North Middlesex University Hospital NHS Trust

Draft 2018/19 Quality Account

Quality Account contents

Comment [EK1]:

Foreword from the chair and chief executive – To be completed

Welcome to the 2018/19 Quality Account for North Middlesex University Hospital NHS Trust.

TBC

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

(Signatures)
Peter Carter, Chair (Interim)
Maria Kane, Chief Executive

Peter Carter
Chair (Interim)

SIGNATURE

Maria Kane
Chief executive

SIGNATURE

Introduction

This document is one of the ways in which we report on the quality of care we provide. The report summarises our performance and improvements against the quality priorities and objectives that we set ourselves in 2018/19 for patient safety, clinical effectiveness, patient experience and staff experience. We have also outlined our quality priorities and objectives for 2019/20. We have detailed how we will achieve and measure our performance. The regulated Statements of Assurance are also included.

About Us

North Middlesex University Hospital NHS Trust (North Midd) 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.

- Local population
    - Haringey ~268,000
    - Enfield ~331,000
- Second most deprived population in the country.

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.

North Middlesex University Hospital key figures	2016/17	2017/18	2018/19
A&E attendances	167,021	175,167	173,085
Outpatient attendances	376,348	401,072	408,309
Admissions	83,804	79,608	80,323
Operations / procedures	39,193	37,642	36,599
Babies born	5,047	4,707	4437

On average each day North Mid cares for:

- 474 patients in A&E
- 220 patients admitted to our wards
- 100 patients undergo major or minor surgery
- 1118 outpatients attend clinics
- 12 babies born in our maternity unit

In addition we provide approximately over 800 X-rays, radiology tests and blood test appointments.

We are a founder member of University College London Partners (UCLP), 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 – by the end of March 2019 we had a headcount of 3,381 staff, over 60% of whom live locally in Enfield and Haringey.

The Trust services are organised across three clinical divisions

- Medicine and Urgent Care
- Surgery, Cancer and Associated Services
- Womens' Childrens and Support Services.

Our vision and strategy

The Trust's vision is to provide outstanding emergency, acute, maternity and elective care and services delivered by skilled, compassionate and dedicated staff for the diverse population we serve in north London and beyond.
The vision is delivered via three strategic objectives for 2018/19. These are to:

- provide excellent outcomes for patients
- provide excellent experience for patients and staff
- provide excellent value for money.

We are in the process of underpinning these objectives with defined sets of agreed objectives for the three divisions and the corporate services, as well as for individual departments, teams and staff members.

North Mid's future strategic direction will be shaped and enhanced by joint working with healthcare partners and the Sustainability and Transformation Plan (STP) for North Central London.

Future Direction

Demand for health services is growing, and the health needs of our population are changing. North Middlesex Hospital needs to change to help ensure that our future remains bright. In our local area people are living longer, but with more complex, long-term health needs. These changes require us to work with partners to develop a 'whole health & care system approach". This approach aims to promote wellbeing, prevent disease and support people to manage their own health conditions better and reduce avoidable hospital attendances and admissions.

We serve some of the most deprived populations not only in London but across England. We also observe in the populations we serve significant variations in life (and healthy life) expectancy. We know that deprivation greatly impacts on the physical and mental health wellbeing of our population. Deprived communities access health care more frequently and have more complex needs; many have multiple health and social problems which exacerbate these.

Hospitals often end up being the first place people access when they cannot, or do not know how to access other health care services. We need to work with partners across Enfield and Haringey to help direct services to the greatest population need.

Within this context, the hospital has faced some significant challenges over the last 3 years. It has had well documented problems with delivery of the emergency care standard and a number of high profile concerns regarding the adequacy of supervision of junior doctors in the Emergency Department. There have been a number of quality concerns investigated by a number of different regulatory bodies.

However, the latest CQC report published in September 18 shows that these are being addressed and there is confidence that the organisation is 'on the up'.

Alongside the challenge of delivering access standards and balancing quality metrics, the financial position of the Trust has deteriorated significantly going from a modest surplus in 14/15 to a significant deficit at the end of 17/18.

We are clear on our priorities for 18/19 and beyond. These are as follows:

- Improving the culture of the organisation
- Improving recruitment & retention
- Safely delivering standards
- Ensuring value for money
- Improving governance – both clinical and corporate

In March 2016 the Trust partnered with the Royal Free London group with the intention to become a full member by April 2017. RFL provided an initial period of senior level support to help the stabilisation of the organisation. The clinical partnership between our organisations was announced in September 17. The work to date between the organisations has particularly focused on the implementation of Clinical Practice Groups and also the Global Digital Exemplar Fast Follower bid that we are progressing with NHS Digital and RFL.

The Royal Free London have developed a proposal around the development of their Group structure that they believe will deliver both quality and financial benefits across the organisation. The headlines of these proposals are as follows:

- Clinical Practice Groups
- Global Digital Exemplar
- Quality Improvement Strategic partner
- Leadership and management development training
- Decontamination services
- Outpatient dispensing services
- PropCo
- Pathology
- Corporate services consolidation
- Portfolio review of services

The Trust has commenced work on a medium and long-term financial model which has assessed a number of significant transformation projects. The Trust has assessed that as a base case the financial position of the Trust will deteriorate by approximately £3m per annum. However, we have modelled a number of significant interventions ("big bets") that are likely to improve this position over a graduated period. The model has made assumptions that as the impact of transformational changes embed, and the new delivery model matures, increased benefits will be realised.

The successful delivery of the five big-bets within the control of NMUH mitigates the impact of the on-going I&E position by around £16m in Yr5, resulting in a deficit of around £19m by the end of 2023/24.

It is believed that closer working with the Royal Free would enhance the Trust's strategic big bets by £2-£4m, resulting in an indicative £15-17m bottom-line deficit. Further analysis remains on-going to understand how the gap to break even may be bridged.

As part of the Case for change development, the Trust undertook a wide engagement exercise with staff, local residents, councillors, regulatory & commissioning bodies and local members of parliament. This included four independently facilitated sessions with Healthwatch organisations in Enfield and Haringey.

In total over 400 staff members attended sessions and over 300 external stakeholders also attended sessions where we presented on the Case for change.

Staff demonstrated a strong wish to retain autonomy for NMH in terms of decisions for the hospital as a whole and preserve our identity, while simultaneously supporting further collaboration across
other local system partners such as primary and community services. All staff groups acknowledged the importance of our relationship with RFL, but were also were resolute that North Mid continues to work alongside local community and mental health services to serve our local population.

Some staff were particularly concerned regarding any potential movement of clinical services away from the NMUH site would compromise the specific services that have developed around our population needs. This was also an issue raised by external stakeholders who were concerned that there may be some cherry picking of elective services, and the adverse impact that this would have for patients.

We have actively sought views from statutory partners, including our regulators, our commisisoners, and local authorities, as well as elected representatives (MPs and councillors) on the idea of North Mid developing a closer relationship with RFL.

The very clear message we heard from all of these bodies and individuals was that they could see little benefit and significant risk for North Mid and its local populations in joining the 'Group' structure. The Health and Wellbeing Boards expressed a clear view that stability is essential for North Mid staff and residents to continue their

recent improvements, and that organisational form needs to provide certainty and consistency to local residents and staff.

It is clear that given the increasing health demands on the hospital, we are going to have to change the models and delivery of care in order to achieve the patient outcomes and experience that our local population deserve.

However, it is not possible for us to do this alone, or in isolation from other organisations in the sector.

We have shown that the increasing number of patients with chronic conditions (both physical and mental health) will need us to work with our primary and community care partners to ensure that there is a coordinated model that empowers patients to as far as possible have responsibility for their own health. However when they do call on health providers, we want them to be able to access the most appropriate clinician.

The publication of the CQC report in September 18 gives a very different perspective on the hospital – one that is improving, where the culture is much more inclusive and empowering, and where caring is 'good' across the board. There is a belief in the senior leadership team to move the organisation on to the next step and 'go for good'.

There is ongoing support for the clinical partnership within the organisation. There is genuine enthusiasm and excitement about what could be achieved through Clinical Practice Groups and improving pathways. The Global Digital Exemplar Fast Follower will allow us to be able improve clinical capture and sharing of information that will be improve clinician experience as well as demonstrating the tangible improvements delivered through CPGs.

However, we have not found, heard or seen any evidence which, taken together, could be interpreted as a robust case for North Mid to seek to enter into a closer partnership with Royal Free London group, ie by becoming a full member of the RFL group, nor which makes a strong case for such a partnership being necessary to address the five top challenges that North Mid has previously articulated as being essential for it to address.

On the contrary, we have received a significant weight of evidence that becoming a full member of the RFL group could risk the stability, local accountability and highly valued services particular to our local communities, and that the advantages of RFL membership would be substantially dwarfed by the disadvantages it would have on North Mid and its local populations.

In October 2018 the Trust Board that there is insufficient evidence to demonstrate a case for change for the Trust to become a member of the Royal Free London Group. However it supports the continuation of the clinical partnership.

The Sustainability and Transformation Plan (STP) for North Central London (NCL)

North Middlesex University Hospital NHS Trust continues to be an active participant in the Sustainability and Transformation Plan (STP) for North Central London. STPs have been established accross England to promote cooperation between NHS providers, commissioners and social care at regional level, transforming both clinical and non-clinical services.

We support the defined key principles for the NCL STP[1]

- We will put the **health and wellbeing of our population** at the heart of our plan;
- We will work in a new way as a **whole system; sharing risk, resources and reward**. Health and social care will be integrated as a critical enabler to the delivery of seamless, joined-up care;
- We will move from pilots and **projects to interventions** for whole populations built around communities, people and their needs. This will be underpinned by research-based delivery models that move innovation in laboratories to frontline delivery as quickly as possible;
- We will make the best the standard for everyone, by **reducing variation** across North London;
- In terms of health, we will give children the best start in life and work with people to help them to remain independent and **manage their own health and wellbeing**;
- In terms of care we will work together to **improve outcomes, provide care closer to home**, and people will only need to go to hospital when it is clinically essential or economically sensible;
- We will ensure **value for tax payers' money** through increasing efficiency and productivity, and consolidating services where appropriate;
- To do all of this we will do things radically differently through **optimising the use of technology**;
- This will be delivered by a **unified, high quality workforce** for North London

Quality delivery through our digital strategy – to be updated

The trust is in the process of becoming a Global Digital Exemplar – Fast Follower (GDE-FF) with RFL as our GDE partner. There is also synergy with other GDE-FF programmes in North Central London, at Whittington Health and Great Ormond Street, as well as with the North London Partners Digital working group. This programme will become a key enabler for improving care quality in our organisation through

- An integrated solution of clinical portal, clinical noting, nursing documentation and team communication, with defined benefits of timely identification of deteriorating patients, improved team handover, and availability of patient information at the point of care
- integrated information flow with primary care, social care and other providers through the NCL Health Information Exchange

[1] http://www.northlondonpartners.org.uk/downloads/plans/NLPHC-STP-Strategic-Narrative-June-2017.pdf

- Clinical decision support through structured clinical records that reflect treatment algorithms and pathways developed through the Clinical Practice Groups, as well as electronic prescribing and medicines management

During 2018/19 the trust launched its digital programme - #DigitalNorthMid.
The organisation's digital vision is to use Technology and data to:

- give patients greater control over their health
- give our staff the right tools to work effectively and safely
- improve patient safety and health outcomes

The aims of the programme are outlined below:

Connected Patients	Supported Staff	Information & Analytics	Infrastructure & Integration
Empower patients to manage their own health and any of their interactions with us	Enable staff to access information in one place so they can make the right decisions and deliver safe & effective care	Deliver 'whole system' intelligence that provides the insight to improve quality, efficiency and patient outcomes	Provide secure, resilient and accessible platforms and allow systems talk to each other safely & securely, using open standards

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

Patient Safety, Patient Experience and Clinical Effectiveness are the three strands of Quality. North Middlesex University Hospital NHS Trust is committed to embedding continuous quality improvement into the organisational culture.

During 2018/19 a number of improvements were made to strengthen the organisation's capacity and assurance in regards to all aspects of corporate and quality governance.

Improvements included:

- a significant overhaul of its vision, strategic objectives, and BAF to ensure that these were all aligned
- Introduction of the Executive Assurance Forum was introduced to bring together the sources of data it needs to ensure on-going assurance that the Trust has robust systems of governance, risk management and internal control and, where quality indicators flag areas of concern, to prompt the necessary corrective action.
- Increase in the capacity of both the central and divisional governance teams
- interim serious incident investigators have worked with clinical staff to improve their skills in investigations and report writing. The fruits of this mentoring work are clear in the improvement seen in the quality of investigations being undertaken, in particular an increased focus on the 'human factors' contributing to incidents.

- A team of clinicians are part of a human factors training programme provided by UCL Partners.
- Quality improvement training was provided for 40 staff using the IHI method for improvement principles.
- Learning events
- Simulation training
- The Trust has adopted the Always Events methodology to co-produce, implement and embed a Patient Experience Strategy

During 2018/19 the Trust commenced a Governance Improvement Programme (GRIP) with the focus of fully addressing a number of important issues:

- Concerns raised by CQC (2016 inspection), Good Governance Institute and Deloitte
- Difficulty gaining traction on key quality indicators reported to Board such as the rate of harm free care, timely incident and complaints investigation
- The current risk rating attached to BAF001 '*If the Trust does not embed clear governance arrangements then there will be unacceptable variability in the implementation of standards and quality of care'* remained at 16 at the time.

The programmes remit was delivered through 8 work streams:

- Establish the programme
- Strategy
- Strengthen leadership capacity and capability
- Strengthen the governance Infrastructure
- Improve intelligence for governance
- Develop Governance Capability
- Process Redesign
- Strengthen Reporting and Assurance

With the focus of:

- setting out a clear quality strategy for the organisation, designed to embed a 'Safety 2' culture i.e. learning is based on learning from positive interactions with patients and low grade incidents as well as SIs
- Equipping all senior leaders members with the skills needed to provide effective leadership of governance
- Working towards creating an integrated governance function which gives good oversight of clinical and corporate risks, learning from the experiences of successful trusts
- Continuing efforts to create an open and transparent culture where staff and patients feel able to raise concerns and be heard
- Improving the way information is used at trust-wide and local level to understand the drivers for safety and quality, prioritise where action is taken and provide assurance governance processes have had a positive impact on safety and quality

- Developing the capacity and capability of divisional and corporate teams to embed good governance locally
- Embedding effective oversight and escalation of clinical and corporate governance issues floor to Board
- Ensuring there are robust core processes in place to support prevention of harm to patients and staff and encourage learning where something goes wrong
- Provide objective evidence-based measures to assist in assessing whether the controls and mitigations in BAF001 are effective.

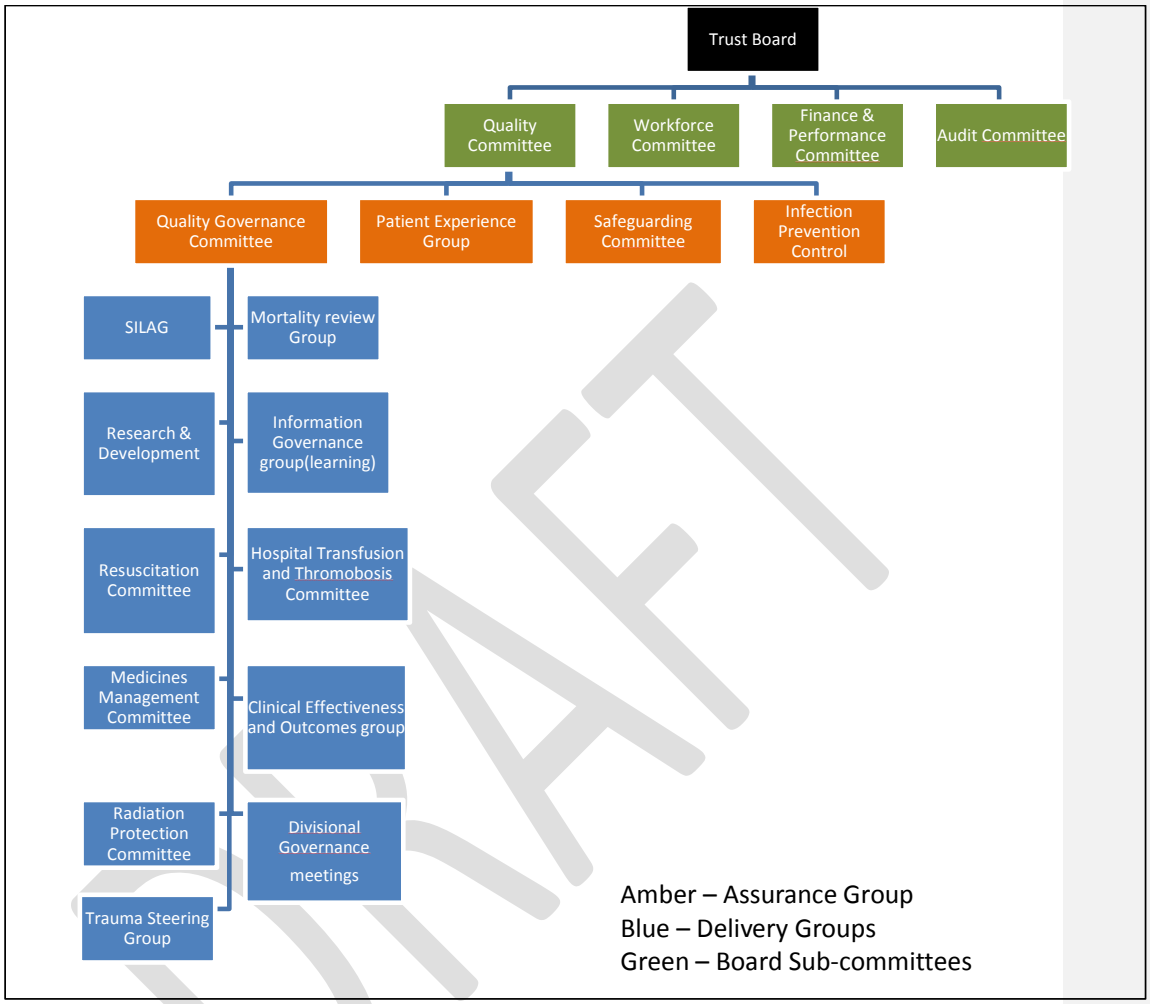
Outcome measures for the programme

- HSMR and SHMI (mortality data) within range
- % harm free care at or above national average
- Total incidents reported at or above national average based on NRLS benchmarking
- % incidents which are low and no harm increasing and at least 90% of the total
- Downward trend in the numbers of SIs sand complaints recorded
- No never events
- Thematic analysis shows reduction in repeat causes of harm
- Improved staff and patient FFT
- Improvements in Staff survey questions, particularly in these questions
    - Last error/incident/near miss reported
    - Organisation encourages reporting of errors
    - Know how to report unsafe practice
    - Would feel secure raising concerns about unsafe practice
    - Organisation treats staff involved in errors fairly
    - Staff given feedback about changes made in response to errors reported
    - Care of patients is the organisation's top priority
    - Able to give the quality of care I aspire to

The majority of these deliverables required to achieve the outcomes were realised in 2018/19, work will continue in 2019/20 to ensure improvements are maintained and developments across all areas continue..

During 2018/19 the Board reviewed its effectiveness in discharging its duties and responsibilities; as a result the committee structure underwent some change in order streamline reporting and removes duplication of effort. The main Trust Board assurance committee to oversee quality is the Quality Committee (QC) previously known as the Patient Safety and Quality Committee. The main Trust-wide operational committee for quality is the Patient Safety and Outcomes Committee (PSOC) where the three divisions, as well as the trust wide Quality Governance teams come together to progress all aspects of quality governance, going forward this committee will be retitled the Quality Governance Committee to more accurately reflect its remit.

See below updated committee structure for 2019/20.



#DigitalNorthMid

Royal Free London NHS Foundation Trust (RFL) and North Middlesex University Hospital NHS Trust (NMUH) share a vision to use clinical information technology to improve quality and safety of care, the experience of staff and patients, and value for money.

In August 2017 the NMUH Trust board confirmed our status as Clinical Partner of the Royal Free Group (RFG). Evidence suggests that delivering both clinical and non-clinical services at scale can improve the standards and outcomes of care and reduce costs. Improvements to patients' experience of services and to expected outcomes can be achieved by reducing unwarranted variations in clinical practice so that it is based on best evidence, influenced by the presenting medical history of the patient.

Clinicians from North Middlesex University Hospital are participating actively in the development of clinical practice groups within the Royal Free Group and its clinical partners. These groups pull together the clinical expertise required for developing new care pathways covering a wide range of common clinical conditions.

NMUH and RFL will work towards harmonisation of processes and governance within very different technical systems, Cerner based at RFL and 'best of breed' at NMUH.
Our digital vision is an enabler to our broader Clinical Strategy and is built upon our recognised strength in informatics and coding and supporting clinicians with timely and relevant information in order to deliver effective Quality Improvement. Electronic systems will be designed to support structured data collection for audit and quality improvement and for decision support. Usability, effectiveness and clinical safety of the IT systems will be a focus of our joint development.
Our GDE Fast Follower (FF) Programme will be underpinned by the following core elements:

- **Digitisation** of our patient records across the organisation, including digital data entry as well as digital access for our clinical teams
- Embedding of best practice **clinical pathways** (and associated clinical decision support) within our clinical systems to reduce unwarranted variation and improve patient safety
- Improvements to data sharing with other care providers and development of systems which facilitate coordination and management of complex pathways across multiple providers (**interoperability / integrated care**)
- Development of a digital platform which will allow us to more actively engage patients in their care (**patient access**)
- Creation of analytics platforms which assist care and activity planning and provide further opportunities for wider population health management (**health analytics**)

The joint programme with RFL will:

- Enable both organisations to accelerate the development of clinical pathways through access to a larger pool of clinical expertise
- Provide a repeatable model that can be shared with other acute providers, irrespective of whether organisations share patients and / or clinical systems

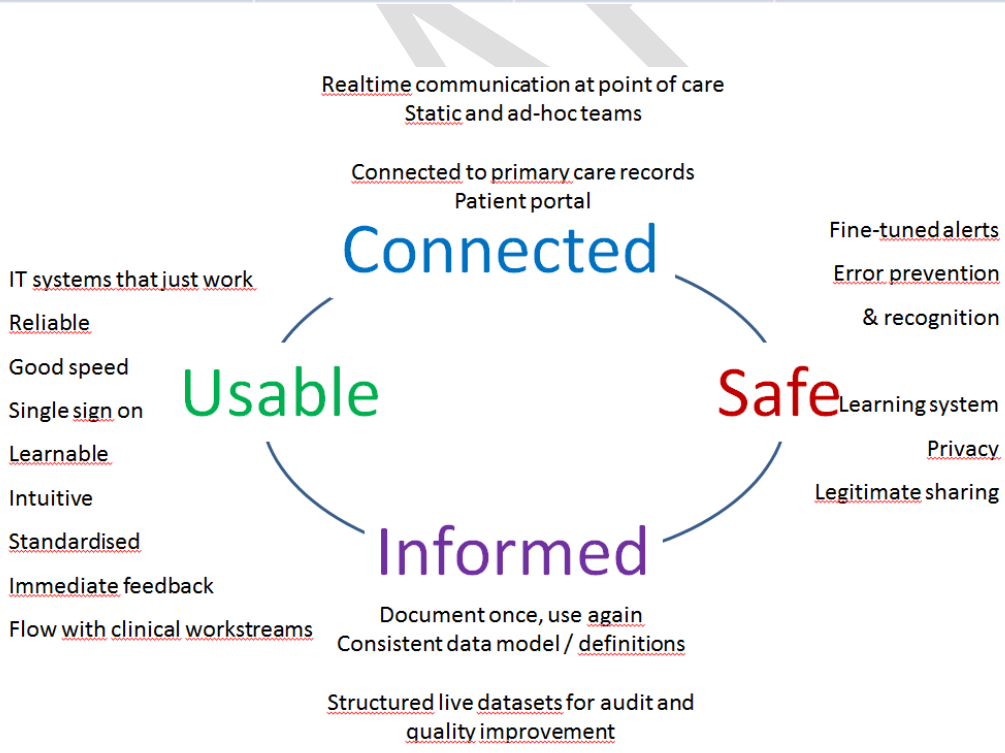
- Enable NMUH to benefit from broader experience gained by RFL as part of the Provider Digitisation Programme (reducing both our costs and the time it will take to implement new systems and technologies)

Our digital vision

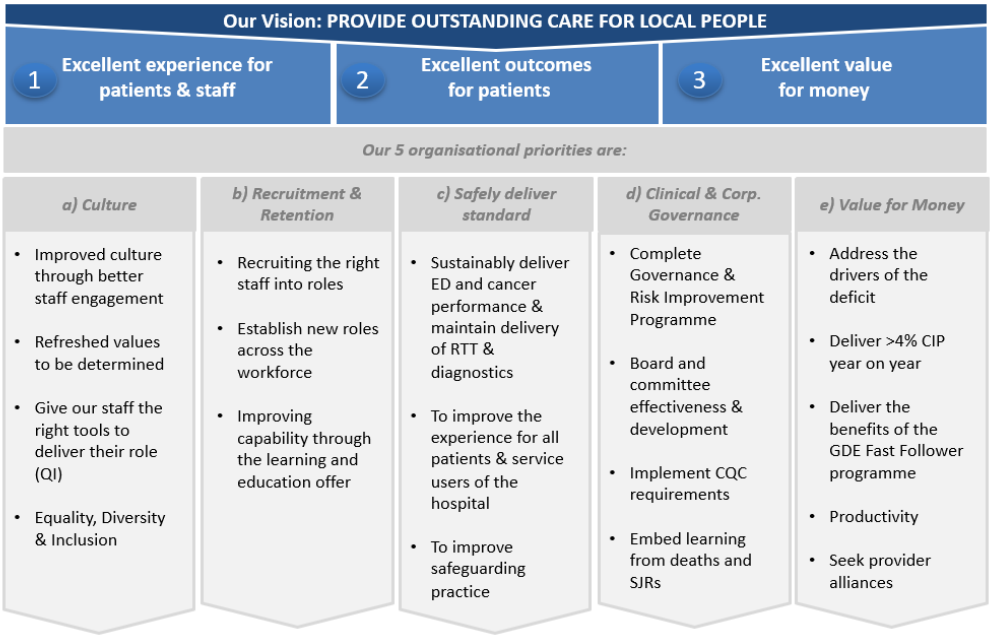
Use Technology and data to

- give patients greater control over their health
- give our staff the right tools to work effectively and safely
- improve patient safety and health outcomes

Connected Patients	Supported Staff	Information & Analytics	Infrastructure & Integration
Empower patients to manage their own health and any of their interactions with us	Enable staff to access information in one place so they can make the right decisions and deliver safe & effective care	Deliver 'whole system' intelligence that provides the insight to improve quality, efficiency and patient outcomes	Provide secure, resilient and accessible platforms and allow systems talk to each other safely & securely, using open standards



Trust vision for Quality Improvement



The Quadruple aim of quality improvement is:

Good for patients

- Safety and quality of care
- Patient experience
- Patient & carer as partners

Good for the population

- Address local people's health needs
- Prevention and earlier diagnosis
- Strategic capability

Good for the taxpayer

- Remove waste and duplication
- Focus on value not balance sheet
- Increase efficiency and productivity

… and staff

- Teamwork
- Involvement
- Joy in work

Why we have chosen to do this

In organisations with an established QI culture, we see that a clear and consistent improvement method is in use and is demonstrable across all areas of the organisation.

Commitment to the chosen methodology has resulted in a sustained and embedded culture of QI.

The key is not the choice of one methodology over another, but the commitment to a coherent, systematic improvement methodology that is anchored in improvement science."

Current quality improvement programmes

- Clinical Practice Groups
  - 4 Medicine: Frailty, COPD, Pneumonia, Pulmonary Embolism
  - 3 Surgery: Haematuria, Prostate, right upper quadrant abdominal pain
  - 1 Neonatal: Keeping mothers and babies together
- Urgent & Emergency Care Improvement programme
  - Emergency Department, Frailty, Ambulatory care, Length of stay, Discharge
- #DigitalNorthMid: GDE – Fast Follower Programme
- Culture and Leadership Programme
- UCLP collaborative projects (Learning from excellence, human factors, NEWS2, emergency laparotomy, pre-term labour etc)
- Gastroenterology service improvement
- Operational efficiencies programme in outpatients & theatres
- End PJ paralysis
- Phlebotomy and Ordercomms
- Chemotherapy day unit
- A&E patient transport
- Local Safety Standards for Invasive Procedures (LocSSIPs)
- Listening into Action – small improvement projects led by staff

What do we need to say here given that we committed to launching during 18/19?

During 2018/19 the trust will launch its quality improvement strategy following consultation with staff and external stakeholders. The strategy sets out how we intend to achieve our objectives through continuous improvement of the quality of care for our patients underpinned by a culture of learning and staff empowerment.

Through this strategy, we want to ensure safe, high quality, patient centred care for all our patients. Therefore, we aim to:

- make patient safety our top priority
- minimise avoidable harm
- deliver up-to-date care
- learn from our service users and carers
- recruit and retain highly motivated caring professionals to deliver this strategy
- strive for excellence in everything we do
- achieve 'good' in the next CQC inspection, striving for 'outstanding' in subsequent years

Summary of our performance against key national priorities in 2018/19

The table below details our performance against the key national priorities (single oversight framework) during 2018/19:

			Q1			Q2			Q3				
Indicator Name	Benchmark	18/19 Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
ED all types monthly performance	National	95%	83.1%	85.2%	89.7%	85.7%	87.9%	86.1%	87.2%	89.3%	85.3%	80.9%	84.3%
Cancer two week wait standard	National	93%	94.68%	96.89%	94.27%	96.39%	95.39%	93.66%	93.61%	94.33%	91.21%	76.52%	
Cancer breast symptom two-week	National	93%	90.91%	93.41%	54.39%	93.33%	84.21%	93.22%	94.39%	93.20%	81.01%	50.00%	
Cancer 31-day DTT to treatment	National	96%	100.00%	97.33%	98.61%	98.78%	98.36%	100.00%	100.00%	97.50%	100.00%	96.00%	
Cancer 31-day subsequent drug	National	98%	100.00%	100.00%	100.00%	89.50%	100.00%	100.00%	100.00%	100.00%	100.00%	90.00%	
Cancer 31-day subsequent radiotherapy standard	National	94%	97.62%	97.92%	100.00%	100.00%	96.00%	100.00%	100.00%	92.59%	100.00%	92.86%	
Cancer 31-day subsequent surgery	National	94%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	92.30%	
Cancer 62-day standard	National	85%	79.66%	86.15%	72.73%	86.42%	69.39%	86.42%	76.92%	76.00%	72.09%	70.59%	
Cancer 62-day screening standard	National	90%	100.00%	85.70%	100.00%	94.40%	75.00%	100.00%	100.00%	66.70%		40.00%	
Diagnostic waiting times	National	99%	98.30%	98.40%	98.70%	99.20%	99.30%	99.70%	99.50%	99.70%	99.60%	99.50%	99.70%
Referral to treatment admitted	National	92%	92.1%	92.4%	92.2%	93.6%	94.1%	95.6%	96.3%	95.8%	95.4%	94.7%	94.2%

Summary of performance for 2018/19 against the single oversight framework indicators:

Metric	Period	Target	18/19 Peformance
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	Apr18 - Feb 19	92%	94.2%
A&E maximum waiting time of four hours from arrival to admission/transfer/discharge	Apr18 - Feb 19	95%	85.9%
62 day wait from urgent GP referral for suspected cancer	Apr18 - Jan 19	85%	78.4%
62 day wait from first treatment from NHS cancer screening service referral	Apr18 - Jan 19	90%	89.3%
C difficile average from plan	Apr18 - Feb 19	0	2.1
Summary hospital level mortality indicator	Apr18 - Sep18	100%	80.4%
Maximum six week wait for diagnostic procedure	Apr18 - Feb 19	99%	99.2%
Venous thromboembolism (VTE) risk assessment	Apr18 - Dec-18	95%	95.1%

Implementation of Priority Clinical Standards for Seven Day Hospital Services

The seven day hospital services ambition set out by NHS England is for patients to be able to access quality hospital care that will provide 100% of the population with access to the same level of consultant assessment and review, diagnostic tests and consultant-led interventions every day of the week by 2020.
Ten Standards[2] have been developed, of which NHS England supported by the Academy of Medical Royal Colleges, identified four of these standards which if met would be most likely to have the greatest impact on reducing variation in mortality risk. The ten standards are outlined below, with the priority clinical standards indicated in bold print.

1. Patient Experience
2. **Time to first consultant review**
3. Multi-disciplinary Team (MDT) review
4. Shift handovers
5. **Diagnostics**
6. **Intervention / key services**
7. Mental health
8. **On-going review**
9. Transfer to community, primary care and social care
10. Quality improvement

Since 2017 NHSE have asked Trusts to report a yearly self-assessment survey against four of the ten clinical standards (the ten 7DS clinical standards were originally developed by the NHS Services, Seven Days a Week Forum in 2013) with the overall aim of supporting the move to consistent 7 day services. The overall target for each trust is to meet the four standards (90%) by 2020.

The four priority standards were selected to ensure that patients have access to consultant-directed assessment (Clinical Standard 2), diagnostics (Clinical Standard 5), interventions (Clinical Standard 6) and ongoing review (Clinical Standard 8) every day of the week. The overall aim of this is to remove any variation in outcomes for patients admitted to hospitals in an emergency, at the weekend. Over the past two years the Trust has improved in results for the four clinical standards, and in 2018 was meeting the NHSE target.

Clinical standards for 7 day delivery of care	2017	2018
Standard 2 - Time to first consultant review	70%	95%
Standard 5 - Access to diagnostic tests	99%	100%
Standard 6 - Access to consultant-directed interventions	100%	100%

[2] https://www.england.nhs.uk/publication/seven-day-services-clinical-standards/

Standard 8 - Access to consultant-directed interventions	78%	97%

Since 2017 NHS England has asked Trusts to report a yearly self-assessment survey against four of the ten Clinical Standards with the overall aim of supporting the move to consistent 7 day services. The overall target for each Trust is to achieve a rating of 90% for each of the four standards by 2020. The four priority Clinical Standards were selected to ensure that patients have access to:

- Consultant-directed assessment (Clinical Standard 2);
- Diagnostics (Clinical Standard 5);
- Interventions (Clinical Standard 6); and
- Ongoing review every day of the week (Clinical Standard 8).

Over the past two years the Trust has improved in results for the four Clinical Standards, and in 2018 was meeting the NHSE targets. For 2019, NHSE refined its requirements with regard to the four clinical standards, making the requirements more granular, adding additional requirements to report on any activity around the other six Clinical Standards.

The Trust has been conducting a self-assessment against the four standards for the past three years. The results to date have been as follows:

Clinical standards for 7 day delivery of care	**2017**	**2018**
Standard 2 - Time to first consultant review	70%	95%
Standard 5 - Access to diagnostic tests	99%	100%
Standard 6 - Access to consultant-directed interventions	100%	100%
Standard 8 - Access to consultant-directed interventions	78%	97%

- For February 2019 the Trust met two of the four standards.

- The Trust fell below 90% for Clinical Standard 2 for both weekdays and weekends. For Clinical Standard 2, the Trust conducted an audit across all hospital wards on a single day. For the remaining Clinical Standards, the Trust reviewed existing policies within the Trust.

The recommendations set out in this report relate to those areas where compliance is below target, and where these need to be considered and acted on prior to the next audit.

1. **Clinical Standard 2** – The Trust believes that, with the following actions included in the audit, this Standard will be met in all future assessments:

a. Currently due to work patterns in post take ward rounds (medicine and surgery) patients are not being seen in the 14 hours set out. To rectify this the suggestions are:
    i. Explore the cost/feasibility of extending consultant post take ward round coverage to later into the night (in the Acute Medical Unit / the Acute Admissions Unit / Surgical Assessment Unit)
    ii. Explore the cost and feasibility of Emergency Department consultants having a documented post take ward round twice per day in the Clinical Decisions Unit
    iii. Cross speciality review of post take ward rounds within the Trust. This will establish availability of consultants
    iv. Review the accuracy of arrival times on ward entered on Medway

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2. Clinical Standard 5 and 6

a. Overall a review should be conducted of all the Standard Operating Procedures detailed for Standard 5 and 6 -although policies are in place they:
    i. are not specific enough and lack usability
    ii. are not held centrally
    iii. and rarely mention 7 day working week.
b. Although we are already meeting these two Standards the above actions would enhance the visibility of available services to our staff and have a positive impact on the patients in our care.

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3. Clinical Standard 8

a. As mentioned we are not entirely clear about the definition used. Initially we will to go back to NHSE to obtain a clear and auditable definition of what high dependency indicates. Once this is obtained a re-audit will be conducted against this standard.

4. There are two additional recommendations linked to the other Standards detailed that the Trust should undertake:
    a. Standard 4 – conduct an audit of clinical handovers across the Trust. A robust definition will be sought from NHSE.
    b. Standard 3 – Audit of Multi-Disciplinary Team working in the Trust against emergency admissions assessed for complex or on-going needs. A robust definition will be sought from NHSE.

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Freedom to Speak Up

Members of staff are encouraged to raise their concerns with their line managers, team leaders or any other appropriate senior member of staff within their immediate area of work. However, sometimes this can be difficult for staff or they may have raised their concerns and have not had a satisfactory response or feel that it is taking too long to address the concerns raised.

The Trust has a 'Raising Concerns Policy' and this incorporates the Freedom to Speak Up Agenda. The purpose of the 'Raising Concerns Policy' is to encourage and enable staff to raise concerns within the Trust in a constructive and positive manner. The policy is intended to provide reassurance that staff can raise their concerns without fear of reprisals, and safe in the knowledge that they will receive the appropriate support and feedback.

Any member of staff who raises a concern and then suffers any detriment for doing so need to report it and can also speak with the Freedom to Speak Up Guardians.

The trust has Bullying and Harassment facilitators and their contact details can be found on the intranet staff website. Staff can contact them directly or staff can be referred when they raised a concern in relation to bullying and harassment with their managers and/or team leaders or any senior member of staff. FTSU Guardians also refer any staff raising a concern about bullying and harassment to bullying and harassment facilitators.

Staff can also raise their concerns with a member of the Human Resources team who can also advise them.

The trust also has Staff Support Officers. A member of staff may also wish to raise their concern with a member of this team.

Staff may also raise their concern with their union representative.

The trust has two FTSU Guardians and all members of staff are encouraged to raise any patient safety concerns with them. Flyers are displayed throughout the trust with the contact details of the Guardians and contact details can be found on the intranet on the staff site. Any concern raised with the Guardians outside of the patient safety remit is referred to the appropriate personnel and a record of this is kept.

Feedback is usually given to staff by the FTSU Guardians face-to-face and occasionally by Email.
Staff raising concerns is encouraged to complete a feedback form designed by the Freedom To Speak Up Guardians. This will be used to monitor staff responses and will inform FTSU Guardians whether staff felt that they have suffered any detriment following raising a concern.

Data is submitted to The National Guardians Office on a quarterly basis which monitors the number of concerns raised and highlight whether staff has suffered any detriment.

Annual Report – Rota Gaps and Improvement Plans

Awaiting

Learning from Deaths
Mortality rates

This is measured by both Hospital Standardised Mortality ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI). HSMR excludes deaths that are coded in particular ways, e.g. palliative care. SHMI includes all deaths.

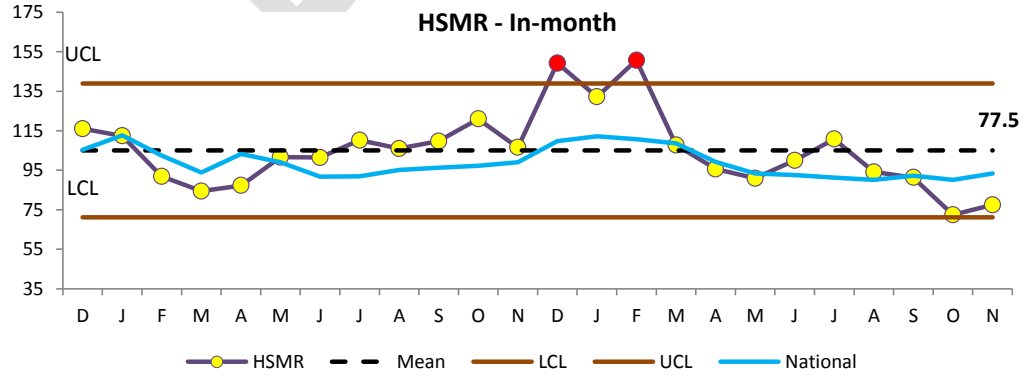
The table below shows the Trust's mortality rates for the last year. For both indicators HSMR and SHMI, the expected level of mortality is 100, with scores between 90 and 110 representing statistically expected levels of mortality. Scores below 90 represent better than expected levels of mortality, and above 110 worse than expected.

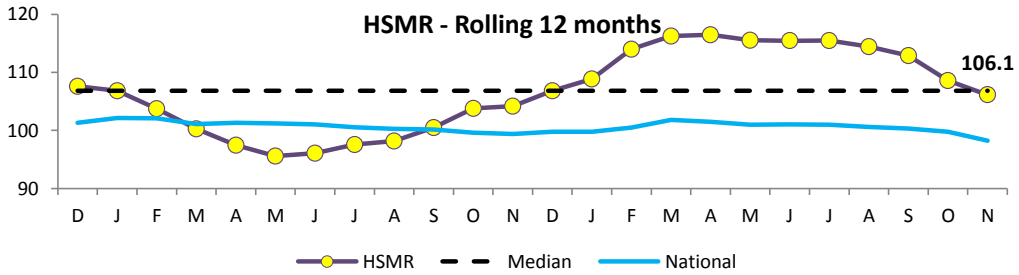
Category	Indicator name	Benchmark	17-18 Target	Q4		Q1			Q2			Q3			Q4			Q1			
				Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
HSMR	Hospital Standardised Mortality Ratio in-month	National	100	84.5	81.0	63.2	83.7	102.0	95.3	98.0	93.2	110.4	95.8	120.8	93.9	150.7	107.8	95.7	90.9	100.0	110.8
	Hospital Standardised Mortality Ratio rolling 12 months	National	100	93.5	91.1	87.7	85.1	86.2	86.0	87.5	89.2	91.7	92.7	94.1	94.0	114.1	116.4	116.6	115.7	115.6	115.6

Category	Indicator name	Benchmark	17-18 Target	Q3			Q4			Q1			Q2			Q3			Q4		
				Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
SHMI	Summary Hospital level Mortality Indicator (SHMI) - in-month	National	100	79.2	92.7	93.0	99.3	82.1	83.1	73.8	73.9	85.2	83.3	76.6	77.6	86.1	81.3	111.8	96.1	109.4	87.0
	Summary Hospital level Mortality Indicator (SHMI) - rolling 12 months	National	100	88.1	89.2	89.6	89.2	87.2	86.2	84.4	82.5	83.2	84.0	83.1	83.6	83.6	83.0	85.1	84.9	87.3	87.6
	Summary Hospital level Mortality Indicator (SHMI) - national report	National	100	88.9			84.9			82.4			83.6			83.9			86.6		

Category	Indicator name	Benchmark	17-18 Target	Q1			Q2			Q3			Q4			Q1			Q2		
				Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Crude Mortality	Crude rate per 1,000 admissions National benchmark	National		12.8	11.8	10.6	10.7	11.1	11.4	11.7	11.8	15.9	16.6	14.2	11.8	14.4	12.5	12.1	11.6	11.7	12.2
	Crude rate per 1,000 admissions in-month	National		8.9	11.4	12.5	10.7	12.1	11.9	12.5	11.0	17.5	18.5	18.4	15.5	11.7	10.7	10.7	12.3	10.7	10.7
	Crude rate per 1,000 admissions rolling 12 months	National	12.7	12.1	11.8	11.9	12.0	11.9	12.1	12.5	12.4	12.5	12.6	13.0	13.4	13.6	13.5	13.4	13.5	13.4	13.3
	Crude rate (non-elective ordinary admissions only)	15-16 outturn	33.5	19.4	25.5	30.0	26.0	27.4	24.4	27.4	24.1	36.9	39.5	37.4	35.4	23.5	23.6	24.1	29.2	25.4	24.7

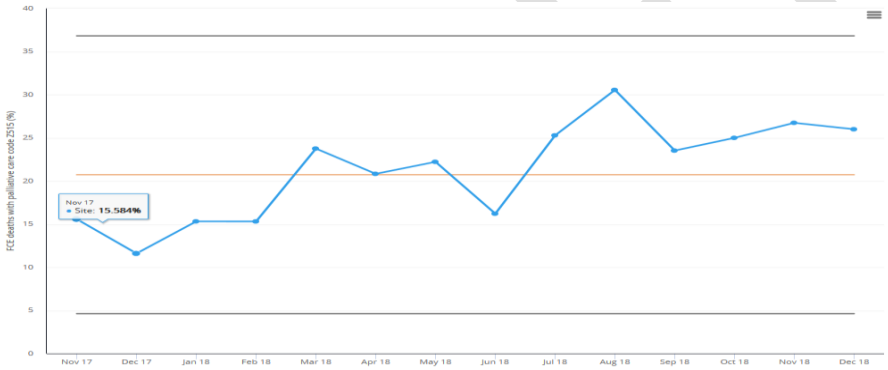
Hospital standardised mortality ratio (HSMR)





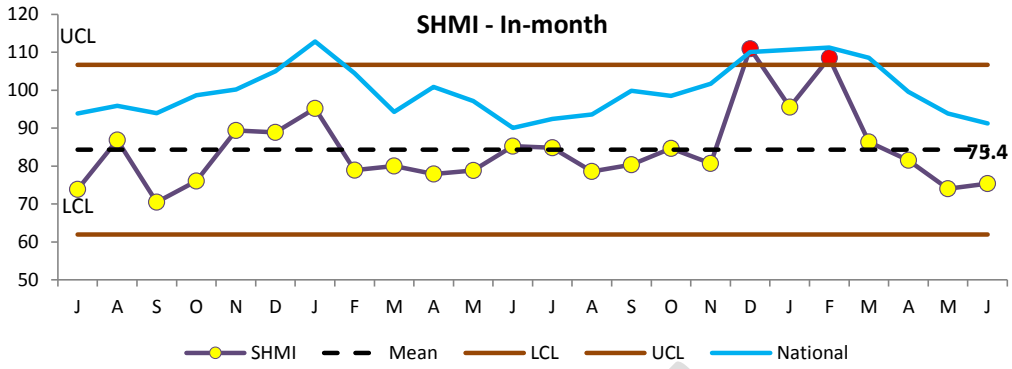
The Hospital-Standardised Mortality Rate (HSMR) for November 2018 (in month) is within the control limits and below the national mean. The rate has declined over the past four months and is currently below the Trust mean performance (105%). The data is available usually 2 months in arrears. The rolling average has fallen below the trust mean for the first time in 12 months.

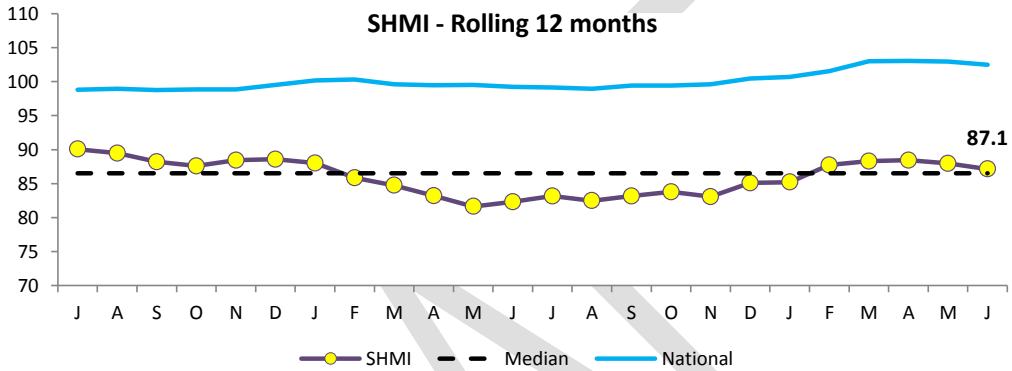
HSMR can be adversely affected by a lack of palliative care input or palliative care coding. The SPC chart below shows the percentage of patients who died with specialist palliative care input. It shows an increase over the last 6 months but is still below the national mean of 32% of cases.



- Recruitment is in process for an 'end of life 'clinical lead role - the purpose of this role is to support education and training around recognition of the dying patient and ensuring appropriate palliative care input (April 2019)
- A palliative care fast track discharge co-ordinator is now in post and an audit is planned to assess if this role is increasing the number of patients dying in their preferred place of death (April 2019)
- The palliative care team are developing an action plan in response to the findings of the 'National audit into care at the end of life' and this is overseen by the 'end of life steering group' (April 2019)

Summary Hospital Level Mortality Indicator (SHMI)





The SHMI rolling average remains substantially lower than the national mean. This demonstrates a substantially lower than expected death rate.

SHMI includes deaths in hospital and up to 30 days afterwards. Further analysis of SHMI data has shown that the organisation has one of the highest proportions of deaths in hospital rather than in the 30 days afterwards. This is further evidence of difficulties in discharging patients at the end of life to a hospice, home or other preferred place of death.

- The appointment of the palliative care fast track co-ordinator will help to support the wishes of patients at the end of life who want to die outside of a hospital setting. An audit of the number of patients know to palliative care who are discharged will be undertaken (April 2019)

Disease specific alerts

The Care Quality Commission (CQC) issued a mortality outlier alert for two procedures between March 2017 and February 2018:

- Therapeutic operations on jejunum and ileum procedures
- Therapeutic endoscopic procedures on upper GI tract

Action taken

A case notes review was undertaken of inpatients that underwent either procedure during the time period March 2017-February 2018 and subsequently died during the same admission. In addition the information the National Emergency Laparotomy Audit (NELA) 2016/7 was used to inform this review.

Results

Therapeutic operations on jejunum and ileum procedures

Total deaths identified - 17 cases, 10 analysed

None of the patients in this cohort had complications related to the procedure undertaken. The quality of care was judged to be adequate or good in 9/10 patients. In one case the care was felt to be unsatisfactory. 5/10 of the patients had advanced cancer (pancreas, gastric and duodenal tumours)
Lapses in care that may have contributed to the death of the patient.

- In one case there was a failure to escalate a deterioration in the NEWS score on the days leading up to the patient's death

Therapeutic endoscopic procedures on upper GI tract
Total deaths identified 40 cases, 30 analysed
Age range 40-96 mean 72 years
30 cases were reviewed using the SJR process. The findings were:
25/30 cases the care was felt to be adequate, good or outstanding. 5/30 cases lapses in care may have contributed to the death of the patient. Two of these cases had already been investigated via the serious incident investigation process. The key findings in the SI investigations were:

- Communication with the family did not lead to a full understanding of risks of the procedure
- No treatment escalation plan in place
- Delay in requesting a surgical opinion
- Failure to recognise deterioration and escalate appropriately

Lapses in care that may have contributed to the death of the patient

- In one case the patient suffered a gastric perforation after an upper GI endoscopy and suffered a cardiac arrest on the ward. The patient was being investigated for a possible tumour and the gastric perforation was felt might be related to the long period of gastric dilatation due to obstruction prior to presentation.
- In two cases deterioration in the patient was not identified and escalated appropriately.
- In one case there was a delay in recognising the development of acute kidney injury.

Areas for improvement:

- Recognition and escalation of deterioration
- Delay of 1st consultant review
- Palliative care
- Acute Kidney Injury

-
Conclusions

1. The patients in this cohort had many co-morbidities and many were in the terminal phase of their illness
2. There was evidence of a failure to recognise and escalate deterioration in a small proportion of cases
3. Earlier palliative care input would have enhanced care and improved the standardised mortality ratio for these patients
4. There were no concerns identified in relation to quality care during the actual procedures

5.

Action plan

	Action	Lead
1	Delivering the End of life Care Strategy to improve the recognition and management of patients at the end of life	Director of Nursing
2	Business plan to be developed for the continuation of the 7 days services pilot	Divisional Director
3	Ensure the NEWS2 escalation tool is embedded across the organisation by the use of audit data	Critical Care Outreach Matron
4	Review of compliance against NICE guidance on management of AKI (CG 169)	Deputy Medical Director

Disseminating Learning form mortality reviews

Learning identified from mortality reviews is disseminated in a number of ways. Mortality leads are encouraged to take the lessons back and share them at their local mortality meetings. The lessons are also shared via the patient safety message of the week and in the quarterly patient safety newsletter.

Learning from mortality reviews was the topic for the quarterly patient safety learning event in December 2018. The event brought together staff from across the organisation. It opened with a family who had lost a baby due to congenital cardiac disease sharing their experiences of bereavement. They summarised their experiences by saying the most important things when communicating with a family dealing with a loss are compassion, kindness and love. Judith Hendley, head of patient safety policy at NHS Improvement explained how mortality reviews fit into effective and sustainable quality improvement. The importance of taking re-attendance with the same problem seriously was highlighted by Cath Pearce, emergency medicine consultant. Vikki Howarth the CCOT matron shared a personal story of the need for health professionals to be courageous in initiating end of life discussions. Jessica Sui, palliative care consultant explained the need to involve the palliative care team earlier to allow the patient to be part of the conversation about their priorities for the end of life.

Medical Examiner

A national network of medical examiners was recommended by the Shipman, Mid-Staffordshire and Morecambe Bay public inquiries. In October 2017 Lord O'Shaughnessy, Parliamentary Under Secretary of State for Health, announced that a national system of medical examiners will be introduced from April 2019. Medical examiners are specifically trained independent senior doctors (from any specialty) who will be part of a national network. Overseen by a National Medical Examiner, they will scrutinise all deaths within secondary care with primary care gradually being phased in.

The stated aims of the role are to:

- confirm the proposed cause of death of a patient and ensure accurate completion of the Medical Certificate of Cause of Death (MCCDs)
- advise whether the death needs referral to the Coroner for further investigation
- detect and report clinical governance concerns

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This is achieved by a

- proportionate review of medical records
- interaction with the attending doctor
- interaction with the bereaved

The above should be completed within 24 hours of the medical notes being received (for cases not investigated by the Coroner). This means that a 7 day service is required.

A business case is being developed to establish the role. The funding will come from the existing fees paid to clinicians completing the second part of the death certificate.

Supporting bereaved families

An action plan has been developed to address the national guidance on supporting bereaved families.

◊ Infection control

MRSA Bacteraemia

The national objective for all Trusts in England for 2018/19 was to have zero avoidable MRSA bacteraemia. All MRSA bacteraemia are subject to a post infection review (PIR) by the Trust in conjunction with the Commissioning Support Unit (CSU) on behalf of the Clinical Commissioning Group.

During 2018/19 1 MRSA bacteraemia was assigned to North Midd therefore missing our target of zero MRSA Bacteraemia.

Clostridium difficile Infection (CDI)

The Trust's objective was to have no more than 33 cases of avoidable Clostridium difficile infection. Each case is subjected to root cause analysis investigation and further reviewed together with the North East London Commissioning Support Unit (NEL CSU) on behalf of our commissioners to identify whether there were any lapses in care which the Trust can learn from. A lapse in care means that correct processes were not fully adhered to and therefore the Trust did not do everything it could to try to prevent a Clostridium difficile infection. By the end of the financial year the Trust reported 26 cases of Clostridium difficile infection, therefore meeting the objective of having no more than 33 cases. Following review of 24 cases by the NEL CSU together with the Infection, Prevention and Control team, 21 of the 24 cases were found not to have any lapses in care that led to the acquisition of Clostridium difficile infection.

◊ Patient Safety Incidents

The 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. All patient incidents are reviewed at a daily meeting. Where significant harm may have been caused to patients, further root cause analysis investigation is undertaken.

Incidents
During 2018/19 the trust reported a total of 9137 patient safety incidents. The table below breaks down the number of incidents reported by level of harm.

Level of harm	Number of Incidents Reported 2018/19
No harm	6944
Low harm	2113
Moderate harm	59
Severe harm	7
Death/Catastrophic	14
Total	9137

Serious Incidents
During 2018/19 the trust reported a total of 52 SIs. A number of the SIs reported related to the provision of sub optimal care and delayed diagnosis/treatment. As a result thematic reviews were completed for these 2 categories to establish commonalities between the cases and provide a clear focus for improvements

During 2018/19 we have worked to improve the rigor, quality and timeliness of these investigations. All incidents and serious incidents (SIs) are shared with the CCGs and via national reporting mechanisms.

Learning and actions identified as a result of a serious incident are shared and monitored via the trust's serious incident actions and learning group which ensures that actions from SIs are completed as well as sharing learning through the divisional governance structure and trust wide learning events. Work will continue to build on further improvements to the ways in which we share learning, and ensure timely completion of actions will continue in 2019/20

Further root cause analysis training was provided during 2018/19 for 30 members of staff which also covered duty of candour, and enabled us to increase our SI Investigation capabilities with a strong focus on understanding how to review incidents from a human factors perspective, through to the development of recommendations and subsequent action plans.

During 2019/20 the trust will continue to build on human factors capability (understanding how our behaviours impact on performance, abilities and application of that knowledge in clinical settings).Thus building expertise in order to support improvements in the care we deliver, and the way in which we work together; taking care of both patients and staff.

Duty of Candour

The Trust is committed to being transparent, open, honest and accountable to patients and their families when serious incidents occur. In order to ensure this takes place whenever a patient comes to significant harm, senior clinicians speak to patients and their families to offer a sincere apology for the events that have taken place, advise of any actions that will be taken including investigations, provide a point of contact, support and provide the patient and their family the opportunity to raise any concerns that they have, or areas of care that they would like us to investigate.

The Trust aims to share all investigation reports with the patient harmed and/or their family, they are invited to meet with the investigation team/or appropriate leads. This provides an opportunity to go through the report together, hear what actions have been taken to ensure similar incidents do not happen again in the future, and to address any further questions that the patient or their family may have.

During 2018/19 the arrangements for carrying out Duty of Candour (DoC) were reviewed to support and equip staff to robustly and consistently fulfil the DoC requirements as set out in regulation 20 [3] and to ensure that this happens in a compassionate, effective and timely manner.

During 2018/19 the trust rolled a number of training sessions with a number of sessions supported by the General Medical Council (GMC) for clinicians and other staff groups.

Never Events

Three Never Events, as defined by NHS England's Serious Incident Framework, were recorded at the Trust in 2018/19. Root cause analysis investigations have been completed so that lessons will be learned and robust action taken to prevent similar incidents happening again at North Middlesex University Hospital NHS Trust.

Becoming a learning organisation

Throughout 2017/18 we have worked to improve how we learn from incidents and patient experience. All incidents are discussed at a daily meeting with representation from all divisions. All Serious Incidents (SIs) are discussed monthly and a newsletter produced with trust-wide learning points from SIs.

We continue to ensure that we support staff when they are involved in incidents through a number of avenues including our Schwartz rounds which allows staff to share and discuss their experiences of how being involved in managing difficult clinical situations has affected them.

[3] http://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf

Staff also have access to our Serious Incident Aftercare service (SIA) which is a service set up to support staff and teams following serious/traumatic incidents at work to provide group support (debrief) facilitated by trained trust staff. The aim of the debriefing is primarily to educate and assist individuals to recognise and understand normal reactions to traumatic or extremely stressful events; and to educate as to when it is appropriate to seek further help and support (if necessary) in future.

Quality Learning Days

In May 2018 the trust held the 1st in a series of "Learning from ….." events. This is an open forum, bringing together multi professional teams as a means of sharing learning and good practice.
During 2018/19 the events held were;

- Learning from Never Events
- Learning from – Individuals not labels
- Learning from Death
- Learning from Excellence

At these events we heard personal testimonies from clinicians, patients and families coming in to share their experience, presentations from national subject experts. All events were well attended by a cross section of staff.

Quality Improvement Celebration Day

The Trust held its 2nd Quality Improvement Celebration day on 20th March 2019. This was an opportunity for all staff and external stakeholders to hear from different teams across the hospital have undertaken to improve patient care.

The day demonstrated that the appetite and pace with which the application of QI methodology to make improvements is growing

Patient Experience

The organisation uses a number of indicators to determine the quality of patient experience. The Friends & Family Test (FFT)[4] and complaints are two of the mechanisms organisations can use to understand patient experience, and then use this to focus and drive improvements.

The FFT was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way for patients and their carers to give their views after receiving care or treatment across the NHS.

2018/19 Performance Friends & Family Test and Complaints

[4] https://www.nhs.uk/NHSEngland/AboutNHSservices/Pages/nhs-friends-and-family-test.aspx

				Q1			Q2			Q3			Q4		
Category	Indicator Name	Benchmark	18/19 Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Patient FFT	A&E - FFT % Positive	National	84%	60.0%	60.0%	71.0%	70.0%	77.0%	65.6%	67.7%	65.9%	59.3%	59.7%	57.0%	
	I/P- FFT % Positive	National	95%	96.0%	85.0%	87.0%	84.0%	84.0%	90.2%	85.7%	85.9%	85.0%	89.2%	88.9%	
	Maternity- FFT % Positive	National		97.0%	75.0%	79.0%	78.0%	73.0%	74.8%	75.3%	79.3%	82.3%	84.1%	81.1%	
	Outpatients - FFT % Positive	National	92%	90.0%	75.0%	76.0%	76.0%	75.0%	75.4%	76.1%	74.8%	73.3%	76.0%	75.2%	
COM	Written Complaints response rate within deadline	National	80%	58%	68%	40%	73%	40%	88%	44%	20%	26%	67%	67%	

2017/18 Performance Friends & Family Test and Complaints

				Q1			Q2			Q3			Q4		
Category	Indicator Name	Benchmark	17/18 Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Patient FFT	A&E - FFT % Positive	National	84%	45.7%	48.0%	48.0%	46.0%	51.0%	59.0%	58.0%	66.0%	63.0%	67.0%	69.0%	66.0%
	I/P- FFT % Positive	National	95%	96.0%	96.0%	97.0%	96.0%	96.0%	92.0%	94.0%	92.0%	91.0%	90.0%	94.0%	94.0%
	Maternity- FFT % Positive	National		88.0%	91.0%	`	93.0%	89.0%	97.0%	95.0%	93.0%	95.0%	95.0%	91.0%	92.0%
	Outpatients - FFT % Positive	National	92%	77.0%	85.0%	85.0%	85.0%	85.0%	87.0%	83.0%	88.0%	86.0%	86.0%	85.0%	89.0%
COM	Written Complaints response rate within deadline	National	80%	74%	68%	53%	81%	73%	75%	75%	56%	60%	75%	67%	73%

Complaints

During 2018/19 the trust received a total of 386 complaints compared to 409 received during 2017/18 representing approximately 6% decrease. During 2018/19 the trust only met/exceeded the target response rate to complaints within deadline in September 2018.

The significant drop in the performance rate during Q3 can be attributed to issues experienced in regards to staff capacity issues due to vacancies and sickness, as well as gaps in senior leadership oversight in the absence of the executive lead responsible for complaints management at the time.

A significant proportion of complaints received related to concerns/isssues regarding all aspects of clinical treatment, this includes issues pertaining to admission, discharge and transfer arrangements, missed/delayed diagnosis and medication.

Concerns regarding the attitude of staff accounted for 19% of complaints which is consistent with the picture during 2017/18.

During 2018/19 the trust closed 367 complaints, of which over 50% were upheld, and approximately a quarter of complaints not upheld.

Listening into Action (LiA)

During 2018/19 the Trust used “Listening into Action” approach to carry out an organisational LiA Pulse Check and LiA Leadership Audit, both of these tools provide an opportunity for the Trust to hear and see through the eyes of NHS staff and leadership their view where the Trust is doing well, as well as suggesting improvements. **Listening into Action** is about harnessing all the good ideas from anyone in Team North Mid, and then making them happen

LiA Pulse Check

- A survey goes out to all staff for response via email, intranet, mobile phone, tablet, or on paper
- Responses are completely anonymous
- Staff may also suggest up to 3 changes to improve patient care and/or reduce day-to-day frustrations
- Results are available by organisation, role, specialty and site
- Reports show your results by the CQC 5 domains of safe, caring, effective, responsive and well led

LiA Leadership Audit

- supports trusts to check-in with leaders to see how well they feel the organisation is managing change.
- These results are also reported by the CQC 5 domains
- We've got more than a dozen teams from across the Trust taking forward Listening into Action (LiA) projects in A&E, urology, outpatients, paediatrics, and more.
  In March 2018 the trust held quality improvement event – “Pass it On” to celebrate and share ourr successes.
- Join us and help to build on our efforts to make North Mid even better for us and

Improvements at the hospital thanks to Listening into Action

- We launched our Women's Network with special guest Yvonne Coghill CBE
- We've opened a new frailty assessment room in our A&E department so that patients over 65+ have a dedicated space to be treated.
- We've installed an Amazon locker in the atrium for staff and local residents to collect Amazon deliveries from.
- We've revamped our Staff Zone to make it easier for staff to find out the benefits of being part of Team North Mid.
- Our pharmacy team have fixed their prescription payment machine - something that had been broken for over a year. They have also introduced a star of the month award.
- Set up a staff running club. They meet every morning at 7.45am outside Trust Head Quarters.
- We've transformed our staff room in the emergency department to make it bigger, brighter and more peaceful.
- Our Gynaecology team has train its staff so they can offer more nurse-led services and improve patient experience.
- We've extended out-of-hours car parking hours
- We've introduced an all-day children's phlebotomy service

- We've given guidance about how to update your contact information in phone directory
- The Outpatients team has introduced a 'Staff of the Month' award
- Lengthened admission times for ambulatory care patients into WADU
- Guidance on our standard email signature
- Introduced a staff only area in the restaurant
- Refreshed our equality, diversity and inclusion information on our website
- Improved signage in A&E and much more...

Section 2 – Priorities for improvement and statements of assurance from the board

Delivery of the 2018/19 Quality Priorities

The tables below summarises the Trust's performance against delivering the quality priorities that were agreed in last year's Quality Account.

How did we do?

Patient Safety	
Quality Priority: Partially Achieved	**Implementation of NEWS2** - Full implementation of NEWS2 by March 2019 as per Patient Safety Alert NHS/PSA/RE/2018/003 - Resources to support the safe adoption of the revised National Early Warning Score (NEWS2) issued: 25 April 2018 – resulting in the implementation of NEWS2 across the Trust by March 2019 - 50% reduction in the number of incidents where early warning scores are found to be part of the cause - Subject to the sign-off of the Trust's GDE-FF programme, successful rollout of an electronic mobile system for nurse documentation of NEWS2 scores, for team handover and communication
Summary/What we've done/delivered	• NEWS2 has been rolled out in all adult in-patient areas (non obstetric) since 6th December 2018. There is an ongoing programme of audit to ensure the tool is being used effectively. The new vital signs chart includes an inpatient sepsis screening tool which is used to guide the care of patients with a suspicion of sepsis and an action log to ensure effective documentation of escalation. • Prior to and during the roll out of NEWS 2 there was an education programme to inform staff of the changes and how to use the tool to ensure early identification of the deteriorating patient. • NEWS2 has been implemented in day surgery, the medical day hospital and heamatology day unit. The emergency department have trained their staff in the use of NEWS 2 and are waiting for the next print run of their assessment cards to implement its use.
What the data shows	Audits to date have demonstrated good compliance with NEWS2.
Achievements (notable)	Full roll out across adult in-patient areas (not including maternity who continue to use a MEWS tool) and all out patient areas that monitor patients vital signs.
What we're going to do next to continue	• There is a rolling programme of audit to ensure that the tool is being used to its maximal benefit. Ongoing education of Medical and Nursing staff is being undertaken.

improvement	• Early discussions have taken place with a view to continuing the use of NEWS2 following the implementation of electronic patient monitoring.
How this benefits patients	NEWS 2 is a sensitive tool, designed to identify and escalate the early signs of physiological deterioration.
Other related QI initiatives during this period	We designed and implemented a combined DNACPR/TEP and MCA document to help medical staff to document the correct pathway for escalation and intervention towards the end of life.
Quality Priority: Not Achieved	**Development, implementation and evaluation of Local Safety Standards in Invasive Procedures (LocSSIP's)** Measures of success: 1. We will have evidence of 80% of procedures carried out in the trust covered by a LocSSIPs 2. We can demonstrate the adherence through audits 3. 0 Surgical procedure never events 4. A reduction in the number of incidents relating to surgical invasive procedures with a moderate to severe level of harm
Summary	41 procedures have been identified which will be covered by 21 LocSSIPs. To date 3 LocSSIPs have been completed covering 5 procedures. By the end of the financial year it is envisaged that approximately 20% (9) of procedures across the organisation will be covered by a published LocSSIPs, whilst this falls far from the organisation's aspiration to have 80% of procedures covered by a LocSSIPs by March 2019, the programme is now moving at pace and completion of this work is likely to conclude at the end of Summer 2019. To date the organisation have declared 3 never events relating to surgical procedures, 2 relating to ophthalmology surgery and 1 relating to a retained foreign object. At this stage no audits have taken place in regards to the effectiveness of completed LocSSIPs. The number of surgical invasive procedures with a moderate to severe level of harm reported during Q1 – Q3 for 2018/19 was 1 (investigated as a serious incident) out of 114 reported incidents in this category (less than 1%); when compared to 2017/18 for the same period there were 61 reported incidents of which 5 were moderate harm or above (8%), this constitutes a significant reduction in the number of incidents of this nature leading to significant harm.
What we've done/delivered	1. Completed LocSSIPs ready for publication on the dedicated intranet page: • cataract surgery/IOL implants • regional anaesthesia • neonatal intubations 2. Meeting of representatives from all divisions held in December 2018 • Agreed list of LocSSIPs, and leads assigned for the majority of projects. 3. LocSSIPs in development

	• Central lines,vascaths and Picc lines • Out of theatre adult intubations • Paediatric and neonatal invasive procedures • Maternity division – leads named, checklist for procedures on Womens Assessment Day Unit and labour ward drafted • Chest drains
Achievements (notable)	Raising awareness and the profile of LocSSIPs across the organisation • Intranet page set up • Multiple interviews uploaded to discuss LocSSIPs • Grand round presentation • Templates for developing a LocSSIPs available on shared drive

What we're going to do next to continue improvement	• Engage remaining specialties
	• Recruit a lead and team for theatre and outpatients procedures LocSSIPs, this will need input from multiple divisions
	• Support those teams with allocated leads who might need more resources and time to develop LocSSIPs
	• Educate non-theatre staff on the benefits of using checklists, and standardizing procedures to reduce variation and the potential for errors:
	  • Resources on intranet
	  • A 'roadshow' in early February to visit wards, talk to staff and distribute materials e.g. posters

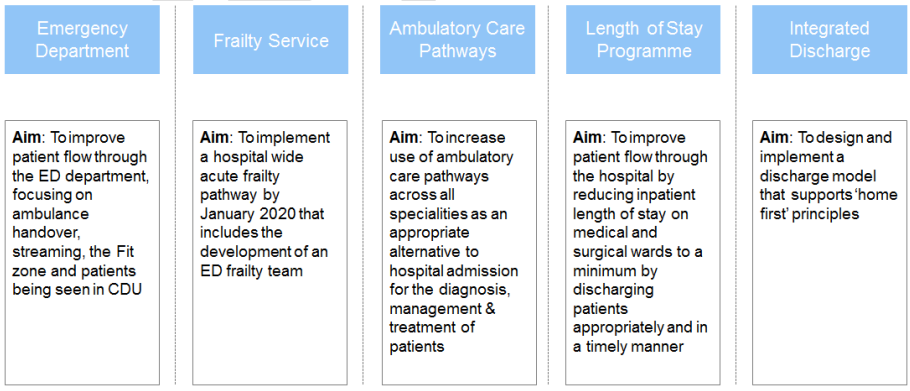
Other related QI initiatives during this period	Human factors training – have liaised with the leads to remain updated about the launch of this training, so local LocSSIPs leads can be directed to it and encourage team participation
Quality Priority: Achieved	**Develop human factors understanding and capability** 1. Better HF training for staff – Increased number of staff trained in HF (underpinned by a detailed training plan) 2. SBAR and Safety huddles embedded across the organisation demonstrated through audits 3. HF considered in the redesign of clinical pathways, standard operating procedures, IT systems and devices. Medical Director to sponsor the programme
Summary / What we've done/delivered	• Trained 350 members of staff across the organisation in the basic principles of human factors • Undertaken a training needs analysis for the provision of human factors training to each staff group • Established a hospital at night meeting to improve team work • Established a twice daily cardiac arrest huddle to improve the confidence and capability of the cardiac arrest team • Extended the 'learning from excellence' programme trust wide • Embedded human factors principles alongside the LocSSIP programme to maximise change of successful implementation • Implemented NRFIT LP needles across the organisation to introduce a forced function to prevent medication errors • Redesign of DNACPR/TEP/MCA form to encourage completion by combining three forms into one form and therefore making doing the right thing easier • NEWS2 form and inpatient sepsis pathway combined to encourage completion and prompt identification and escalation of possible deterioration or sepsis using HF principles

	• Encouraged uploading of photographs to email accounts to encourage respectful communication and build team ethos • Designed a patient safety walkabout programme to address work as imagined vs work as done gap • Introduced 'Just culture' principles to incident investigations – this will be monitored through the SI closure checklist.

What the data shows	• Hospital at night programme has been evaluated and shown that
	  • 90% of staff felt more aware of sick patients in the hospital after introduction of the meeting
	  • 85% of staff felt referrals between specialties happened earlier and were easier
	  • 90% of staff felt more supported overnight
	  • 85% of staff felt patient safety had improved
	• The cardiac arrest arrest meeting has been evaluated and shown
	  • 97% of staff were more aware of the members of the cardiac arrest team, their grade and competencies after the introduction of the briefing
	  • 88% of staff felt more prepared for cardiac arrests
	  • 82% of staff felt more confident in practising particular skills or competencies during an arrest
	  • 97% felt gaps in staffing were more likely to be identified as a result of the briefing
	• There have been over 1170 greatixes submitted across the organisation
	• Safety walkabout demonstrated that the NRFit needles are now in use across the organisation and the old type have been removed from all clinical areas
	• Increase in completion rate of TEP forms from 23% to 67%
	• Increase in completion of MCA forms from 1.5% to 23%

Achievements (notable)	• Establishment of the Cardiac arrest and hospital at night meeting • Improvement in completion of TEP • 'Learning from excellence' programme won the HSJ patient safety best poster presentation
What we're going to do next to continue improvement	• Embed the human factors training programme across the whole organisation • Further work on ensuring SBAR is used for all escalation conversations • Obtain consistent engagement from surgical teams in hospital at night team • Focus on improvement in completion of MCA assessments as part of end of life decision making • Ensure the governance processes underpinning the learning from excellence programme are in place to support the learning aspect
Other related QI initiatives during this period	• Overlap with GRIP programme • Overlap with Culture and leadership programme

Clinical Effectiveness

Quality Priority:	**Implement the Safer, Faster Better Transformation programme 2018/19 objectives** 1. Deliver the Safer, Faster, Better Emergency improvement trajectory 2. Increase the number of patients discharged in time to be "Home for lunch" 3. Reduce the number of patients where their discharge to another health or social care setting is delayed or where they require a package of care or supported discharge to be put in place
Summary / What we've done/ delivered	During 2018/19 the Safer Faster Better Programme (SFB) was disbanded with a newly form Urgent and Emergency Care Improvement Programme (UECIP) encompassing the overall aims/principles of the SFB principles. The UECIP incorporates five workstreams. All of these are important to achieving flow through the Trust, and each has a clear goal for the six months to July 2019. ▪ Three of these areas build on work conducted over winter 18/19, which had three aims: – To **improve processes on wards** in order to increase early/total discharges and improve flow from ED to the wards, as well as to make the escalation process more effective – To **enable assessment units to pull patients** from ED, thereby reducing the length of time these patients spent in ED – To enable **efficient allocation of ED cubicles** at times of high pressure, to facilitate flow through ED and to support the ED department with ED huddles and 'breach-busting' ▪ This plan sets out the actions required to maintain momentum across these areas, as well as to continue progress across the other UECIP workstreams The programme sets out the aim to maintain progress against the 5 areas outlined below.  The new programme reports to the A&E NMUH Delivery Board. The work of the UECIP will continue during 2019/20.

Patient Experience

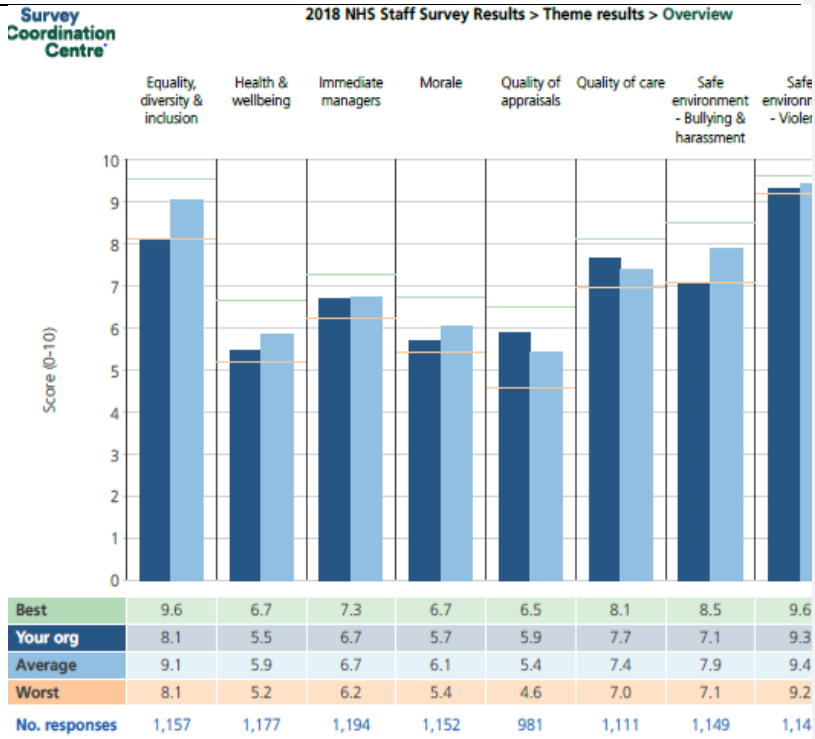
Quality Priority: Partially achieved	**Improve Patient Experience Outcomes through improved FFT results** 1. Improve patient experience in the emergency department resulting in an improved performance in the Friends and Family Test (FFT) so it meets or exceeds the London Benchmark 2. Improved patient experience in maternity resulting in an improved performance in the Friends and Family Test (FFT) so it meets or exceeds the London Benchmark 3. Improve patient experience in Outpatients resulting in an improved Friends and Family Test (FFT) which meets or exceeds the London benchmark 4. Improve the experience of inpatients using cancer services resulting in improved performance in the 2017 national cancer inpatient survey in comparison to the 2016 national survey results. 5. Develop a Patient Experience Strategy using Always Events as a methodology to implement the strategy
Summary / What we've done/delivered	Whilst results in all areas have not met the London Benchmark there have been improvements in comparisons to 2017/18. FFT results in December 2018: • ED – 60.6% response rate with 59.32% positively recommending. • Maternity – 15.53% response rate with 82.32% positively recommending. • Outpatients - 73.29% positively recommended • The National Cancer Patient Experience Survey 2017 results have been published. NMUH's Overall ratings continue to improve, with year on year increases in reported positive experience. Patients also reported more positively on areas including involvement in decisions about care and treatment, and being treated with dignity and respect. However, there is a identified need to accelerate the pace of change. The Trust when benchmarked nationally was at number 140 compared with being at number 146 in the previous year. The Lead Cancer Nurse and Cancer Manager jointly lead on embedding change across the specialties. • The Patient Experience Strategy was approved by the Trust Board in August 2018 and launched in September.
What the data shows	See above.
Achievements (notable)	Using Always Events and linking with the Listening into Action programme up to February 2019, the first of the 7 Always Events is being implemented. The first of the 7 Always Events, "I will always receive information that is clear, up-to-date, accurate and that I can understand" is being implemented. The 3 work streams are: 1. Linking Always Events with Listening into Action with the Radiotherapy team being the point of care team testing change ideas with plans to share with other teams. The ideas being undertaken are to undertake a fresh eyes walkthrough with patients focussing on the current provision of written information in the Radiotherapy department. This will provide a benchmark of the information that is currently provided and patients can feedback on whether the information provision meets their needs and whether the locations of the patient information are appropriate for their visit. There is also a patient survey that volunteers who have recently joined the team will administer

	using a face to face approach. - 2. Liaise with the LiA Team that is working on improving the Outpatient Call centre – focus on ensuring that patients are involved in the review of the patient appointment letters. - 3. Reviewing and updating the Inpatient Welcome Pack and Inpatient booklet to support patients during their hospital stay from admission to discharge.
What we're going to do next to continue improvement	The numbers of patients completing the FFT surveys remains low and there is a need to increase these with staff providing the survey as a part of the discharge process. Volunteers are being all acted to areas with the greatest need to support the staff to collect the feedback. The Matrons and ward/department leads report on FFT results and the action plans at the PEG. The next actions are to implement the 2nd Always Event – "I will always find it easy to find my way around the hospital". In our efforts to improve in this area, a small signage / way finding task and finish group has been established. We are working closely with our Estates team and local Health watch groups and their patient volunteers to use patient appointment letters to check their usability in way finding across the hospital site. This work will provide patient feedback on our signage and the priorities that will make the most impact on improving patient experience of finding their way around. An implementation plan has been developed for the 3 years of the strategy and an action plan is being drafted by working with the divisional management teams to ensure that there is cross-divisional learning and embedding of good practice to make Always Events a reality.

Staff Experience

Quality Priority: Achieved	**Improve Staff Experience** 1. Improve the experience for staff working at the Trust so that there is an increase in the percentage of staff who would recommend the Trust as a place of work to their friends and family 2. Improve the experience for staff working at the Trust so that there is an increase in the percentage of staff believing that the Trust provides equal opportunities for career progression or promotion 3. Embed Just Culture principles and framework as part of the Incident, Serious Incident and HR processes.
Summary / What we've done/delivered	**2018 Annual Staff Survey** The NHS Staff Survey was published on February 26th 2019, it was completed by 1242 North Midd staff (39.1%). For the first time, the results have been clustered into ten themes:

	• Equality, diversity and inclusion • Health and wellbeing • Immediate managers • Morale • Quality of appraisal • Quality of care • Safe Environment – Bullying and harassment • Safe Environment – Violence • Safety culture • Staff engagement The detailed report can be found at http://nhsstaffsurveys2018.com/files/NHS_staff_survey_2018_RAP_full.pdf When benchmarking against the 43 acute hospital Trusts that used Picker, the Trust is the second most improved. When comparing North Midd against other acute hospitals using Picker, staff scored the trust higher than average in the 'quality of care" and 'quality of appraisals' and average for 'support from managers' and 'staff engagement'. Out of the 44 comparable questions the Trust improved in 32. This suggests that the initiatives that have been carried out by the Trust over 2017 are having a positive impact. The trend analysis over the past four years would also support this view. However, there is still significant work that needs to be done when it comes to Bullying and Harassment. The Trust scored at the lowest levels when compared to other acute Trusts. This has been a long standing issue for North Middlesex University Hospital. The Trust has recently introduced a culture and leadership programme supported by NHS Improvement and entitled Outstanding Leaders, Outstanding Care. This will focus on embedding positive leadership behaviours. Similarly, there needs to be focused work around Equality, Diversity and Inclusion. The Trust performed at the lowest levels when compared to acute colleagues. The Trust has appointed a new Equality, Diversity and Inclusion Lead and is also participating in collaborative projects with Barnet, Enfield and Haringey Mental Health Trust to start tackling issues raised.
What the data shows	The following table graph demonstrates the Trust's results.

	
Achievements (notable)	Out of the 44 comparable questions the Trust improved in 32. When benchmarking against the 43 acute hospital Trusts that used Picker, the Trust is the second most improved.
What we're going to do next to continue improvement	Based on the results of this year's staff survey, the trust will prioritise and invest in initiatives to improve: a) Equality, diversity and inclusion **b)** Bullying and harassment

All qualities priorities for 2018/19 will continue to be monitored either as continued quality a priority for 2019/20; and/or through the Trust's existing structures for improvement and assurance.

Quality priorities for delivery in 2019/20

Improving patient experience, patient safety, clinical outcomes and staff experience remain our over-arching objectives. When selecting our priorities for 2018/19, we considered where we need to embed and consolidate the work begun in the previous year(s).

The Trust also held a Sign up to safety kitchen table event attended by wide cross section of staff and disciplines with information gathered feeding into identifying/prioritising areas for improvement.

The Trust's quality priorities for 2019/20 have been agreed following internal consultation with a multidisciplinary team of senior clinicians, the senior management

teams, the quality committee and external consultation with the Health Overview and Scrutiny Committees of Enfield and Haringey local authorities, our commissioners, our local Commissioning Support Unit (CSU), and Enfield and Haringey Healthwatch organisations.

The following table details the rationale for each priority and clarify the objectives.

Patient Safety

1. Development, implementation and evaluation of Local Safety Standards in Invasive Procedures (LocSSIP's)	
Why have we chosen this priority?	Local Safety Standards for Invasive Procedures are a mechanism of ensuring consistent application of safety critical interventions for high risk procedures. NHS provider organisations are required to develop local procedures based on national best practice examples and this will continue to form a major quality priority for the organisation in 2019/20.
What are we trying to improve?	The rationale for choosing this priority is due to the fact that the Trust has had a number of Never Events during the last 2 financial years which are related to surgical/invasive procedures.
What will success look like?	1. We will have evidence of 80% of procedures carried out in the trust covered by a LOCSSIPs 2. We can demonstrate the adherence through audits 3. 0 Surgical procedure never events 4. A reduction in the number of incidents relating to surgical invasive procedures with a moderate – severe level of harm
How will we monitor progress	1. Development, testing and roll out of LocSSIP's will be led by NATSSIPs lead, as part of a multi-professional team. 2. Task force will continue to coordinate the development of these procedures, test their effectiveness and to report to appropriate committees on progress. 3. NatSSIPs programme to report quarterly to the Patient Safety and Outcomes Committee

2. Develop Human Factors Understanding and Capability	
Why have we chosen this priority?	To support clinical teams to improve patient safety by enhancing clinical performance through an understanding of human factors. An understanding of Human Factors will provide staff/teams with an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on theirs and others behaviour and performance, abilities and application of that knowledge in clinical settings.

	Incident investigations have demonstrated that that the solutions put forward to address learning do not demonstrate a recognition or depth of understanding of human factors principles in order to identify robust actions resulting in sustainable change. The Trust now has 4 clinicians on the Human Factors training programme hosted by UCLP. These clinicians will form a task group ensuring junior doctor representative on the group, and cascade and embed the HF training across the organisation
What are we trying to improve?	The rationale for choosing this priority is due to the finding of Human Factors as root causes or contributory factors in several Serious Incidents and Never Events at the Trust in 2017/18. The Trust wishes to improve the following areas: - Improve the quality of patient handover between clinicians and teams by using the SBAR tool - Improve the effectiveness of the "Hospital at Night" team to strengthen working across teams and enabling the team to share appropriate information to ensure the right patients receive the right care at the right time (Getting it right first time) - Findings from the staff survey demonstrated that staff do not all feel able to raise concerns at the point that clinical care treatment and care is being delivered in order to improve patient care or protect patients from harm.
What will success look like?	1. Increased number of staff trained in HF (underpinned by a detailed training plan) 2. Continue to embed the use of SBAR and Safety huddles across the organisation demonstrated through audits 3. HF considered in the redesign of clinical pathways, standard operating procedures, IT systems and devices
How will we monitor progress	1. Monitoring of training plan to ensure targeted and appropriate level of training 2. Human Factors Task group reporting into PSOC

3. Implementation of National Early Warning Score 2	
Why have we chosen this priority?	Failure to recognise or act on signs that a patient is deteriorating is a key patient safety issue. It can result in missed opportunities to provide the necessary care to give the best possible chance of survival.

	Building on our work over the last 2 years through our deteriorating patients workstream the Trust sees the implementation of the National Early Warning Score 2 as a key patient safety priority. NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. NHS England, NHS Improvement and Royal College of Physicians issued a joint alert; NHS/PSA/RE/2018/003 - Resources to support the safe adoption of the revised National Early Warning Score (NEWS2) issued: 25 April 2018, to highlight the existing resources to support adoption of NEWS2. NHS England's aim is for all acute hospital trusts and ambulance trusts to fully adopt NEWS2 for adult patients by March 2019
What are we trying to improve?	Ensure timely detection and response in regards to: • better identification of patients likely to have sepsis • improved scoring for patients with hypercapnic respiratory failure • recognising the importance of new-onset confusion or delirium
What will success look like?	- Continued levels of good compliance with NEWS2 (target of 80%) as per Patient Safety Alert NHS/PSA/RE/2018/003 - Resources to support the safe adoption of the revised National Early Warning Score (NEWS2) issued: 25 April 2018 – resulting in the implementation of NEWS2 across the Trust. - 50% reduction in the number of serious incidents where the early warning scores are found to be part of the cause – a baseline will be taken in quarter 1 of 19/20 baseline. - As part of the trust's digital programme - successful rollout of an electronic mobile system for nurse documentation of NEWS2 scores, for team handover and communication
How will we monitor progress	- Monitored via the Patient Safety & Outcomes Committee - Divisional Governance meetings to ensure regular review at a local level and timely intervention. - GDE-FF delivery board

Clinical Effectiveness Priorities

Quality Improvement	
Why have we chosen this priority?	Implementation of an effective approach to quality improvement underpins successfully and timely delivery in all areas of trust business The quadruple aim of quality improvement **Good for patients** • Safety and quality of care • Patient experience • Patient & carer as partners **Good for the population** • Address local people's health needs • Prevention and earlier diagnosis • Strategic capability **Good for the taxpayer** • Remove waste and duplication • Focus on value not balance sheet • Increase efficiency and productivity **and staff** • Teamwork • Involvement • Joy in work In organisations with an established QI culture, we see that a clear and consistent improvement method is in use and is demonstrable across all areas of the organisation. Commitment to the chosen methodology has resulted in a sustained and embedded culture of QI. **The key is not the choice of one methodology over another, but the commitment** to a coherent, systematic improvement methodology that is anchored in improvement science."
What are we trying to improve?	The key components of outstanding and financially sustainable Trusts • Open and quality focussed Culture • Leadership • Engagement with staff and patients • Good Governance • QI Methodology Build QI capability within the organisation
What will success look like?	• Provide targeted training for all staff (ward to Board) • Support the Board and Senior Management teams to understand the organisation's QI approach and its components and know how data is analysed in a QI context

	• Provide indepth training for identified QI Champions in the uses of the organisation's chosen methodology. • Greater number of staff trained in Quality Improvement methodology • Central repository of all QI projects to encourage spread of improvements where applicable Appointment of an improvement team Development of coaching and expertise Development of a North Mid Improvement Faculty Implementation plan Year 1- • Continue to use LiA to develop a culture of staff led change and introduce staff to simple techniques for testing change and measuring impact. • Use LiA to identify QI champions and coaches to support implementation of dosing approach. • Develop Business case and specification • Communication approach • Set up **Quality Improvement Guiding Board** • Procure QI Training Partner • Recruit QI faculty • Delivers development & training for Board and Senior Leaders • Provides intensive development & training for QI experts & coaches • Designs & delivers QI awareness programme for staff-August Year 2 onward – North Mid Improvement Faculty – Provides QI coaching & expertise to teams – Provides regular QI training & development sessions for staff
How will we monitor progress	Through the establishment of a Quality Improvement Guiding Board, as well as through the existing quality improvement structure.

Patient Experience

- Improve Patient Experience Outcomes through improved FFT results • Improve patient experience in the Emergency Department resulting in an improved performance in the Friends and Family Test (FFT) so it meets or exceeds the London Benchmark • Improved patient experience in Maternity resulting in an improved performance in the Friends and Family Test (FFT) so it meets or exceeds the London Benchmark • Improve patient experience in Outpatients resulting in an improved Friends and Family Test (FFT) which meets or exceeds the London benchmark • Improve the experience of inpatients using cancer services resulting in improved performance in the 2018 national cancer inpatient survey in comparison to the 2017

national survey results. •	
Why have we chosen this priority?	The rationale and measurement for this priority remains the same as in previous years. As the trust still aim to meet the London benchmark. Improving the experiences of care is a top priority area for the Trust. Our Patient Experience Strategy is being co-produced with Enfield Health watch and will use Always Events as a methodology to implement the strategy. "An Always Event is a clear, action-oriented, and pervasive practice or set of behaviours that: • Provides a foundation for partnering with patients and their families; • Ensures optimal patient experience and improved outcomes; and • Serves as a unifying force for all that demonstrates an ongoing commitment to person- and family-centred care. First trust in the country to co produce its patience experience strategy using always events methodology - over 200 patients participated in the survey. The revised patient experience strategy will be launched in Q2 2018/19. The National Patient Surveys are used to monitor our patients' experience of care and benchmark against other providers nationally. The Friends and Family Test (FFT) is used to capture patient feedback on their experiences of care, benchmark internally and inform our quality improvement plan. Inevitably, on occasion, the Trust will get things wrong and it is really important that when we do, our patients feel empowered to raise their concerns with us. Complaints and other patient feedback enable the Trust to identify where we need to improve so we can take action to put these matters right to ensure future patients do not suffer the same poor experience.
What are we trying to improve?	We want all our patients to have a positive experience of receiving care at North Middlesex Hospital. Consequently, we want to deliver improved patient experience as measured by the Friends and Family Tests. These simple tests demonstrate how our patients rate the care we provide and whether they would recommend North Middlesex Hospital to their friends or 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
What will success look like?	Improved performance in the patients' Friends and Family Tests, particularly in the Emergency Department, Outpatients and Maternity services so that 90% of our patients would recommend us to their friends or family by the year end. Improved performance in the 2017/18 national patient experience survey in comparison to our 2016/17 survey results. Improved performance in the 2017 national cancer in-patient

	survey in comparison to the results of the 2016 national survey. Implementation of the Patient Experience Strategy.
How will we monitor progress	The implementation of the Patient Experience Strategy is led by the Assistant 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 and Friends and Family Test results are formally reported to the Trust board. A Self-Assess workshop using the NHS Improvement Patient Experience Improvement Framework Assessment Tool,was held in March 2019 which brought together external stakeholders that included, commissioners, Health watch groups and Trust staff from all clinical divisions and was facilitated by a Senior Improvement Manager from NHS Improvement. The Action plan resulting from this piece of work will be implemented and monitored via the Patient Experience Committee The results of the national cancer in-patient survey will be monitored at the Trust Cancer Board, trust-wide patient experience and the cancer governance meeting.

Staff Experience

Improve Staff Experience through improved FFT results - .	
Why have we chosen this priority?	As outlined in the summary of results of the 2018 Staff Survey, the trust lowest scores were in the following 2 areas: Based on the results of this year's staff survey, the trust will prioritise and invest in initiatives to improve: a) Equality, diversity and inclusion **b)** Bullying and harassment
What are we trying to improve?	Improve staff satisfaction as measured by the annual staff survey 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, so that the Trust outperforms the average for London trusts.
What will success look like?	- increase in the percentage of staff believing that the Trust provides equal opportunities for career progression or promotion from Q3 - 100% application of the just culture framework for relevant incidents from Q2 - Introduction of First Step management/leadership skills programme based on collective/compassionate leadership - As part of the culture and leadership programme the Trust will be refreshing the values and introducing a set of leadership behaviours to inform a leadership development

	programme - Arrange focus groups to identify what staff are experiencing in terms of inappropriate behaviour - Continue to realise improvements through the LiA programme
How will we monitor progress	Through the monitoring of the action plan developed in response to the staff survey, reporting to the workforce committee monthly. Staff survey specific action plan will be incorporated in the Trust staff engagement action plan. This action plan will be monitored by the Staff and Patient Experience Committee quarterly. The monitoring of divisional action plans will be through the divisional performance meetings. Progress will be monitored through the Annual Staff Survey Improvement Programme which encompasses a number of work streams aimed at improving the staff experience across the Trust. Monitoring of progress made through the LiA programme

Statements of assurance from the board

1. During 2018/19 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 2017/18 represents 89.5% of the total income generated from the provision of relevant health services by the North Middlesex University Hospital NHS Trust for 2017/18.

2.
During 2018-19 134 National Clinical Audits (NCA) and 9 National Confidential Enquires (NCE) were issued (143 in total). Out of the 93 (section 1.1) applicable to the health services North Middlesex University Hospital provides 27 were deemed not appropriate for participation during 2018-19.

North Middlesex Hospital Trust participated in 61 (45.52%) National Clinical Audits and 7 (77.78%) National Confidential Enquiries which covered the relevant health services provided by the Trust (68 – 73.12%) in total section 1.2).

33 of the 68 reports are yet to be published
6 NCA's and 1 NCE are no longer applicable to be completed for North Middlesex University Hospitals

- Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit.
    - Response from IBD Registry: I'm afraid I have no record of 'North Middlesex University Hospital NHS Trust' submitting data to the Registry. We had correspondence with your site in 2017 regarding setting us up on the payment system at your Trust, but we did not receive a reply after the company details were sent.
- National Comparative Audit of Blood Transfusion programme - Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children
    - It was felt by the Hospital Transfusion Team (HTT) that we would have 0 – 2 requests over the proposed audit period and therefore it was agreed that NMUH would not participate as the numbers would be too small to provide meaningful data and it would be possible for us to received 100% poor performance from the possible single entry.
- National Comparative Audit of Blood Transfusion programme - Management of massive haemorrhage
    - The HTT agreed and signed up to participate in this audit. A Haematology Register agreed to lead and to complete the audit proformas. Disappointingly – dispute numerous prompts the work was not performed. As it turned out there was only one patient meeting the criteria within the audit period and this patient was transferred to another hospital, so the information was not part of NMUH, part ambulance and part Royal London Hospital.

- Medical and Surgical Clinical Outcome Review Programme - In-hospital management of out-of-hospital cardiac arrest
    - This audit does not apply to our acute Trust as we do not do any intermediate care work
- National Ophthalmology Audit (NOD) - Adult Cataract surgery
    - Project closes August 2019
    - Data not contributed to this audit round, data expected for next audit cycle
- National Audit of Intermediate Care (NAIC)

- The project has both a Commissioner level audit and a Provider level audit where organisational level metrics are collected. The Provider level audit also has a service user audit and a Patient Reported Experience Measure (PREM).
    - Not applicable to NMUH
- Child Health Clinical Outcome Review Programme -NCEPOD Long-term ventilation in children, young people and young adults
    - The Trust can confirm that we have no patients that meet the criteria and therefore will be withdrawing from this study.

Out of the 28 reports published within the reporting period all of the data required was collected within the reporting period (section 1.2) – 3 NCE and 25 NCA

- There has only been 1 report returned with a completed action plan in the reporting period
    - Falls and Fragility Fractures Audit programme (FFFAP) - Fracture Liaison Service Database
    -

There are currently 19 NCA's and 2 NCE which are classified as cause for concern as we have not received the actions from the recommendations from the leads

Within table 1.2 the numbers of cases submitted to each audit or enquiry are also included and this confirms that the trust submitted on average 77% of the number of registered cases required by the terms of the audit or enquiry.

During 2018-19 184 local audits were registered via Datix. 3 were recorded as abandoned and only 39 went through the full Clinical Audit cycle. On review the Trust will have a more robust Clinical Audit plan for the financial year which will;

- Meet the requirements for external monitoring
- Monitor the progress made in completing the yearly plan
- Monitor the quality of clinical audit activity
- Monitor the impact of the programme

The plan will be reviewed and monitored at the Trust's Clinical Effectiveness and Outcome Group, which is held monthly.

3. The number of patients receiving relevant health services provided or subcontracted by North Middlesex University Hospital NHS Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 520. This was across all our active specialties including

Oncology, Stroke & Cardiovascular, Obs & Gynae, Diabetes, HIV, Rheumatology and paediatrics, anaesthetics, hepatology and health services research.

4. A proportion of North Middlesex University Hospital's income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between North Middlesex University Hospital and any person or body they entered into contract, agreement or arrangement with for the provision of relevant health services, through the commissioning for quality and innovation payment framework.

The Trust agreed Cquin schemes for 2017/18 with local CCG's in December 2016 and these have been included in the contract. This is based on 2.5% of total contract financial value. 1.5 % of Contract value has been assigned to national schemes which there are 6 indicators consisting of 13 elements within these indicators.
0.5% of schemes value to support STP engagement – The Trust has been Meeting on a weekly basis with our local commissioners agree and identify STP activity changes going forward in 17/18.
0.5% value if Provider delivers it's agreed organisational control total.
There is a realisation that the Cquins have a collaborative approach with several health services needing to input to make these work. With this in mind commissioners are trying to facilitate working groups so these can be jointly achieved. Cquins are discussed regularly in 3 separate meetings as they overlap – STP/ Cquins / Contract technical.

Comment [EK2]: TBC

There are 4 indicators which have been agreed with NHSE – this equates to 2% of actual contract value and included in the signed contract at December 2016.

CQUIN Schemes	CQUIN Type	Q1	Q2	Q3	Q4
		Risk Rating	Risk Rating	Risk Rating	Risk Rating
Health and well-being	CCG	n\a	n\a	n\a	TBC
Reducing the impact of serious infection (sepsis - Antibiotics)	CCG				TBC
Improving mental health needs who present to A&E	CCG				TBC
Offering Advice and guidance	CCG				TBC
E-referrals	CCG				TBC
Supporting Proactive and safe discharge	CCG				TBC
Medicines Optimisation	NHSE				TBC
Adult intravenous Systemic Anti-Cancer Therapy (SACT)	NHSE				TBC

Automated exchange transfusion for Sickle Cell Care	NHSE				TBC
Improving haemoglobinopathy Pathways through ODN	NHSE				TBC

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 CQC has not taken enforcement action against North Middlesex University Hospital NHS Trust during 2018/19.

7. North Middlesex University Hospital NHS Trust has not participated in any special reviews or investigations by the CQC during 2018/19.

North Middlesex University Hospital last underwent a full, scheduled CQC inspection between 20th & 23rd May 2018 and 19 & 21 June 2018 inspecting the following:

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

This inspection was undertaken using the CQC inspection framework which assessed whether services are:

- Safe
- Effective
- Caring
- Responsive
- Well led

The chart below depicts the CQC ratings awarded to each service and the Trust overall. A copy of the full inspection report can be accessed via the CQC website – see https://www.cqc.org.uk/provider/RAP

Ratings for North Middlesex University Hospital NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement → ← Sept 2018	Good ↑ Sept 2018	Good → ← Sept 2018	Requires improvement → ← Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement → ← Sept 2018
Medical care (including older people's care)	Requires improvement → ← Sept 2018	Requires improvement → ← Sept 2018	Good ↑ Sept 2018	Requires improvement → ← Sept 2018	Requires improvement → ← Sept 2018	Requires improvement → ← Sept 2018
Surgery	Good ↑ Sept 2018	Good → ← Sept 2018	Good → ← Sept 2018	Requires improvement ↓ Sept 2018	Good → ← Sept 2018	Good → ← Sept 2018
Critical care	Requires improvement → ← Sept 2018	Good → ← Sept 2018	Good → ← Sept 2018	Good → ← Sept 2018	Good ↑ Sept 2018	Good ↑ Sept 2018
Maternity	Requires improvement Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018
Services for children and young people	Requires improvement ↓ Sept 2018	Good → ← Sept 2018	Good → ← Sept 2018	Good ↑ Sept 2018	Requires improvement → ← Sept 2018	Requires improvement → ← Sept 2018
End of life care	Requires improvement → ← Sept 2018	Requires improvement → ← Sept 2018	Good ↑ Sept 2018	Requires improvement → ← Sept 2018	Requires improvement → ← Sept 2018	Requires improvement → ← Sept 2018
Outpatients	Requires improvement Sept 2018	N/A	Good Sept 2018	Good Sept 2018	Requires improvement Sept 2018	Requires improvement Sept 2018
Overall*	Requires improvement → ← Sept 2018	Requires improvement → ← Sept 2018	Good ↑ Sept 2018	Requires improvement → ← Sept 2018	Requires improvement → ← Sept 2018	Requires improvement → ← Sept 2018

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

The next scheduled CQC inspection is in summer 2019.

8. North Middlesex University Hospital NHS Trust submitted records during 2018/19 (April 2018 to January 2019) 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:

NHS Numbers Percentages are

99.1% for admitted patient care
99.5% for outpatient care
95.1% for accident and emergency care.

General Medical Practice Codes was:

99.0% for admitted patient care;
98.6% for outpatient care; and
98.6% for accident and emergency care

9. North Middlesex University Hospital Information Governance Assessment Report overall score for 2018/19 was – standard not met

Comment [EK3]: Colour and percentage to be added

10. Not applicable for 2018/19.

11. North Middlesex University Hospital NHS Trust will be taking the following actions to improve data quality:

In the past year we have made significant progress in our trust-wide data quality improvement plan.

Some of the notable highlights were:

- Establishment of monthly Data Quality Improvement Group meetings to resolve and prioritise data quality measures. This includes members from the Data Quality team, Finance, Income, Costing, Information Governance, Performance and Information.

- A new Data Quality KPI dashboard has been developed to highlight outstanding data quality issues raised in the Data Quality Improvement Group meetings and from other stakeholders across the Trust aiming to provide assurance to the Trust that there is improvement and rigorous monitoring is in place. The dashboard contains a number of data quality indicators and as such we continue to prioritise work around these.

- A new 'Challenges/Claims' dashboard has been developed to monitor the trend patterns of Challenges that the Trust receives. This is being continuously monitored to ensure the data quality team identifies different areas of Challenges the Trust receives and design processes to reduce the number of Challenges.

- The data quality refresher training programme has been designed in an attempt to address data quality issues at source to ensure accuracy and validity of data.

- An internal audit (kite marking) process to provide assurance to the Trust about the quality levels of the data feeding the performance indicators was initiated. Furthermore, kite-marking audit for RTT was implemented which involved testing the reporting against agreed set of criteria recommended by the Audit Commission in each of the data quality categories (accurate, complete, valid, reliable, timely, and relevant).

- Performing data quality audits and liaising with the services to record all patient activity accurately to ensure income generation for the Trust is maintained.

For 2019-20, the plan is to continue to reduce the number of challenges received from CCGs to data quality as well as to focus on the Patient Demographic System

(PDS) Spine portal connectivity with the hospital patient administration system. This project will ensure that the Trust has the up-to-date demographic and GP details of the patients which will assist with improving data quality issues.

27. Learning from deaths

27.1 During 2018/19 TBC of North Middlesex University Hospital patients died. This comprised of the following number of deaths which occurred in each quarter of the reporting period:

223 in the first quarter,
251 in the second quarter,
278 in the third quarter,
299 in the fourth quarter.

Learning from death data – 2018/19 By the 3st March 2019:	Quarter 1 April 18 - June 18	Quarter 2 July 18 - Sept 18	Q3 TBC	Q4 TBC
Number of deaths in their care* (source: Datix and Qlikview)	**223**	251		
Number of deaths subject to case record review (desktop review of case notes using a structured method)	**118 (54%)**	219 (87%)		
Number of deaths classified as category A	**23**	97		
Number of deaths classified as category A that have had a case record review	**20 (87%)***	50 (52%)		
Number of deaths classified as category B	**40**	110		
Number of deaths classified as category B that have had a case record review	**13 (33%)**	110 (100%)		
Number of deaths investigated under the Serious Incident framework (and declared as serious incidents)	3 (1%) (web62683, web62850, web62173)	1		
Number of deaths that were reviewed/investigated and as a result considered more likely than not to be due to problems in care	1	2		
Number of deaths of people with learning disabilities	**1 (web62204)**	3		
Number of deaths of people with learning disabilities that have been reviewed	**1 (as above)**	2		
Number of deaths of people with learning disabilities considered more likely than not to be due to problems in care	**0**	0		

27.4 Learning from case record reviews and investigations outlined in the table below.
27.5 Actions taken outlined in the table below.

Lessons learned: Treatment escalation issue

End of life care:
Several reviews mentioned that the focus of care was upon reaching a diagnosis in patients where curative treatment was not realistic and perhaps an earlier recognition of the need of end of life planning and palliative care input may have been more appropriate. There was also the need to use 'individualised priorites for the end of life care (IPELC) earlier in a patient's care and use them as a way of documenting conversations with the patient and family. It was also noted that the patient should be spoken to on their own if they wished to ensure their wishes were not overridden by the family. There was also a reminder to use link workers to translate in these conversations rather than the family.

The number of patients who had a treatment escalation plan completed at the same time as a DNACPR decision had improved but there is still room for improvement. The discussions about ceilings of care should be held by the team looking after the patient rather than it being dealt with by on call doctors. In some reviews the family were surprised by the deterioration in their family member and this highlighted the need to keep families informed that death might be imminent.

Bowel obstruction
Three patients whose care was reviewed were elderly with many co-morbidities and developed bowel obstruction. The chance of survival in all three was low. Two patients elected to have surgery but died due to complications. One chose not to and died with palliative care input. These cases highlighted the difficulties in decision making in situations like this and the need to communicate the risks and benefits to the patient or family clearly. In some situations a second opinion form a surgical colleague may be indicated.

Treatment escalation plans
Lack of clear 'treatment escalation plans (TEP)' was a feature of several mortality reviews. This led to inappropriate referrals to critical care and lack of appropriate end of life care planning. There has been an improvement in the use of treatment escalation plan in place following the introduction of the combined formof the 'Do not resuscitate', TEP and mental capacity assessment form. The most recent audit showed an increase of patients with a TEP in combination with a DNACPR form from 23% to 78% following the introduction of the form. However all patients with a DNACPR form should have a TEP and so further work to ensure all staff are aware of this are underway. One initiative to improve this is that when the critical care outreach team (CCOT) review a patient after step down from critical care they ensure a TEP is in place.

End of life care
A common finding in mortality reviews was that a patient died in hospital while waiting for a hospice place or a package of care to support their death at home. There is a fast track process in place to try to ensure patients die in their preferred place. A fast track discharge co-ordinator has been recruited to the palliative care team and an increase in patients known to the palliative care team being discharged has been noted. A re-launch of the referral criteria for palliative care is taking place in March 2019 with an audit of referrals planned for April 2019

Ascitic drains
Delays in obtaining access to ascitic drainage were highlighted in reviews as being a concern. These did not contribute to the death of the patients but were identified as lapses

in care. The work to establish a 'planned treatment and investigation unit' will provide a pathway for these procedures to occur. A demand and capacity assessment is underway at present

Microbiology guidance
Two mortality reviews demonstrated a deviation from trust wide microbiology guidance for treatment of infection. In neither of these cases the deviation contributed to the death of the patient. Microbiology guidelines are available as part of a smartphone application called 'Microguide' which enables clinicians to check microbiology advice at the bedside of patients. The antibiotic stewardship programme is undertaking a variety of measures to ensure correct usage of antibiotics. This includes antibiotic stewardship rounds, 72 hour review of antibiotics and an increased focus on the use of antibiotics by the pharmacy team. The national sepsis CQUIN monitors progress in this area.

Next steps for 2019/20:

- Improve timeliness of completion of using the trust risk management system
- Continue to carry out weekly screening to maintain the number of deaths reviewed.
- Identify organisation wide learning to inform improvement work and to share
- Report potential serious incidents via incident reporting process
- Continue with the provision of SJR training programme scheduled
- Peer support for reviews

27.6 As a result of the actions taken in response to the learning from cases reviewed and investigated staff have been equipped to have open honest and supportive conversations with patients and their families.
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Part 3 Updates on Domains Actions To be updated

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 2018	October 2016 - September 2017	Value	**0.8363**	1.0000	N/A	N/A
		Banding	**3**	N/A	N/A	N/A
December 2017	July 2016 - June 2017	Value	**0.8241**	1.0000	N/A	N/A
		Banding	**3**	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 'lower than 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 in line with the trust's revised procedure for learning from deaths 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 2018	October 2016 - September 2017	Specialty coding	**0.0**	1.9	0.0	18.3
		Diagnosis coding	**25.0**	31.2	11.5	56.3
		Combined	**25.0**	31.5	11.5	59.8
December 2017	July 2016 - June 2017	Specialty coding	**0.0**	1.9	0.0	18.6
		Diagnosis coding	**28.9**	30.8	11.2	58.3
		Combined	**28.9**	31.1	11.2	58.6

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 have recruited a lead MacMillian Nurse
A service review was completed which resulted in the recruitment of an additional clinical nurse specialist.
Cancer services improvement plan in place to address data quality and patient experience challenges

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 2018 (provisional)	April 2016 - March 2017	EQ VAS	**2.205**	-0.241	-6.507	3.273
		EQ-5D Index	**0.082**	0.086	0.006	0.135
August 2017	April 2015 - March 2016	EQ VAS	**0.268**	-0.817	-4.644	4.966
		EQ-5D Index	**0.072**	0.088	0.021	0.157

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 both measures has improved between the reporting periods shown above, but performance against the EQ-5D Index remains slightly 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:

PROMS scores have been skewed by a very small number of patients. The trust have requested the raw data in order to hone down on the specifics of what and why; in order to make improvements and learn from this cohort of patients. Progression of this action is ongoing due to;

- potential Data Sharing issues and we may need this passed through the Caldicott Guardian, an
- PROMS have have advised there may be challenges in extrapolating the data due the complexity of the calculation

(iii) Hip replacement surgery

Publication Date	Reporting period	Measure	NMUH Value	National Average	National Lowest	National Highest
February 2018 (provisional)	April 2016 - March 2017	EQ VAS	**9.923**	13.434	8.523	20.150
		EQ-5D Index	**0.310**	0.445	0.310	0.537
		Oxford Hip Score	**16.427**	21.799	16.427	25.068
August 2017	April 2015 - March	EQ VAS	**8.170**	12.404	4.962	18.720

	2016	EQ-5D Index	**0.343**	0.438	0.320	0.524
		Oxford Hip Score	**17.200**	21.607	16.884	24.755

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 between the two reporting periods against the EQ VAS measure, but remained below the national average. The Trust's performance against the EQ-5D Index and Oxford Hip Score worsened between the two reporting periods, and was the lowest in the country in 2016-17.

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:

Data quality in respect of data pertaining to Knee and Hip replacements has improved significantly (approximately 100%). Improvements in compliance are due to a review and streamlining of the Hospital Coding Processes, data cleansing and validation of NJR data over the past 12 months (e.g. spurious data where post-op PROMS questionnaires being sent to patients yet to have surgery).

(iv) Knee replacement surgery

Publication Date	Reporting period	Measure	NMUH Value	National Average	National Lowest	National Highest
February 2018 (provisional)	April 2016 - March 2017	EQ VAS	**3.542**	6.977	1.008	14.502
		EQ-5D Index	**0.266**	0.324	0.242	0.404
		Oxford Knee Score	**13.552**	16.547	12.508	19.876
August 2017	April 2015 - March 2016	EQ VAS	**3.538**	6.222	1.631	12.628
		EQ-5D Index	**0.254**	0.320	0.198	0.398
		Oxford Knee Score	**13.746**	16.365	11.955	19.970

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 the EQ VAS and IQ-5D Index measures between reporting periods, while the Trust's performance against the Oxford Knee Score measure worsened. The Trust's performance against all three measures remained 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:

Data quality in respect of data pertaining to Knee and Hip replacements has improved significantly (approximately 100%). Improvements in compliance are due to a review and streamlining of the Hospital Coding Processes, data cleansing and validation of NJR data over the past 12 months (e.g. spurious data where post-op PROMS questionnaires being sent to patients yet to have surgery).

Patients readmitted to a hospital within 28 days of being discharged.

Please note that this indicator was last updated in December 2013 and future releases have been temporarily suspended pending a methodology review.

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 2017	2016-17	**63.6**	68.1	60.0	85.2
August 2017	2014-15	**59.3**	68.9	59.1	86.1

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's performance improved over the previous reporting period against this measure, but it has historically been 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:

Ensuring that the trust's focus at all levels within the organisation remains firmly centred on improving patient experience - an aim that features very heavily as a key theme throughout this report. The hospital is always looking at new and innovative ways to collect and understand patients and carers views on how 'user friendly' and professional we are. These methodologies include hand held units for electronic questionnaires, text messaging, and use of the internet. An ambitious programme to widen these initiatives is ongoing.

Staff who would recommend the trust to their family or friends

Publication Date	Reporting period	NMUH Value	National Average	National Lowest	National Highest
February 2019	2018				
February 2018	2017	**54%**	69%	47%	89%
February 2017	2016	**51%**	69%	49%	85%

Comment [EK4]: Awaiting performa

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 slightly over the previous reporting period against this measure, but it has historically been 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:

Ensuring that staff feel valued and supported at all levels of the organisation through a programme of workforce related initiatives such as the implementation of a robust action plan in response to the trust's 2017 staff survey which will focus on; assuring equal opportunities for career progression and promotion; raising awareness of the trust's 'zero tolerance' approach to violence in the workplace; raising awareness of and confidence in the effectiveness of the trust's incident reporting procedures; ensuring staff know how to report malpractice and wrong-doing and feel safe in doing so. The trust will build upon the work recently carried out as part of the cultural diagnostic exercise, and continue to recognise and reward excellent performance and patient care.

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
May-18	Q4 2017-18	**tbc**	tbc	tbc	tbc
Feb-18	Q3 2017-18	**63%**	86%	63%	99%
Nov-17	Q2 2017-18	**51%**	87%	51%	99%
Aug-17	Q1 2017-18	**47%**	87%	47%	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 has improved against this measure during 2017-18, but has remained worse 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 improvement on the Friends and Family test continues to be a priority for the Trust in 2018-19 as referenced earlier in this report. The aim is for North Middlesex to be fully cemented as the local hospital of choice with patients having good faith in the both the quality and safety of services that we provide.

Inpatients

Publication Date	Reporting period	NMUH Value	National Average	National Lowest	National Highest
May-18	Q4 2017-18	**tbc**	tbc	tbc	tbc
Feb-18	Q3 2017-18	**93%**	96%	71%	100%
Nov-17	Q2 2017-18	**95%**	96%	76%	99%

Aug-17	Q1 2017-18	**96%**	96%	78%	100%

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 2017-18 has fallen slightly, but continues to show a positive inpatient experience, albeit slightly 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:

Ensuring that improvement on the Friends and Family test continues to be a priority for the Trust in 2018-19 as referenced earlier in this report. The aim is for North Middlesex to be fully cemented as the local hospital of choice with patients having good faith in the both the quality and safety of services that we provide.

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
June 2018	Q4 2017-18	**tbc**	tbc	tbc	tbc
March 2018	Q3 2017-18	**95.1%**	95.3%	76.1%	100.0%
December 2017	Q2 2017-18	**95.4%**	95.2%	71.9%	100.0%
September 2017	Q1 2017-18	**95.4%**	95.1%	51.4%	100.0%

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 has consistently achieved the 95% standard against this metric, and has been above or close to the national average throughout 2017-18.

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:

The trust have standardised the reporting process in order to capture VTE incidents
The trust have recruited a VTE clinical nurse specialist
Monthly audits are now in place to align VTE data with the safety thermometer
VTE guidelines to be updated with 2018/19 NICE guidance

Rate of C.difficile infection

Publication Date	Reporting period	NMUH Value	National Average	National Lowest	National Highest
July 2017	2016-17	**18.7**	13.2	0.0	82.7
July 2017	2015-16	**22.2**	14.9	0.0	67.2

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 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 2016-17.

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 the Trust continues to have zero tolerance in respect of avoidable hospital-acquired infections. Current actions include root cause analysis being carried out following all incidences and lessons learned from any avoidable outcomes. Screening programmes are routine throughout the Trust and hand hygiene audits take place on a monthly basis across all patient-facing areas and are measured against a strict compliance threshold.

Patient safety incidents and the percentage that resulted in severe harm or death

April 2017 – March 2018

Publication Date	Reporting period	Measure	NMUH Value	National Average	National Lowest	National Highest
***	April 2017 – September 2017	Number of Patient Safety Incidents	**4,064**	5,122	1,301	14,506
		Rate of incidents (per 1000 bed days)	**45.3**	41.1	23.1	69.0
		No. resulting in severe harm or death	**16**	19	1	92
		% resulting in severe harm or death	**0.4%**	0.4%	0.0%	2.1%
September 2018	October 2017 - March 2018	Number of Patient Safety Incidents	**2546**	4,955	1485	19,897
		Rate of incidents (per 1000 bed days)	**26.69**	40.8	21.1	58.39
		No. resulting in severe harm or death	**5**	19	1	51
		% resulting in severe harm or death	**0.2%**	0.4%	0.0%	0.3%

The trust has implemented a number of mediums for sharing learning through learning events and a regular patient safety newsletter in a timelier manner. As highlighted earlier in this report learning from incidents and reducing harm remains a top priority for the organisation. Initiatives such as the roll out of human factors training across the organisation should support improvements in the way staff and teams perform their roles thus impacting and improving patient safety and experience.

Annex 1: Statements from Commissioners, local Healthwatch organisation

Statement from Haringey Clinical Commissioning Group

Statement from Haringey Healthwatch

Annex 2
Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.
NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:
• the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance

• the content of the Quality Report is not inconsistent with internal and external sources of information including:

- o board minutes and papers for the period April 2018 to 08 May 2019
- o papers relating to quality reported to the board over the period April 2018 to 08 March 2018
- o feedback from commissioners dated **
- o feedback from local Healthwatch organisations dated **
- o the 2018 national patient survey ***2019
- o the 2018 national staff survey February 2019
- o the Head of Internal Audit's annual opinion of the trust's control environment dated ***
- o CQC inspection report dated September 2018

• the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered

• the performance information reported in the Quality Report is reliable and accurate

• there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

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

• the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality

Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board:

18/06/2018 Date.....Chairman
18/06/2018 Date.....Chief Executive

Appendix 1 – National Clinical Audits and National Confidential Enquiries

See page **.

Appendix 2

The reports of 45 local clinical audits were reviewed by the provider in 2017/18 and North Middlesex University Hospital NHS Trust intends to take the following actions to improve the quality of healthcare provided as detailed in table 1 below.