North Middlesex University Hospital NHS
NHS Trust

2015/16 Quality Account – Version 2

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

Statement on quality from the chief executive

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

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

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

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

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

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

Introduction

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

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

Each day, North Middlesex Hospital cares for:

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

In addition we provide:

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

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

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

Our vision and strategy

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

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

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

Our 10-year journey of improvement and growth

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

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

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

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

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

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

Improved care pathways

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

Key issues and risks – new challenges in 2015/16

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

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

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

Summary of our performance in 2015/16

Performance against key national priorities in 2015/16

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

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

A&E challenges

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

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

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

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

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

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

Mortality rates

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

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

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

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

Never Event

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

Infection control

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

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

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

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

Julie Lowe

Chief executive

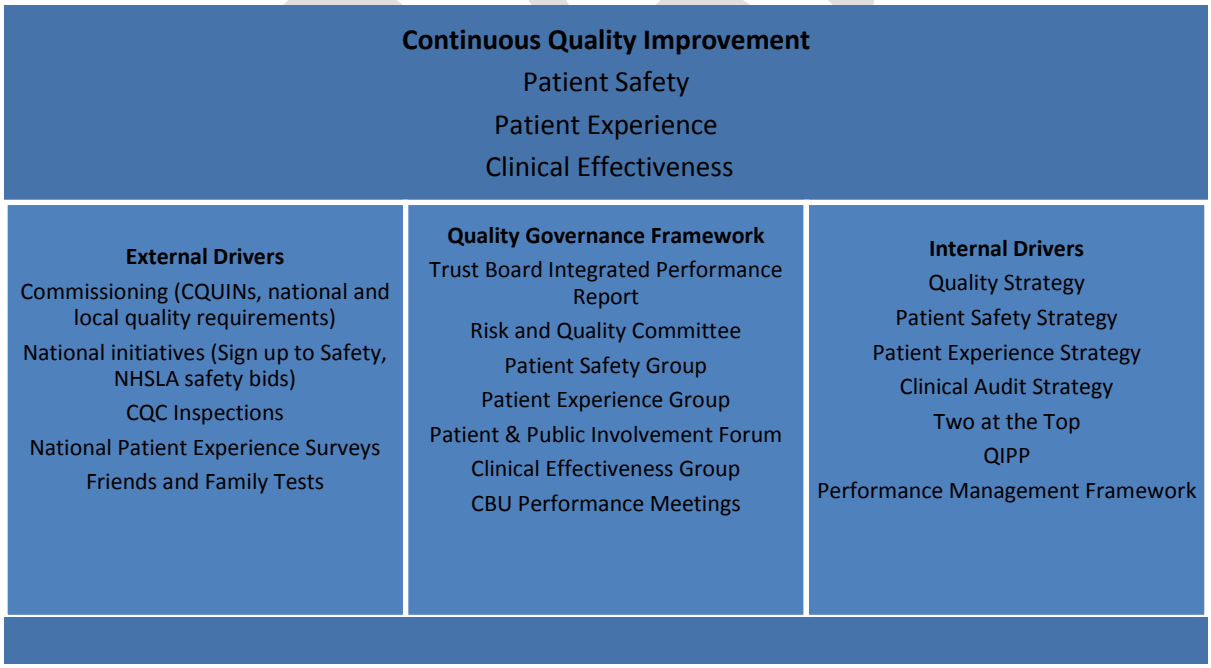
How quality is embedded in our culture at North Middlesex University Hospital

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

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

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

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



Duty of Candour

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

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

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

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

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

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

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

N.B. Insert second table here.

Sign Up to Safety

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2015 Staff Awards Winners

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

Chair's award for lifetime achievement in the NHS

Jan Cardenas, *community midwife*

Hilary Sinclair, *consultant rheumatologist*

Gerry Brown, *data quality manager*

Clinical excellence award

Mariya Savova and Ana Monserat, *maternity support workers*

Education excellence award

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

Improvement award

Sally Utting, *ophthalmology nurse*

Patient experience and involvement award

Sue Williams, *colorectal nurse specialist*

Top quality patient care award

Fola Babsola, *surgical care nurse*

Teamwork (team) award

Cardiology nursing team

Teamwork (individual) award

Val Johnson, *trauma coordinator and fracture clinic sister*

Unsung hero award for NHS staff

Accident and Emergency reception team

Unsung hero award for partner organisation

Patient transport team

ByNorth Community Partnership award

Apprentice project team

Chief Executive's award for Leadership

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

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

Delivery of the 2015/16 Quality Priorities

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

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

Patient Safety Priorities for delivery in 2015/16

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

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

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

Why we chose this priority?

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

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

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

What we wanted to improve?

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

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

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

What would success look like?

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

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

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

How we monitored progress?

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

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

What we achieved during 2015/16

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

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

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

Priority 2: Reducing the harm from patient falls

Why we chose this priority?

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

What we wanted to improve?

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

What would success look like?

Sustained reduction in the falls rate

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

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

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

What we achieved during 2015/16

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

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

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

Why we chose this priority?

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

What we wanted to improve?

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

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

Continue and improve the robust use of the SSKIN Bundle

Expanded training in pressure ulcer prevention and management

Improve access to pressure relieving equipment and effective barrier products.

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

What would success look like?

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

Reduction in the number of avoidable hospital acquired pressure ulcers

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

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

How we monitored progress?

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

What we achieved during 2015/16

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

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

Patient Experience Priorities for delivery in 2015/16

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

Why we chose this priority?

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

What we wanted to improve?

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

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

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

What would success look like?

National Patient Surveys

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

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

Friends and family test

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

What we achieved during 2015/16

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

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

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

Why we chose this priority

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

What we wanted to improve

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

How we monitored progress

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

What would success look like?

Increased referrals to the End of Life Care Team

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

Expanded service provision to seven days a week

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

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

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

Priority 3: Improving care for patients with dementia

Why we chose this priority?

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

What we wanted to improve?

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

How we monitored progress?

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

What would success look like?

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

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

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

What we achieved in 2015/16

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

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

Clinical Effectiveness Priorities for delivery in 2015/16

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

Why we chose this priority?

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

What we wanted to improve?

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

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

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

How we monitor progress?

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

What would success look like?

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

What we achieved during 2015/16

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

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

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

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

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

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

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

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

Priority 3: Design and Implement an Anaesthetics Service Improvement Plan

Why we chose this priority?

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

What we wanted to improve?

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

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

How we monitored progress?

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

What would success look like?

Substantive recruitment to all anaesthetic vacancies

Provision of 24/7 Critical Care Outreach Team

Provision of 7/7 specialist pain nursing service

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

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

Commission TIVA equipment in anaesthetics

What we achieved during 2015/16

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

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

QUALITY PRIORITIES FOR DELIVERY IN 2016/17

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

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

Patient safety:

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

Clinical effectiveness:

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

Patient experience:

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

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

NMUH Workforce priority:

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

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

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

Why have we chosen this priority?

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

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

1. Failure to recognize the severity of the illness

2. Inadequate first-line treatment with fluids and antibiotics

3. Delays in administering first-line treatment

4. Delay in source control of infection

5. Delay in senior medical input

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

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

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

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

What are we trying to improve?

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

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

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

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

What will success look like?

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

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

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

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

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

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

Reduction in total antibiotic consumption per 1,000 admissions

Reduction in total consumption of carbapenem per 1,000 admissions

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

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

How will we monitor progress?

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

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

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

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

Why have we chosen this priority?

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

What are we trying to improve?

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

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

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

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

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

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

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

What will success look like?

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

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

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

More than 20% of patients being discharged before midday.

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

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

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

How will we monitor progress?

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

1. Emergency Department

2. Assessment and Short Stay

3. Wards

4. Out-of-Hospital partners

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

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

Why have we chosen this priority?

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

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

What are we trying to improve?

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

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

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

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

What will success look like?

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

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

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

How will we monitor progress?

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

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

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

Why we have chosen this priority?

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

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

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

What will we improve?

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

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

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

What will success look like?

Increased staff satisfaction as measured by the annual staff survey.

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

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

How will we monitor progress?

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

Statements of assurance from the board

Red text indicates data from 2014/15 awaiting review

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

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

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

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

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

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

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

2.4 The national clinical audits and national confidential enquiries that North Middlesex University Hospital NHS Trust participated in, and for which data collection was completed during 2014/15, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

INSERT NATIONAL CLINICAL AUDIT AND NATIONAL CONFIDENTIAL ENQUIRY TABLE HERE

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

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

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

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

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

6. Not applicable.

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

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

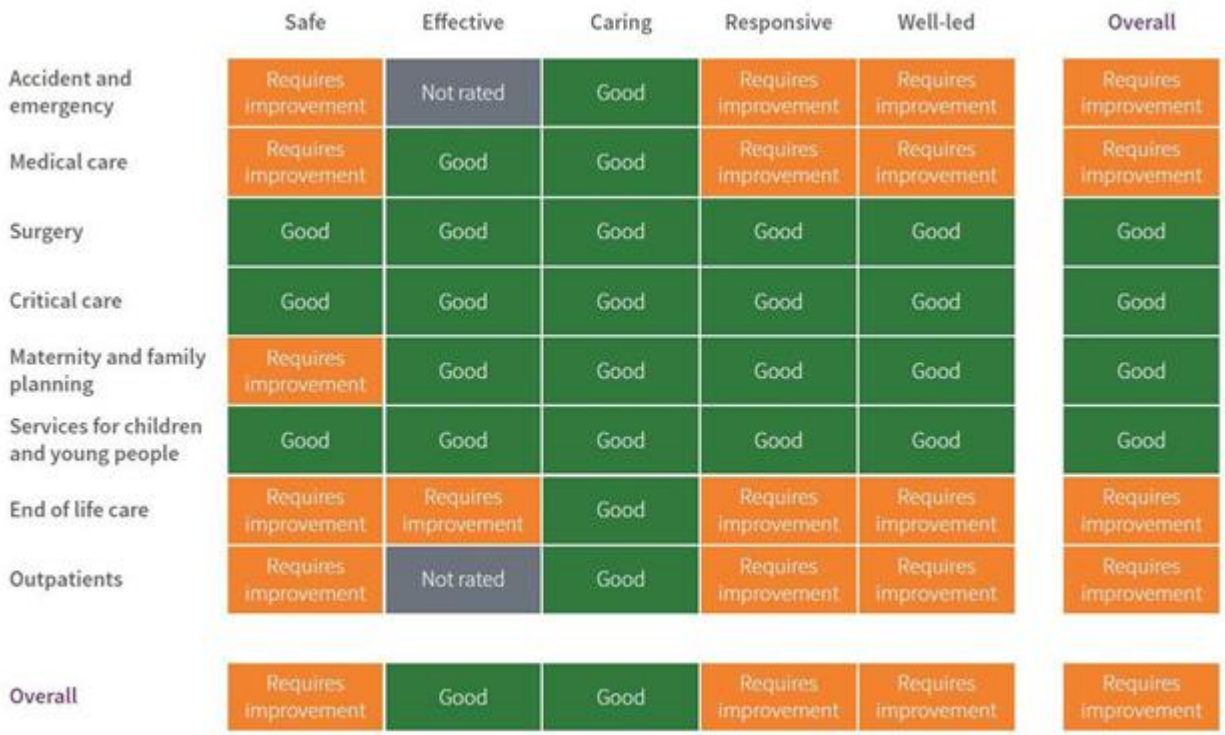
- Safe
- Effective
- Caring
- Responsive
- Well led

The following services were inspected:

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

- Paediatrics
- Outpatients
- End of Life Care

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



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

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

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

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

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

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

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

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

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

Domain 1 - Preventing people from dying prematurely

Summary Hospital-Level Mortality Indicator (SHMI)

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

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

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

Key SHMI Banding 1 = 'Higher than expected'
2 = 'As expected'
3 = 'Lower than expected'

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The Trust's SHMI rate is banded 'as expected'.

The North Middlesex University Hospital NHS Trust has taken the following actions to improve this rate, and so the quality of its services, by:

Ensuring that all deaths that occur in the hospital are closely reviewed as routine to assure that the best possible care was given to patients in all cases. Any subsequent learning events are shared within the organisation as appropriate.

(b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.

(ii) Percentage of deaths with palliative care coding.

Publication Date	Reporting period	Measure	NMUH Value	National Average	National Lowest	National Highest
March 2016	October 2014 - September 2015	Treatment Rate	**0.0**	1.6	0.0	19.2
		Diagnosis Rate	**21.2**	26.5	0.2	53.5
		Combined Rate	**21.2**	26.6	0.2	53.5
January 2016	July 2014 - June 2015	Treatment Rate	**0.0**	1.6	0.0	18.4
		Diagnosis Rate	**21.1**	25.9	0.0	52.9
		Combined Rate	**21.1**	26.0	0.0	52.9

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The Trust's percentage of deaths with palliative care coding which is lower than the national average.

The North Middlesex University Hospital NHS Trust has taken the following actions to improve this rate, and so the quality of its services, by:

The Trust undertook a review of palliative care coding and corrected its practice from 2014 onward. This is reflected in the reported scores, which show a consistent performance lower than the national average.

Domain 2 - Enhancing quality of life for people with long-term conditions

Not applicable to the North Middlesex University Hospital NHS Trust

Domain 3 - Helping people to recover from episodes of ill health or following injury

PROMS; patient reported outcome measures.

(i) Groin hernia surgery

Publication Date	Reporting period	Measure	NMUH Value	National Average	National Lowest	National Highest
February 2016	April 2014 - March 2015	EQ VAS	**-4.320**	-0.504	-4.698	4.676
		EQ-5D Index	**0.076**	0.084	0.000	0.154
August 2015	April 2013 - March 2014	EQ VAS	**0.124**	-1.048	-5.798	2.856
		EQ-5D Index	**0.068**	0.085	0.008	0.139

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The trust's performance against the EQ VAS measure has seen deterioration between the reporting periods shown above, while performance against the EQ-5D Index has shown improvement.

The North Middlesex University Hospital NHS Trust [intends to take / has taken] the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

TBC

(ii) Varicose vein surgery

Note: No varicose vein surgery data available for 2014-15. No data previous to 2013-14 available.

Publication Date	Reporting period	Measure	NMUH Value	National Average	National Lowest	National Highest
August 2015	April 2013 - March 2014 (Unadjusted)	Aberdeen Varicose Vein Questionnaire	**-10.226**	-8.701	-19.385	-2.721
		EQ VAS	**-1.429**	-0.548	-12.045	19.143
		EQ-5D Index	**0.073**	0.093	-0.096	0.467

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The Trust's performance was slightly below the national average for this measure in the only available data set covering the financial year 2013-14. Please note that the data is not currently case-mix-adjusted.

The North Middlesex University Hospital NHS Trust [intends to take / has taken] the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

TBC

(iii) Hip replacement surgery

Note: Only unadjusted hip replacement surgery data available for 2013-14

Publication Date	Reporting period	Measure	NMUH Value	National Average	National Lowest	National Highest
February 2016	April 2014 - March 2015	EQ VAS	**9.873**	11.953	6.425	17.390
		EQ-5D Index	**0.431**	0.437	0.331	0.524
		Oxford Hip Score	**19.390**	21.444	16.292	24.652
August 2015	April 2013 - March 2014 (unadjusted)	EQ VAS	**7.667**	11.462	3.804	27.815
		EQ-5D Index	**0.450**	0.436	0.068	0.586
		Oxford Hip Score	**20.519**	21.380	14.576	24.949

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The Trust's performance was slightly below the national average but shows improvement between the two reporting periods. Please note that the data is not currently case mix adjusted.

The North Middlesex University Hospital NHS Trust [intends to take / has taken] the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

TBC

(iv) Knee replacement surgery

Note: No knee replacement surgery data available for 2014-15

Publication Date	Reporting period	Measure	NMUH Value	National Average	National Lowest	National Highest
February	April 2014 -	EQ VAS	**5.881**	5.783	1.423	15.423

2016	March 2015	EQ-5D Index	**0.295**	0.315	0.204	0.418
		Oxford Knee Score	**15.471**	16.148	11.475	19.492
August 2015	April 2013 - March 2014	EQ VAS	**1.719**	5.191	-2.477	16.010
		EQ-5D Index	**0.299**	0.318	0.215	0.425
		Oxford Knee Score	**14.338**	15.996	11.933	19.709

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The Trust's performance improved against two of the three measures between reporting periods, but remains below the national average.

The North Middlesex University Hospital NHS Trust [intends to take / has taken] the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

TBC

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

This indicator on the HSCIC Indicator Portal was last updated in December 2013 and the next update is due to take place in August 2016.

(i) aged 0 to 15

Publication	**Reporting period**	**NMUH**	**National**	**National**	**National**

Date		Value	Average	Lowest	Highest
Dec 2013	2011-12	**7.88%**	10.01%	3.75%	14.94%
Dec 2013	2010-11	**6.27%**	10.01%	4.04%	16.05%

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The trust's performance is slightly higher in the most recent reporting period above but both figures remain significantly better than the national average.

The North Middlesex University Hospital NHS Trust [intends to take / has taken] the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

Ensuring that paediatric patients can be fast tracked to dedicated day care facilities for treatment where clinically appropriate and help to avoid frequent and regular unplanned admissions to hospital. This helps children and carers to experience treatment in a less daunting and more comfortable environment.

(ii) aged 16 and over

Publication Date	Reporting period	NMUH Value	National Average	National Lowest	National Highest
Dec 2013	2011-12	**12.56%**	11.45%	4.88%	17.15%
Dec 2013	2010-11	**11.30%**	11.43%	6.67%	17.10%

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The trusts' performance over time has been broadly in line with the national average for this measure although there is an increase between the data time periods above.

The North Middlesex University Hospital NHS Trust [intends to take / has taken] the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

Ensuring that patients groups such as Sickle Cell suffers for example are helped in both the community and day care centres to better understand their signs and symptoms and take quicker action. This enables patients to experience treatment in a more appropriate and comfortable setting and avoid frequent (and often lengthy) unplanned admissions to hospital wards. Feedback from patients around this amended care pathway has been very positive indeed.

Domain 4 - Ensuring people have a positive experience of care

Responsiveness to the personal needs of patients

Publication Date	Reporting period	NMUH Value	National Average	National Lowest	National Highest
August 2015	2014-15	**59.3**	68.9	54.4	86.1
August 2015	2013-14	**65.5**	68.7	54.4	84.2

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The Trust's performance has historically been below the national average for this measure.

The North Middlesex University Hospital NHS Trust [intends to take / has taken] the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

TBC

Staff who would recommend the trust to their family or friends

Publication Date	Reporting period	NMUH Value	National Average	National Lowest	National Highest
February 2015	2015	**49%**	69%	46%	85%
February 2015	2014	**59%**	65%	38%	89%

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The Trust's performance has historically been below the national average for this measure.

The North Middlesex University Hospital NHS Trust [intends to take / has taken] the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

TBC

Patients who would recommend the trust to their family or friends

A&E

Publication Date	Reporting period	NMUH Value	National Average	National Lowest	National Highest
Jan-16	Q3 2015-16	**63%**	87%	25%	99%
Oct-15	Q2 2015-16	**84%**	88%	69%	100%
Jul-15	Q1 2015-16	**85%**	88%	39%	98%

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. Reporting on this measure within the Quality Accounts this year is optional. The Trust achieved a performance slightly below the national benchmark in the first half the 2015-16 financial year, but performance dipped in Q3 (in-line with other major acute Trusts in London), although in the case of North Middlesex Hospital this reflects the difficulties faced by one of the busiest A&E departments in the country over the winter period.

The North Middlesex University Hospital NHS Trust [intends to take / has taken] the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

TBC

Inpatients

Publication	Reporting period	NMUH	National	National	National

Date		Value	Average	Lowest	Highest
Jan-16	Q3 2015-16	**93%**	96%	74%	100%
Oct-15	Q2 2015-16	**96%**	96%	75%	99%
Jul-15	Q1 2015-16	**92%**	96%	77%	99%

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. Reporting on this measure within the Quality Accounts this year is optional. The Trust's performance during 2015-16 has been broadly similar and continues to show a positive inpatient experience.

The North Middlesex University Hospital NHS Trust [intends to take / has taken] the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

TBC

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

Patients admitted to hospital who were risk assessed for venous thromboembolism

Publication Date	Reporting period	NMUH Value	National Average	National Lowest	National Highest
March 2016	Q3 2015-16	**96.6%**	95.4%	78.5%	100.0%
December 2015	Q2 2015-16	**97.0%**	95.8%	75.0%	100.0%
December	Q1 2015-16	**96.4%**	96.0%	86.1%	100.0%

2015					

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The trust's performance has historically been at or above the national average for this measure.

The North Middlesex University Hospital NHS Trust [intends to take / has taken] the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

TBC

Rate of C.difficile infection

Publication Date	Reporting period	NMUH Value	National Average	National Lowest	National Highest
July 2015	2014-15	**28.2**	15.1	0.0	62.2
July 2015	2013-14	**15.2**	14.7	0.0	37.1

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The Trust continues to review all cases of C.Difficile infection to determine whether infection was cause by a lapse in care. The Trust has an agreed target with commissioners for this measure, which was met during 2014-15.

The North Middlesex University Hospital NHS Trust [intends to take / has taken] the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

TBC

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

Publication Date	Reporting period	Measure	NMUH Value	National Average	National Lowest	National Highest
November 2015	October 2014 - March 2015	Number of Patient Safety Incidents	**3,530**	4,539	443	12,784
		Rate of incidents (per 1000 bed days)	**40.2**	36.3	3.6	82.2
		No. resulting in severe harm or death	**12**	23	2	128
		% resulting in severe harm or death	**0.3%**	0.5%	0.0%	5.2%
November 2015	April 2014 - September 2015	Number of Patient Safety Incidents	**3,498**	4,196	35	12,020
		Rate of incidents (per	**43.6**	35.3	0.2	75.0

		1000 bed days)				
		No. resulting in severe harm or death	**7**	20	0	97
		% resulting in severe harm or death	**0.2%**	0.5%	0.0%	82.9%

The North Middlesex University Hospital NHS Trust considers that this data is as described for the following reasons:

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator.

The North Middlesex University Hospital NHS Trust has taken the following actions to improve this [percentage / proportion / score / rate / number], and so the quality of its services, by:

Annex 1: Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

Annex 2: Statement of directors' responsibilities for the quality report