Annual Report and Quality Account 2023-24

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Our values

Contents

Part 4 - Quality account

This section presents the Quality Account for 2023-24. The Quality Account is a report about the quality of services offered by NHS healthcare provider published annually. The quality of the services is measured by reviewing patient safety, the effectiveness of treatments that patients receive and patient feedback. This report is accessible to patients, carers, professionals and the public. It details the Trust's commitment to quality through the standard of services we provide. It is important for the Trust to be able to share the improvements made to the services we deliver to local communities and stakeholders.

How Quality is Embedded

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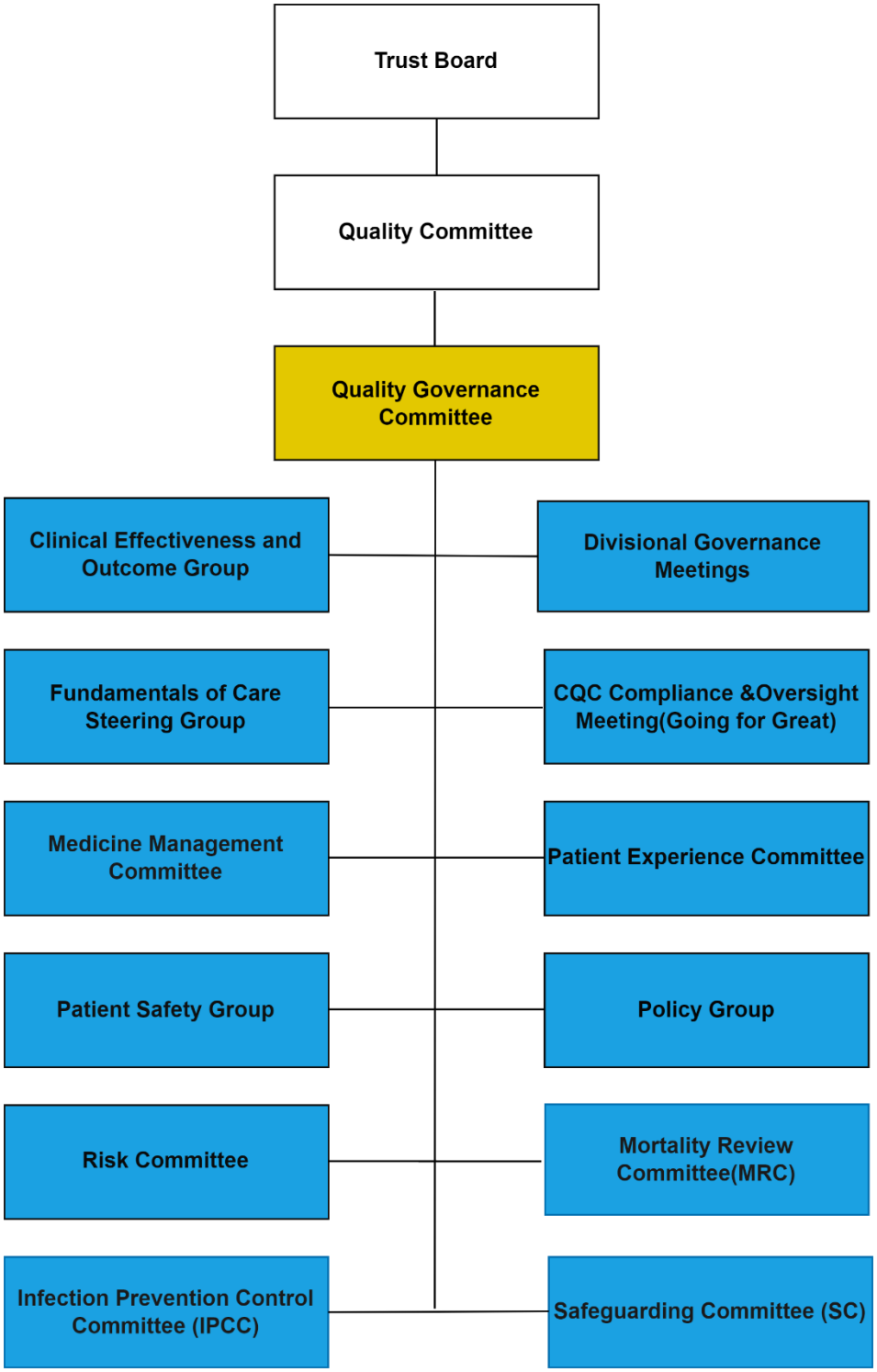
The Quality Governance Committee is the trust-wide operational committee with oversight for all aspects of quality. The four divisions; "Medicine and Urgent Care", "Surgery, Anaesthetics, Critical Care and Associated Services", "Women's, Children's, Cancer and Diagnostics", and Community Services, as well as Trust-wide quality governance teams collaboratively review and progress all aspects of quality governance through this committee.

Figure 1 shows the reporting structure through to the Trust Board filtering back down to ward-level quality outcomes. This is in-line with previous years 2023-24 structure.

Figure 1 – Quality Governance Reporting Structure



A new work plan was put in place for the following committees (MRC,IPCC and SC) to report into QGC in Quarter 1 2024

Care Quality Commission (CQC)

The North Mid is required to be registered with the CQC and is currently registered for the following regulated activities:

- Maternity and midwifery services
- Family planning services
- Termination of pregnancies
- Treatment of disease, disorder, or injury
- Assessment of medical treatment for persons detained under the 1983 Mental Health Act
- Surgical procedures
- Diagnostic and screening procedures

CQC Compliance and Oversight Meeting (Going for Great)

The Trust is committed to ensuring quality standards for its service users are consistently delivered. During Q3 2023/24 the Trust reviewed the remit, aims, deliverables and goals of the CQC Compliance and Oversight Meeting (Going for Great). As a result, the project charter is now clearly defined and, aligned with the objectives of the Patient First strategy. Underpinning the programme of works for Going for Great is the continual development of a robust assurance framework which aims to work alongside divisions to achieving its vision.

The Trust continues to develop an awareness of regulatory standards as the golden thread that connects patient care to good quality outcomes. Such activities will ensure divisional teams are being supported in evaluating their services within a standardised framework. This initiative aims to empower teams to maximise their potential in striving towards an outstanding CQC rating.

Inspections

The overall rating for the Trust has remained as 'Requiring improvement' since 2019 following completion of the last full inspection dated September and December 2023. A copy of the full inspection report published on 28 March 2024 can be access via the CQC's website – see www.cqc.org.uk/location/RAPNM.

The table below presents the Trust's overall rating from the most recent well-led inspection conducted in September and December 2023, as published on 28 March 2024. Additionally, it includes the final reports for CQC inspections and ratings for specific services published between 2018 and 2024.

Table 32 - Over-all Trust CQC Inspection and Rating

	Safe	Effective	Caring	Responsive	Well-led	Overall
Over-all Trust	Required Improvement	Required Improvement	Good	Required Improvement	Required Improvement	**Required Improvement Mar 2024**

CQC Inspection and Rating of Specific Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical Care (Including Older People's care)	Required Improvement	Good	Good	Required Improvement	Required Improvement	**Required Improvement Mar 2024**

Service for Children & Young People	Required Improvement	Good	Good	Good	Required Improvement	**Required Improvement Oct 2019**
Critical Care	Required Improvement	Good	Good	Good	Good	**Good- Sept 2018**
End of life Care	Required Improvement	Required Improvement	Good	Required Improvement	Required Improvement	**Required Improvement Sept 2018**
Maternity	Inadequate	Good	Good	Good	Inadequate	**Inadequate Dec 2023**
Outpatient	Required Improvement	Not Rated	Good	Good	Required Improvement	**Required Improvement Sept 2018**
Surgery	Good	Good	Good	Required Improvement	Good	**Good Sept 2018**
Urgent and Emergency Care	Required Improvement	Good	Good	Good	Good	**Good Oct 2019**

The CQC did not take enforcement action against the Trust during the last financial year.

In 2023, the CQC introduced the Single Assessment Framework (SAF), facilitating continual service updates for providers through the new single assessment framework. This approach aims to expedite improvements in ratings, emphasising the five key questions and quality statements as central components of the regulatory approach, guiding providers, commissioners, and system leaders in delivering high-quality, person-centered care.

In addition, most inspections will now focus on individual specialties as opposed to looking at a core service; as a result of this approach not all CQC inspections will impact on a Trust's overall rating.

In May 2023, the North Mid received an unannounced inspection of its maternity services as part of the national maternity inspection programme. This programme seeks to provide a current assessment of hospital maternity care nationwide and aid the CQC in comprehending successful practices for fostering learning and improvement at both local and national levels. The final report for maternity services was received in December 2023. The CQC rated safety and well-led aspects as 'inadequate', resulting in an overall rating of 'inadequate' for maternity services.

The Trust commissioned the NHS England Maternity Improvement team for a diagnostic assessment following the 'inadequate' rating from the CQC. Identified improvements prompted discussions with NHS England, the CQC and Healthcare Safety Investigation Branch (HSIB) now known as Maternity and Newborn Safety Investigation (MNSI), leading to consideration of joining the Maternity Safety Support Programme.

In September and December 2023, the North Mid received planned inspections that concentrated on the specific subject areas of Trust wide well-led and medical care services. The final report, published on 28 March 2024, rated the medical care services as 'Requires Improvement'. This rating pertained to safety, responsiveness, and well-led categories, while effectiveness and caring were rated as 'Good'.

The North Mid was inspected based on all available information regarding the Trust, including trends of improvement and or deterioration. The overall rating of the Trust has not changed following the CQC inspection in September and December 2023, and the Trust rating remained as 'Required Improvement.'

The CQC identified several areas of good practice across the Trust:

- Leaders were committed and had an appropriate range of skills and experience to lead the and its services.
- The Trust was grounded and connected to the local community.
- Leaders and staff were passionate and committed to delivering high quality patient care.
- The Trust had effective structures, systems and processes in place to support the delivery of its strategy including board sub committees, divisional committees, team meetings and senior management meetings.
- The Trust collected reliable data and analysed it.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.
- The Trust has active staff networks which included, LGBT+, Ethnicity, Multi-Faith & Belief, and the Women's Network.

The inspection also noted a number of areas of focus that require improvement:

- The Trust must ensure that services where there is a poor culture are identified and offered appropriate support to bring sustained improvement.
- The Trust must ensure that staff in leadership roles have access to leadership development in a timely manner, particularly to ensure their people management skills are in place.
- The Trust must ensure that HR processes particularly in relation to performance are completed in a timely manner.
- The Trust must ensure that learning and improvements take place in a timely manner by ensuring the investigations into complaints, incidents and mortality are concluded within stated timescales.
- The Trust should continue its work to ensure staff are trained in quality improvement approaches so they can embed the Patient First strategy in their services.
- The Trust should ensure that all medicines are stored at the recommended temperature and managed in line with the provider's policy.

Following the CQC specialised maternity and medical care service inspection, as well as the Trust well-led inspection in 2023/2024, the Trust has implemented robust monitoring mechanisms to oversee the execution of the action plans. These plans are monitored weekly at the divisional level and reported monthly to the CQC Compliance and Oversight Meeting (Going for Great), which subsequently feeds into the Quality Committee meeting and the Trust Board.

Quality Performance

Data pertaining to quality performance in line with the standard operating framework can be found in Section 2.6 - Operational Performance in Part 2.

Digital Strategy

North Mid prides itself on being ambitious, inclusive and forward-thinking. As part of the Trust's Patient First strategy, the #DigitalNorthMid team endeavours to challenge digital boundaries and position the hospital as digital thought leaders.

#DigitalNorthMid

Outlined in Section 2.3 – Outstanding Care of Part 2, are details of how the Trust has achieved Healthcare Information and Management Systems Society (HIMSS) Electronic Medical Record Adoption Model (EMRAM) Stage 5 accreditation, going from fourth from bottom out of 232 Trusts for Digital Maturity to being within the top 19% of digitally most-mature Trusts. Section 2.3 also outlines how the Trust has completed its three-year Global Digital Exemplar programme which has delivered quality, safety and efficiency benefits.

Achievement of HIMMS EMRAM Stage 5 accreditation has set the foundations for the next phase of the Trust's digital development, which includes empowering patients to manage their own appointments, accessing their hospital records online, and making greater use of hospital and population health data to address health inequalities and improve care.

All of this has set the foundations for the next phase of the Trust's digital development, which includes empowering patients to manage their own appointments and access their hospital records online and making greater use of hospital and population health data to address health inequalities and improve care.

Empowering our patients and staff

In the last year we have made really good progress on the "People" pillar of the Digital strategy, supporting digital inclusion for staff and patients:

- For staff, we have introduced a new digital learning platform to complement our mandatory and statutory training platform, it includes a digital gap-analysis / self-assessment which points colleagues to the right online courses.

- For our patients we have introduced self-check-in and have begun the rollout of our Zesty portal app which will allow patients to book, re-book and manage their own appointments.

Case Study – Electronic Vitals and Observations

We have been using e-vitals in our inpatient wards for almost three years and more recently going live in our ED. Instant benefits for our patients and staff include:

- Clinical Oversight – providing a global view for teams of patients' observations, making it easier to spot, monitor, and treat the people who are most unwell.

- Safety Culture – door to door monitoring; observations from arrival in the ED, through ward stay, to discharge meaning we can better support flow by helping our patients as they move along their care pathway.

- Digital Transformation – bringing the ED in line with systems used at other EDs across London and continuing the Trust's evolution in unifying its electronic patient record.

Improving our efficiency through Digital

Single sign-on has changed the way our teams access clinical systems at the North Mid. This innovative piece of technology is exactly what it says on the tin – staff no longer need to repeatedly type usernames and password to access the computers and applications we use on a daily basis to deliver care. Since introducing the system:

- 92% of our most commonly used clinical systems are available through single sign-on.
- 1,800 staff currently use it.
- 45,000 successful sign-Ons every seven days.
- Over 12 million single sign-on events since we introduced it last year.

North Mid in the Community – Digital Integration

During 2023-24, along with the rest of the Trust, IT and Digital welcomed our new North Mid in the Community colleagues. Integrating Enfield Community Services is a complex task including many digital workstreams such as migrating the RIO community electronic patient record system, buying new kit and infrastructure (laptops, PCs, network and telephony) for all the community sites and welcoming our 600 new members of staff ensuring that we provide them with fast and effective IT and Systems support.

Freedom of Information (FOI) Compliance

Details of the Trust's compliance with the FOI Act is set out in Section 3.2 – Annual Governance Statement in Part 3.

Infection Prevention and Control

Clostridium Difficile Infection (CDI)

The Trust reported 24 cases of hospital onset healthcare associated (HOHA) CDI cases in 2023-24. Whilst this is just above the set objective for the financial year (23), it is below the 29 cases reported the previous year. All CDI cases received a post infection review where good practice and lessons learnt can be identified. The good practice and lessons learnt are then cascaded back to the relevant clinical teams.

Methicillin Resistant Staphylococcus Aureus (MRSA)

The national objective for all NHS Trusts in England from 2013 was to have zero avoidable MRSA bloodstream infections. In 2023-24 there were no cases of MRSA bloodstream infections reported by the Trust. All cases deemed hospital acquired undergo a clinical review process and are discussed in a multi-disciplinary team meeting where learning and preventable actions, if any, are identified.

Covid-19 operational challenges and response

Covid-19 has continued to be a challenge and throughout 2023-24 the Trust entered the third year of the pandemic with proportionally high numbers of Covid-19 cases in both patients and staff that continued to decline throughout the year. During the Covid-19 pandemic there have been many changes in national guidance both in hospitals and in the community. NMUH continued to comply with national guidance and made changes as required and monitoring cases closely. The emergence of the new Covid-19 variants resulted in some wards being closed due to outbreaks and high numbers of staff with Covid-19 related absences. The Omicron variant remained dominant throughout 2023-24. The Trust continued to implement robust infection control measures to combat the spread of Covid-19 and to support patient flow through the hospital. The Infection Prevention and Control (IPC) team continued to provide crucial on-going specialist advice, guidance and supporting the updated Covid-19 response: living with Covid-19 document. In addition, NHS trusts were advised to follow the National Infection Prevention and Control manual (NIPCM) which NMUH adopted too.

In addition to outbreak meetings, the infection prevention and control team re-introduced daily Covid-19 operational meetings to:

support the site managers with flow and to reduce the risk of further onward transmission.

ensure continuity the daily meetings continued at weekends and involved the tracking of all patients identified as contacts.

ensure patients identified as contacts were managed appropriate, if they became positive then rapid isolation and reduced the risk of onward transmission.

North Mid reported low numbers of hospital onset Covid-19 cases compared to similar Trusts across London (UK Health Security Agency data), due to early identification of patient contacts, daily screening and appropriate isolation management. In addition to supporting with Covid-19, the infection prevention and control team maintained the wider healthcare associated infection agenda in accordance with the Health and Social Care Act (2008) ‘The Hygiene Code’.

4.1 Looking Back: Our Quality Priorities 2023-24

Patient First

Patient First forms the bedrock to achieving the Trust's Quality Priorities ensuring the continuous focus of the Trust's strategic goals within the three statutory domains of quality:

- Patient Safety
- Clinical Effectiveness
- Patient Experience

Details of the Patient First strategy is set out in Part 1.

2023 saw incredible accomplishments and advancements in how the Trust is accountable, across all levels, for delivering the Trust's strategy. The Trust continued to mature the Patient First Management System and our Strategic Deployment Reviews (SDRs). The executive directors, along with the clinical divisions and corporate teams, used scorecards in these reviews to monitor delivery of key improvements aimed at achieving our True North. SDRs provide accountability for performance by leaders and teams across organisation.

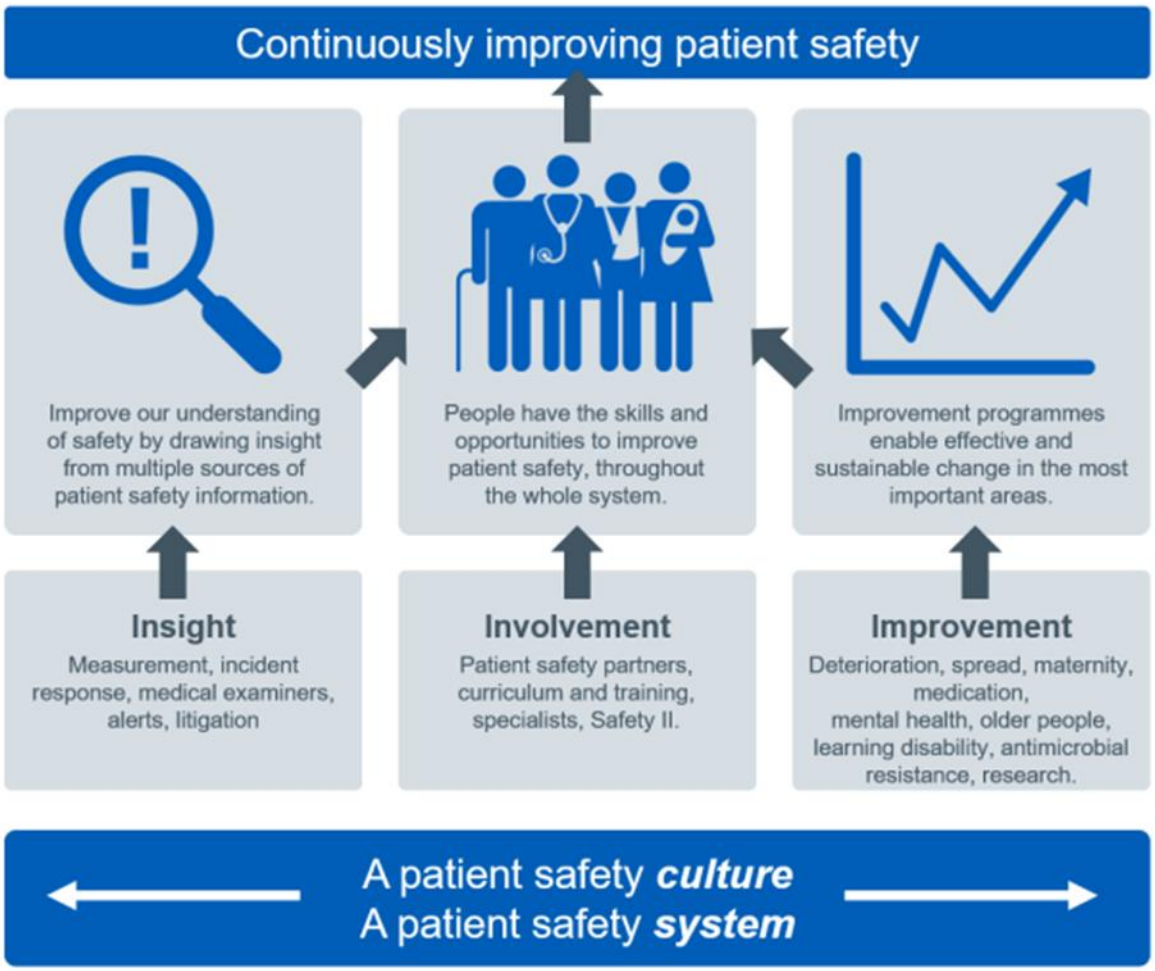
Patient Safety

NHS Patient Safety Strategy

Quality Account – Patient Safety Incident Response Framework
In 2019 NHS England published the National Patient Safety Strategy (NPSS). The strategy set out a safety vision for the NHS:

"…**to continuously improve patient safety.** To do this the NHS will build on two foundations: **a patient safety culture** and a **patient safety system**."

Figure 1. Summary of the NPSS



Patient Safety Incident Response Framework

The **Patient Safety Incident Response Framework (PSIRF)** forms a key component of delivering the 2019 National Patient Safety Strategy. PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients. The PSIRF replaces the Serious Incident Framework (SIF) (2015) and makes no distinction between 'patient safety incidents' and 'Serious Incidents'. As such it removes the 'Serious Incidents' classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

Defining our patient safety incident profile

Safety and governance are embedded within the Trust through the corporate and divisional structures. The Chief Executive is supported by the Medical Director and Chief Nurse and Midwifery Officer, supported by their deputies, the Quality Governance team and Patient Safety Specialist.

The Quality Governance and divisional governance teams are responsible for overseeing the management of risks, and the processes for managing incidents and investigations are described in detail in the PSIRF Policy and the trust incident management policy.

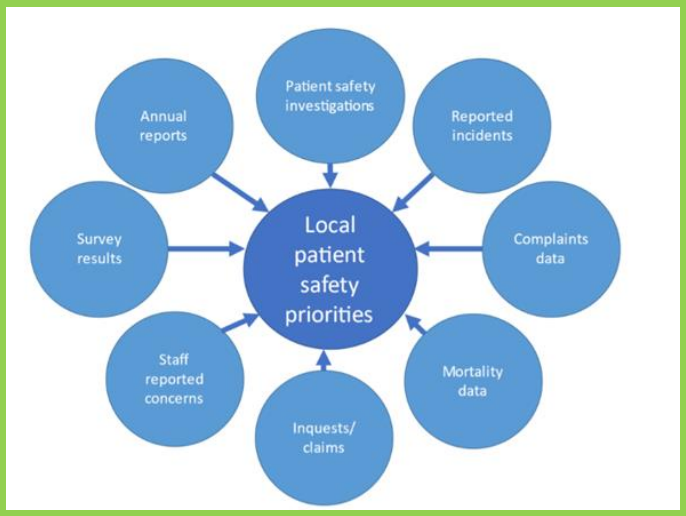
The Trust has a continuous commitment to learning from patient safety incidents and we have developed our understanding and insights into patient safety matters over a number of years. We have the trust Quality Governance Committee and board committee - Quality Committee meetings who have oversight of the Trust's patient safety improvement activity.

PSIRF sets no rules or thresholds to determine what needs to be learned from to inform improvement, apart from where a national requirement has been stipulated. To fully implement the Framework the Trust completed a review of all patient safety incidents to understand and prioritise areas that the organisation needs to learn from to improve.

Engagement with key stakeholders was undertaken alongside a review of data from various sources resulting in the development of the Trust's safety profile. This process has also involved identification and specification of the methods used to maximise learning and improvement. This has led to the development of the local focus for our patient safety incident responses.

Data Sources: Identification of patient safety issues

PSIRF provides us with the freedom to focus our resources on patient safety incidents, or groups of incidents, that provide the greatest opportunities for learning and improving safety for our patients and system. Implementation of newer learning response types will enable safety processes to become more efficient and existing resources used more effectively. The Patient Safety Incident Response Plan (PSIRP) is based on a thorough analysis of safety themes and trends across several key data points and discussions with staff, patients and stakeholders. Intelligence reviewed includes:



In addition, the following were also reviewed:

- Risks
- Feedback from staff and patients.
- Freedom to Speak up reports
- Thematic reviews e.g. Absconding
- This has led us to identify priorities for our learning responses, enabling us to use our investigation resource in the way the organisation deems best.

The priorities identified in the PSIRP will be regularly reviewed against quality governance reports and surveillance to ensure they are responsive to unforeseen or emerging risks.

Following a thematic analysis of both hard and soft intelligence, key patient safety priorities have been identified. The choice of these patient safety events has been driven mainly by a) risks to safety and b) the greatest potential for our organisation to currently achieve the most learning, to inform service and quality improvement in these areas.

These patient safety events have been identified as:

- Deteriorating Patients
- Delay / Failure to act on results
- Cancer patients - missed diagnosis and lost to follow up
- Inappropriate transfer or discharge leading to an adverse effect on the patient.
- Any maternity/paediatric incident with substantial potential for learning and improvement outside of those identified as national priorities

The criteria for consideration for other patient safety events for a more resource intense patient safety incident investigation (PSII) response are:

Table 33 - Criteria for other Patient Safety Events for consideration of a PSII response

Criteria	Considerations
Potential for learning and improvement	• Increased knowledge: potential to generate new information, novel insights, or bridge a gap in current understanding • Likelihood of influencing: healthcare systems, professional practice, safety culture. • Feasibility: practicality of conducting an appropriately rigorous PSII • Value: extent of overlap with other improvement work[2]; adequacy of past actions
Systemic risk	• Complexity of interactions between different parts of the healthcare system

The Trust PSIRF policy and plan were ratified at trust board on 28th March 2024. The Trust has transitioned to PSIRF in quarter 1 of 2024-25.

Training

During 2023-24 staff have undertaken key patient safety and PSIRF training as below:

Table 34 - National Patient Safety Syllabus

Level	Title	Duration (Approx)	Who
1	Essentials of patient safety	30 minutes	• All Staff
1	Essentials of patient safety for boards and senior leadership	30 minutes	• Board • Senior Leadership

2	Access to practice	45 minutes	• Learning Response and Engagement Leads • Senior Leadership with Patient Safety remit/portfolio • Teams with Patient Safety, Patient Experience and Quality Improvement remit/portfolio

PSIRF Training

The roll out of PSIRF training commenced in 2023-24. A core cohort of staff have initially been trained to enable an effective transition to the new framework. Staff trained to date represent quality governance, improvement, clinical division, other corporate teams, the non-executive chair of the Quality Committee, the medical director and the chief nurse and midwifery officer.

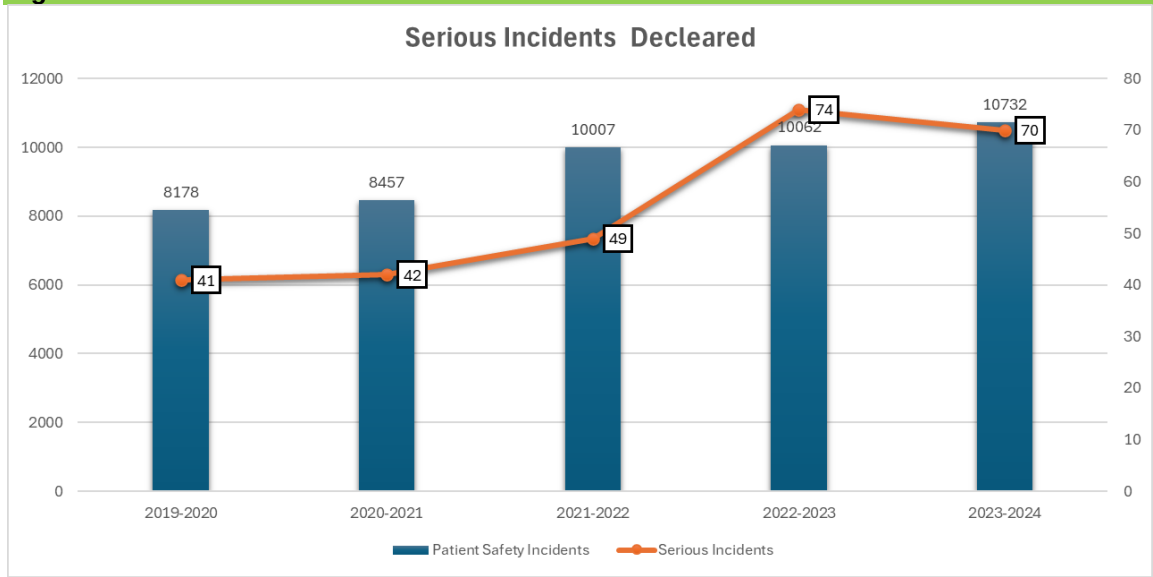
Systems approach to learning from patient safety incidents training for health and social care providers, commissioners, and executives		
LOT 4a	LOT 4b	LOT 4c
Systems approach to learning from patient safety incidents	Systems approach to learning from patient safety incidents oversight training	Engaging with patients, families, and staff following a patient safety incident training
2-day/12 hours (minimum duration)	1-day/6 hours (minimum duration)	1-day/6 hours (minimum duration)
For: • **All learning response leads (Band 8a and above, medical staff with quality governance remit)** • **All those in PSIRF oversight roles (see Lot 4b)**	For: All those in PSIRF oversight roles – Quality Governance, Senior Leadership, non-executive director for quality, medical director, chief Nurse	For: • All engagement leads (Band 8a and above, medical staff with quality governance remit) • All those in PSIRF oversight roles (see Lot 4b)
Training to support the development of core understanding and application of systems-based patient safety incident response throughout the healthcare system - in line with NHS guidance, based upon national and internationally recognised good practice.	Training to support the development of expert understanding and oversight of systems-based patient safety incident response throughout the healthcare system - in line with NHS guidance, based upon national and internationally recognised good practice.	Training to support the development of expertise in engaging and involving patients, families, carers and staff affected by patient safety incidents, in line with NHS guidance, based upon national and internationally recognised good practice. To include the duty of candour, and 'Engagement' principles

Serious Incidents (SIs) and Never Events

The Governance Review Panel (GRP) chaired by the Deputy Chief Nurse - Quality Governance, meets weekly to monitor and review new incidents including serious incident investigation reports as defined within the NHS England's Serious Incident Framework (March 2015). In addition, actions are monitored and reviewed by the panel to ensure adequate assurance on preventing reoccurrence of similar incidents in the future.

During 2023-24, there were seventy (70) serious incidents reported on the Strategic Executive Information System (StEIS). All serious incidents are reported to Integrated Care Board (ICB) via the StEIS and a lead investigator is assigned by the relevant division. All serious incidents are uploaded to the national reporting and learning system.

Figure 2:SIs declared



Lessons learned following each investigation were shared with staff through various methods including the '7-minutes learnings', Teams meets, huddles, Patient Safety Group (PSG), 'message of the week 'and hot topics by Maternity. Learning from incidents is shared through trust-wide quality governance intranet page.

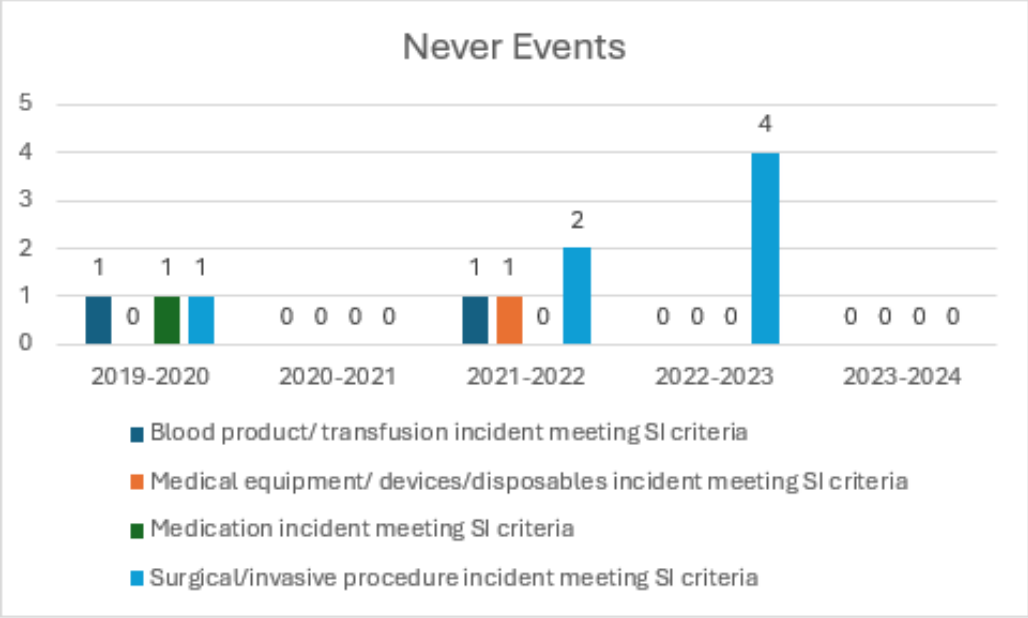
Never Events

Never events are defined as:

> 'Serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.'

In 2023/24, the NHS reported a total of 370 serious incidents appeared to meet the definition of a Never Event in the Never Event list 2018 (published 28 February 2018) as indicated in the provisional publication of Never Event s reported occurring 01 April 2023 to 31 March 2024 (published on 9 May 2024).

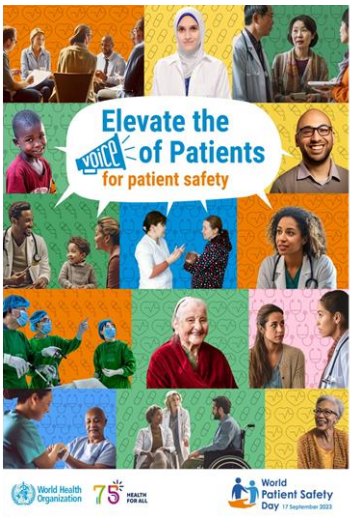
The graph below shows that during 2023-24, no incident met the Never Event criteria. This indicates that by working together, healthcare professionals, patients, and the Trust as a whole continue to work to improve patient safety, reducing the incidence of Never Events and ensuring that patients receive the best possible care and support.


Never Events
5
4
3
2
1
0
1 0 1 1
0 0 0 0
1 1 0 2
0 0 0 4
0 0 0 0
2019-2020
2020-2021
2021-2022
2022-2023
2023-2024
Blood product/ transfusion incident meeting SI criteria
Medical equipment/ devices/disposables incident meeting SI criteria
Medication incident meeting SI criteria
Surgical/invasive procedure incident meeting SI criteria

Learning Event

In September 2023, in celebrating World Patient Safety Day, a joint event was held with the quality governance, patient experience team and the patient safety specialist. The theme was ‘Engaging Patients for Patient Safety – Elevating the Patient voice’. The event included a stall in the atrium, inviting feedback and ideas from patients, families, staff and carers on treatment as well as improvement work and co-design. Our volunteers played a significant role in assisting with this learning event which we value.

The Microsoft Teams (MS) team learning event included presentations from the divisions, information on the National Patient Safety Strategy and Introduction of Patient safety incident framework. This event highlighted the importance of engaging patients to help us as a Trust to shape and improve the services.



Healthcare Safety Investigation Branch Maternity, now the Maternity and Newborn Safety Investigations Special Health Authority (MNSI)

The Healthcare Safety Investigation Branch (HSIB) maternity investigation programme is part of a national action plan to make maternity care safer. HSIB undertakes approximately 1,000 independent maternity safety investigations a year to identify common themes and influence systemic change. All NHS Trusts with maternity services in England refer incidents to HSIB. In October 2023 HSIB transformed into two bodies: MNSI and the Health Services Safety Investigations Body (HSSIB). The name of the new organisation is the Maternity and Newborn Safety Investigations Special Health Authority (MNSI).

From 1 April 2023 to March 2024, The Trust referred seven (7) cases to the HSIB/MSNI for investigation. The reasons for referral were three (3) hypoxic ischaemic encephalopathy (HIE) cases , one (1) Early Neonatal Death, one (1) intrapartum stillbirth and two (2) cases were rejected(HIE).

Some of the changes that were introduced following the reviews is highlighted in the Trust learning template below (Figure 3).

Figure 3: Trust Practice Changes

Trust practice changes

All mothers should have a risk assessment at each contact leading to a holistic overview of all known risk factors and a review of the plan of care.

On 5th May 2023 we launched the new Antenatal risk assessment form and supporting Aide Memoir to be completed at every AN contact

Mothers should have access to the information that they require during their pregnancy. The trust must support staff to use the local and national guidance in respect of interpreting services and translation.

We have received funding from NCL to be the trial site for CardMedic™ a website and app designed to improve communication with patients across any barrier – language, visual, hearing, cognitive impairment or PPE

Support staff to recognise, escalate and appropriately act upon a CTG which identifies a decompensated baby in a timely way

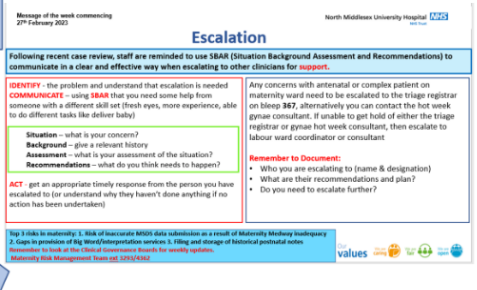
CTG action plan:

- 2 hourly co-Ordinator/SpR care reviews for all labouring women
- Cares stickers
- Upgrade central monitoring system
- Hourly fresh eyes
- Senior CTG review prior to commencing syntocinon/active pushing

All cases are reviewed by a multidisciplinary team, feedback is given individually and via Message of the Week, Case Review Feedback, Risky Business News Letter, Safety Huddles, Governance Boards, Maternity Skill Updates, Accessible shared learning folder.

HSIB HEALTHCARE SAFETY INVESTIGATION BRANCH

MNSI Maternity & Newborn Safety Investigations



Message of the week commencing 27th February 2023

North Middlesex University Hospital NHS

Escalation

Following recent case review, staff are reminded to use SBAR (Situation Background Assessment and Recommendations) to communicate in a clear and effective way when escalating to other clinicians for support.

IDENTIFY - the problem and understand that escalation is needed
COMMUNICATE – using SBAR that you need some help from someone with a different skill set (fresh eyes, more experience, able to do different tasks like deliver baby)

Situation – what is your concern?
Background – give a relevant history
Assessment – what is your assessment of the situation?
Recommendations – what do you think needs to happen?

ACT - get an appropriate timely response from the person you have escalated to (or understand why they haven't done anything if no action has been undertaken)

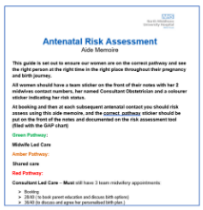
Any concerns with antenatal or complex patient on maternity ward need to be escalated to the triage registrar on bleep **367**, alternatively you can contact the hot week gynae consultant. If unable to get hold of either the triage registrar or gynae hot week consultant, then escalate to labour ward coordinator or consultant

Remember to Document:

- Who you are escalating to (name & designation)
- What are their recommendations and plan?
- Do you need to escalate further?

Top 3 risks in maternity: 1. Risk of inaccurate MSDS data submission as a result of Maternity Medway inadequacy 2. Gaps in provision of Big Word/interpretation services 3. Filing and storage of historical postnatal notes
Remember to look at the Clinical Governance Boards for weekly updates.
Maternity Risk Management Team ext 5293/4562

our values



Antenatal Risk Assessment
Aide Memoire

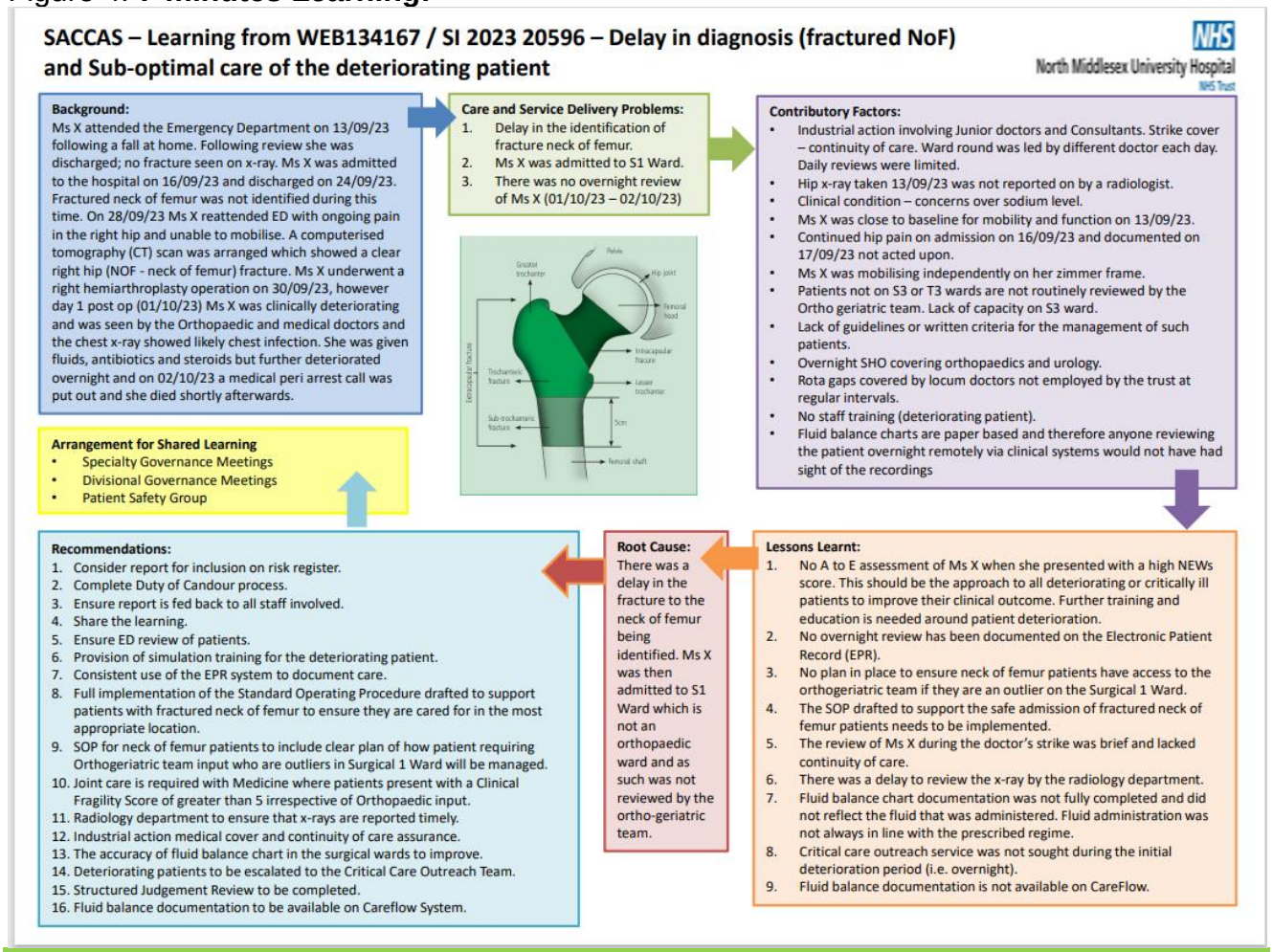
Gemba Walk

Gemba with purpose took place on 5th October 2023 and 25 March 2024 to Cape Town Ward by the Deputy Medical Director and Patient Safety Specialist. Key recommendations for improvement were shared with the team including consideration of a KPI dashboard to review performance and visiting exemplar wards at other Trusts to build knowledge and application of the reablement/rehab ethos.

7-minute learning:
The '7- minute learning', was designed to be delivered as a short briefing regarding a particular subject. The learnings provide a mixture of new information such as learning from Serious Incidents/Case Reviews and is based on research, which suggests that seven minutes is an ideal time span to concentrate and learn. Learning for seven minutes is manageable in most services, and learning is more memorable as it is simple and not clouded by other issues and pressures.

The 7-minute learning is produced by the governance team following approval of all serious incidents at the Governance Review Panel for shared learning with all staff. An example is displayed in Figure 4 below.

Figure 4: **7-minutes Learning:**



Perinatal Mortality Review Tool (PMRT)

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

Between April 2023 and March 2024, there were twenty-one (21) cases that met the eligibility criteria for a PMRT review. The eligible cases were stillbirths and late foetal losses. In addition, there were six (6) cases led by other trusts where the patient had varying degrees of care at North Mid .

From twenty-one (21) cases, eighteen (18) reviews were completed three (3) remain in progress and four (4) cases were not supported for review because they relate to Medical Termination of Pregnancies not requiring further investigation. The progress is within maternity incentive scheme (MIS) timeframes.

For seven (7) of the cases, there were no care and -service delivery problems identified. Six (6)cases identified care issues which had no impact on the outcome. In five (5) cases, care and service delivery problems were identified which may have contributed to the outcome. For most cases, the families have been involved in the PMRT reviews.

Patient Experience

Here at North Mid, our vision is to deliver outstanding care to local people and is supported by our Patient First Strategy, of which one of our three overarching objectives is to ensure we offer our patients and staff an excellent experience.

Patient Experience Strategy 2023-2028

The Patient Experience 5-year Strategy was launched in 2023 and includes four key priorities:

- Partnership (Involvement)
- Improvement (Listening)
- Excellent Patient Experience (Responding)
- Accessibility and Equity (Include)

Priority 1 - Partnership (Involvement)

The patient experience team are in the process of implementing the Patient Partnership Council (PPC). We currently have 20 recruits three of which are already volunteers for the Trust. The first meeting was held on 18 April 2024 to discuss role descriptions, aims and objectives. The other 17 recruits are being monitored as they go through the recruitment process. The aim is to have patients' partners represented at relevant meeting, patients

voices to be heard and for patient partners to work in collaboration with staff to help co-design services.

The Armed Forces Covenant was signed on 14 November 2023 demonstrating our commitment and support to the Armed Forces community. The Trust has also been awarded Bronze Accreditation for the Employment Recognition Scheme. Our aim is to now achieve Silver Accreditation. Silver Award holders demonstrate support for Defence by employing at least one reservist, and actively communicating and upholding a positive stance to their employees via established HR policies and procedures. Silver Award holders support reservists by showing flexibility to plan for and allow them to fulfil their annual training and mobilisation commitments.

Priority 2 - Improvement (Listening)

Our Trust will continue to obtain feedback from our patients and carers via, Friends and Family Test, CQC National Surveys, Patient Advice and Liaison Service (PALS) and Complaints, HealthWatch and social media so we can better understand the needs of our patients and make improvements where necessary.

We have supported our staff with quality improvement initiatives by launching our “North Mid Loves Our Patients” campaign on 14 February 2024 which allowed us to showcase improvements projects throughout the Trust. We aim to continue this initiative to encourage our staff to improve the quality of care we provide and patient experience.

Priority 3 - Excellent Patient Experience (Responding)

Our Visitors’ Charter has now been placed in all our wards and this demonstrates our expectations from visitors and what they can expect from our staff. Our Nutrition and Hydration Sub-Group allows us to address issues raised in the previous CQC National Survey related to nutrition and hydration. All the relevant stakeholders come together monthly to help address concerns raised and improve the quality of the service.

Priority 4 - Accessibility and Equity (Include)

We run an Accessibility Steering Group twice a week to promote equity of access and allow us to identify areas for improvement. We held an “Access for All” event on 4 June 2024 to ensure staff are aware and u to date with importance of accessibility and what it means for our patients. Access Able have undertaken a review of our Trust under the Disability Charter in 2023-24. Results have been analysed and used to improve accessibility for those that access our services. The completed audit has enabled the team to produce Access Guides to patient facing areas, this includes flooring, lighting, accessibility to wards and additional support. The Guides will be published on the Trust Website to enable our service users to plan their journey a head of time. Access guides will also include neuro diverse disabilities. Access Guides are due to go live in June 2024.

National Inpatient Survey 2022

Sample: Patients discharged in November 2022. 1250 Surveys mailed, 273 completed, response rate 23%.

Where patient experience is best

- ✓ Noise from other patients: patients not being bothered by noise at night from other patients
- ✓ Disturbance from hospital lighting: patients not being bothered at night by hospital lighting
- ✓ Noise from staff: patients not being bothered by noise at night from staff
- ✓ Feedback on care: patients being asked to give their views on the quality of their care
- ✓ Privacy for examinations: patients being given enough privacy when being examined or treated

Where patient experience could improve

- Food outside set meal times: patients being able to get hospital food outside of set meal times, if needed
- Help with eating: patients being given enough help from staff to eat meals, if needed
- Waiting to get to a bed: patients feeling that they waited the right amount of time to get to a bed on a ward after they arrived at the hospital
- Waiting to be admitted: patients feeling that they waited the right amount of time on the waiting list before being admitted to hospital
- Contact: patients being given information about who to contact if they were worried about their condition or treatment after leaving hospital

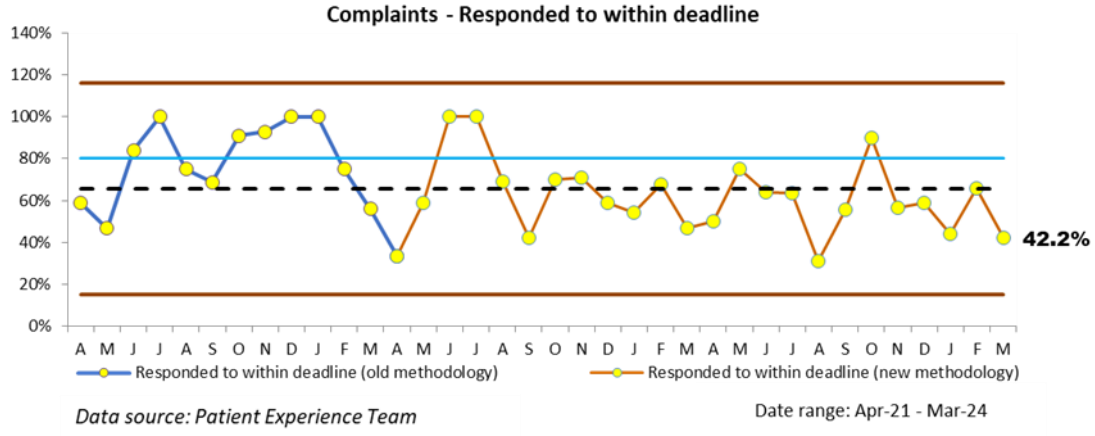
The Trust continues to make improvements on feedback mechanisms to encourage more of our patients and carers to provide us with feedback.

- A Standard Work document is being implemented for Patient Stories to ensure patients voices are heard at board level and to further support service development.
- Different language options are available for FFTs on the App and via the QR code to increase Accessibility.
- FFT Feeback via various options, QR Code on posters, SMS text messaging, Interactive Voice messaging (IVM), cards and iPad App.
- Additional Training for Staff on the Envoy system is scheduled for 10th May 2024. This would include staff being able to access “You said We did” templates which can be displayed on the wards, and feedback data that can be used to improve services.
- Work has commenced to ensure community home visits have feedback mechanisms in place. The plan is for the community teams to use a combination of QR codes and cards to capture feedback in the community. The community QR Code has already been set up. This will provide valuable information in identifying gaps in service delivery.

Complaints

Complaints provide us with vital information about quality of care and how are services are run. They tell us about how responsive, safe, effective, caring, and well-led we are as a trust. Complaints provides us with the opportunity to learn from our mistakes and make improvements to enhance patients' safety and patient experience.

363 complaints were received between April 2023- March 2024. Response times varied averaging at approximately 60% of complaints being responded to within the deadline over the course of the last 12 months. Complaint drafts are no longer Quality Assured by the Head of Patient Experience prior to going to the Chief Executive. Final complaint responses are sent to the Divisional Directors of Nursing (DDONs) for quality assurance prior to going to the Chief Executive.



Complaint management involves resolving complaints in a timely manner and identifying opportunities to make systemic improvements. It is essential that appropriate and timely actions are taken to continually improve the quality of the services being provided when failures are identified. It was identified that improvements were required with the quality of complaint drafts as well as the response time. All complaints which are upheld have an associated action plan which is monitored by the service to ensure relevant improvement are made.

Improvement Plan:

The Trust has put in place an improvement plan which includes the following:

- Offer face to face/online and away day complaint drafting sessions to divisions.
- Deliver drafting session to Service Managers.
- Offer support and guidance to staff with the Complaints process, Complaint policy and Standard Operating Procedure.
- Complaint officers reaching out to clinical team face to face where possible.
- Round table discussions for complex cases.
- Patient Experience Learning Forum (PELF) to identify learning from complaints.
- Governance meetings to include learning from complaints.

The top three themes and trends for complaints during April 2023- March 2024 include: Communication 58, Patient Care 160, Values and Staff Behaviours 64.

Patient Advice and Liaison Service (PALS)

A total of 2,865 PALS cases were received in April 2023- March 2024, 96 more than the previous financial year. The top three themes and trends for Complaints during April 2023- March 2024 include: Appointments 1105, Communications 619, Values 498.

Compliments

The Trust logged a total of 369 compliments for all divisions in April 2023 - March 2024. Compliments are shared with the divisions to showcase the positive experiences patients have had in our care. Compliments boosts the moral of staff and encourage them to continue to make positive changes to their service.

Local Resolution Meetings (LRMs) are offered to complainants to provide an opportunity for them to meet with key staff to talk through concerns raised and identify immediate actions where possible. The trust held 66 LRMs in April 2023- March 2024, 19 of those were closed in 2023.

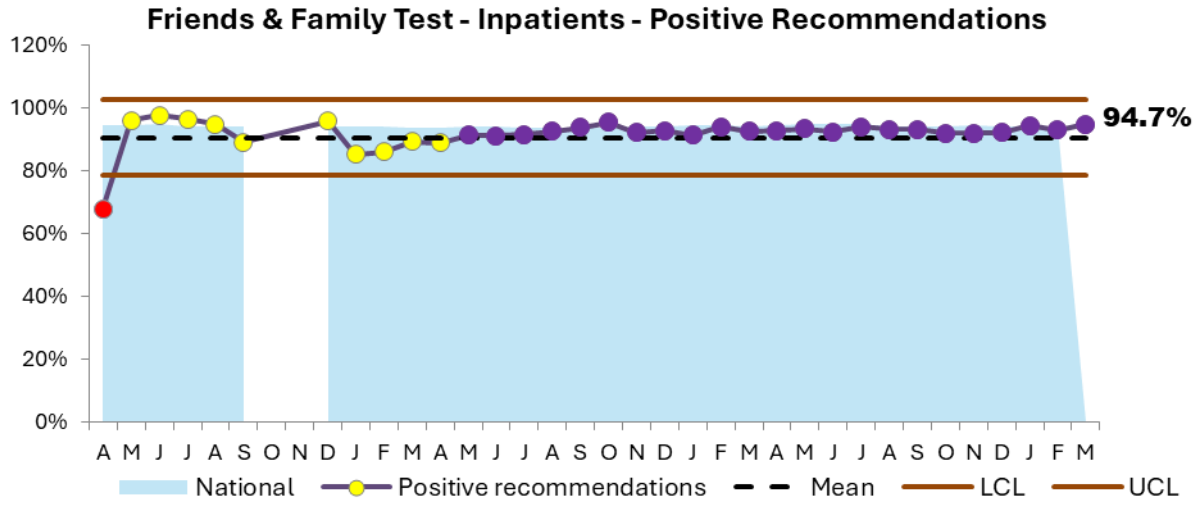
There are two live Parliamentary Health Service Ombudsman (PHSO) cases currently. Three cases were closed for Medicine and Urgent care - two were closed in December 2023 and one was closed in February 2024.

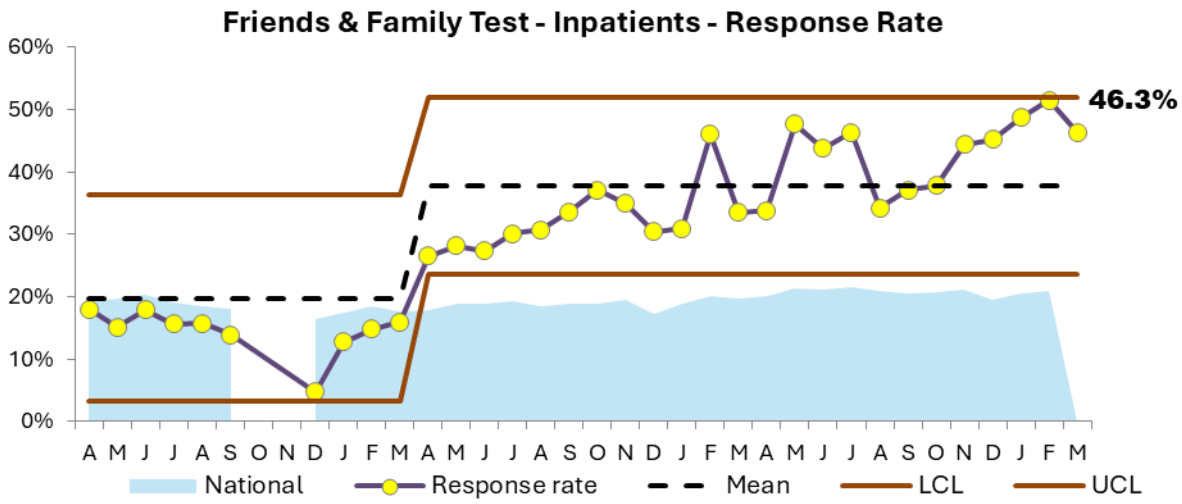
Friends and Family Test (FFT)

Positive recommendations figures have been consistently above 90% since March 2022 and remain in line with the national position. The response rate continues the upward trend from 93% in February 2024 to 94.7% in March 2024. The Trust has achieved above the national level since April 2022.

Improved response numbers can be attributed to:

- Day Units have been added to inpatient areas.
- Increased SMS usage to collect feedback has been implemented.
- Reintroduction of posters with QR codes on display on the wards.
- Dedicated staff promoting and using multiple options to collect feedback.
- Gemba walk about to resolve issues in a timely manner.




Friends & Family Test - Inpatients - Response Rate
60%
50%
40%
30%
20%
10%
0%
46.3%
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M
National
Response rate
Mean
LCL
UCL

“North Mid Loves Our Patients” Campaign Launch

On 14 February 2024 - Valentines Day, we launched our new campaign, "North Mid Love Our Patients." This initiative was designed to enhance awareness among both patients and staff, emphasising our commitment as an organisation that, we listen, we act, and we care about feedback about our services. This is also in line with our strategic objectives to provide an Excellent Experience for Patients and Staff.

We showcased five projects at the event which was implemented as a direct response from patient feedback within different divisions. Staff members were able to share their insights on the improvements during a 1–2-minute speech.

- (Matron, Oncology ward)- spoke about patient Bereavement Bags, leaflets and Lantern.
- (Ward manager, Topaz) - Spoke about Listening Ear Devices.
- (Associate Director of Nursing Medicine and Urgent Care) - ED's current waiting time Poster with QR code.
- (Rainbow Ward manager) - Spoke about their Patient Information Poster.

This is the first of many events which will allow us to demonstrate all the amazing improvement projects and new initiatives implemented through listening to our patients. In order to capture the love we have for our patients, we videoed members of staff to telling us how they show their love to their patients.

We also launched the new patient experience internet and intranet pages which went live on the 14 February - this will be a valuable resource for patients and staff.

Volunteers

The Trust had 106 volunteers during April 2023- March 2024 placed in locations / services / activities below:

- Wayfinding (pool) – 50

- Wards – 25 (ASU, Podium1, S1, S2, S3, T3 Surgical, AMU, Topaz, Emerald, T4, T7, Amber, Starlight/Rainbow)
- ED – 7
- Pet therapy- 6
- Admin – 5 (PACS, haematology, PALS, cardiology, volunteering)
- Dietetics and Nutrition – 4
- Maternity - 3
- Pharmacy – 3
- Art project – 2
- Music therapy – 1
- Magician – 1
- IT- 1
- Informatics- 1

The Trust holds quarterly coffee mornings for our volunteers to demonstrate our appreciation and gratitude for all their hard work and commitment. This is also an opportunity for the volunteers to feedback what is working well and what we can improve on. Volunteers' week is from 1-7 June 2024 and we intend to hold an event for the volunteers and present them with certificates and gifts.

Pet Therapy

The Trust invested in providing Pet Therapy to our patients which has had a positive response and has enhanced patient experience. The presence of the pets improved the well-being of our patients, simply by making the hospital environment happier and more enjoyable. Patients' visitor and staff benefited from these visits. Each month different pets were introduced which made the experience even more exciting for the patients.

Chaplaincy

Our Trust chaplains offer pastoral and spiritual care to all our patients and their carers, friends, and family as well as staff. We have a new member of staff who has joined the team

as our new Roman Catholic Chaplain. Our Chaplaincy team is diverse and represents our local community.

- Pesach provisions (e.g. for the Seder meal) was provided for Jewish patients and was available for wards to collect from reception.
- Shabbat provisions are made available in the Emergency Department.
- Eid was celebrated by having an event for staff with refreshments and a talk from our Muslim chaplain. Children on the wards were presented with gifts.
- Iftar packs were available for staff during Ramadan.
- Diwali was celebrated by handing out sweets as well as communication disseminated to staff and patients via the intranet and internet.
- Christmas was celebrated with carol singing and a service.
- Easter was celebrated by having an Easter egg competition and Easter eggs were given to the children by the spiritual team.

Improvements have been made to the Our Space Room for patients and staff from all religions to have a calm space to utilise. New furniture was purchased, and donations have been provided to replace the carpet in the Muslim prayer room.

Clinical Effectiveness

During 2023-24 the Trust has focused on its strategic themes under the Patient First strategy, of which clinical effectiveness plays a fundamental part of supporting clinical improvement across the Trust:

Patient	Our audit/QI and GIRFT programmes allows us to understand more about the patients we serve and deliver the services that matter them
Outstanding Care	Our team has a crucial role in measuring the effectiveness of what we do at North Mid and supporting clinicians to improve and through supporting the Clinical Practice Group (CPG) programmes we are delivering improved outcomes and experience for patients
Partnerships	The common ground for working with system partners is the shared understanding of care delivery and care demand which is underpinned by meaningful data analysis
Sustainability	We will support our teams to demonstrate that the care they deliver care is eligible for Best Practice Tariffs

National Audits

The Trust's participation in national clinical audits and registries and Trust wide audits demonstrate progress related to all clinical audit activity and outcomes in the Trust.

In the financial year 2023-24 there were 54 mandatory National Audits (including National Confidential Enquiry into Patient Outcome and Death (NCEPOD)) and 1 National Audit that were applicable and covered the relevant health services that the North Mid provides. The Trust participated in 51 mandatory National Audits and was unable to participate in four. This is outlined in Appendix 1 which also details associated number of cases submitted in each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

A focused effort was made by the Clinical Effectiveness team in 2023-24 to ensure that a systematic approach towards national audits were undertaken, leading to a significant completeness of data quality. An overview of national audit activity was provided effectively in line with national standards and the requirement of participation in the Healthcare Quality Improvement Partnership commissioned National Clinical Audit and Patient Outcome Programme (NCAPOP). The participation allows access to national audit performance data so that Trust can benchmark clinical outcomes against other Trusts and specialities.

At the beginning of each financial year the Clinical Effectiveness team create a trust-wide National Audit Plan. This plan includes details such as the responsible audit lead, division / specialty, frequency, and method of data submission. Updates on the progress of each audit is provided by the Divisions within the Clinical Effectiveness and Outcomes Group (CEOG) meeting.

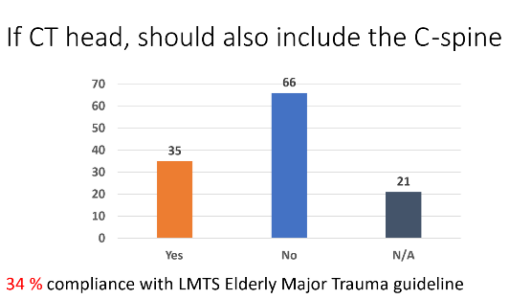
In addition to the above, recommendations derived from National Audit reports are shared to the divisions and specialties to foster learning and ensure active participation. Moreover, there's an encouragement to regularly update on the progress of recommendations, including outlining development plans for their completion.

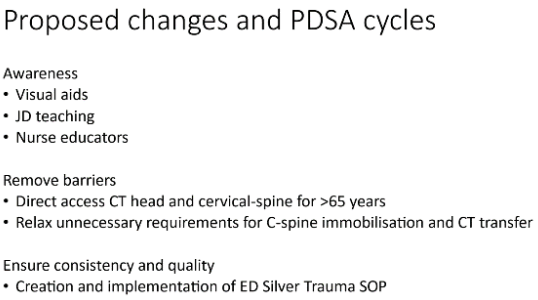
A significant achievement has been the exceptional performance of the Trust in the Trauma Audit and Research Network (TARN) which allows clinical emergency services to benchmark their service with other providers across the country. The Trust overall significant improvement towards this last year and the projection will be to sustain this achievement based on the audit compliance.

- Rehab Prescriptions - 98% of patients receiving a rehab prescription.
- Trauma patients often have specialty access and theatre availability.
- Care of older trauma patients - The panel uplifted the 83% self-assessment score to 100%. The Trust is currently working on creating a Trauma in Older People standard operating procedure which will be signed off before the next review period. There is also excellent Clinical Practice Group (CPG) work underway to improve quality of patient care for ortho-geriatric patients. The CPG team are costing and building a model that provides a geriatric review for all trauma patients.
- Violence reduction – The Violence Reduction team is clearly well integrated with the hospital and the pathway improvements from the past year are to be commended.

However there are areas to focus on which include the time to Computed tomography (CT). This has declined this past year due to volume of patients and inability to fully assess trauma patients in the compromised space within the Emergency Department. Work is underway to

improve auto-vetting for scans including CT head and CT C spine as a combination in frail patients who have head injuries.





This overall significant improvement has led to continuous development to ensure the rate of improvements to Trauma patients within the Trust. This recognises the multifaceted involvement of various healthcare teams throughout the Trauma pathway. Such an integrated strategy aims to promote cohesive teamwork to uphold care standardisation with the Trust.

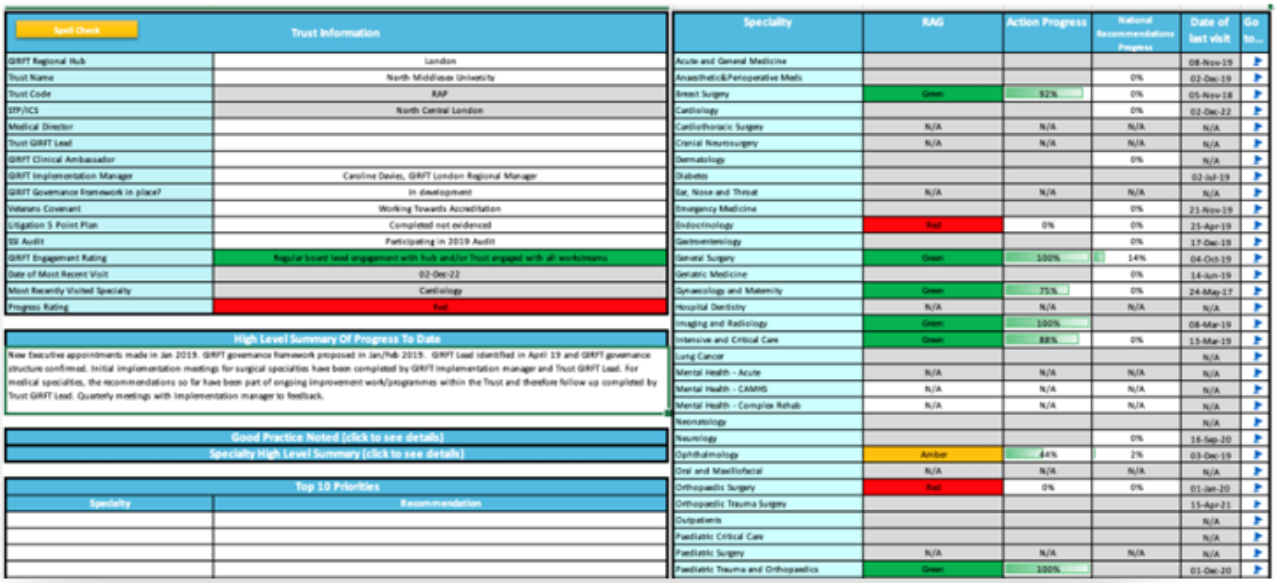
Getting It Right First Time (GIRFT)

The North Mid GIRFT programme has been invigorated following a hiatus due to staff changes and national updates to the programme .

The Trust attended two meetings with London GIRFT in October 2023 and January 2024 to establish a new GIRFT plan for the year. The Trust's Clinical Effectiveness team are currently reviewing how local Trusts in the region are managing GIRFT and sharing a model. They are also undertaking a focused dive into each specialty for the next 12 months, with the agreement of three aims which will align with GIRFT standards which they were expected to work on throughout the year.

The Trust has also established a GIRFT Steering Group that meets monthly, with a quarterly clinical effectiveness outcomes group that shares work underway with divisional leads, nursing and medical directorate.

Table 35 – GIRFT position



Spell Check	Trust Information
GIRFT Regional Hub	London
Trust Name	North Middlesex University
Trust Code	RAP
ITP/ICS	North Central London
Medical Director	
Trust GIRFT Lead	
GIRFT Clinical Ambassador	
GIRFT Implementation Manager	Caroline Davies, GIRFT London Regional Manager
GIRFT Governance Framework in place?	In development
Veterans Covenant	Working Towards Accreditation
Litigation 5 Point Plan	Completed not evidenced
SSI Audit	Participating in 2019 Audit
GIRFT Engagement Rating	Regular board level engagement with Hub and/or Trust engaged with all workstreams
Date of Most Recent Visit	02-Dec-22
Most Recently Visited Specialty	Cardiology
Progress Rating	Red

High Level Summary Of Progress To Date
New Executive appointments made in Jan 2019. GIRFT governance framework proposed in Jan/Feb 2019. GIRFT Lead identified in April 19 and GIRFT governance structure confirmed. Initial implementation meetings for surgical specialties have been completed by GIRFT Implementation manager and Trust GIRFT Lead. For medical specialties, the recommendations so far have been part of ongoing improvement work/programmes within the Trust and therefore follow up completed by Trust GIRFT Lead. Quarterly meetings with Implementation manager to feedback.

Good Practice Noted (click to see details)
Specialty High Level Summary (click to see details)

Top 10 Priorities	
Specialty	Recommendation

Specialty	RAG	Action Progress	National Recommendations Progress	Date of last visit	Go to...
Acute and General Medicine				08-Nov-19	
Anaesthetic&Perioperative Medi			0%	02-Dec-19	
Breast Surgery	Green	92%	0%	05-Nov-18	
Cardiology			0%	02-Dec-22	
Cardiothoracic Surgery	N/A	N/A	N/A	N/A	
Cranial Neurosurgery	N/A	N/A	N/A	N/A	
Dermatology			0%	N/A	
Diabetes				02-Jul-19	
Ear, Nose and Throat	N/A	N/A	N/A	N/A	
Emergency Medicine			0%	21-Nov-19	
Endocrinology	Red	0%	0%	25-Apr-19	
Gastroenterology			0%	17-Dec-19	
General Surgery	Green	100%	14%	04-Oct-19	
Geriatric Medicine			0%	14-Jun-19	
Gynaecology and Maternity	Green	75%	0%	24-May-17	
Hospital Dentistry	N/A	N/A	N/A	N/A	
Imaging and Radiology	Green	100%		08-Mar-19	
Intensive and Critical Care	Green	88%	0%	13-Mar-19	
Lung Cancer				N/A	
Mental Health - Acute	N/A	N/A	N/A	N/A	
Mental Health - CAMHS	N/A	N/A	N/A	N/A	
Mental Health - Complex Rehab	N/A	N/A	N/A	N/A	
Neonatology				N/A	
Neurology			0%	16-Sep-20	
Ophthalmology	Amber	44%	2%	03-Dec-19	
Oral and Maxillofacial	N/A	N/A	N/A	N/A	
Orthopaedic Surgery	Red	0%	0%	01-Jan-20	
Orthopaedic Trauma Surgery				15-Apr-21	
Outpatients				N/A	
Paediatric Critical Care				N/A	
Paediatric Surgery	N/A	N/A	N/A	N/A	
Paediatric Trauma and Orthopaedics	Green	100%		01-Dec-20	

Clinical Practice Groups (CPG)

The CPG methodology is designed to reduce unwarranted variation in clinical outcomes through the implementation of evidence based, standardised clinical practice and processes as core operating standards.

The CPG team are producing excellent results in all pathways. Their most recent successes are the ongoing frailty work and the Same Day Emergency Care (SDEC) pathways to improve our ambulatory care. The trusted assessor pathway from the London Ambulance Service to SDEC is now established and a hot and cold SDEC is in place.

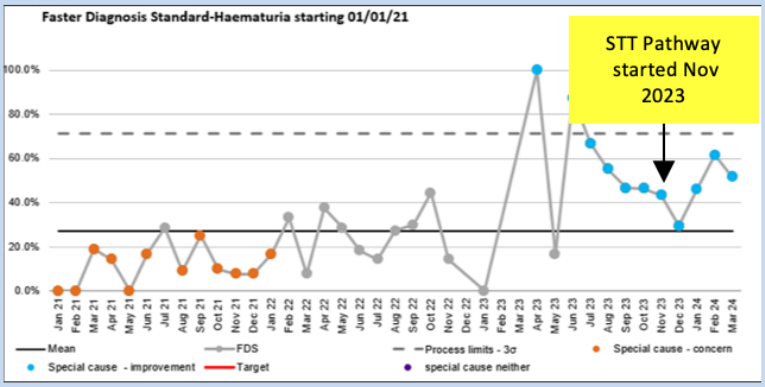
The team remain in close collaboration with the Royal Free London Group to ensure the CPG streams are aligned for the future.

Data

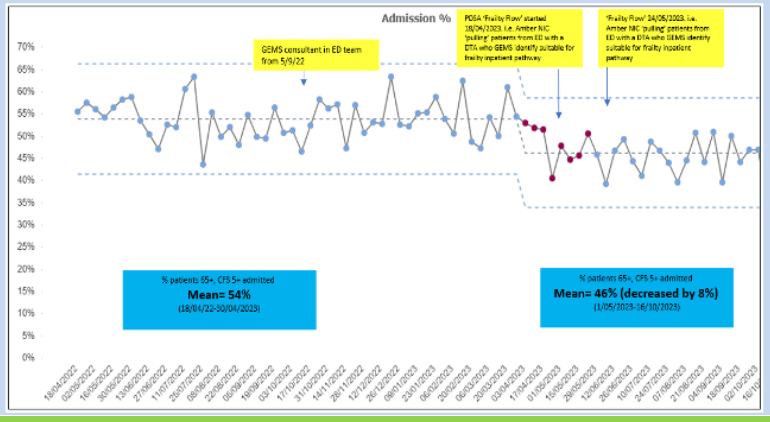
Key metrics for current active CPG pathways:

Pathway	Measure	Baseline (Prior to CPG)	Target	Current Performance
Frailty	CFS scoring for patients 65 years and older in ED	0% (NMUH)	80%	60% (NMUH)
Frailty	Average LOS for patients on HSEP wards	15 days	<15 days	13.6 days (NMUH)
Frailty	Admission conversion for patients 65+ with a CFS of 5+	52%	< 50%	46%
Prostate	2WW target	40%	93%	100%
Prostate	FDS	18%	75%	55.5%
Haematuria	2WW	90%	93%	100%
Haematuria	FDS	30%	75%	55.8%
SDEC	No of patients seen per day	28 avg. per day	60 pts per day	42 avg. per day

28-day Faster Diagnosis Standard (FDS) for patients on Haematuria straight-to-test (STT) pathway:



Admission Conversion for patients on Frailty Pathway:



Overview of timelines for each pathway

Pathway	2018	2019	2020	2021	2022	2023	Q4 23/24	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25
Frailty											
Prostate											
Haematuria											
Same Day Emergency Care (SDEC)											
Pulmonary Emoli (PE)											
Chronic Obstructive Pulmonary Disease (COPD)											
Right Upper Quadrant Pain (RUQP)											
Lung Cancer											
Keeping mothers and babies together (KMBT											
Wheezy Child											

Key	
	New pathway on track
	Existing pathway for mainstreaming
	Pathway not yet started
	Pathway paused

Local audits and Quality Improvement Projects

Local audits provide the framework to improve quality in a systematic and collaborative way, to ensure care is being provided effectively in line with local and national standards. This enables the Trust to assess and provide assurance on the quality of services being delivered and enables the Trust to evaluate and identify areas for improvement. Participation in local audits provides access to local audit performance data so that Trust can benchmark outcomes against Trusts services and implement the required improvements.

An overview of local audit activity was conducted and completed by the relevant Divisions and Specialties with the aim of sharing findings, celebrating success, identifying, and acting on areas for improvement through learning from the outcome data and action plans were developed, monitored were be implemented.

145 Local audit and Quality improvement projects were registered in 2023-24.

	Progressing on schedule, evidence of progress	Completed, evidence of compliance with standards or action plans to achieve compliance	Abandoned	Total
Local Audit	55	20	1	76
Quality Improvement Project	57	11	1	69
Total	112	31	2	145

The Clinical Effectiveness team are currently working with the divisions to assist in the completion of the 112 open Local Audits and QI Projects.

Of the local audits and QI projects that have completed their cycle, we identified below examples from across the Trust that demonstrate some of the actions taken to improve and sustain the quality and safety to patients of our services following audit findings.

Parenteral Nutrition (PN) Service Evaluation- This audit was conducted by the Nutrition Team; the focus of this audit was to assess the indication and appropriateness of PN and

assessing the length of time patients are on PN due to an increase in PN referrals. The outcome of this audit showed that more than 50% of our PN patients started on PN were from surgical and 26% of patients were on ITU indicating the training being delivered primarily to these specialties is appropriate. This audit highlighted the need for continuation of focusing training on surgical and ITU for all staff. PN training should ideally be within these specialties including dietitian, pharmacy, medical and nursing to allow cross learning using NCEPOD studies but tailoring to Trust's local service need/current issues.

Patient experience: cannulation and transfusion on the haematology day unit - This audit was centred around getting a better understanding patients' views of cannulation and transfusion at North Mid to improve their experiences (i.e. increase efficiency, reduce discomfort). The results identified that North Mid patients were mainly impressed by the level of care they're receiving, however helpful suggestions were provided to improve comfort of day unit facilities, provide femoral line training to nurses and increase the number of staff. The key messages were that patient satisfaction can be optimised by reducing anxiety.

High Corneal Astigmatism in Pre-operative Cataract Patients - This audit was conducted to evaluate percentages of pre-operative cataract patients who have corneal astigmatisms >1.75D and >2.0D. The aim was to compare against regional standards and to improve patient care by demonstrating necessity for equipment and software to fully assess corneal astigmatism and therefore appropriately offer Toric intraocular lens. The biometry data for the last 150 patients at North Mid were assessed in the cataract pre-operative clinic, 23% of patients had at least one eye with corneal astigmatism of patients had at least one eye with corneal astigmatism. North and Central London guidelines recommend that Toric lenses are offered for astigmatism, the Toric lenses are not currently provided at North Mid, because the Trust does not have the equipment required to formally assess astigmatism (corneal tomography machine and / or the IOL-Master Toric software), however patients were refer elsewhere. North Mid performs on average 1400 cataract surgeries per year, so this equates to 224 cataract surgeries per year where Toric lenses should be offered. The outcome is that currently, 46 patients per year are referred from North Mid to other hospital providers for corneal tomography, aim is now to investigate whether we can obtain funding of a corneal tomography machine and Toric lens software for IOL-Master so that Trust can offer Toric lenses to patients with high corneal astigmatism. The team aim raise awareness amongst staff and patients about the NCL guidelines for Toric lenses in corneal astigmatism to ensure cross learning.

In 2023-24 the Trust held two improvement days (Spring and Autumn) which included clinical and non-clinical teams to highlight the Trusts' Patient First improvement projects, patient experience and clinical effectiveness initiatives.

To contribute to the improvement of patient safety, care and experience, clinicians, nurses, and allied healthcare professionals registered and took part in local audits and quality improvement projects. Prizes were awarded to the best teams which used Quality Improvement (QI) methodology effectively, best co-production by a Multi-Disciplinary Team (MDT) group, best sustainability of change and people's choice. The winners are listed below:

- **QI Methodology:** work on Transforming the management of tobacco dependency: A focus on improving provision of Nicotine Replacement Therapy

- **Co-production by an MDT group:** Work on Patient Information Videos on Systemic Anti-Cancer Therapy to Improve Patient Experience and Access to Information: a North/North East London Collaboration.

- **Sustainability of change:** T Huseyin, L Parker, H Crook, S Akinol, T Owolabi, E Chidenga, P Sandajan, A Rahman, and L Odeh for their work on Sickle Cell Crisis - Time to First Dose.

- **People's choice**: U Wokoh, J Elliott and A Fakokunde for their work on Whose Job is it Anyway? - Risk Reporting in Gynaecological Surgery at North Middlesex University Hospital.

Learning and recommendations from these local clinical audits have been reviewed and recommendations taken forward as required. Reports of local clinical audits are disseminated to the Trust's Clinical Divisions for their actions.

4.2 Board Statements of Assurance

Services and Income

During 2022-23 the North Mid provided 49 relevant health services (46 at the North Mid and 3 in community services). The income generated by the relevant health services reviewed in 2022-23 represents 93.5% of the total income generated from the provision of relevant health services by the North Mid for 2022-23.

National Audit Summary

During 2023-24, 50 national clinical audits and 5 national confidential enquiries covered relevant health services that North Mid provides. During that period the Trust participated in 90% of national clinical audits and 100% of national confidential enquiries organisational questionnaires completed and 18.75% of clinician questionnaires completed which it was eligible to participate. The national clinical audits and national confidential enquiries that North Mid was eligible to participate in during 2023-24 are shown in Appendix 1.

Research and Development (R&D)

NHS Trusts are required to facilitate patient access to innovative treatments and the chance to engage in research. This responsibility is outlined in both the NHS Constitution and the UK Policy Framework for Health Care and Social Research. The evaluation of a research-oriented culture within NHS organisations is now conducted by the CQC.

Research demonstrates that organisations actively involved in research are safer and enhance the quality of care (NHS England, Research Plan, 2017). Hospitals engaged in research exhibit lower mortality rates compared to those that are not, and this impact extends beyond research participants. Active research Trusts conducting high-quality research elevate their organisational standing and bolster their reputation. Offering staff opportunities to engage in research can enhance the organisation's attractiveness as an employer. The National Institute for Health and Care Research (NIHR) outlined an ambitious strategy in 2021 to enhance impact, excellence, inclusion, collaboration, and effectiveness in research within NHS trusts (What is research and why it is important, Best research for best health, NIHR 2021).

Facilitating and conducting research at North Mid aligns the Trust with regional and national agendas to deliver evidence-based medicine in the NHS and foster health and wealth through research and innovation. Supporting clinical research aligns with the obligations imposed on NHS organisations to promote research and the utilisation of research evidence in their service provision.

Research and Development at North Mid persistently supports research activity across the Trust in various specialties. The primary research activity involves enrolling patients in high-quality NIHR portfolio-adopted multi-center studies, for which the Trust receive funding from the formerly known as North Thames Clinical Research Network (NT CRN), currently merged into the new Research Delivery Network (RDN).

Regrettably, research activities experienced setbacks due to the success and mitigation of recruitment during the Covid-19 pandemic, especially in the realms of cancer in general and commercial studies in particular. The absence of income from commercial studies has posed a threat to R&D offices nationwide. This situation has been particularly detrimental post-pandemic recovery, where portfolios from commercial studies have been slow to regenerate, resulting in low accruals and income loss.

Summary of Activity

Figure 1 represents the number of studies open at North Middlesex Hospital from 2010 until 2023-24. The grey bar represents pandemic time. It is clear from this graph that division 1 (oncology) and division 6 have the highest number of studies opened, oncology on a downtrend and division 6 on an uptrend.

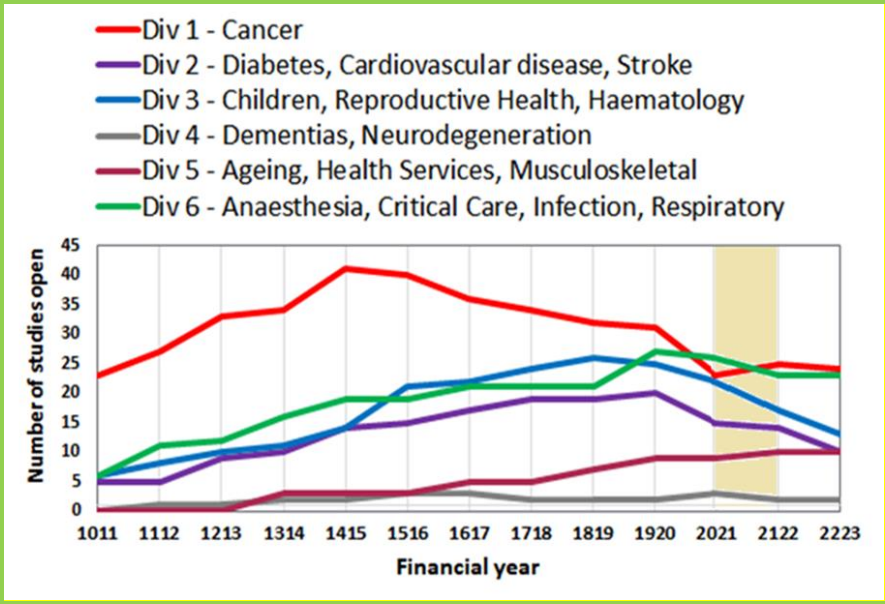
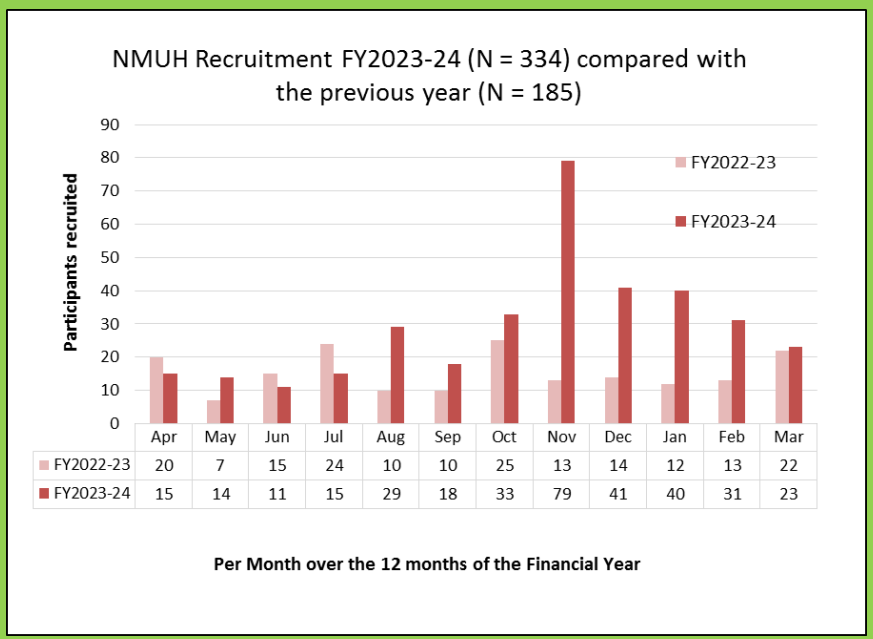


Figure 2 shows our last financial accruals compared with the previous year. An improvement and ascending trend is clearly visible in this graph which reinforce our expectations of recovery post-pandemic.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
FY2022-23	20	7	15	24	10	10	25	13	14	12	13	22
FY2023-24	15	14	11	15	29	18	33	79	41	40	31	23

The following Tables show at end of the financial year 2023-24 the current studies on recruitment and ongoing set-up studies.

Studies on recruitment. Red = Commercial. Data is not annualised, but since the trial started

Study title	Specialty	Target	Current accruals
TRACC-B	GI onc	36	18
ATNEC	Breast onc	3	10
PARABLE	Breast onc	6	2
GENENTECH*	Breast onc	4	1
PEARLS	RadioTx	6	15
ATLANTA	RadioTx	5	15
REFINE LUNG	Lung Onc	24	1
PIVOTAL BOOST	RadioTx	5	40
SPRUCE	RadioTx	5	1
TRACC-C	GI onc	15	1
GENOMICC	Inf Disease	20	412
UK-ROX	ITU	52	104
RAPID-MIRACLE	LAS	3	5
SCRIPT	Inf Disease	7	18
REMAP-CAP	ITU	60	130
PQIP	Peri-Op	15	40
DNA LACUNAR	Stroke	48	10
PLORAS	Stroke	65	45
ASPRE-T	RH&C	68	14
Early vs late	RH&C	30	22
ESPRIT2	RH&C	4	0
Bioresource	Genetics	4	111

Studies on set-up. Red =Commercial

STUDY TITLE	SPECIALTY	SET UP STATUS	ESTIMATED START OF RECRUITMENT
RAMON	Lung oncology	Internal feasibility review	May 2024
STAMPEDE 2	Urology oncology (radiotherapy)	Internal feasibility review	May 2024
PACE NODES	Urology oncology (radiotherapy)	Final sign off	February 2024
BACH-B	Paediatrics (ED)	Clinical training & sign off	February 2024
ELEVATE	Breast oncology	Costings, training	March 2024
HORIZON1	Lung oncology	Internal feasibility review	May 2024
SKYSCRAPER 15	Lung oncology	Regular approvals pending	July 2024
GIANT PANDA	Maternity	Protocol training	May 2024
PANDA	Maternity	Protocol training	June 2024
HERD	Head & Neck oncology	Internal feasibility review	March 2024
DPD	Skin oncology	Final sign off	March 2024
IMPROVE	Community respiratory services	Final sign off	February 2024
RID TB	Tuberculosis	Protocol training	April 2024
PBT	Breast Oncology	Internal feasibility review	April 2024
CHEMOBRAIN	Breast Oncology	Internal feasibility review	June 2024
Improving Black Health Outcomes	Haematology	Internal feasibility review	March 2024
SICKLE EYE	Haematology	A/w PI confirmation	April 2024
SMILES	Haematology	Internal feasibility review	March 2024

Challenges

The main challenge during the period covered by this report has been financial. We have secured through a Business Case the support for our commercial staff.

A financial model was developed for the Business Case. The model supports the impression that it is expected that the R&D office commercial income will go back to self-sufficiency in around two years.

Strategic Opportunities

The most important opportunity is the proposed merger with the Royal Free London Group. The benefits that will result include:

- Patients from both trusts will have access to a larger number and choice of trial opportunities.
- Patients will have more rapid access to trials increasing the likelihood of successful recruitment where the window for recruitment is restricted or recruitment is competitive across UK / International sites.
- Patients will have earlier access to innovative drugs and devices and better access to complex interventions. This includes earlier access to novel interventions.
- Greater insights into population health and inequalities will drive patient level benefit through improvements of local services.
- Patients will be able to access trials closer to home with familiar research and clinical teams reducing inequalities of trial access to North Mid patient populations and staff.
- Patients will benefit from closer monitoring and improved outcomes through trials and a better experience of clinical research.
- Patients with rare disorders requiring specialist care and support though clinical trials will have easier and more rapid access to studies that are open anywhere in the merged Royal Free London Group.
- Clinical trials will be designed and hosted which are more likely to meet local patients' needs.

Performance in Initiating and Delivering Clinical Research

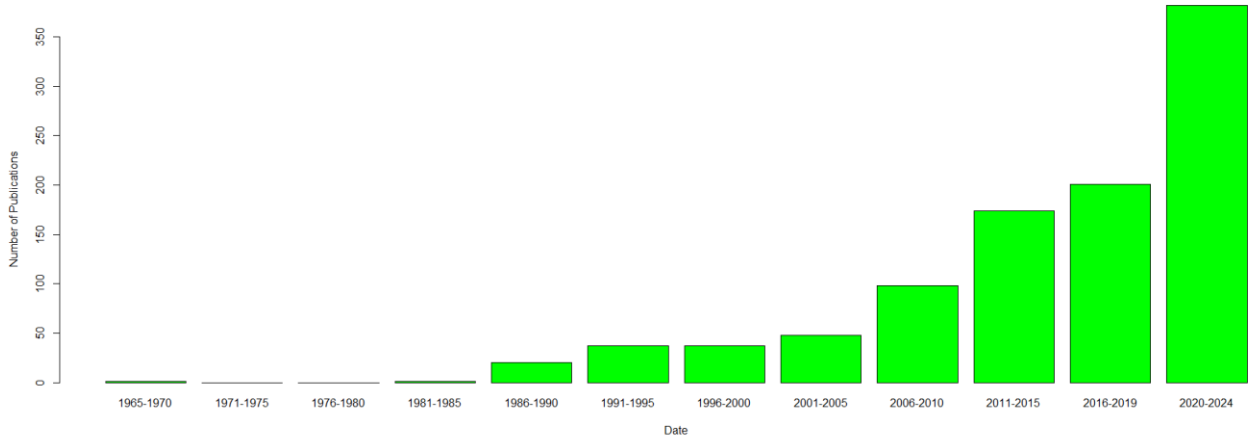
The National Institute for Health and Care Research measures the performance of all providers of NHS services in initiating and delivering research on behalf of the Department of Health and Social Care. The Government uses this information to ensure that clinical research in England is conducted efficiently and effectively. The Trust's research and development reports for 2023/2024 can be accessed through the NIHR website – see https://www.nihr.ac.uk/ .

Milestones for 2023/2024

- We have optimised our recruitment efforts, resulting in a notable increase in accruals.
- Our strategic alignment with Trust, regional, and national initiatives has been instrumental in addressing health inequalities, particularly through our inclusive approach to underserved communities and the expansion of our portfolio of Haemoglobinopathy trials.
- We have enhanced the Royal Free London Group's capabilities by engaging patients who typically have limited accessibility to healthcare services.
- Resource allocation has been strategically directed towards our areas of expertise, such as oncology.
- Our collaborative efforts with industry partners have bolstered our attractiveness and competitiveness, further augmented by the advantageous shared Market Force Factor with the Royal Free London Group.
- Through the STAR alliance, we have successfully attracted research collaborations from University College London Hospitals.

Publications

Figure 3 shows the number of publications by quinquennium. During 2020 to 2024 North Middlesex Hospital produced or collaborated in 382 papers. The first publication happened in 1967 in Lancet by T.Livanov, D.Ferriman and VH James. (Recovery of hypothalamus-pituitary-adrenal function after corticosteroid therapy, Lancet 1967; 2:856-9).



Looking forward

Ancestry diversity plays a pivotal role in realizing the potential of the coming Precision Medicine. The fruition of the Genetic Revolution hinges upon the acquisition of substantial DNA data from diverse minority populations and individuals of varied ancestries. A significant limitation of contemporary genetic knowledge lies in the lack of diversity within reference genomes, hindering the inference of novel therapeutic approaches for individuals from diverse ethnic backgrounds.

North Middlesex Hospital, serving a diverse population, with its merger with Royal Free Hospital, is exceptionally well-positioned to address this gap in our understanding engaging our population in future trials based on genetics and innovations in Personalised Medicine, for example cancer trials.

CQUINs and Secondary Uses Service

The CQUINs (Commissioning for Quality and Innovations) payment framework was re-introduced into the 2023-24 fiscal year with the Trust participating in 11 core indicators which can be seen in table 40 below.

Table 40 – CQUINs - *Deadline for Quarter 4 submission is 26th May 2024*

Ref	CQUIN Title	Clinical Leads	Payment Basis	Q1	Q2	Q3	Q4
CQUIN01	Flu vaccinations for frontline healthcare workers	Kim Perry	Max – 80% Min – 75%				
CQUIN02	Supporting patients to drink, eat and mobilise (DrEaM) after surgery	Gillan Johnson	Max – 80% Min – 70%	94% 94/100	93% 93/100	100% 59/59	In Progress
CQUIN03	Prompt switching of intravenous to oral antibiotic	Cecilia Drapeau	Max – 40% Min – 60% LOWER % = better performance	60% 60/100	39% 39/100	35% 35/100	9% 9/100

CQUIN04	Compliance with timed diagnostic pathways for cancer services	Mike Hawkes	Max – 55% Min – 35%	**Not in progress**	**Not in progress**	**Not in progress**	**Not in progress**
CQUIN05	Identification and response to frailty in emergency departments	Richard Robson	Max – 30% Min – 10%	62% 62/100	50% 50/100	47% 47/100	In Progress
CQUIN06	Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service	Allen Stein	Max – 1.5% Min – 0.5%	0.64% 83/12,948 Apr – 38 May – 22 Jun – 23	0.86% 107/12,372 Jul – 37 Aug – 38 Sept - 32	0.85% 112/13,031 Oct – 42 Nov – 35 Dec – 35	0.81% 106/12,970 Jan – 35 Feb – 71 Mar –
CQUIN07	Recording of and response to NEWS2 score for unplanned critical care admissions	Jeronimo Moreno-Cuesta	Max – 30% Min – 10%	**Not in progress**	**Not in progress**	50% 28/56	44.68% 21/47
CQUIN10	Treatment of non-small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway	Zaheer Mangera	Max – 85% Min – 80%	25% 1/4	53.12% 17/32	**Failed to submit**	In Progress
CQUIN12	Assessment and documentation of pressure ulcer risk	Joy Monye	Max – 85% Min – 70%	65.29% 111/170	80.10% 153/191	100% 100/100	In Progress
CQUIN13	Assessment, diagnosis and treatment of lower leg wounds	Lola Akinyemi	Max – 50% Min – 25%	9.66% 17/176	6.32% 6/95	52.38% 11/21	57.14% 16/28
CQUIN14	Malnutrition screening for community hospital inpatients		Max – 90% Min – 70%	56.80% 96/169	50% 90/180	93% 93/100	In Progress

Reporting against core indicators

Domain 1 – Preventing people from dying prematurely

Mortality rates are measured by both Hospital Standardised Mortality ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI). The methodology differs between the two metrics. HSMR includes deaths in hospital but excludes deaths with palliative care coding. SHMI includes all deaths in hospital and in the 30 days after discharge. Trust performance in relation to SHMI and HSMR is outlined in Section 2.6 – Operational Performance in Part 2.

The Trust has a responsibility to ensure that we learn from mortality cases. Table 41 below details the Trust performance and review of relevant cases.

Table 41 – Learning from deaths

Learning from death data	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
During 2023-24 **1,223** of NMH NHS Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period.	317	269	300	337	1223

Learning from death data	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
During 2023-24 there were 16 stillbirths delivered from 24 weeks and neonatal deaths after 22 weeks. This comprised the following number of deaths which occurred in each quarter of that reporting period	2	5	7	2	16
By 31 March 2024, 1,223 case record reviews and 828 CAT A & B investigations have been carried out in relation to the deaths included above (1,223). In 828 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was	272	231	224	101	828
25 representing just under 2% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. These numbers have been estimated using review of structured judgement reviews completed and deaths that were investigated via a serious incident process.	4.1% (13)	2.2% (6)	1.6% (5)	0.3% (1)	2.04%

Key learning identified from case reviews and investigations includes:

1. **ERCP (Endoscopic Retrograde Cholangio Pancreatography)**
   It has been noted in MRG through learning from deaths and inquests a small cohort of similar cases where there has been death after ERCP. These are all frail elderly, in whom there is significant risk from doing and not doing the procedure. The division has been asked to conduct a governance review over the last few years and to identify common themes and agree actions. This may involve the initiation of a MDT review of the appropriateness of such tests.

2. **Inpatient Falls:**
   A high index of suspicion is needed for bony injuries, especially in frail elderly or when there is pain despite normal plain imaging. In these cases, a low threshold is required for more detailed imaging such as CT or MRI. Lying and standing BP (Blood Pressure) is needed for all patients admitted with a fall or who fall on the wards. These learning points have been shared within the Care of the Elderly (COE) and divisional governance meetings and included in teaching sessions in COE and ED.

3. **Organ donation:**
   a case where early involvement of the Organ Donation lead did not happen and there was prolonged ITU care which may have added to distress. ED to look at the process for contacting the SNOD in these situations to ensure optimal management

4. **Dermatology In patient pathway review**
   Following an inquest the Trust has revised the SOP for in patient reviews by the dermatology service and this new document has been widely disseminated

5. **Induction**

As a result of individuals being identified who didn't know how to contact specialist services out of hours a review of all induction documents has been conducted. A standardised table showing to refer to all teams both in and out of hours has been produced and included in all. A detailed review of all induction documents is now being conducted by the deputy medical director with a team of junior doctors to standardise them, and include more generic helpful information as well as tracking who receives these documents, and having them available on the intranet

6. VTE process

A process is now available through EPMA to identify individuals who are not on VTE. For 3 months, this was handed to the ward team to review, and document why the patient was not appropriately treated or to commenced on treatment. This showed a reduction in patients having omitted or incorrect doses. A project is now being led by the deputy medical director with a team of junior doctors to ensure this process is embedded in all wards.

Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm

Patient safety incidents and the percentage that resulted in severe harm or death – Review of National Reporting and Learning System data.

Publication Date	Reporting Period	Measures	North Mid	National Average	Lowest	Highest
May 2024	April 2022 – January 2024	Number of Patient Safety Incidents	17953	-	-	-
		Rate of incidents (per 1000 bed days)	33.4	-	-	-
		No. resulting in severe harm or death	126	-	-	-
		% resulting in severe harm or death	0.70%	-	-	-
April 2022	April 2021 – March 2022	Number of Patient Safety Incidents	9,286	14,252	3,441	49,603
		Rate of incidents (per 1000 bed days)	55.3	-	23.67	205.52
		No. resulting in severe harm or death	104	7116	3	216
		% resulting in severe harm or death	0.11%	0.40%	0.08%	0.04%
September 2021 March 2020		Number of Patient Safety Incidents	7,976	12,402	3,169	37,572
	April 2020 –	Rate of incidents (per 1000 bed days)	53.8	-	27.2	118.7
	March 2021 (1 year)	No. resulting in severe harm or death	42	6,828	4	261

		% resulting in severe harm or death	0.5%	0.4%	0.1%	1.3%
		Number of Patient Safety Incidents	3,917	6,276	1,392	21,685
	April 2019 –	Rate of incidents (per 1000 bed days)	45.76	49.8	26.3	103.8
	September 2019 (6 months)	No. resulting in severe harm or death	9	6	0	95
		% resulting in severe harm or death	0.21%	0.10%	0	0.44%
September 2019		Number of Patient Safety Incidents	3,349	5,841	1,278	22,048
	October 2018 - March	Rate of incidents (per 1000 bed days)	39.32	46.06	16.90	95.94
	2019 (6 months)	No. resulting in severe harm or death	12	6.4	1	72
		% resulting in severe harm or death	0.36%	0.10%	0.08%	0.32%

It is important to note that there will always be some variation in the figures reported by the National Reporting and Learning System (NRLS) in comparison to numbers quoted from Trust systems..

Please note that NHS England only have data available up to June 2022. However, they only display total numbers for the Country with no breakdown by trust, or national averages. This would mean we are unable to populate the remaining gaps in the table as the data is not available.

Incidents

During 2023-24 the Trust maintained a good level of incident reporting across all areas. The substantial proportion of incidents still result in no harm or low harm but reflects the organisations commitment to learning from all incidents irrespective of level of harm.

Overall, the Trust remains within the median range for the number of incidents reported by similar type Trusts (acute non specialist). The Trust continues to maintain a good reporting culture across the organisation. The rate of incidents graded as severe or death falls below the national average. All incidents resulting in severe harm or death have the appropriate level of review and investigation to ensure that all opportunities for learning are identified and improvements made as required; and more importantly that the Trust is open and transparent with patients, families and carers where things have gone wrong.

During 2023-24 the Trust reported 70 incidents as meeting the threshold as a reportable ‘Serious Incident’ (SI), and these are detailed in table 42 below:

The patient, families and carers are given the opportunity to contribute to the investigation terms of reference to ensure their concerns are addressed. Following completion of the investigation the patient, family and / or carers are offered a copy of the final report, along

with the opportunity to meet with Trust staff to discuss the report findings, and any improvements that have been made.

Table 42 – Serious Incidents

Incident Category	Number of SI's
Abuse/alleged abuse of adult patient by third party	1
Apparent/actual/suspected self-inflicted harm meeting SI criteria	2
Confidential information leak/information governance breach meeting SI criteria	1
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	7
Disruptive/ aggressive/ violent behaviour meeting SI criteria	1
HCAI/Infection control incident meeting SI criteria	1
Incident affecting patient's body after death meeting SI criteria	1
Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)	6
Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant)	3
Maternity/Obstetric incident meeting SI criteria: mother only	1
Medical equipment/ devices/disposables incident meeting SI criteria	1
Medication incident meeting SI criteria	7
Screening issues meeting SI criteria	1
Slips/trips/falls meeting SI criteria	12
Sub-optimal care of the deteriorating patient meeting SI criteria	7
Substance misuse whilst inpatient meeting SI criteria	1
Surgical/invasive procedure incident meeting SI criteria	3
Treatment delay meeting SI criteria	13
VTE meeting SI criteria	1
Total	**70**

No 'Never Events' were reported during the financial year as detailed in Section 4.1 – Looking Back: Our Quality Priorities.

The Trust shares learning from incidents and serious investigations at the patient safety group, '7-minute learning summaries' these are shared locally and are available via the Trust's intranet for all staff to access. Other means such message of the week and hot topics of key finds and recommendations in maternity which is shared. Learning from incidents is also used to inform quality improvement projects and workstreams for improvement.

During 2023-24 the Trust transitioned from reporting to a new National Reporting Learning System (NRLS) to Learning from Patient Safety Events (LfPSE).

Rota Gaps - Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016

Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 stipulate that where Health Education England are unable to appoint to training posts, the Trust will endeavour to fill medical staffing rota gaps via the bank service. Any vacant shifts are identified by the Trust's rota coordinators and then published via Locum's Nest for filling with qualified medical bank workers. Once a shift has been filled, the rota coordinators then manage the timesheet process electronically. The Trust's bank rates are aligned to the Pan London rates and where there are deviations, the Trust has a clear escalation process.

Our partnership with Locum's Nest's was confirmed as finalists for two awards at the prestigious 2023 HSJ Partnership Awards. Our partnership working was named as a finalist for both the Best Acute Sector Partnership award and the Workforce and Wellbeing Initiative of the Year award.

The national recognition comes after the impact the collaborative work with Locum's Nest has, and continues to have, on patient care and staff experience at North Mid. Since 2018, the Trust has been working with Locum's Nest to design and implement technology-enabled processes with the aim of reducing total agency use and spending, increasing the number of doctors working at North Mid and improving the care patients receive at North Mid.

Expanding the Trust's reach to more doctors through Locum's Nest's services helped reduce waiting times and increase patient safety whilst also increasing staff retention and engagement at North Mid.

4.3 Looking to the Future: Our Plans 2024-25

Patient First - Onward to 2023 and beyond

Excitedly, the Trust will continue the journey to embed and mature the Patient First strategy through training leaders and teams, experimenting with improvement tools and modelling the behaviours that develop and sustain a culture of continuous improvement.

Looking forward for Clinical Effectiveness

The Trust is reviewing the scope of responsibility of the Clinical Effectiveness team within the wider governance and safety picture and the data analytics provision for clinical improvement. NorthMid have identified that there is a resource need to support the uploading of clinical data to participate in National Audits and are considering a central or divisional model to assist the clinicians in the next financial year.

The Trust has organised and hosted a trust-wide improvement day in April 2023 to include non-clinical teams in addition to clinical teams to highlight the Trusts' Patient First, patient experience and clinical effectiveness initiatives and the work that has been undertaken to deliver these initiatives. The Trust is looking forward to hosting another improvement day in 2024 on a much bigger scale.

CQUINs

The CQUIN scheme has been paused for 2024/25, pending the findings of a review of quality incentives. This is confirmed in recent updates to the NHS Payment Scheme. During the pause there will be a list of non-mandatory indicators that can be used by systems if they wish to operate a 'CQUIN-like' scheme locally: NorthMid has decided to participate in the below CQUINs for 24/25

Ref	CQUIN Title
CQUIN01	Flu vaccinations for frontline healthcare workers
CQUIN02	Tranexamic acid prior to surgery
CQUIN04	Recording of and response to NEWS2 score for unplanned critical care admissions
CQUIN05	Recording of Paediatric Early Warning System for patients aged <18
CQUIN06	Identification and response to frailty in emergency departments
CQUIN07	Prompt switching of intravenous to oral antibiotic
CQUIN08	Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service
CQUIN15	Assessment, diagnosis and treatment of lower leg wounds
CQUIN16	Assessment and documentation of pressure ulcer risk

4.4 Stakeholder and Directors' Statements

Statements to be obtained from named organisations once the draft has been sent to them

Statement of Assurance following review on behalf of Joint Health Overview and Scrutiny Committee for North Central London

Statement of Assurance following review on behalf of Haringey Healthwatch, by the Research and Engagement Manager

Statement of Assurance following review on behalf of North Central London Integrated Care Board

Single Oversight Framework indicators

The Trust's performance against the single oversight framework has been outlined throughout the report to cover the following five domains:

- Quality of care, access and outcomes
- Preventing ill health and reducing inequalities
- Leadership and capability
- Finance and Use of Resources
- People

Statement of Directors' responsibilities for the quality report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Account) Regulations to prepare the Quality Account for each financial year. NHS England has issued guidance to NHS foundation trust boards and NHS trusts 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 trust annual reporting manual 2022-23 and supporting guidance.

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

- Board minutes and papers for the period April 2023 to March 2024
- Papers relating to quality reported to the Board over the period April 2023 to March 2024
- Feedback from commissioners dated TBC
- Feedback from Healthwatch Haringey dated TBC
- Feedback from the Joint Health Overview and Scrutiny Committee for North Central London submitted on TBC
- The National Patient Surveys:
    - 2023 Maternity Survey published January 2024
    - 2022 Adult Inpatient Survey published August 2023
- The 2023 National Staff Survey
- CQC inspection report dated 28 March 2024
- Targeted CQC Inspections reports dated:
    - May 2023 – Maternity Services
    - September 2023- Medical Care Services
    - July 2022 – Emergency Department
    - August 2021 – Sickle Cell Services
- The Quality Report presents a balanced picture of the 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.

The Quality Report has been prepared in accordance with NHS England's annual reporting manual and supporting guidance (which incorporates the Quality Account 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.

Signed..... Date…....

Mark Lam
Chair

Signed..... Date…....

Dr Nnenna Osuji
Chief Executive / Accountable Officer

4.5 Appendices

Appendix 1 - National Audits submitting and reaching full case ascertainment in 2023-24

Division	Title	AUDIT - Number of cases required	AUDIT - Number Submitted	%
Corporate	Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)	1	1	100%
Medicine and Urgent Care	Falls and Fragility Fracture Audit Programme (FFFAP): National Audit of Inpatient Falls (NAIF)	4	4	100%
Medicine and Urgent Care	Falls and Fragility Fracture Audit Programme (FFFAP): National Hip Fracture Database (NHFD)	151	151	100%
Medicine and Urgent Care	Improving Quality in Crohn's and Colitis (IQICC)	TBC0	0	0%
Medicine and Urgent Care	Major Trauma Audit	Data hack meant no submissions.		-
Medicine and Urgent Care	National Adult Diabetes Audit (NDA) - National Core Diabetes Audit	Mass submission due end of May 2024		-
Medicine and Urgent Care	National Adult Diabetes Audit (NDA) - National Diabetes Foot Care Audit	TBC	TBC	
Medicine and Urgent Care	National Adult Diabetes Audit (NDA) - National Diabetes Inpatient Safety Audit (NDISA)	6	6	100%
Medicine and Urgent Care	National Audit of Dementia (NAD) - Care in general hospitals	65	65	100%
Medicine and Urgent Care	National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project (MINAP)	150	150	100%
Medicine and Urgent Care	National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management (CRM)	62	62	100%
Medicine and Urgent Care	National Cardiac Audit Programme (NCAP) - National Heart Failure Audit	216	216	100%
Medicine and Urgent Care	National Early Inflammatory Arthritis Audit (NEIAA)	26	26	100%
Medicine and Urgent Care	National Lung Cancer Audit (NLCA)	228	228	100%
Medicine and Urgent Care	National Oesophago-Gastric Cancer Audit (NOGCA)	43	43	100%
Medicine and Urgent Care	National Respiratory Audit Programme (NRAP) - Adult Asthma Secondary Care	22	22	100%
Medicine and Urgent Care	National Respiratory Audit Programme (NRAP) - Chronic Obstructive Pulmonary Disease Secondary Care	76	76	100%
Medicine and Urgent Care	Sentinel Stroke National Audit Programme (SSNAP)	163	163	100%
Medicine and Urgent Care	Society for Acute Medicine Benchmarking Audit (SAMBA)	TBC	TBC	
Surgery	BAUS Nephrostomy Audit	TBC	TBC	
Surgery	Case Mix Programme (CMP)	192	192	100%
Surgery	Elective Surgery (National PROMs Programme)	111	111	100%

Division	Title	AUDIT - Number of cases required	AUDIT - Number Submitted	%
Surgery	Medical and Surgical Clinical Outcome Review Programme - Rehabilitation following critical illness	28	28	100%
Surgery	National Audit of Breast Cancer in Older Patients (NABCOP)	216	216	100%
Surgery	National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer	46	46	100%
Surgery	National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer	229	229	100%
Surgery	National Emergency Laparotomy Audit (NELA)	75	73	97%
Surgery	National Gastro-Intestinal Cancer Audit Programme (GICAP) - National Bowel Cancer Audit (NBOCA)	Submission not needed	Submission not needed	N/A
Surgery	National Joint Registry	192	192	100%
Surgery	National Ophthalmology Database Audit (NOD) - Age-related Macular Degeneration Audit (AMD)	69	69	100%
Surgery	National Ophthalmology Database Audit (NOD) - National Cataract Audit	1212	1212	100%
Surgery	National Prostate Cancer Audit (NPCA)	461	461	100%
Surgery	Perioperative Quality Improvement Programme (PQIP)	0	0	
Surgery	Transurethral Resection and Single instillation intra-vesical chemotherapy Evaluation in bladder Cancer Treatment (RESECT) Improving quality in TURBT surgery.	50	72	144%
Women, Children, Cancer & Diagnostics	Mind the Gap: An Investigation into Maternity Training for Frontline Professionals Across the UK	TBC	TBC	
Women, Children, Cancer & Diagnostics	Child Health Clinical Outcome Review Programme - Transition from child to adult health services	51	51	100%
Women, Children, Cancer & Diagnostics	Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal mortality confidential enquiries	2	2	100%
Women, Children, Cancer & Diagnostics	Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal mortality surveillance	2	2	100%
Women, Children, Cancer & Diagnostics	Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal mortality and serious morbidity confidential enquiry	13	13	100%
Women, Children, Cancer & Diagnostics	Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Surveillance	13	13	100%
Women, Children, Cancer & Diagnostics	National Adult Diabetes Audit (NDA) - National Pregnancy in Diabetes Audit (NPID)	21	21	100%
Women, Children, Cancer & Diagnostics	National Audit of Care at the End of Life (NACEL)	Submission paused	Submission paused	N/A
Women, Children, Cancer & Diagnostics	National Child Mortality Database (NCMD) Programme	16	16	100%

Division	Title	AUDIT - Number of cases required	AUDIT - Number Submitted	%
Women, Children, Cancer & Diagnostics	National Maternity and Perinatal Audit (NMPA)	16	16	100%
Women, Children, Cancer & Diagnostics	National Neonatal Audit Programme (NNAP)	55	55	100%
Women, Children, Cancer & Diagnostics	National Paediatric Diabetes Audit (NPDA)	227	227	100%
Women, Children, Cancer & Diagnostics	National Respiratory Audit Programme (NRAP) - Paediatric Asthma Secondary Care	85	85	100%
Women, Children, Cancer & Diagnostics	Perinatal Mortality Review Tool (PMRT)	13	13	100%

Audits submitting data but not reaching full case ascertainment in 2023-24

Status	Division	Title	AUDIT - Number of cases required	AUDIT - Number Submitted	%
Quality Account	Surgery	Child Health Clinical Outcome Review Programme - Testicular torsion	8	1	13%
Quality Account	Women, Children, Cancer & Diagnostics	Medical and Surgical Clinical Outcome Review Programme - End of Life Care	6	2	33%
Quality Account	Women, Children, Cancer & Diagnostics	Medical and Surgical Clinical Outcome Review Programme - Endometriosis	6	1	17%
Quality Account	Women, Children, Cancer & Diagnostics	National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy12)	10	1	10%

Audits where participation has not been possible in 2023-24

Status	Division	Title	AUDIT - Number of cases required	AUDIT - Number Submitted	%
Quality Account - Trust Not Participating	Medicine and Urgent Care	2023 Audit of Blood Transfusion against NICE Quality Standard 138	0	0	0%
Quality Account - Trust Not Participating	Medicine and Urgent Care	2023 Bedside Transfusion Audit	0	0	0%
Quality Account - Trust Not Participating	Medicine and Urgent Care	Serious Hazards of Transfusion UK National Haemovigilance Scheme	0	0	0%

Action taken in response to national audit findings during 2023-24

Title	Action taken or planned
National Neonatal Audit Programme (NNAP)	Parental consultation within 24hrs of admission (NMU - 95.6% | LON - 91.7%) Term admissions (NMU - 4.9% | LON - 3.8%) (ATAIN – avoiding term admissions in neonates) – business case is underway to appropriately staff transitional care model on the post-natal ward. Improvement in cord clamping
TARN	Rehab Prescriptions - 98% of patients receiving a rehab prescription NorthMid Trauma patients often have specialty access & theatre availability Care of older trauma patients - The panel uplifted the 83% self-assessment score to 100%. The Trust is currently working on creating a Trauma in Older People standard operating procedure which will be signed off before the next review period. There is also excellent CPG work underway to improve quality of patient care for ortho-geriatric patients. The CPG team are costing and building a model that provides a geriatric review for all trauma patients. Work is underway to improve auto-vetting for scans including CT head and CT C spine as a combination in frail patients who have head injuries.
Ophthalmology	Met the target of 70% of routine lasers within the 10-week timeline (90%). Opportunities for training on outcomes, more laser personnel, and duties of a failsafe officer. Also, for investment in PASCAL argon laser to improve efficiency, better patient experience etc
National Diabetes Foot care Audit (NDFA)	advises to increase awareness among patients and other HCP re foot ulcers and recommend daily walk-in clinics for acute foot ulcers. Teaching sessions for A&E and acute medical team on how to manage and refer patients urgently to meet NICE guidance is underway. A business case for a second podiatrist has been submitted.
MBBRACE - reducing death and harm at childbirth	NMH stillbirth rate is >10% above national average compared to similar trust, SBL care bundle is helping, but rates are still higher than national average, recommendations: 50/68 recommendations are fully met ? results: CDH - MDT for mother and baby combined, collaborative approach to R and D, counselling, information sheets for parents, congenital registry collaboration, consensus on optimal management, psycho social report, FU, minimal travel for antenatal care period. Perinatal mortality RV - feedback from parents re baby deaths after 22/40 HSEB maternity programme - Independent review re safer maternity care to identify themes on safety post Ockenden.

Glossary

A glossary of terms and acronyms used within this document

A		
ABC Parents	Achieving a Better Community Parents	A parent education programme which provides new parents, with little or no knowledge of child health, the confidence to care for their child's common illnesses as well as provide lifesaving skills.
AfC	Agenda for Change	The current NHS grading and pay system for NHS staff, with the exception of doctors, dentists, apprentices and some senior managers.
AfPP	Association for Perioperative Practice	
AGS	Annual Governance Statement	A document which identifies the internal controls in place and their effectiveness in delivering sound finance, good governance and a high level of probity
AMU	Acute Medical Unit	
AO	Accountable Officer	The Executive Director responsible and accountable for funds entrusted to the Trust.
B		
BAF	Board Assurance Framework	A system for managing the key risks to the delivery of the Strategic Objectives.
BME	Black and Minority Ethnic	
BPPC	Better Payment Practice Code	A code of practice setting out standards for the payment of creditors
C		
CDI	Clostridium Difficile Infection	
CETV	Cash Equivalent Transfer Value	The actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time
CFFSR	Counter Fraud Functional Standard Return	Provides assurance regarding compliance with the functional standards
CO^2	Carbon dioxide	
CO^2e	Carbon dioxide equivalent	
COE	Care of the Elderly	
COVID	Corona Virus Disease	
CPG	Clinical Practice Group	
CQC	Care Quality Commission	Independent regulator of all health and social care services in England
CQUIN	Commissioning for Quality Innovation	A sum of money (2.5% of contract value) that is given to providers by commissioners on the achievement of locally and nationally agreed goals
D		
DEXA	Dual Energy X-ray Absorptiometry	A bone density scan uses low dose X-rays to see how dense or strong bones are
DHSC	Department of Health and Social Care	The ministerial department which leads, shapes and funds health and social care in England
DNAs	Did Not Attends	Number of patients who do not attend their appointments
DSPT	Data Security and Protection Toolkit	The DSP Toolkit is an online self-assessment tool that allows organisations that have access to NHS patient data to measure their performance against the National Data Guardian's 10 data security standards.
E		
ED	Emergency Department	
EDI	Equality, Diversity and Inclusion	
EFL	External Financing Limit	

EMRAM	Electronic Medical Record Adoption Model	EMRAM measures clinical outcomes, patient engagement and clinician use of Electronic Medical Record technology to strengthen organisational performance and health outcomes across patient populations.
ERF	Elective Recovery Fund	
F		
FFT	Friends and Family Test	A single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care
FOI	Freedom of Information / Act	Freedom of Information Act – an Act which makes provision for the disclosure of information held by public authorities or by people providing services for them
FTSU / FTSUG	Freedom to Speak Up / Guardian	Enables staff to raise concern when they feel that they are unable to do so by other routes.
G		
GIRFT	Getting It Right First Time	A national programme designed to improve medical care within the NHS by reducing unwarranted variations.
GRP	Governance Review Panel	
H		
HFMA	Healthcare Financial Management Association	
HIMSS	Healthcare Information and Management Systems Society	HIMSS is a global advisor, thought leader and member-based society committed to reforming the global health ecosystem through the power of information and technology.
HOHA	Hospital Onset Healthcare Associated	
HSIB	Healthcare Safety Investigation Branch	
HSMR	Hospital Standardised Mortality Ratio	A method of to enable the comparison of the actual number of deaths between hospitals.
I		
ICB	Integrated Care Board	ICBs are responsible for NHS services, funding, commissioning, and workforce planning across an ICS area.
ICO	Information Commissioner's Office	Upholds information rights in the public interest.
ICS	Integrated Care System	ICSs bring together NHS, local authority and third sector bodies to take on responsibility for the resources and health of an area or 'system'. Their aim is to deliver better, more integrated care for patients.
IG	Information Governance	Ensures necessary safeguards for, and appropriate use of, patient and personal information. Key areas are information policy for health and social care, IG standards for systems and development of guidance for NHS and partner organisations
IGSG	Information Governance Steering Group	
IMD	Index of Multiple Deprivation	
J		
K		
kWh	kilowatt hours	A measurement of energy
L		
LCFS	Local Counter Fraud Specialist	
M		
MARS	Mutually Agreed Resignation Scheme	
MDT	Multi-Disciplinary Team	

MNSI	Maternity and Newborn Safety Investigation	
MRSA	Methicillin-Resistant Staphylococcus Aureus	a bacterium responsible for several difficult-to-treat infections in humans
N		
NCL	North Central London	Made up of Barnet, Camden, Enfield, Haringey and Islington
Never Event		A serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. NHS England defines the list of never events every year
NIHR	National Institute for Health and Care Research	
NIS	Network and Information Systems	Network and Information Systems (NIS) Regulations 2018 are aimed at boosting the overall level of cyber security and physical resilience of network and information systems
NIS	Network and Information Systems Regulations 2018	
North Mid	North Middlesex University Hospital NHS Trust	
NRLS	National Reporting and Learning System	
NTCRN	North Thames Clinical Research Network	
O		
P		
PALS	Patient Advice and Liaison Service	offers confidential advice, support and information on health-related matters to patients, their families, and their carers
PMRT	Perinatal Mortality Review Tool	
PPC	Patient Partnership Council	
PPE	Personal Protective Equipment	PPE is equipment that will protect the user against health or safety risks at work.
PSG	Patient Safety Group	
PSIRF	Patient Safety Incident Response Framework	sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety
PSP	Patient Safety Partner	The PSP role provides patients, carers, and other lay people with the opportunity to support and contribute to a healthcare organisation's governance and management processes for patient safety
PTL	Patient Tracking List	
Q		
QI	Quality Improvement	
R		
R&D	Research and Development	Work directed towards the innovation, introduction, and improvement of products and processes
REGOs	Renewable Energy Guarantees of Origin	Certification of the renewable source of electricity, e.g. from wind or solar energy.
Royal Free London	Royal Free London NHS Foundation Trust	
RTT	Referral to Treatment Time	The waiting time between a patient being referred and receiving treatment
S		
SAR	Subject Access Request	
SDEC	Same Day Emergency Care	The provision of same day care for emergency patients who would otherwise be admitted to hospital

SHMI	Summary Hospital Level Mortality Indicator	Reports mortality at trust level across the NHS in England using standard and transparent methodology
SI	Serious Incident	
SIRO	Senior Information Risk Officer	A senior manager who will take overall ownership of the organisation's information risk policy
SJR	Structured Judgement Review	
SRR	Significant Risk Register	Lists all operational risk rated at 15 and above
StEis	Strategic Executive Information System	
T		
TAC	Trust Accounts Consolidation	
TDT	Tobacco Dependency Treatment	
TU	Trade Union	
U		
V		
W		
WDES	Workforce Disability Equality Standard	A set of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of Disabled and non-disabled staff.
WRES	Workforce Race Equality Standard	A metric to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of black and minority ethnic (BME) board representation
WTE	Whole Time Equivalent	A means of comparing the number of staff.
Y		
Z		