similarly, in 2015/16 the Trust also commissioned the Methods Analytics Stethoscope tool. This also enables us benchmark our performance against a suite of clinical quality indicators so we can identify where we are an outlier and take corrective action.

One example of this was our Safety Thermometer performance. In August 2015 our Stethoscope analysis identified that we were an outlier for:

- Our low harm free care scores
- Treatment for VTE.

Consequently we reviewed our safety thermometer survey process and identified that some ward managers had been completing the survey incorrectly which resulted in inaccurate and poorer than expected scores. As a result of this we reviewed our safety thermometer survey and verification process to improve the rigor of the process. This has resulted in a significant improvement in the Trust's harm free care scores. This provides an example of how the Trust's investment in benchmarking clinical and business intelligence tools enables us to quickly identify where the Trust is at risk of being an outlier and taking correct action before it is escalated to the Trust from a system partner. The Trust is convinced that this provides a more rigorous means for us to analyse and compare the quality of our clinical services, than the internally generated specialty specific outcome measures we devised previously.

Priority 3: Design and Implement an Anaesthetics Service Improvement Plan

Why we chose this priority?

Feedback from our trainees suggested that our Anaesthetics service could be reorganised and modernised to improve the quality of services provided to patients. The Trust reviewed the configuration of its Anaesthetics service provision which resulted in a remodelling of the service and an expansion in the number of consultant anaesthetists at the Trust. At the time of writing the 2014/15 Quality Account, the Trust was using locum consultants pending the successful recruitment of substantive consultants. The appointment of these additional substantive consultants would present the Trust with a unique opportunity to review, innovatively reshape and improve its anaesthetics and pain service provision. Furthermore, we also chose to concentrate on this priority because the CQC inspection report identified the need for the Trust to review the provision of specialist pain nurse support across the Trust.

What we wanted to improve?

The Trust created a new interim post of Clinical Director for Anaesthetics to devise and lead the implementation of the service improvement plan to reorganise the department to enable better quality service provision, 7 days a week. This would also enhance the standing and reputation of the anaesthetics department at North Middlesex Hospital.

This would be accompanied by an expansion of the Critical Care Outreach Team to enable 24 hour, 7 day a week service provision across the Trust. The specialist pain nurse provision would also be expanded so as to enable access to specialist pain nurses 7 days a week.

How we monitored progress?

The Trust developed an Anaesthetics Service quality dashboard to monitor the quality of the service and this was reported internally and shared with commissioners at the Clinical Quality Review Group. The Service Improvement Plan was reviewed and agreed by the Trust Executive who monitored the implementation of the plan and the achievement of key project milestones.

What would success look like?

Substantive recruitment to all anaesthetic vacancies

Provision of 24/7 Critical Care Outreach Team

Provision of 7/7 specialist pain nursing service

Agreement and achievement of service improvement plan which will include a commitment to:

Developing the care of high dependency patients both within the critical care complex and out on our wards.

Commission TIVA equipment in anaesthetics

What we achieved during 2015/16

Priority	Objective	What we achieved	Status
Priority 3: Design and implement an anaesthetics service improvement plan	Recruit to 28 anaesthetic medical posts	The Trust has appointed to all the vacant anaesthetic posts. All but two of the appointments are currently in post, with the last 2 appointments taking up their positions in June and July respectively.	Achieved
	Introduce Total Intravenous Anaesthesia (TIVA) at North Middlesex Hospital	Total Intravenous Anaesthesia equipment was purchased and a training programme implemented so that the Trust could provide TIVA from July 2015.	Achieved
	Add Suggamadex and Desflurane to the Trust's medicine formulary	Both suggamadex and desflurane were added to the Trust's medicine formulary and entered clinical use from September 2015.	Achieved
	Expand the Critical Care Outreach Team service to 24 hours, seven days a week.	The Critical Care Outreach Team service was expanded to a twilight service from 2nd November 2015 and then to a 24 hours a day, seven days a week from 1st December 2015.	Achieved
	Expand the specialist pain service to a 7 day a week service	The specialist pain service was expanded to a seven day a week service with effect from 1st December 2015.	Achieved

<table>
<tr><th colspan="14">Priority 3: Design and implement an anaesthetics service improvement plan</th></tr>
<tr><th></th><th>Benchmark or target</th><th>Apr-15</th><th>May-15</th><th>Jun-15</th><th>Jul-15</th><th>Aug-15</th><th>Sep-15</th><th>Oct-15</th><th>Nov-15</th><th>Dec-15</th><th>Jan-16</th><th>Feb-16</th><th>Mar-16</th></tr>
<tr><td>Recruit to anaesthetics vacancies</td><td>Recruit to 28 vacancies</td><td>1</td><td>3</td><td>9</td><td>13</td><td>13</td><td>23</td><td>23</td><td>23</td><td>24</td><td>25</td><td>28</td><td>28</td></tr>
<tr><td>Finalise and implement anaesthetics quality improvement plan</td><td>Introduce TIVA and add Desflurane and Sugmmadex to Trust Formulary</td><td colspan="3" rowspan="3">Implementation of the Anaesthetics Quality Improvement Plan ongoing.</td><td colspan="3">Desflurane and Sugammadex added to Trust formulary. TIVA Pumps purchased</td><td colspan="6" rowspan="3">Anaesthetics quality improvement plan completed.</td></tr>
<tr><td>Expand critical care outreach team to 24/7 service</td><td>Launch 24/5 CCOT service</td><td colspan="3">24/7 CCOT service launched 01/12/2015</td></tr>
<tr><td>Expand specialist pain service to 7/7 service</td><td>Launch 7/7 service</td><td colspan="3">7/7 Pain CNS service launched 01/12/2015</td></tr>
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QUALITY PRIORITIES FOR DELIVERY IN 2016/17

In identifying our quality priorities for 2016/17, we have decided to maintain the overarching objectives of improving quality by improving the patient experience, patient safety and clinical outcomes. However we have also been mindful to select priorities that are also aligned to the Care Quality Commission's 5 quality domains of safety, effectiveness, caring, responsive and well led clinical services. When selecting our priorities we have taken account of addressing areas of existing poor performance against national quality priorities during 2015/16, such as the four hour Accident and Emergency access standard. Our quality improvement objectives for 2016/17 have also been selected taking account of ongoing national priorities such as the Sign Up to Safety Campaign and the areas of improvement identified in the NHS Outcomes Framework such as Healthcare Associated Infections and Pressure Ulcers. In this important respect, our process for selecting this year's priorities has developed from last year's process. Finally, we have taken our performance against last year's priorities into account, and where there remains important work to be done to achieve priorities that have been previously identified, these have been reflected upon and updated for inclusion in this year's quality improvements. However, in addition to the key quality priorities identified in this section for 2016/17. There remains a broad programme of quality improvement work that complements these priorities and which will remain ongoing as part of business as usual. Our process for determining and agreeing our priorities has seen us consult internally with a multidisciplinary team of senior clinicians, as well as the senior management team and the Trust's Risk and Quality Committee. We have also consulted with the Health Overview and Scrutiny Committees of Enfield and Haringey local authorities, our commissioners, our local Commissioning Support Unit, and most importantly, our patients. The Trust will undertake a number of listening events where patients from across the Trust in addition to formally consulting our Patient Representative Forum.

As a result of this extensive consultation programme, the Trust has selected the following quality improvement priorities:

Patient safety:

1. Deliver further improvements in our management of deteriorating patients in particular by improving how we care for patients with sepsis whilst maintaining antimicrobial stewardship

Clinical effectiveness:

1. Deliver the Safer, Faster, Better transformational programme to improve patient flow across the organisation so that our patients are seen by the right clinician, in the right clinical environment at the right time

Patient experience:

1. Improve the experience of our patients, with a particular focus on Outpatients and the Emergency Department

2. Improve the experience of patients who complain to us about our services by delivering further improvements in our response times to patient complaints.

NMUH Workforce priority:

1. Improve the staff health and wellbeing at work so that more of our staff would recommend the trust as a place to work or come to receive care for their friends and family

The Risk and Quality Committee will monitor the delivery of the Quality Account on behalf of the Board on a bi-annual basis. In addition, sub-groups of the committee will monitor relevant priorities and provide assurance to the committee on a quarterly basis.

Patient Safety Priority: Continue to improve the management of deteriorating patients and in particular, patients who have sepsis whilst improving antimicrobial stewardship

Why have we chosen this priority?

Sepsis is a common and potentially life-threatening condition where the body's immune system goes into overdrive in response to an infection, setting off a series of reactions that can lead to widespread inflammation, swelling and blood clotting. This can lead to a significant decrease in blood pressure, which can mean the blood supply to vital organs such as the brain, heart and kidneys is reduced – potentially leading to death or long-term disability. Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 32,000 deaths in England attributed to Sepsis annually. Of these some estimates suggest 11,000 could have been prevented.

The Parliamentary and Health Service Ombudsman (PHSO) published Time to Act in 2013 which found that recurring shortcomings in relation to the Sepsis management included:

1. Failure to recognize the severity of the illness

2. Inadequate first-line treatment with fluids and antibiotics

3. Delays in administering first-line treatment

4. Delay in source control of infection

5. Delay in senior medical input

An avoidable death of a 3 year old, also published by the PHSO in 2014 highlighted the need to improve care and pathways for patients with Sepsis. The Secretary of State announced a number of measures to improve the recognition and treatment of Sepsis in January 2015. The NCEPOD Just Say Sepsis! report also made a number of recommendations about the need for better identification and treatment of Sepsis. In June 2015, North Middlesex University Hospital received a Dr Foster mortality outlier alert relating to patients who attended with sepsis. A casenote review identified that the Trust needed to improve the management of patients presenting with sepsis in order to ensure that each patient receives high quality care.

Problems in achieving consistent recognition and rapid treatment of Sepsis are currently thought to drive the number of preventable deaths. It is the failure to recognise the severity of the illness, or to recognise that the illness is Sepsis, until the condition has reached a state of rapid onset and consequential patient deterioration, that plays a significant role in its effects.

Antimicrobial stewardship is an important patient safety issue because Antimicrobial resistance (AMR) has risen alarmingly over the last 40 years and inappropriate and overuse of antimicrobials is a key driver. The number of new classes of antimicrobials coming to the market has reduced in recent years and between 2010 and 2013, total antibiotic prescribing in

England increased by 6%. This leaves the prospect of reduced treatment options when antimicrobials are life-saving and standard surgical procedures could become riskier with widespread antimicrobial resistance.

What are we trying to improve?

The timely identification of patients presenting as emergencies with sepsis by increasing the percentage of patients who present to ED whose clinical condition meets the criteria for sepsis screening and were correctly screened for sepsis.

The trust also wants to improve the management of patients in ED who present with severe sepsis, Red Flag Sepsis or septic shock by increasing the percentage of patients who are administered intravenous antibiotics within an hour and who subsequently receive an empiric review within three days of the prescribing of antibiotics.

In addition to improving the management of patients presenting as emergencies with sepsis, the Trust also wants to improve the management of inpatients who develop sepsis during their admission. The trust will do this by improving the timely identification of deteriorating patients and subsequent treatment of inpatients who have sepsis.

Our aim to improve antimicrobial stewardship through reducing total antibiotic consumption (measured as defined daily doses (DDDs) per 1000 admissions) as well increasing antibiotic prescription reviews within 72 hours of commencing an antibiotic.

What will success look like?

> 90% of patients presenting in ED with sepsis undergoing sepsis screening

Continuous improvement in the percentage of ED patients with sepsis who receive IV antibiotics within an hour

Consistent achievement of compliance with patient observation requirements recorded via NEWS charts

Continuous improvement in the percentage of inpatients who develop sepsis and who are screened for sepsis

Continuous improvement in antimicrobial stewardship by increasing the percentage of patients with sepsis (both ED presentations and admitted inpatients) who receive an empiric review within 3 days of initial antibiotics prescription.

Reduction in sepsis associated mortality as measured by the sepsis Dr Foster HSMR mortality basket.

Reduction in total antibiotic consumption per 1,000 admissions

Reduction in total consumption of carbapenem per 1,000 admissions

Reduction in total consumption of piperacillin-tazobactam per 1,000 admissions

Establish a baseline for antibiotic prescriptions reviewed within 72 hours and deliver an improvement trajectory

How will we monitor progress?

The Trusts sepsis improvement work stream is led by a consultant anaesthetist and reports to the Patient Safety Group. Implementation of these objectives will be incorporated into the Safer, Faster, Better programme and reported to the Patient Safety Group.

The impact of this quality improvement work on sepsis related mortality as measured by Dr Foster using HSMR will be monitored at the Mortality Monitoring Committee.

The antimicrobial stewardship work stream will report to the Patient Safety Group as part of the medication safety work stream. Implementation of these objectives will be incorporated into the Safer, Faster, Better programme and reported to the Patient Safety Group.

Clinical effectiveness priority: Deliver the Safer, Faster Better Programme to improve patient flow across the organisation so that our patients are seen by the right clinician, in the right clinical environment at the right time

Why have we chosen this priority?

The Safer, Faster, Better transformational programme is our response to the deterioration in performance against the national A&E 4 hour target. However, this transformational programme is not limited to our Emergency Department; it is comprehensive in its approach and ambitious in its scope. As such, the Safer, Faster, Better Programme will deliver improvements in quality that transcend safety, experience effectiveness and benefit admitted patients across the Trust. As such the projects within the Safer, Faster, Better programme incorporate changes to clinical pathways in order to deliver further improvements to our national patient survey results, friends and family test scores as well as increased staff satisfaction with the quality of care we provide our patients.

What are we trying to improve?

The Safer, Faster, Better programme aims to improve the quality of care for admitted patients and patients in the Emergency Department by:

Reducing the time between patients arriving in the Emergency Department, being triaged and receiving their treatment.

Reducing the number of patients waiting longer than 4 hours in the Emergency Department for admission.

Increasing the number of patients who are admitted from the Emergency Department temporarily for assessment for less than one day

Reducing the number of patients transferred between wards on more than one occasion.

Reducing the length of time patients unnecessarily spend in hospital by discharging more patients earlier in the day

Reducing the length of time patients unnecessarily spend in hospital by reducing the number of patients experiencing delayed discharges who are fit to go home, but need a package of care or supported discharge

What will success look like?

More than 95% of Emergency Department patients being triaged within 15 minutes of arrival in the Emergency Department.

More than 95% of Emergency Department patients starting their treatment within an hour of arriving in the Emergency Department

More than 95% of Emergency Department patients being admitted or treated and discharged within 4 hours of arrival.

More than 20% of patients being discharged before midday.

A XX% reduction in delayed transfers of care for medically optimised patients who are ready for discharge but require a package of care or supported discharge to be put in place.

Improved performance in the Emergency Department and Inpatient Friends and Family Test results.

Improved performance in the 2016/17 national inpatient patient experience survey.

How will we monitor progress?

The Safer, Faster, Better Programme comprises four distinct project groups focused on:

1. Emergency Department

2. Assessment and Short Stay

3. Wards

4. Out-of-Hospital partners

Each project group is led by a triumvirate comprising a consultant, senior nurse and senior manager who are accountable for project delivery and who report to the Safer, Faster, Better Executive Sponsor Group which reports to the Trust Board. In addition, the Safer, Faster, Better Delivery Group which reports to the Systems Resilience Group for Enfield and Haringey Clinical Commissioning Groups.

Patient Experience Priority: Improve the patient experience, particularly in the Emergency Department and Outpatients Departments whilst delivering further improvements in the response times for formal complaints.

Why have we chosen this priority?

The Trust made significant improvements in the national inpatient patient experience survey in 2015/16. Patients responses improved across 60 questions in the survey and there were no questions where the Trust scored lower in 2015/16 than in 2014/15. Furthermore the Trust's average score improved from 68.2 in 2014/15 to 71.3 during 2015/16. These improved scores represent significant steps forward in delivering a better experience for our patients. However, there is still scope for improving the patient experience further. Our Friends and Family Test scores remain good but are inconsistent and we want to improve these further. In particular, the Trust will concentrate on improving the patient experience of patients using our Emergency Department and our Outpatients department.

Inevitably, on occasion, the Trust will get things wrong and it is really important that when we do so, our patients feel empowered to complain. Complaints enable the Trust to identify where we have got things wrong so we can take action to put these matters right to ensure future patients do not suffer the same poor experience. During 2015/16, we significantly improved the turnaround times for complaints, so that more patients received a response to their complaints, outlining what action we took in response to their complaint within the target deadline. The Trust, therefore, has made substantial progress in delivering an improved patient experience, however we are clear that there remains work to do in order to ensure that each and every patient receives a really positive experience when they are under our care.

What are we trying to improve?

We want all our patients to have a positive experience of receiving care at North Middlesex Hospital. Where our patients do not have a positive experience, we want them to complain so we can put that right and so that our patients feel like we listen to them and take their complaints seriously. Consequently, we want to deliver improved patient experience as measured by the two Friends and Family Tests. This simple test demonstrates how our patients rate the care we provide and whether they would recommend North Middlesex Hospital to their friends or family. We also survey our staff in a similar manner because we feel it is important to gauge how our staff feel about the standard of care we provide and whether they feel that the care they provide is of sufficient quality as to lead them to recommend North Middlesex Hospital to their friends and family.

In addition to delivering further improvements in our Friends and Family Test results, we also want to continue to deliver improvements in our national patient experience surveys. During 2016/17 the CQC will undertake 3 national patient experience surveys; the annual adult inpatient survey, an A&E patient experience and a children and young people patient experience survey. The Trust wants to deliver improved patient experience survey results in each of these important surveys.

The Trust delivered significant and continuous improvements in the response times for formal complaints received by the Trust during 2015/16. The Trust does not want to discourage complaints as they present important learning opportunities that enable the Trust to identify areas where the patient experience can be improved. Therefore, the Trust does not want to focus on reducing the number of formal complaints. Instead the Trust wants to consolidate the improvements in complaints response times to ensure they are sustained and further improvements over the 2016/ year are delivered. In addition, the Trust wants to increase the action taken and learning arising from complaints by ensuring that action is always taken in response to formal complaints that following investigation is upheld.

We also want to improve our engagement with patients, particularly regarding how we work with patients to improve the patient experience. We launched a refreshed public and patient involvement forum in 2015/16 and in 2016/17 we want to build on this and use the patient and public involvement forum to increase the involvement of our patients in decisions and actions taken to improve the patient experience. This refreshed group is to be embedded at the heart of the Trust's patient experience improvement work so that the Trust effectively engages with all its local patient populations so that our understanding of our patients' different needs and preferences are understood and influence decisions and actions taken to improve services across the Trust.

What will success look like?

Improved performance in the patients' Friends and Family Tests, particularly in the Emergency Department and Outpatients

Improved performance in the 2016/17 national inpatients patient experience survey in comparison to our 2015/16 inpatient survey results.

Sustained improvements in formal complaints response times so that 80% or more of formal complaints are consistently responded to within target deadlines

How will we monitor progress?

The implementation of the patient experience improvement plan is led by the Deputy Director of Nursing and is monitored at the Patient Experience Group which is chaired by the Director of Nursing and reports to the Trust Board's Risk and

Quality Committee. In addition, the Trust's performance in national patient experience surveys, Friends and Family Test results and formal complaints response times are formally reported to the Trust Board.

NMUH Workforce priority: Improve staff health and wellbeing at work so that more of our staff would recommend the trust as a place to work or come to receive care for their friends and family

Why we have chosen this priority?

Estimates from Public Health England put the cost to the NHS of staff absence due to poor health at £2.4bn a year – around £1 in every £40 of the total budget. This figure excludes the cost of agency staff to fill in gaps, as well as the cost of treatment. As well as the economic benefits that could be achieved, evidence from the staff survey and elsewhere shows that improving staff health and wellbeing will lead to higher staff engagement, better staff retention and better clinical outcomes for patients.

The Five Year Forward View made a commitment 'to ensure the NHS as an employer sets a national example in the support it offers its own staff to stay healthy'. This quality account priority builds on this promise and the developments made across England during the past year through some of the work being undertaken within NHS England's Healthy Workforce Programme to help promote health and wellbeing for NHS staff and improve the support that is available for them in order for them to remain healthy & well.

A key part of improving health and wellbeing for our staff at North Middlesex Hospital, is giving them the opportunity to access schemes and initiatives that promote physical activity, provide them with mental health support and rapid access to physiotherapy where required.

What will we improve?

We will introduce a range of physical activity schemes for staff. We will design and launch a selection of physical activity schemes with an emphasis on promoting active travel, building physical activity into working hours and reducing sedentary behaviour. We will explore the possibility of introducing physical activity sessions for staff which could include a range of physical activities such as; team sports, fitness classes, running clubs and team challenges.

We will improve access to physiotherapy services for staff. We will design and introduce a fast track physiotherapy service for staff suffering from musculoskeletal (MSK) issues to ensure staff who are referred via GPs or Occupational Health can access it in a timely manner without delay.

We will introduce a range of mental health initiatives for staff. We will review our existing offer of mental health and emotional support that we already provide to staff our staff and seek to expand this offering to potentially include increasing access to stress management courses, line management training, mindfulness courses, counselling services including sleep counselling and mental health first aid training;

What will success look like?

Increased staff satisfaction as measured by the annual staff survey.

Reduced staff sickness due to musculoskeletal (MSK) injuries and work related stress.

An increase in the percentage of staff who would recommend the Trust as a place to work or receive care to their friends or family.

How will we monitor progress?

The implementation of our Staff Health and Wellbeing Improvement Plan will be monitored at the Workforce and Education Committee and also reported to our commissioners at the Clinical Quality Review Group Meeting.

Statements of assurance from the board

Red text indicates data from 2014/15 awaiting review

1. During 2015/16 the North Middlesex University Hospital NHS Trust provided 35 relevant health services.

1.1 The North Middlesex University Hospital NHS Trust has reviewed all the data available to them on the quality of care in 35 of these relevant health services.

1.2 The income generated by the relevant health services reviewed in 2015/16 represents 92.4% of the total income generated from the provision of relevant health services by the North Middlesex University Hospital NHS Trust for 2015/16.

2. During 2014/15 48 national clinical audits and 4 national confidential enquiries covered relevant health services that North Middlesex University Hospital NHS Trust provides.

2.1 During that period North Middlesex University Hospital NHS Trust participated in 78% national clinical audits and 100% national confidential enquiries which it was eligible to participate in.

2.2 The national clinical audits and national confidential enquiries that North Middlesex University Hospital NHS Trust was eligible to participate in are as follows:
National Clinical Audits - see table 1 below
National Confidential Enquiries – see table 2 below

2.3 The national clinical audits and national confidential enquiries that North Middlesex University Hospital NHS Trust participated in during 2014/15 are as follows:
National Clinical Audits - see table 1 below
National Confidential Enquiries – see table 2 below

2.4 The national clinical audits and national confidential enquiries that North Middlesex University Hospital NHS Trust participated in, and for which data collection was completed during 2014/15, 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.

INSERT NATIONAL CLINICAL AUDIT AND NATIONAL CONFIDENTIAL ENQUIRY TABLE HERE

3. The number of patients receiving relevant health services provided or subcontracted by North Middlesex University Hospital NHS Trust in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 510.

4. A proportion of North Middlesex University Hospital NHS Trust's income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between North Middlesex University Hospital

NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2015/16 and for the following 12 month period are available electronically at:
INSERT LINK TO CQUIN REPORT HERE

The Commissioning for Quality and Innovation (CQUIN) payment framework allows the Trust and Commissioners to develop and agree quality requirements in the annual contracts. The Trust is financially incentivized for achieving targets within the CQUIN Indicators. The financial incentive is equivalent to 2.5% of the Actual Contract Value and is split between Indicators which are either nationally mandated (1.0%) or locally agreed (1.5%). The locally agreed CQUIN Indicators are developed via clinical discussion and negotiation between Primary Care (CCG) and Secondary Care (Acute) Clinicians. The CQUIN Indicators are aimed at developing innovative and challenging quality targets that will have a positive clinical impact on the local healthcare population. Although final values for 2015/16 based on the year end position are yet to be agreed in full with local commissioners a summary of the CQUIN Indicators for 2015/16 can be found below:

5. North Middlesex University Hospital NHS Trust is required to register with the Care Quality Commission and its current registration status is registered with the CQC with no conditions attached to the registration. The Care Quality Commission has not taken enforcement action against North Middlesex University Hospital NHS Trust during 2015/16.

6. Not applicable.

7. North Middlesex University Hospital NHS Trust has not participated in any special reviews or investigations by the CQC during the reporting period of April 2015 to March 2016.

North Middlesex University Hospital underwent an announced, scheduled CQC inspection between 4th and 6th of June, 2014. This inspection was undertaken using the CQC inspection framework which assessed whether services are:

- Safe
- Effective
- Caring
- Responsive
- Well led

The following services were inspected:

- Accident & Emergency
- Medical Wards (including care of the elderly)
- Surgery
- Critical Care
- Maternity

- Paediatrics
- Outpatients
- End of Life Care

The chart below depicts the ratings awarded to each service and the trust overall.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and family planning	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

The CQC noted one area of concern, for which it issued a compliance notice regarding Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing. People who use services did not always have their health and welfare needs met by sufficient numbers of appropriate staff in that mandatory training records did not accurately reflect training undertaken across the trust and dementia awareness training was not undertaken across the trust.

A compliance action plan was submitted to the commission by the required deadline and the Trust achieved the improvements in staff training required by the compliance action.

A copy of the CQC inspection report can be accessed here: http://www.cqc.org.uk/sites/default/files/new_reports/AAAA1827.pdf

8. North Middlesex University Hospital NHS Trust submitted records during 2014/15 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

- 99.0% for admitted patient care
- 99.4% for outpatient care and
- 94.7% for accident and emergency care.
- The percentage of records in the published data which included the patient's valid General Medical Practice Code was:
- 99.8% for admitted patient care;
- 99.7% for outpatient care; and
- 99.7% for accident and emergency care

9. North Middlesex University Hospital Information Governance Assessment Report overall score for 2015/16 was 73% and was graded Green – satisfactory

10. No longer required for inclusion in quality accounts for 2015/16.

11. North Middlesex University Hospital NHS Trust will be taking the following actions to improve data quality:
The North Middlesex Hospital has invested in two additional permanent band 4 data quality staff and three apprentices within the corporate Data Quality Department. This will enabled the Trust to initiate a series of robust processes to monitor and improve Data Quality Trust wide. These include: (1) Apprentice developmental programme with the aim to transfer suitably trained apprentices into operational departments (2) Dedicated band 4 corporate DQ clerk for each Clinical Business Units (CBUs). (3) Weekly meetings with Service managers led by Data Quality Manager. (4) Data Quality attendance and agenda item on all CBUs Management Meetings. (5) Development of weekly updated issues tracker which is available electronically to all staff. (6)Development of Data Quality dash board for all CBUs. (7) Rolling programme of monthly data quality audits. (8) Presentation and training sessions for all administrative staff. (9) Development of a mandatory e-learning Data Quality package. (10) Development of pre-submission validation checks. (11) Data Quality update and monitoring at the weekly Director led Business Meeting. ()12) Monthly report to Finance Committee.

Domain 1 - Preventing people from dying prematurely

Summary Hospital-Level Mortality Indicator (SHMI)

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

Publication Date	Reporting period	Measure	NMUH Value	National Average	National Lowest	National Highest
March 2016	October 2014 - September 2015	Value	**0.9914**	1.0000	N/A	N/A
		Banding	**2**	N/A	N/A	N/A

January 2016	July 2014 - June 2015	Value	**1.0064**	1.0000	N/A	N/A
		Banding	**2**	N/A	N/A	N/A

Key SHMI Banding 1 = 'Higher than expected'
2 = 'As expected'
3 = 'Lower than expected'

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The Trust's SHMI rate is banded 'as expected'.

The North Middlesex University Hospital NHS Trust has taken the following actions to improve this rate, and so the quality of its services, by:

Ensuring that all deaths that occur in the hospital are closely reviewed as routine to assure that the best possible care was given to patients in all cases. Any subsequent learning events are shared within the organisation as appropriate.

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

(ii) Percentage of deaths with palliative care coding.

Publication Date	Reporting period	Measure	NMUH Value	National Average	National Lowest	National Highest
March 2016	October 2014 - September 2015	Treatment Rate	**0.0**	1.6	0.0	19.2
		Diagnosis Rate	**21.2**	26.5	0.2	53.5
		Combined Rate	**21.2**	26.6	0.2	53.5
January 2016	July 2014 - June 2015	Treatment Rate	**0.0**	1.6	0.0	18.4
		Diagnosis Rate	**21.1**	25.9	0.0	52.9
		Combined Rate	**21.1**	26.0	0.0	52.9

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The Trust's percentage of deaths with palliative care coding which is lower than the national average.

The North Middlesex University Hospital NHS Trust has taken the following actions to improve this rate, and so the quality of its services, by:

The Trust undertook a review of palliative care coding and corrected its practice from 2014 onward. This is reflected in the reported scores, which show a consistent performance lower than the national average.

Domain 2 - Enhancing quality of life for people with long-term conditions

Not applicable to the North Middlesex University Hospital NHS Trust

Domain 3 - Helping people to recover from episodes of ill health or following injury

PROMS; patient reported outcome measures.

(i) Groin hernia surgery

Publication Date	Reporting period	Measure	NMUH Value	National Average	National Lowest	National Highest
February 2016	April 2014 - March 2015	EQ VAS	**-4.320**	-0.504	-4.698	4.676
		EQ-5D Index	**0.076**	0.084	0.000	0.154
August 2015	April 2013 - March 2014	EQ VAS	**0.124**	-1.048	-5.798	2.856
		EQ-5D Index	**0.068**	0.085	0.008	0.139

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The trust's performance against the EQ VAS measure has seen deterioration between the reporting periods shown above, while performance against the EQ-5D Index has shown improvement.

The North Middlesex University Hospital NHS Trust [intends to take / has taken] the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

TBC

(ii) Varicose vein surgery

Note: No varicose vein surgery data available for 2014-15. No data previous to 2013-14 available.

Publication Date	Reporting period	Measure	NMUH Value	National Average	National Lowest	National Highest
August 2015	April 2013 - March 2014 (Unadjusted)	Aberdeen Varicose Vein Questionnaire	**-10.226**	-8.701	-19.385	-2.721
		EQ VAS	**-1.429**	-0.548	-12.045	19.143
		EQ-5D Index	**0.073**	0.093	-0.096	0.467

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The Trust's performance was slightly below the national average for this measure in the only available data set covering the financial year 2013-14. Please note that the data is not currently case-mix-adjusted.

The North Middlesex University Hospital NHS Trust [intends to take / has taken] the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

TBC

(iii) Hip replacement surgery

Note: Only unadjusted hip replacement surgery data available for 2013-14

Publication Date	Reporting period	Measure	NMUH Value	National Average	National Lowest	National Highest
February 2016	April 2014 - March 2015	EQ VAS	**9.873**	11.953	6.425	17.390
		EQ-5D Index	**0.431**	0.437	0.331	0.524
		Oxford Hip Score	**19.390**	21.444	16.292	24.652
August 2015	April 2013 - March 2014 (unadjusted)	EQ VAS	**7.667**	11.462	3.804	27.815
		EQ-5D Index	**0.450**	0.436	0.068	0.586
		Oxford Hip Score	**20.519**	21.380	14.576	24.949

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The Trust's performance was slightly below the national average but shows improvement between the two reporting periods. Please note that the data is not currently case mix adjusted.

The North Middlesex University Hospital NHS Trust [intends to take / has taken] the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

TBC

(iv) Knee replacement surgery

Note: No knee replacement surgery data available for 2014-15

Publication Date	Reporting period	Measure	NMUH Value	National Average	National Lowest	National Highest
February	April 2014 -	EQ VAS	**5.881**	5.783	1.423	15.423

2016	March 2015	EQ-5D Index	**0.295**	0.315	0.204	0.418
		Oxford Knee Score	**15.471**	16.148	11.475	19.492
August 2015	April 2013 - March 2014	EQ VAS	**1.719**	5.191	-2.477	16.010
		EQ-5D Index	**0.299**	0.318	0.215	0.425
		Oxford Knee Score	**14.338**	15.996	11.933	19.709

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The Trust's performance improved against two of the three measures between reporting periods, but remains below the national average.

The North Middlesex University Hospital NHS Trust [intends to take / has taken] the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

TBC

Patients readmitted to a hospital within 28 days of being discharged.

This indicator on the HSCIC Indicator Portal was last updated in December 2013 and the next update is due to take place in August 2016.

(i) aged 0 to 15

Publication	Reporting period	NMUH	National	National	National

Date		Value	Average	Lowest	Highest
Dec 2013	2011-12	**7.88%**	10.01%	3.75%	14.94%
Dec 2013	2010-11	**6.27%**	10.01%	4.04%	16.05%

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The trust's performance is slightly higher in the most recent reporting period above but both figures remain significantly better than the national average.

The North Middlesex University Hospital NHS Trust [intends to take / has taken] the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

Ensuring that paediatric patients can be fast tracked to dedicated day care facilities for treatment where clinically appropriate and help to avoid frequent and regular unplanned admissions to hospital. This helps children and carers to experience treatment in a less daunting and more comfortable environment.

(ii) aged 16 and over

Publication Date	Reporting period	NMUH Value	National Average	National Lowest	National Highest
Dec 2013	2011-12	**12.56%**	11.45%	4.88%	17.15%
Dec 2013	2010-11	**11.30%**	11.43%	6.67%	17.10%

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The trusts' performance over time has been broadly in line with the national average for this measure although there is an increase between the data time periods above.

The North Middlesex University Hospital NHS Trust [intends to take / has taken] the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

Ensuring that patients groups such as Sickle Cell suffers for example are helped in both the community and day care centres to better understand their signs and symptoms and take quicker action. This enables patients to experience treatment in a more appropriate and comfortable setting and avoid frequent (and often lengthy) unplanned admissions to hospital wards. Feedback from patients around this amended care pathway has been very positive indeed.

Domain 4 - Ensuring people have a positive experience of care

Responsiveness to the personal needs of patients

Publication Date	Reporting period	NMUH Value	National Average	National Lowest	National Highest
August 2015	2014-15	**59.3**	68.9	54.4	86.1
August 2015	2013-14	**65.5**	68.7	54.4	84.2

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The Trust's performance has historically been below the national average for this measure.

The North Middlesex University Hospital NHS Trust [intends to take / has taken] the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

TBC

Staff who would recommend the trust to their family or friends

Publication Date	Reporting period	NMUH Value	National Average	National Lowest	National Highest
February 2015	2015	**49%**	69%	46%	85%
February 2015	2014	**59%**	65%	38%	89%

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The Trust's performance has historically been below the national average for this measure.

The North Middlesex University Hospital NHS Trust [intends to take / has taken] the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

TBC

Patients who would recommend the trust to their family or friends

A&E

Publication Date	Reporting period	NMUH Value	National Average	National Lowest	National Highest
Jan-16	Q3 2015-16	**63%**	87%	25%	99%
Oct-15	Q2 2015-16	**84%**	88%	69%	100%
Jul-15	Q1 2015-16	**85%**	88%	39%	98%

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. Reporting on this measure within the Quality Accounts this year is optional. The Trust achieved a performance slightly below the national benchmark in the first half the 2015-16 financial year, but performance dipped in Q3 (in-line with other major acute Trusts in London), although in the case of North Middlesex Hospital this reflects the difficulties faced by one of the busiest A&E departments in the country over the winter period.

The North Middlesex University Hospital NHS Trust [intends to take / has taken] the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

TBC

Inpatients

Publication	Reporting period	NMUH	National	National	National

Date		Value	Average	Lowest	Highest
Jan-16	Q3 2015-16	**93%**	96%	74%	100%
Oct-15	Q2 2015-16	**96%**	96%	75%	99%
Jul-15	Q1 2015-16	**92%**	96%	77%	99%

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. Reporting on this measure within the Quality Accounts this year is optional. The Trust's performance during 2015-16 has been broadly similar and continues to show a positive inpatient experience.

The North Middlesex University Hospital NHS Trust [intends to take / has taken] the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

TBC

Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm

Patients admitted to hospital who were risk assessed for venous thromboembolism

Publication Date	Reporting period	NMUH Value	National Average	National Lowest	National Highest
March 2016	Q3 2015-16	**96.6%**	95.4%	78.5%	100.0%
December 2015	Q2 2015-16	**97.0%**	95.8%	75.0%	100.0%
December	Q1 2015-16	**96.4%**	96.0%	86.1%	100.0%

2015					

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The trust's performance has historically been at or above the national average for this measure.

The North Middlesex University Hospital NHS Trust [intends to take / has taken] the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

TBC

Rate of C.difficile infection

Publication Date	Reporting period	NMUH Value	National Average	National Lowest	National Highest
July 2015	2014-15	**28.2**	15.1	0.0	62.2
July 2015	2013-14	**15.2**	14.7	0.0	37.1

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The Trust continues to review all cases of C.Difficile infection to determine whether infection was cause by a lapse in care. The Trust has an agreed target with commissioners for this measure, which was met during 2014-15.

The North Middlesex University Hospital NHS Trust [intends to take / has taken] the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

TBC

Patient safety incidents and the percentage that resulted in severe harm or death

Publication Date	Reporting period	Measure	NMUH Value	National Average	National Lowest	National Highest
November 2015	October 2014 - March 2015	Number of Patient Safety Incidents	**3,530**	4,539	443	12,784
		Rate of incidents (per 1000 bed days)	**40.2**	36.3	3.6	82.2
		No. resulting in severe harm or death	**12**	23	2	128
		% resulting in severe harm or death	**0.3%**	0.5%	0.0%	5.2%
November 2015	April 2014 - September 2015	Number of Patient Safety Incidents	**3,498**	4,196	35	12,020
		Rate of incidents (per	**43.6**	35.3	0.2	75.0

		1000 bed days)				
		No. resulting in severe harm or death	**7**	20	0	97
		% resulting in severe harm or death	**0.2%**	0.5%	0.0%	82.9%

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator.

The North Middlesex University Hospital NHS Trust has taken the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

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

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

North Middlesex University Hospital NHS
NHS Trust

BACKGROUND INFORMATION FOR THE BEH NCL JHOSC SUB GROUP MEETING (13 MAY 2016)

Risk and Quality Committee

MEETING DATE:	28th April 2015

TITLE:	CQC action plan assurance update

AGENDA ITEM:	4.1	**PAPER:**	E

EXECUTIVE SUMMARY: This paper outlines the Trust's response to the recommendations contained in the CQC Quality Report and the action it is taking to improve the quality of services provided. The Trust's position against the implementation of the action plan as at **16th April** is included as an appendix.

ACTION REQUESTED OF THE MEETING:

For discussion	x	For noting	
For decision			
For assurance	x		

Which Strategic Objective does this paper impact most upon?:	SO1 – Provision of Excellent Clinical Outcomes SO2 – Positive experiences for patients, GPs and all stakeholders
How does the paper demonstrate progress towards the specified strategic objective?:	This paper includes the Quality Improvement plan being implemented to address the recommendations arising from the CQC Inspection of June 2014. Its Implementation will ensure the Trust's services are rated as at least 'good' when they are next inspected by the CQC.

LINKS WITH THE:		
BAF:	Corporate Risk Register 2583: CQC Rating of Requires Improvement on FT authorisation	**Risk score:** 15
IPR:	N/A	
Other:	N/A	

THIS PAPER HAS BEEN PREVIOUSLY CONSIDERED BY:	None

AUTHOR AND TITLE:	Dane Satterthwaite, Associate Director of Governance

RISK & QUALITY COMMITTEE MEETING
Tuesday, 28th April 2015

CQC Quality Improvement Plan monitoring process

1.0 Introduction

Following receipt of the CQC Quality Report from the inspection during June, the Trust has considered and responded to each recommendation contained in the Quality Report. Where the Trust has accepted the recommendation, the Trust has agreed to undertake remedial action. The Trust is committed to implementing a Quality Improvement Plan that has been designed in response to each of the accepted recommendations contained in the Quality Report. This Quality Improvement Plan has been designed with the objective of resulting in improvements to the quality of services provided by the Trust so as to ensure they get ratings of at least 'good' when they are next inspected by the CQC.

This paper outlines the governance process for monitoring and assuring the implementation of the Quality Improvement Plan.

2.0 Quality Improvement Plan

Where the Trust has accepted a recommendation contained in the CQC Quality Report, the Trust has identified what level of the organisation is required to take action in response to the recommendation. Some recommendations require action to be taken both at a corporate level and local CBU level, or in different CBUs. Therefore each recommendation is assigned to each of the CBUs that are required to undertake action. Where a recommendation requires action to be taken by more than one CBU, copies of the recommendation appears aligned to each CBU in the Quality Improvement Plan. This will ensure effective monitoring of the implementation of actions across each CBU.

Each recommendation is assigned to the relevant CBU Managing Director, Clinical Director or Head of Nursing, or corporate manager to devise an action to improve quality and identify the evidence that will demonstrate this action has been implemented effectively.

Each recommendation is RAG rated based on the following:

1. Red:
    a. Action identified but implementation has not yet started
    b. Action underway but progress is behind plan – recovery plan required.
2. Amber
    a. Action underway and is on schedule
    b. Action is complete, but evidence not yet reviewed by Associate Director of Governance
3. Green
    a. Evidence demonstrating action has been effectively implemented received and reviewed by the Associate Director of Governance.

3.0 Key achievements to date

Since the previous Risk and Quality Committee, the following CQC actions have been delivered:

Must do recommendations:

1. Mandatory training compliance across the Trust reached the 80% target as at 08/04/2015.

2. Ambulatory Care Unit and the Day Hospital have relocated to their permanent and refurbished accommodation in Pymmes
3. Vacating Ambulatory Care and Day Hospital from Clinic 4 and implementation of key OPD improvements including the prohibition of short notice clinics. With the exception of urgent cancer clinics, all clinics must be arranged at least 2 weeks in advance.

Should do recommendations:

1. Approved the recruitment of an additional pain nurse to increase service provision to 7/7
2. Approved the recruitment of an additional End of Life CNS to increase service provision to 7/7
3. Increased safety and quality in A&E by providing improved accommodation for psychiatric patients, improved medicine security and improved access to food and drink for patients.
4. Improved standard of documentation across CBU2 and Maternity
5. Improved process for booking clinic appointments, online/email address introduced, staffing for appointments call centre expanded resulting in 90% of calls being answered within 30 seconds. Short notice clinics prohibited except for target patients.
6. Installed 8 new permanent spaces in the Mortuary
7. Introduced new Peri-natal notes for Maternity to improve accessibility and quality of medical records.
8. The Trust is conducting a review of the implementation of the Barnet, Enfield and Haringey Clinical Strategy with Sweet Group, this report will go to May's Trust Board.
9. Increased dementia awareness training with an additional 186 staff trained since 1st January.
10. Palliative Care and maternity guidelines have been reviewed.
11. Audited the use of new DNA CPR Forms to improve documentation of competency and DNA CPR discussions. This audit demonstrated that of the 79 DNACPR forms reviewed 50(63%) had been discussed with a relative or family/carer 19(24%) had been discussed with the patient in question 9(11%) had been discussed with both the patient and family/carer and 17(22%) had been signed in the patients best interests without communication with either the patient or family/carer.
12. Increased the number of substantive nursing staff in Neonatal Unit.

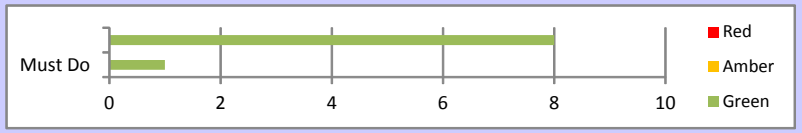
3.0 Conclusion

The committee is asked to discuss this paper.

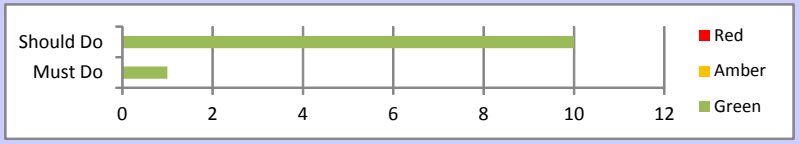
Dane Satterthwaite
Associate Director of Governance
16th April 2015

Appendix 1 – CQC Quality Improvement Plan score card 16th April 2015

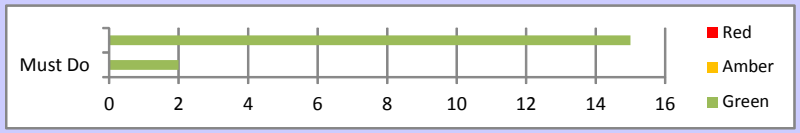
Corporate	Number of	Current Status of Recommendation			
Type of Recommendation:	Recommendations	Red	Amber	Green	Total
Must Do	1	0	0	1	1
Should Do	8	0	0	8	8



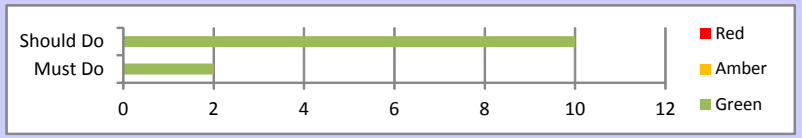
CBU1	Number of	Current Status of Recommendation			
Type of Recommendation:	Recommendations	Red	Amber	Green	Total
Must Do	1	0	0	1	1
Should Do	10	0	0	10	10



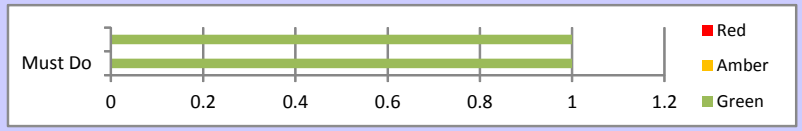
CBU2	Number of	Current Status of Recommendation			
Type of Recommendation:	Recommendations	Red	Amber	Green	Total
Must Do	2	0	0	2	2
Should Do	15	0	0	15	15



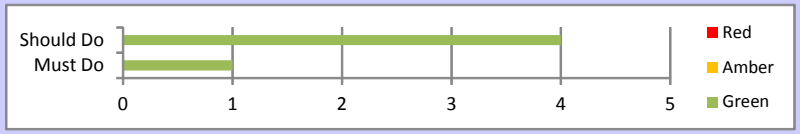
CBU3	Number of	Current Status of Recommendation			
Type of Recommendation:	Recommendations	Red	Amber	Green	Total
Must Do	2	0	0	2	2
Should Do	10	0	0	10	10



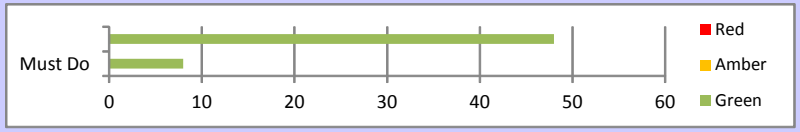
CBU4	Number of	Current Status of Recommendation			
Type of Recommendation:	Recommendations	Red	Amber	Green	Total
Must Do	1	0	0	1	1
Should Do	1	0	0	1	1



CBU5	Number of	Current Status of Recommendation			
Type of Recommendation:	Recommendations	Red	Amber	Green	Total
Must Do	1	0	0	1	1
Should Do	4	0	0	4	4



TRUSTWIDE TOTAL	Number of	Current Status of Recommendation			
Type of Recommendation:	Recommendations	Red	Amber	Green	Total
Must Do	8	0	0	8	8
Should Do	48	0	0	48	48



Appendix 2 – CQC Quality Improvement Plan

Must Do/ Should Do	CBU/Corporate	Core Service	Domain	CQC Recommendation	Further Action to be taken	Evidence of implementation	Action Lead	Due date for completion	Date Completed	RAG status	Update
Must	C	Trustwide	Well-led	Take action to improve its training - both mandatory and non-mandatory - and its recording and administration of training records and training renewal requirements	1. Agree recovery plan and trajectories to deliver 80% compliance with statutory and mandatory compliance by December 2014. 2. Deliver 80% with statutory and mandatory training compliance by December 2014 3. Implement action plan in response to Compliance Action in inspection report.	1. Statutory and Mandatory Training Recovery plan 2. Monthly CBU performance against Statutory and Mandatory Training KPIs	1. Stanley Okolo 2. All CBU Management Teams	1. 30/08/2014 2. 31/12/2014	1. 29/08/2014 2. Ongoing	G	08/04/2015 - Trustwide Mandatory Training Compliance = 80.1% versus trajectory of 80% Ongoing performance to be tracked through Performance Management Framework and monthly CBU performance meetings.
Should	C	Trustwide	Responsive	Improve patient discharge arrangements at weekends	1. Implement Nurse led discharges to support expedited discharges 2. Review therapies and AHP working patterns to support increased discharges at weekends. 3. Explore increasing number of doctors at weekends and extension of Ambulatory Care opening at weekends 4. Introduce improved medical handover process to track potential patient discharges over the weekend. 5. Increase clinical capacity on the wards over weekends to increase discharges.	1. Nurse Led Discharge process in place. 2. Increased discharges before 10am. 3. Matron on over weekends to expedite weekend discharges 4. Nurse led discharge continues to be rolled out in surgery 5. Break the cycle project work with key external stakeholders 6. Daily AMIC list to increase the visibility of AMIC patients to improve discharges.	1. Paul Reeves 2. Joanne McCaffrey & Achim Schwenk 3. Richard Gourlay & CBU2	31/12/2014	16/04/2015	G	External review of therapies in July 2014 indicated capacity within the team to support weekend discharges. Phase 2 of this review to be arranged for November 2014 in order to agree an action plan for 7 day working within Therapies. Ongoing improvement work will be monitored via Break The Cycle and Inpatient Transformation Board
Should	C	Trustwide	Well-led	Review arrangements for the consistent capture of learning from incidents and audits and ensure that learning and audit data is always conveyed to staff	1. Appoint new Head of Clinical Governance and Risk Management 2. Internal Audit Review incident learning process and implement improved system for learning from incidents and sharing lessons learned with front line staff	1. new Head of Clinical Governance and Risk Managmenet post created 2. Internal Audit Lessons Learned Audit Report and implementation of recommendations	Dane Satterthwaite	1. 31/12/2014 2. Report completed August 2014, action plan due date for implementation 31/12/2014	1. 03/11/2014	G	1. Head of Clinical Governance and Risk Management commenced in post. 2. SI process review undertaken. Internal Audit Action plan recommendations are being implemented. 3. Clinical Audit process reviewed.
Should	C	Trustwide	Effective	Review the provision of specialist pain nurse support across the whole hospital	Review provision of specialist pain nurse service to deliver 7 day service across Trust.	Paper to report findings of review of pain nurse specialist service. Expanded Pain nurse service to 7 day service	Paul Reeves	31/03/2015	16/04/2015	G	16/04/2015 Additional Pain Nurse being recruited to expand team to three giving 7/7 service provision. Also, Anaesthetics demand and capacity review undertaken, need for additional Anaesthetist with interest in pain identified. Additional anaesthetist 50:50 pain service being recruited.
Should	C	Trustwide	Well-led	Ensure consistent ownership and knowledge of the risk register across all nursing and medical staff	1. Appoint new Head of Clinical Governance and Risk Management. 2. Provide Ward managers and CNS with risk management training and raise awareness of CBU risk registers for managers across the Trust.	Training records, enhanced CBU risk registers.	Dane Satterthwaite	31/12/2014	1. 03/11/2014	G	1. Head of Clinical Governance and Risk Management commenced in post 2. Risk Register presentation delivered to Matrons and Ward sisters meeting (05/11/2014)
Should	C	Trustwide	Well-led	Review development and promotional prospects and progress for staff such as healthcare assistants	Review KSF for HCSW Review HCSW establishment and ensure promotion opportunities for HCSW are promoted internally Approach LETB to implement additional Assistant Practitioner posts at the Trust	Paper to report findings of review of HCSW KSFs, HCSW establishment and promotion opportunities. LETB bid submission for AP posts	Paul Reeves & Helen Rushworth	31/12/2014	16/04/2015	G	HCSW Skill mix review undertaken. Monthly HCSW forum launched. HCSW competency booklet developed and currently being implemented across Trust. Trust has obtained funding for 5 AP posts for 2015/16 from the LETB.

Should	C	Trustwide	Responsive	Accelerate plans to move to 7-day working across all core services. For example, some investigations are not available 7 days a week and none are 24/7. The support for patients recovering from surgery is limited at weekends with no access to occupational therapists, physiotherapists or clinical nurse specialists.	1. CBU3 Management Team to review provision of Therapies services OOH and at weekends and develop business case to extend service to weekends.	Business Case for extending Thearpies services to weekends and provision of services.	Jo McCaffrey & Achim Schwenk	31/03/2015		G	External review of therapies in July 2014 indicated capacity within the team to support weekend discharges. Phase 2 of this review began 10/11/14 in order to agree an action plan for 7 day working within Therapies for January 2015. Therapies 7 day working project plan developed. EoLC 7/7 service will be launched following recruitment of additional CNS following successful bid to MacMillan. 3rd Pain Nurse CNS being recruited to enable 7/7 Pain service which will be supported by additional anaesthetic consultant with special interest in pain.
Should	C	Trustwide	Safe	Review the impact of the Barnet, Enfield, Haringey strategy, its impact on staffing levels and its potential impact on quality of care.	1. Undertake interim review of impact of BEH Clinical Strategy and potential impact on quality of care. 2. Commission comprehensive review of implementation of BEH Clinical Strategy. 3. Further skill mix review undertaken. Assured continued 1:6 qualified nurse to patient skill mix provision. AUKUH acuity tool used to ensure skill mix is appropriate.	Interim Board Paper reporting on evaluation of BEH clnical strategy on quality of care. Sweet Group report on BEH Impact	1. Richard Gourlay 2. Richard Gourlay 3.Paul Reeves	1. 30/09/2014 2. 31/03/2014 3.30/10/2014	1. 25/09/2014	G	1. Interim review of impact of BEH Clinical Strategy submitted to Trust Board in September. 16/04/2015 - Data submitted to Sweet Group for report to be received by end of April. Report to be reported to part 1 of May's Trust Board.
Should	C	Medicine	Well-led	Review the needs of people living with dementia across the hospital to ensure that they are being met	1. Appoint new Nurse Lead for dementia to support Clinical Lead fo dementia 2. Roll out additional Dementia and delirium training 3. Presentation to CEOs & Chairs at the Transformation Board 18.09.14. 4. Write revised strategy 5. Participate in Haringey CCG MCA/DOLs Champions to improve support for Dementia care patients. 6. Expansion of Dementia training in ED and across the organisation. 7. Dementia steering group launched led by Deputy Director of Nursing and Consultant Lead for Dementia Care.	Reinvigorated Dementia Steering Group Improved Dementia Awareness Training Rate	1. Paul Reeves 2. Dr Sohpie Edwards and new Lead Nurse for dementia 3. Dr Edwards and new Nurse Lead	1. 31/10/2014 2. 31/12/2014 3. 30/11/2014 4. 30/11/2014 5. 31/01/2015	1. 31/10/2014	G	1. New Dementia Nurse lead appointed (MB CBU2 Matron) to support Clinical Lead for Dementia 2. Dementia Champions appointed for each ward. 4. Dementia Strategy Working Group to meet first week in December. 5. Julie F to lead on Trust's engagement with Haringey CCG's MCA/DOLS Champsions initiative. 6. trust has appointed Dementia Lead Matron from another Trust to be Matron for Acute Medicine wards in the Tower.
Must	1	Trustwide	Well-led	Take action to improve its training - both mandatory and non-mandatory - and its recording and administration of training records and training renewal requirements	1. Agree recovery plan and trajectories to deliver 80% compliance with statutory and mandatory compliance by December 2014. 2. Deliver 80% with statutory and mandatory training compliance by December 2014 3. Implement action plan in response to Compliance Action in inspection report.	1. Statutory and Mandatory Training Recovery plan 2. Monthly CBU performance against Statutory and Mandatory Training KPIs	1. Stanley Okolo 2. All CBU Management Teams	1. 30/08/2014 2. 31/12/2015	1. 29/08/2014 2. Ongoing	G	Trustwide performance 80.1% CBU1 = 76.4% 08/04/2015 Performance to be monitored via Performance Management Framework.
Should	1	Accident & Emergency	Safe	Review the use of the decontamination room in A&E which poses a contamination risk to the rest of the hospital. This was closed during our inspection following highlighting our concerns.	1. Amend Major Incident Plan to reflect decontamination room being taken out of use. 2. Conduct review of decontamination room at Emergency Planning Committee	Amended Major Incident Policy (version 10.6 available on intranet) Emergency Planning Committee	Sarah Eastwood.	1. 30/08/2014 2. 31/12/2014	1. 29/08/2014	G	Major Incident Plan amended and available on intranet. Awaiting outcome of Emergency Planning Committee review of Decontamination Room. Decontamination Room labelling removed and room now clearly identified as Shower Room 30.
Should	1	Accident & Emergency	Safe	Ensure that medicines are stored safely in A&E and that systems for recording take home medication are consistent throughout the hospital	1. Implement pre-pack register. 2. Change drug storage arrangements	For discussion and action planning at CBU1 Management Meeting 05.09.14	Sarla Drayan / Natasha Knutt	01.10.14	16/04/2015	G	19/01/2015 Swipe card access to storage rooms installed. Quote received, PO raised on APTOS for lockers. Awaiting delivery of new medication storage lockers. 16/04/2015 - Medicine lockers installed.

Should	1	Accident & Emergency	Safe	Ensure that staff undertake risk assessments for those patients at risk of falls or pressure sores	1. Agree recording process. 2. Staff training for all ED staff.	Audit sample of clinical records	Anna Langthorne / Natasha Knutt	01.10.14	04/20/2015	G	Falls risk assessments tool implemented in A&E. ADG awaiting receipt of audit results 01/12/2014 - Added to A&E Departmental action plan. Audit delayed. 04/02/2015 Audit received for Dec 14 and Jan 15 Pressure Area documentation = 56%, NEWS chart usage = 86%, Falls protocol = 44%
Should	1	Accident & Emergency	Safe	Review the risk assessments for the ligature points noted in the psychiatric assessment room in A&E	Health and Safety Manager to review ligature risks and remove any risks identified.	Report from the Estates Department confirming risk level.	Anna Langthorne / Natasha Knutt	22.09.14	17/03/2015	G	Waiting for Estates to cost and supply resources required 13.10.14. Quotes for works being obtained. 01/12/2014 Kelly Eaton chasing Bouygues on behalf of CBU. 12/12/2014. Quotes to be provided by Bouygues by 21/01/2015 10/02/2015 Ceiling vent resolved, alarm strip being removed 10/02/2015, furniture is on order and padding for the corner of the wall is due for delivery 02/03/2015, door handles being resolved, were scheduled to be removed 06/02/2015 but this was not done, Estates are chasing. 17/03/2015 all ligature points removed. Temporary padded protection for corner of wall installed.
Should	1	Accident & Emergency	Responsive	Ensure that there is adequate provision of food and drink for patients in A&E who are waiting for long periods including at night.	Cost and secure agreement to recruit staffing for this role. Implement enhanced food & drink service provision.	Staff in post and new service implemented	Anna Langthorne / Natasha Knutt	01.11.14		G	01.11.14 - Depends on recruitment to HCSW posts - update needed from A&E Matron 19/01/2015 Estates are reviewing provision of vending machines in ED to improve access to food and drink. 08/04/2015 - House keeper shifts have been increased and split to increase coverage to assist patients with food and drink.
Should	1	Accident & Emergency	Responsive	Improve investigation and response times to complaints particularly in A&E and outpatients	1. Improve performance management of complaints response times in A&E and Outpatients. 2. Deputy Director of Nurses appointed as Executive Lead for Patient Experience to lead improvements in complaints management 3. Review provision of Clinical Governance and Risk Coordinators across trust to provide additional support for complaints response.	Improved complaints response performance	1. CBU Management Teams (CBU1) 2. Julie Firth 3. CBU Management Team (CBU1)	31/03/2015	15/04/2015	G	15/04/2015 - Improvements in turn around times for complaints being delivered. Presently 7 overdue complaints. Ongoing performance to be monitored via complaints tracker and performance management framework.
Should	1	Accident & Emergency	Well-led	Ensure that the lines of responsibility between A&E and childrens' services over the responsibility for the paediatric A&E are clear to staff during a period of change.	Confirmation of the agreed change in professional reporting arrangements for Paediatric A&E nursing staff to be communicated to all A&E staff.	Formal letter communicating the professional reporting change to be drafted and sent to all staff working in A&E as well as the Managing Director for CBU 5 for onwards communication to her teams	1. Roberta Fuller	31/12/2014	w/c 08.09.14	G	Formal letter communicating the professional reporting change to be drafted and sent to all staff working in Paediatric A&E as well as the Managing Director for CBU 5 for onwards communication to her teams 01/12/2014 - Overdue action Anna L and Roberta to agree wording and send to every substantive member of Paediatric A&E staff. Collect minutes for joint meetings which have been launched. 05/02/2015 letter sent to staff and copy received by DS.

Should	1	Accident & Emergency	Safe	Improve consistency of use of early warning scores for deteriorating patients	Management discussion at the CBU1 Management meeting w/c 01.09.14 and agreed communication plan.	Audit sample of clinical records	Anna Langthorne / Natasha Knutt	w/c 08.09.14	04/02/2015	G	NEWS Charts rolled out in A&E. Audit of sample of clinical records by 14.11.14. Awaiting receipt of audits 01/12/14 Audits not started in November, added to A&E Departmental action plan with revised due date of 31/12/14. 19/01/2015 - Awaiting receipt of audit reports. 04/02/2015 - Audit for December and January received NEWS chart usage = 86%
Should	1	Accident & Emergency	Responsive	Improve the privacy and dignity of patients during the reception process and waiting times to see a clinician within the Urgent Care Centre during the reception process.	1. Conduct audits of complaints relating to privacy and dignity whilst waiting for treatment / consultation in A&E in the past 12 months. 2. Review use of security desk and explore possible refurbishment as private cubicle for patients attending UCC	Patient experience survey - to be designed and delivered by the A&E team. Plus reduction in complaints regarding privacy & dignity whilst waiting in A&E	Anna Langthorne / Natasha Knutt	01.11.14 to give time to gather data on patient experience. 2. 31/01/2015		G	01.12.14 Urgent Care Centre Navigator Booth being created as part of the development of UCC model of care. £50k set aside to complete the work. Project delayed pending CCG agreement to commission UCC model of care. Further meeting 05.12.14. 19/01/2015 - awaiting update on progress regarding UCC commissioning decision. Refurbishment works business case being scoped with Bouygues pending commissioner decision. 08/04/2015 - Signs put up advising patients who want private appointment to inform reception.
Should	1	End of Life Care	Safe	Review inconsistency around documentation of 'do not attempt cardio-pulmonary resuscitation' DNA CPR forms	Launch British Resus Council DNA CPR forms which capture capacity assessment	Revised DNA CPR form in use and audit of compliance with mental capacity assessments in place	Vikki Howarth	30/11/2014	14/10/2014	G	New DNAR forms launched at Grand Round 7th October 2014. All previous DNAR forms removed on 13th and 14th October and replaced with new version. Audit of new forms planned for end of November. Audit report received. Audit to be repeated in March 2015. 17/03/2015 March DNACPR audit received.
Must	2	Trustwide	Well-led	Take action to improve its training - both mandatory and non-mandatory - and its recording and administration of training records and training renewal requirements	1. Agree recovery plan and trajectories to deliver 80% compliance with statutory and mandatory compliance by December 2014. 2. Deliver 80% with statutory and mandatory training compliance by December 2014 3. Implement actio nplan in response to Compliance Action in inspection report.	1. Statutory and Mandatory Training Recovery plan 2. Monthly CBU performance against Statutory and Mandatory Training KPIs	1. Stanley Okolo 2. All CBU Management Teams	1. 30/08/2014 2. 31/12/2016	1. 29/08/2014 2. Ongoing	G	Trustwide performance = 80.1% CBU2 = 78.9% 08/04/2015 Ongoing performance to be monitored via Performance Management Framework
Must	2	Medicine	Responsive	Ensure that the provision of ambulatory care maintains people's privacy and dignity	1. Complete project in place to temporarily relocate OPAU and Day Hospital to improve patient experience pending completion of permanent relocation of Ambulatory Care Service in February 2015 2. Complete project to permanently relocate OPAU, Day Hospital and Ambulatory Care Unit in better accommodation	1. Temporary relocation of OPAU and Day Hospital to temporary accommodation (Project led by Natasha Black) 2. Permanent relocation of OPAU, Day Hospital and Ambulatory Care to permanent refurbished accommodation	1. CBU2 Management Team 2. CBU2 Management Team	1. 22/09/2014 2. 28/02/2015	1. 05/10/2014 17/03/2015	G	OPAU & Day Hospital moved to Tower Zero on 5th October 2014. New Ambulatory Emergency care Unit due to move to Pymmes Zero February 2015. 17/03/2015 New Ambulatory Care Unit and day hospital opened.
Should	2	Medicine	Safe	Improve medical recording to remove anomalies and inconsistencies in records, paying particular attention to elderly care wards and take steps to improve the security of records in Surgery	1. Appoint 2 Practice Development Nurses (PDNs). 2. Conduct programme of documentation audits across wards. 3. Re-launch regular documentation audit reporting to Patient Safety Group.	1. Audit documentation standards and completion of documentation requirements across Medicine and Care of the Elderly.	Anna Langthorne	30/11/2014	10/02/2015	G	SMT 10/11/14 - Local audits yet to be undertaken across Acute Medicine and Care of the Elderly. Nursing documentation audits to be undertaken in November 10/02/2015 Documentation audits received from Head of Nursing.

Must	3	Outpatients	Responsive	Take action to ensure that outpatients department is responsive to the needs of patients in that appointments are made in a timely manner, those with urgent care needs are seen within target times, cancellations are minimised and complaints are responded to.	1. Identify and agree trust wide target time for patients to receive routine new out patient appointment e.g. within 10 working days. 2. Develop action plan to deliver agreed target. 3. Review out-patient waiting times performance for routine and urgent patients. 4. Develop KPIs to demonstrate performance. 5. Encourage use of Chose and Book by local GPs. 6. Review escalation process is robust to address access issues. 7. Monitor complaint turn around times and review complaint issues to ensure addressed 8. Review level of cancellations, agree authorisation and criteria for cancellations 9. identify agreed target level	1. Deliver reduced level of cancellations 2. Delivery timely responses to complaints	Sara Davenport	31/12/2014	16/04/2015	G	16/04/2015 - with exception of Urology and Colorectal (which have both seen significant increases in 2 week referrals), Trust is consistantly hitting 2 week cancer wait targets at specialty level as well as composite trust level. Continue to consistently hit RTT but patients are getting appointemtns within 8 weeks except for endocrinology. Trust has initiated email address for patients to cancel and amend clinic appointments. Additional staff available to call centre = 90% of calls currently answered within 30 seconds. Short nitce clinics prohibited (except for 2 week cancer target patients). All clinics now require 2 weeks notice for patients. Waiting list initiatives enable provision of weekend clinics. Presently there is only 1 outstanding complaint for OPD.
Must	3	Trustwide	Well-led	Take action to improve its training - both mandatory and non-mandatory - and its recording and administration of training records and training renewal requirements	1. Agree recovery plan and trajectories to deliver 80% compliance with statutory and mandatory compliance by December 2014. 2. Deliver 80% with statutory and mandatory training compliance by December 2014 3. Implement actio nplan in response to Compliance Action in inspection report.	1. Statutory and Mandatory Training Recovery plan 2. Monthly CBU performance against Statutory and Mandatory Training KPIs	1. Stanley Okolo 2. All CBU Management Teams	1. 30/08/2014 2. 31/12/2017	1. 29/08/2014 2. Ongoing	G	Trustwide performance = 80.1% CBU3 = 81.4% 08/04/2015 Ongoing performance to be monitored via performance management framework
Should	3	Outpatients	Responsive	Improve investigation and response times to complaints particularly in A&E and outpatients	1. Improve performance management of complaints response times in A&E and Outpatients. 2. Deputy Director of Nurses appointed as Executive Lead for Patient Experience to lead improvements in complaints management	Improved complaints response performance	1. CBU Management Teams (CBU3) 2. Julie Firth	31/03/2015	15/04/2015	G	CBU have implemented a weekly complaints action tracker. 15/04/2015 only 1 overdue Outpatients complaint. Ongoing performance to be managed via Complaints Tracker and performance management framework.
Should	3	End of Life Care	Effective	Review and implement a system for updating national guidelines in maternity and palliative care	Current End of Life Care guidelines are in line with national recommendations. Guidelines will be reviewed and updated if new guidance is published. Guidelines routeinly reviewed every 2 years.	Revised guidelines available on intranet.	Dr Hagena (Consultant Palliative Care)	Completed.	27/10/2014	G	Completed.
Should	3	End of Life Care	Safe	Improve documentation around assessment of mental capacity in end of life care.	Launch revised DNA CPR forms to capture assessment of capacity.	Audit of DNA CPR form completion to include Mental Capacity Assessment	Vikki Howarth	30/11/2014	14/10/2014	G	New DNAR forms launched at Grand Round 7th October 2014. All previous DNAR forms removed on 13th and 14th October and replaced with new version. Audit of new forms planned for end of November. Initial audit report received. 19/01/2015 Audit to be repeated in March 2015. 17/03/2015 - March DNACPR audit recieved.
Should	3	End of Life Care	Responsive	Improve documented guidance for staff around referral of patients to palliative care	Reviewed referral criteria for patients requiring palliative care to be agreed and disseminated via the intranet.	Renewed referral criteria published.	Dr Hagena (Consultant Palliative Care)	30/09/2014	27/10/2014	G	Completed and available on Trust intranet. Hard copies of referral guidelines available on every ward. Medical Grand Round Training Presentations provided.

Should	3	End of Life Care	Responsive	Increase mortuary capacity beyond current temporary arrangements	Install additional refrigerator in mortuary to increase permanent capacity. Alarms on temporary fridges connected to switchboard.	Increased Mortuary Capacity	Geoff Benge	10/04/2015		G	Non-binding quote obtained from Bouygues for 2 additional 5 body bays. This will increase our capacity by 10 spaces. HTA action plan to be submitted by 30/12/14. 10/02/2015 - Orders for additional fridges placed 8 weeks lead in time for delivery plus 2 additional weeks for installation, attempting to negotiate expedited delivery (6 weeks), anticipate commissioning new fridges week of 6th April. 16/04/2015 - 8 new fridges installed and commissioned, 1 inflatable fridge will be returned end of April, 1 inflatable fridge will remain in situ.
Should	3	Outpatients	Responsive	Review appointment arrangements to ensure that appointments are not booked at unsuitable times or clinics overbooked in error.	1. Review current Outpatients systems and processes and devise detailed improvement plan. 2. Clinic profiles being reviewed to ensure slots available at suitable times or any special requirements for certain slots. 3. Review capacity and demand to ensure suitable capacity so over booking minimal.	OPD Improvement Plan	Sara Davenport	31/12/2014	16/04/2015	G	with exception of Urology and Colorectal (which have both seen significant increases in 2 week referrals), Trust is consistantly hitting 2 week cancer wait targets at specialty level as well as composite trust level. Continue to consistently hit RTT but patients are getting appointemtns within 8 weeks except for endocrinology. Trust has initiated email address for patients to cancel and amend clinic appointments. Additional staff available to call centre = 90% of calls currently answered within 30 seconds. Short nitce clinics prohibited (except for 2 week cancer target patients). All clinics now require 2 weeks notice for patients. Waiting list initiatives enable provision of weekend clinics. OPD Transformation Board will continue to monitor ongoing actions.
Should	3	Outpatients	Responsive	Review the waiting areas in outpatient clinics, particularly the eye, fracture and urology clinics at busy times to prevent people having to stand while waiting.	1. Model numbers of patients attending clinics in those areas. 2. Review waiting room and seating capacity. 3. Adjust clinics or add seating if demand outstrips capacity. 4. Review timeliness of clinic start and finish times. 5. Measure waiting times in clinics.	OPD Improvement Plan	Sara Davenport	31/12/2014	31/03/2015	G	1-3. No work has been done on this. 4.Clinic start and finish times are recorded but not clear where this information is collated. 5. No work collected on clinic start times. Key risk: insufficient OPD staff to support additional work in addition to booking appointments and booking patients in. 21/01/15 OP Reception staff provided some observations but lack of information about pressure points. Paper outlining needs to additional reception staff submitted. 17/03/2015 - additional seating and furniture installed in Clinic 4 following the relocation of AMU and Day Hospital to Pymmes.

Should	3	Outpatients	Responsive	Review follow-up outpatient appointment arrangements to increase capacity to organise follow-up appointments in some of the outpatient clinics. This includes dietician, nephrology, paediatric urology and hepatology clinics where no appointments were available within 5 weeks.	1. Review and if necessary revise Standard Operating Procedures (SOPs) for follow up appointments as part of OPD improvement plan. 2. Review current appointment availability for dietician, nephrology, paediatric urology and hepatology and develop plans with services to reduce to 5 weeks where necessary. 3. Establish Standard Operating Procedures for reviewing slot availability /utilisation rates and escalation process where exceed agreed availability. 4. Review new to follow up ratios and meet best practice. 5. Review and implement Access policy re DNAs 6. Named services review and plan capacity and demand to enable routine follow ups within 5 weeks.	OPD Improvement Plan	Sara Davenport	31/12/2014	16/04/2015	G	with exception of Urology and Colorectal (which have both seen significant increases in 2 week referrals), Trust is consistantly hitting 2 week cancer wait targets at specialty level as well as composite trust level. Continue to consistently hit RTT but patients are getting appointemtns within 8 weeks except for endocrinology. Trust has initiated email address for patients to cancel and amend clinic appointments. Additional staff available to call centre = 90% of calls currently answered within 30 seconds. Short nitce clinics prohibited (except for 2 week cancer target patients). All clinics now require 2 weeks notice for patients. Waiting list initiatives enable provision of weekend clinics. OPD Transformation Board will continue to monitor ongoing actions.
Should	3	Outpatients	Well-led	Improve communication with outpatient staff and their involvement in the development of the service to ensure service vision and values are understood and fully supported by staff. Allow staff increase opportunity to express their concerns related to developments within the trust and how this affects their day to day work.	1. Arrange regular local meetings and 1-1 supervision meetings for all OP staff to ensure they are briefed on trust's vision and values and opportunity for them to raise issues of concern. 2. Ensure appraisals for all staff so individuals understand their role in delivering service and any training needs are identified. 3. Facilitate liaison between specialties and relevant outpatient staff to ensure sharing of information on specialty and future developments, encourage better relationships and communication. 4. Establish Out-Patient Delivery Group with attendance from service management and OutPatient staff to encourage better communication and resolution of operational issues.	OPD Improvement Plan	Sara Davenport	31/12/2014	31/12/2014	G	1. Regular meetings established with Registration staff. Need to arrange for OP and HR staff. 3. 21/01/15 Regular meetings taking place open to OPD staff.
Should	3	End of Life Care	Safe	Improve training for junior doctors on palliative care	1. Add Palliative Care training session to FY and CT training programme and deliver sessions every six months. 2. Add Palliative Care to mandatory training requirements for relevant staff groups	Training records	Dr Hagena (Consultant Palliative Care)	From 30/09/2014	19/01/2015	G	Palliative care education now included in Junior Doctor induction. 2 Grand Round presentations completed. Copies of training presentation received.
Must	4	Trustwide	Well-led	Take action to improve its training - both mandatory and non-mandatory - and its recording and administration of training records and training renewal requirements	1. Agree recovery plan and trajectories to deliver 80% compliance with statutory and mandatory compliance by December 2014. 2. Deliver 80% with statutory and mandatory training compliance by December 2014 3. Implement actio nplan in response to Compliance Action in inspection report.	1. Statutory and Mandatory Training Recovery plan 2. Monthly CBU performance against Statutory and Mandatory Training KPIs	1. Stanley Okolo 2. All CBU Management Teams	1. 30/08/2014 2. 31/12/2018	1. 29/08/2014 2. 17/03/2015	G	Trustwide = 80.1% CBU4 = 82.1% 08/04/2015 ongoing performance to be monitored via Performance Management Framework
Should	4	Surgery	Safe	Improve medical recording to remove anomalies and inconsistencies in records, paying particular attention to elderly care wards and take steps to improve the security of records in Surgery	Audit to be undertaken by the CBU governance coordinator with regard to health record security in CBU led wards and theatres	Audit report by clinical governance coordinator and minutes of the clinical lead meeting / emails to clinicians.	Mr Fafemi	31-Jan-15	17/03/2015	G	Medical notes audits being routinely completed in surgical areas.
Must	5	Trustwide	Well-led	Take action to improve its training - both mandatory and non-mandatory - and its recording and administration of training records and training renewal requirements	1. Agree recovery plan and trajectories to deliver 80% compliance with statutory and mandatory compliance by December 2014. 2. Deliver 80% with statutory and mandatory training compliance by December 2014 3. Implement action plan in response to Compliance Action in inspection report.	1. Statutory and Mandatory Training Recovery plan 2. Monthly CBU performance against Statutory and Mandatory Training KPIs	1. Stanley Okolo 2. All CBU Management Teams	1. 30/08/2014 2. 31/12/2019	1. 29/08/2014 2. Ongoing	G	Trustwide performance = 80.1% CBU5 = 77.1% 08/04/2015 Ongoing performance to be monitored via performance management framework.

Should	5	Maternity	Effective	Review and implement a system for updating national guidelines in maternity and palliative care	Review and update expired clinical guidelines in Maternity	Revised guidelines available on intranet.	Gary Slevin & Bio Fakokunde	31/03/2015	20/04/2015	G	10 October 2014: Action plan for revision and updating of maternity clinical guidelines attached. 11.11 14: work in progress - revised action plan sent through. (54/102 currently under review or will be reviewed) review exercise due to be completed 5/1/15. 10/02/2015 51/102 currently under review or will be reviewed anticipated completion date 31/03/2015. Slippage in delivery due to Research & Practice Development Midwife acting up as HoM until January 2015 17/03/2015 guidelines review prcoess in progress, 25/102 guidelines remain outstanding. Anticipate completion 31/03/2015 16/04/2015 - 12 guidelines outstanding to be approved at guidelines meeting 20/04/2015.
Should	5	Maternity	Safe	Improve access to records for community midwives	1. Review existing process for pulling notes for booking appointments for women who have previously delivered. 2. Hospital transport will take them to agreed locations within community settings each day eg Tynemouth Rd 3. CMW will also be responsible for collecting health records from agreed locations 4. Cost benefit analysis of ipads and digital pens for electronic recording of all care at point of contact	1. Audit number of times health records available at booking appointments NB interdependency with hospital transport and CBU3 capacity for pulling health records for all booking appointments 2. Decide re benefit of remote electronic access in all comm settings versus slight delay in recording on on site electronic system	HoM Janet Pardo/Comm Matron Service Manager for W+Cs	1. 30/09/2014 2. 30/10/2014	1/11/2014 11/11/2014	G	1. ongoing via DATIX reporting - CBU3 to review resources in main file room 2 +3. MW to start their day on site to collect records if transport not available 4.Cost benefit analysis complete completed 1 Oct 2014 10 October 2014: This action has been completed for CBU5 - there is an inderdepency with CBU3 for pulling of notes from main file - the SOP state 48 hrs notification of ntoes for clinic - CBU5 has committed to informain main file 7 days in advance of all clinics - see attached for cost/benefit of IT solution 11/11/14: no further updates
Should	5	Maternity	Safe	Improve the recording of care on the labour ward.	1. Working Party is in place to devise bespoke maternity hand held notes to reflect needs of local population in conjunction with Whittington Health. 2 new notes will include MOEWs charts, care plans with time-managed reviews, SBAR tools - these will be available throughout the pregnancy continuum 3. notes will be launched with training days on what good documentation looks like	1. SoM team to audit documentation 2. Mandatory training to include record keeping and documentation 3. staff handovers and Burning Issues to include reminders on completing all sections of the records	SoM Team HoM/Dep HoM Louisa Griffiths All MW and Obstetricians	1. immediate and ongoing 2. final version of new notes 31/12/2014	16/04/2015	G	10 October 2014: Mock set of notes ready for circulation and comment by maternity, DQ, informatics, coding team prior to wider stakeholder comments. 11.11.14: Dep HoM to take forward - revisions and comments 16/04/2015 - separate pregnancy and birth notes merged into single perinatal notes document which has been in use for bookings since December. 3 monthly maternity documentation audits ongoing.

Should	5	Paediatrics	Safe	Review the heavy reliance on agency staff use to a 20% shortage of paediatric nurses in the neonatal unit.	1. Bespoke recruitment initiatives are in place alongside NHS Jobs recruitment 2. Current students are being interviewed for starting on completion of training 3. B5 nurses are being promoted to hard to fill B6 posts 4. Aim is to reduce vacancy rate to 5% by December with ongoing recruitment using NHS jobs and OS nurses if required - plan in place to utilise proprosal from Team 24 if vacancy rate remains high 5. Recruitment bonus/help with relocation etc	1. Workforce planning action plan to be drafted 2. Monitor of completion at CBU PSSQ meetings monthly	Janet Broughton Managing Director W+Cs	End February 2015	1. Worforce action plan completed - see comment column 2. End February 2015 3. 16/04/2015 - ongoing	G	10 October: Hybrid staffing model devised and agreed by Execs in September 2014 1.Focus on addressing difficult to recruit B6 QIS NNU nurses • Increase B7 by 2.0 wte • Reduce B6 by 2.0 wte • Move 2 senior B5 into B6 posts on a competency framework for 6 months staff identified • Recruit into easier to fill B5 and B7 posts • Additional B7 posts will enable an integrated community team to develop • Recruit into B4 post as a rotational Nursery Nurse for Transitional Care • B6 + B7 posts out to advert • 5.6 wte new starters will be in post in Nov/Dec/Jan – this will leave 7.4 wte nursing vacancies – x2 at B7 and x5.5 at B5 17/03/2015 B7 community post interviews arranged following withdrawal of previous candidate, 2 B6 appointed, to start in May, 1 in July, 1 B5 currently undertaking B6 competency programme to be appointable in April. Due to retirement and internal promotions, there are currently 8WTE vancancies, interviews planned for April and May. Ongoing monitoring via Performance Management Framework.