NOTICE OF MEETING

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

Contact: Robert Mack

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Friday 26 April 2019 14:00 hrs
George Meehan House, 294, High Road Wood Green, London N22 8YX

Councillors: Alison Cornelius and Val Duschinsky (L.B.Barnet), Huseyin Akpinar and Clare de Silva (L.B.Enfield), Pippa Connor and Lucia das Neves (L.B.Haringey)

AGENDA

1. APPOINTMENT OF SUB-GROUP CHAIR

2. FILMING AT MEETINGS

Please note that this meeting may be filmed or recorded by the host Council for live or subsequent broadcast or by anyone attending the meeting using any communication method. Although we ask members of the public recording, filming or reporting on the meeting not to include the public seating areas, members of the public attending the meeting should be aware that we cannot guarantee that they will not be filmed or recorded by others attending the meeting. Members of the public participating in the meeting (e.g. making deputations, asking questions, making oral protests) should be aware that they are likely to be filmed, recorded or reported on.

By entering the meeting room and using the public seating area, you are consenting to being filmed and to the possible use of those images and sound recordings.

3. APOLOGIES FOR ABSENCE

4. DECLARATIONS OF INTEREST

Members of the Committee are invited to identify any disclosable pecuniary or prejudicial interests relevant to items on the agenda. A member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting at which a matter is considered:

(i) must disclose the interest at the start of the meeting or when the interest becomes apparent, and

(ii) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in their borough's Register of Members' Interests or the subject of a pending disclosure must notify their Monitoring Officer of the interest within 28 days of the disclosure.

5. MINUTES (PAGES 1 - 10)

To approve the minutes of the meeting of 5 May 2019.

6. QUALITY ACCOUNTS - GUIDANCE (PAGES 11 - 20)

To note guidance for overview and scrutiny committees from the Department of Health regarding consideration of Quality Accounts (attached).

7. BARNET, ENFIELD AND HARINGEY MENTAL HEALTH TRUST - DRAFT QUALITY ACCOUNT (PAGES 21 - 110)

To consider and comment on the draft Quality Account for Barnet, Enfield and Haringey Mental Health Trust (attached).

8. NORTH MIDDLESEX UNIVERSITY HOSPITAL - DRAFT QUALITY ACCOUNT (PAGES 111 - 206)

To consider and comment on the draft Quality Account for North Middlesex University Hospital (attached).

18 April 2019

Agenda Item 5

MINUTES OF THE MEETING OF JHOSC MENTAL HEALTH SUB GROUP HELD ON FRIDAY 5TH MAY 2017

COUNCILLORS

PRESENT Pippa Connor (Chair) –Haringey, Charles Wright –Haringey, Abdul Abdullahi – Enfield, Anne Marie Pearce – Enfield, Alison Cornelius – Barnet, Caroline Stock - Barnet

ABSENT

OFFICERS: Mary Sexton, Executive Director of Nursing, Quality and Governance, BEH MHT, Andrew Wright, Director of Strategic Development, BEH MHT, Margaret Southcote-Want, Deputy Director of Quality, BEH MHT, Carole Bruce-Gordon, interim Director of Quality and Integrated Governance, Enfield CCG, Peppa Aubyn, Head of Mental Health Commissioning, Enfield CCG, Bridget Pratt, Assistant Director of Quality and Governance, Enfield CCG, Andy Ellis, Scrutiny Officer, Enfield Council.

Also Attending: Deborah Fowler, Chair- Healthwatch Enfield, Patricia Mecinska, Chief Executive – Enfield Healthwatch, Cllr Laurie Williams (Barnet)

1 WELCOME & APOLOGIES

The Chair, Cllr Connor welcomed everyone to the meeting and introductions were made. Apologies were received from Cllr Graham Old (Barnet) with Cllr Caroline Stock attending as a substitute. Apologies also from Maria Kane (BEH MHT), Graham McDougall (Enfield CCG) and Christian Scade (Haringey Council).

2 DECLARATIONS OF INTEREST

Cllr Connor declared an interest as her sister is a GP in Tottenham and Cllr Connor is also a member of the Royal College of Nurses.

3 BARNET, ENFIELD AND HARINGEY MENTAL HEALTH TRUST- DRAFT QUALITY ACCOUNT 2016/17

RECEIVED: An overview of the draft document from Mary Sexton.

NOTED: The following:

(i) That the draft document reflects previous comments received from the JHOSC Sub Group over the past 4 years and will move away from core text to include more visual content.

(ii) The document reflects the CQC Development and Action Plan and it was noted that a full re-inspection will take place in early autumn.
(iii) As in previous years, this is a hybrid document, looking over the past year in addition to priorities for 17/18. The priorities for 17/18 have been agreed with stakeholders and commissioners.
(iv) The final document will be published on the Trust's website on 30th June and will be an inter-active and colour coded version. A hard copy, summary document will also be available.

Mary then took Members through the document, highlighting areas and taking questions as appropriate.

(v) In response to a question relating to 3 actions not being on target within the Improvement Action Plan, it was noted that although funding had been agreed with Enfield CCG, the monies were not received until January 2017, therefore, the actions had to be shown as not on track.
(vi) There followed a general discussion on well-being services being implemented to reduce episodes of crisis. Members were informed that Enfield CCG is working with Enfield Council and the Trust on a Better Care Fund pilot relating to well-being. The Trust really welcomes primary care support to avoid admissions, however, this has yet to be realised as the current bed occupancy rate is 111%.
(vii) A deficit of £12m was posted for the last financial year. It is planned that following proposed savings measures, the deficit will be reduced to £4.6m for this year. However a comment was received that 3 previous price reviews have failed to realise additional funding.
(viii) The savings proposals include reducing agency costs, rationalisation of estates, review of procurement processes and a review of back office functions in conjunction with the Mental Health Trust Alliance.
(ix) It was noted that with the Trust still having low reference costs, there is little capacity to reduce costs without reducing services.
(x) In reply to a question relating to the value of the peer review, Members were advised that the process acted as an invaluable training exercise for staff when being questioned by outside bodies.
(xi) A question relating to staffing levels highlighted that there is less reliance on agency and locum staff with the average vacancy factor for registered nurses now running at 16%. Ideally, the vacancy factor should be running at 6-8%. Agency costs for last year were £1.2m however this has reduced to £700k this year.

(xii) The section on ‘looking Back to 2016/17’ was presented in a very visual style which Members felt was helpful and they were advised that information was collected to reflect themes and trends therefore ensuring improvements are made.

(xiii) Members were concerned that only 65% of patients felt they had benefitted from their care, against a national target of 90%. A question followed in relation to how we compare against other trusts in this context. Members were informed that although there was no national data as yet, individual quality accounts are reviewed to see who is performing well. A supplementary question probed whether patients are asked for their views at the start and completion of their treatment. It was noted that care plans should be written in partnership with the clinician and the patient and then reviewed at the end of the treatment.

(xiv) Some GPs are concerned that they are not informed when patients are discharged and have no knowledge of the state of their medication. In response, Enfield CCG confirmed that meetings between themselves, GPs and the Trust would ensure future engagement with GPs was improved.

(xv) The section on ‘Enablement’ provided details of the different projects being undertaken in each borough. Clarification was provided that the ‘First Steps to Work’ project in Haringey was on a 6 week rolling programme, rather than a one-off event over a period of 6 weeks.

(xvi) A summary of the quality priorities for 2017/18 was provided, along with participation in accreditation schemes, participation in clinical research and data quality.

(xvii) The patient experience is measured in several ways within the draft quality account. The friends and families test (FFT), service user and carer surveys, compliments received and the community mental health survey are all valuable tools.

(xviii) A question was raised, asking how the FFT results compared to the figures for patients feeling they had benefitted from MHT care (see xiii above). In response, the Trust informed Members that as slightly different questions are used, it isn’t possible to compare results.

(xix) It was questioned why there were a higher number of complaints in Haringey and in response the Trust stated that this is likely to be a result of the environment, the declining of leave when requested and complex levels of need.

(xx) It was suggested that as more agency staff are used in Haringey, this may have a detrimental effect on the number of complaints. The Trust said they would consider possible correlation between these figures.

(xxi) It was agreed that compliments were an important form of feedback but a more detailed breakdown would be beneficial.

(xxii) There are less than 200 complaints across a customer base of 150,000 and 10% of complaints have been upheld. It would be useful if the Quality Account could contain detail of what action and learning has resulted from each complaint. The Trust agreed to address this.

(xxiii) With regard to re-admissions, the CCG praised the Trust for having the 2nd lowest rate in London.

(xxiv) Patient safety figures highlighted that more patients are coming to less harm in the Trust's care, however, more narrative is required in the Quality Account in support of patient safety incidents. This will include more detail relating to serious incidents.

(xxv) With regard to the staff survey, a question was raised asking if staff are encouraged to report assaults? They are encouraged to report any incident but an 'assault' can be as little as a tap on the shoulder, which could be the reason for the increase.

(xxvi) The figure quoted for staff experiencing physical violence from other staff over the past year (6%) is being investigated as there were only 2 reported incidents, which doesn't equate to 6% of the workforce.

(xxvii) Staff training figures are effected by issues such as staff being released, having booked a session or not reading the pre-competency assessment (therefore they fail). Some report as being unwell. All of these issues are being addressed in an attempt to improve the figures. For example, reminders are sent advising that 'you will become non-compliant in 12 weeks, so must attend training.'

(xxviii) The Trust confirmed that with a bed occupancy rate of 111%, delayed transfers of care (DTOC) are a significant issue for the Trust.

(xxix) The CCG confirmed that the 2 main causes for delay are access to housing and access to social care. The third cause is advice and guidance to people with no recourse to public funding. The Better Care Fund may be able to support a reduction in DTOC.

(xxx) Members agreed that this issue should be discussed at the wider JHOSC with figures providing a breakdown on the reasons for DTOC in each borough.

(xxxi) The Trust asked that any final comments be provided in writing by Friday 19th May.

(xxxii) Cllr Cornelius requested that the response from the sub-group be broken down into positive comments, areas of concern and amendments/additions to the draft document.

4 MINUTES OF THE LAST SUB-GROUP MEETING

AGREED the minutes from the meeting held on 13th May 2016

5. DATE OF NEXT MEETING

Date to be confirmed

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ENFIELD Connected

ENFIELD Council

Mary Sexton
Executive Director
BEH Mental Health Trust
Trust Headquarters, Orchard House
St Ann's Hospital
St Ann's Road, London, N15 3TH

Please reply to : Andy Ellis

E-mail : Andy.ellis@enfield.gov.uk
Phone : 0208 379 4884
Textphone :
Fax :
My Ref :
Your Ref :
Date : 16th May 2017

Dear Mary,

Quality Account 2016/17 – NCL JHOSC BEH Sub Group Response

This letter is a joint submission to the Trust made by the London Boroughs of Barnet, Enfield and Haringey following consideration of the draft Quality Account at a meeting between the three Boroughs held on 5th May 2017.

Members of the BEH Sub Group are grateful for the presentation of the Trust's Quality Account. It is evident that the priorities highlighted by the Trust are building upon those identified in previous years.

Members were pleased to note that previous comments from the Sub Group had been adopted and included within the draft document. In addition, it was noted that the Development and Action Plan produced following the CQC inspection is reflected in the draft document. In reducing agency costs from £1.2m to £700,000, a greater continuity of staff now exists.

To assist with the completion of the final document, I have provided a summary of Members comments relating to the structure and content of the Account itself.

- **First Steps to Work (P.19)**
  - This section needs to clarify that each course lasts for 6 weeks, on a rolling programme, not just 1 course for 6 weeks.

- **Compliments (P.33)**
  - A more detailed breakdown of the range and nature of compliments would be beneficial.

- **Complaints (P.33)**
  - With approximately 10% of complaints being upheld, it would be useful to include some detail on actions taken and learning identified.

- **Patient Safety Incidents (P.42)**
  - More narrative is required to support the graphic. In addition, it would be helpful to provide a definition of the term 'serious incident.'

- **Staff Survey (P.50)**
  - The narrative in this section should be more specific to reflect all aspects of control and training.

In addition to the detail within the Quality Account, the Sub Group noted, with concern, the current financial deficit of £12m. A savings plan will be instigated in an attempt to reduce the deficit to £4.6m. The savings proposals include a further reduction in agency costs, rationalisation of estates, a review of procurement processes and a review of back-office functions in conjunction with the Mental Health Trust Alliance. Comments from the Lead Commissioner, Enfield Clinical Commissioning Group, highlighted an equally challenging financial position.

The specific funding relating to the redevelopment of the St. Anne's site was discussed along with Delayed Transfers of Care (DToC).The 2 predominant reasons for DToC are access to housing and access to social care. It was agreed that the issue of DToC should be a subject for discussion at the wider JHOSC, with figures provided for each borough.

On behalf of BEH Sub Group Members, I hope the above comments are beneficial and assist with the completion of the final Quality Account.

Yours sincerely,

Councillor Pippa Connor
Chair, NCL JHOSC BEH Sub Group

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Quality Accounts: a guide for Overview and Scrutiny Committees

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Commissioning
Management	IM & T
Planning /	Finance
Clinical	Social Care / Partnership Working

Document Purpose	Best Practice Guidance
Gateway Reference	15794
Title	Quality Accounts: a guide for Overview and Scrutiny commitees
Author	DH
Publication Date	16 Mar 2011
Target Audience	Local Authority CEs
Circulation List	Local Authority CEs
Description	Healthcare providers publishing Quality Accounts in June 2011 have a legal duty to send their Quality Account to the OSC in the local authority area in which the provider has its registered office, inviting comments on the report from the OSC prior to publication.
Cross Ref	Quality Accounts Toolkit 2010/11
Superseded Docs	
Action Required	N/A
Timing	
Contact Details	Richard Owen NHS Medical Directorate Skipton House 80 London Road London SE1 6LH
For Recipient's Use	

Quality Accounts: a guide for Overview and Scrutiny Committees (OSCs).

Healthcare providers publishing Quality Accounts have a legal duty to send their Quality Account to the OSC in the local authority area in which the provider has its registered office, inviting comments on the report from the OSC prior to publication.

This gives OSCs the opportunity to review the information contained in the report and provide a statement on their view of what is reported.

Providers are legally obliged to publish this statement (of less than 1000 words) as part of their Quality Account.

Providers must send their Quality Account to the appropriate OSC by the 30 April each year. This gives the provider up to 30 days following the end of the financial year to finalise its Quality Account, ready for review by its stakeholders.

This mini-guide has been produced specifically for OSCs and draws on relevant information already published in the Quality Accounts toolkit :

http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/Makingqualityhappen/qualityaccounts/index.htm

What is a Quality Account?

Quality Accounts are annual reports to the public from providers of NHS healthcare services about the quality of services they provide. This publication mirrors providers' publication of their financial accounts.

Who has to provide one?

All providers of NHS healthcare services in England, whether they are NHS bodies, private or third sector organisations must publish an annual Quality Account. Providers are exempt from reporting on any primary care or NHS Continuing Health care services.

What is the purpose of a Quality Account?

The primary purpose of Quality Accounts is to encourage boards and leaders of healthcare organisations to assess quality across all of the healthcare services they offer, and encourage them to engage in the wider processes of continuous quality improvement. Providers are asked to consider three aspects of quality – patient experience, safety and clinical effectiveness. The visible product of this process – the Quality Account – is a document aimed at a local, public readership. This both reinforces transparency and helps persuade stakeholders that the organisation is committed to quality and improvement. Quality Accounts therefore go above and beyond regulatory requirements, which focus on essential standards.

If designed well, the Accounts should assure commissioners, patients and the public that healthcare providers are regularly scrutinising each and every one of their services, concentrating on those that need the most attention.

Quality Accounts aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda.

How will they be used?

Quality Accounts will be published on the NHS Choices website and providers will also have a duty to:

• display a notice at their premises with information on how to obtain the latest Quality Account; and

• provide hard copies of the latest Quality Account to those who request one.

The public, patients and others with an interest in their local provider will use a Quality Account to understand:

• where an organisation is doing well and where improvements in service quality are required;

• what an organisation's priorities for improvement are for the coming year; and

• how an organisation has involved service users, staff and others with an interest in the organisation to help them evaluate the quality of their services and determine their priorities for improvement.

Commissioners and healthcare regulators, such as the Care Quality Commission, will use Quality Accounts to provide useful local information about how a provider is engaged in quality and tackles the need for improvement.

Quality Accounts will be public-facing documents, published on NHS Choices

How will the process of producing a Quality Account benefit the provider?

The process of producing a Quality Account is an opportunity for organisations and clinicians to collect, review and analyse information relating to quality, so that they can decide where improvement is needed in such a way that it becomes part of the core business of the organisation.

It can also help with benchmarking against other organisations.

The process of producing a Quality Account also provides an opportunity for providers to engage their stakeholders, including PCTs, LINKs and the public, in the review of information relating to quality and decisions about priorities for improvement.

This sort of quality monitoring and improvement activity can have many purposes for the provider. For example it will help them to assess their risks and monitor the effectiveness of the services they provide; the information could also inform their internal monitoring of compliance with CQC registration requirements.

Why are OSCs being asked to get involved with Quality Accounts?

The Department of Health engaged widely with healthcare providers, commissioners, patient groups and third sector organisations in the development of Quality Accounts.

A key message from our stakeholder engagement activity was that confidence in the accuracy of data and conclusions drawn on the quality of healthcare provided from these figures is key to maximising confidence in those reading Quality Accounts. Without some form of scrutiny, service users and members of the public may have no trust in what they are reading.

OSCs, along with LINKs and commissioning PCTs, have been given the opportunity to comment on a provider's Quality Account before it is published as it is recognised that they have an existing role in the scrutiny of local health services, including the ongoing operation of and planning of services.

The powers of overview and scrutiny of the NHS enable committees to review any matter relating to the planning, provision and operation of health services in the area of its local authority. Each local NHS body has a duty to consult the local overview and scrutiny committee(s) on any proposals it may have under consideration for any substantial development of the health service in the area of the committees' local authorities, or on any proposal to make any substantial variation in the provision of such service(s).

How can OSCs get involved in the development of Quality Accounts?

OSCs are ideally placed to ensure that a provider's Quality Account reflects the local priorities and concerns voiced by their constituents.

If an important local healthcare issue is missing from a provider's Quality Account then the OSC can use the opportunity in the form of a statement to be included in a provider's Quality Account to highlight this omission. Some of these issues might not directly relate to healthcare quality, so their omission by the provider might be unavoidable (given their legal obligation to report on healthcare only) and your commentary should acknowledge that.

Quality Accounts aim to encourage local quality improvements, OSCs can add to the process and provide further assurance by providing comments on the issues they are involved in locally.

OSCs may also wish to comment on how well providers have engaged patients and the public, and how well they have promoted the Quality Account.

OSCs should not feel that they have to comment on areas of the Quality Account where they do not have relevant knowledge. However, conversations between providers and OSCs should start at the beginning of the planning process for the production of a Quality Account so both the provider and the OSC are aware of each other's expectations in the process.

OSCs could therefore comment on the following:

- does a provider's priorities match those of the public;
- whether the provider has omitted any major issues;
- has the provider demonstrated they have involved patients and the public in the production of the Quality Account; and
- any comment on issues the OSC is involved in locally.

What must providers do to give OSCs the opportunity to comment on their Quality Account?

A provider must send their Quality Account to the OSC in the local authority area in which the provider has its registered or principal office located.

They must send it to the appropriate OSC by the 30 April each year. This gives the provider up to 30 days following the end of the financial year to finalise its Quality Account, ready for review by its stakeholders.

The OSC then has the opportunity to provide a statement of no more than 1000 words indicating whether they believe, based on the knowledge they have of the provider, that the report is a fair reflection of the healthcare services provided.

The OSC should return the statement to the provider within 30 days of receipt of the Quality Account to allow time for the provider to prepare the report, which will include the statement, for publication.

If the provider makes changes to the final published version of their Quality Account after having received the statement (possibly as a result of the statement), they are required to include a statement outlining what these changes are.

How does the review of Quality Accounts in April fit in with the other activities carried out by OSCs?

Quality Accounts do not replace any of the information sent to CQC by OSCs as part of CQC's regulatory activities.

Quality Accounts and statements made by commissioners, LINks and OSCs will be an additional source of information for CQC that may be of use operationally in helping to inform their local dialogues with providers and commissioners.

It is recommended that discussions around the proposed content of a Quality Account and review of early drafts of the report is conducted during the reporting year in question so that by April each year OSCs will already have a good idea of what they expect to see in a provider's Quality Account and may have commented on earlier versions.

Where local elections are being held in April and OSCs will not have the opportunity to review Quality Accounts, it is advised that where possible, OSCs discuss plans and suggest content for Quality Accounts with providers when they reconvene in the summer.

Stakeholder engagement in the development of a Quality Account should be a year-long process – ideally starting at the beginning of the reporting year.

Which OSC should a provider send its Quality Account to?

A provider must send their Quality Account to the OSC in the local authority area in which the provider has its registered or principal office located. This may be different from the geographical area of the lead commissioner. In these cases, liaison and co-operation will be the key to achieving a rounded view on the organisation for whose Quality Account you are providing feedback.

Does an OSC have to supply a statement for every Quality Account it is sent?

No. The role of OSCs in providing assurance over a provider's Quality Account is a voluntary one. Depending on the capacity and health scrutiny interests of the OSC, the committee may decide to prioritise and comment on those providers where members and the constituents they represent have a particular interest.

It would be helpful to let the provider know that you do not intend to supply a statement so that this does not hold up their publication.

Does the statement have to be 1000 words longs?

No, this is a maximum set in the Regulations. We have increased the maximum limit for situations where LINks and OSC wish to produce joint comments.

Working with commissioning PCTs, LINks and other stakeholders

Existing DH guidance recommends that scrutiny of services provided, commissioned or planned by a single NHS body covering more than one local authority area, is undertaken by a joint committee.

Joint committees may therefore wish to work together when considering Quality Accounts for organisations that provide services across multiple authority areas such as ambulance trusts. For instance, joint arrangements may already be in place for providing third party comments on providers to the CQC (for instance, to provide comments to CQC about a provider's compliance with registration requirements) and it would be appropriate to use these existing arrangements to discuss provider's Quality Accounts.

It should be noted however that the legal requirement is for a provider to send their Quality Account to the OSC in the local authority area in which the provider has its registered or principal office located and to publish within their final Quality Account any statement that they have provided. It is important therefore that, when OSCs jointly consider a provider's Quality Account, it is the OSCs residing in the local authority area that sends the statement back to the provider. If the statement has been jointly written, it would be appropriate to state who has contributed to it.

How OSCs and other stakeholders work together is left for local discretion as there is variation across authority areas.

When OSCs jointly consider a provider's Quality Account, the OSC residing in the local authority area for the provider should send the statement back to the provider.

What should OSCs do if they receive a Quality Account from a provider with a national presence?

Some OSCs may receive Quality Accounts from multi-site providers. We do not expect an OSC to assure the quality of a national provider. Instead, we ask that the provider demonstrates how they nationally engage stakeholders day-to-day and in the production of the Quality Account.

How does Quality Accounts fit with the wider quality improvement agenda?

The objectives for Quality Accounts are to encourage boards and leaders of healthcare organisations to assess quality across all of the healthcare services

they offer, and encourage them to engage in the wider processes of continuous quality improvement, holding them accountable to stakeholders.

How do Quality Accounts relate to the work of regulators such as CQC and Monitor?

Quality Accounts do not replace any of the information sent to CQC as part of their regulatory activities. Quality Accounts and statements made by commissioners, LINks and OSCs will be an additional source of information for the CQC that may be of use operationally in helping to inform their local dialogues with providers and commissioners.

When providing comments on a Quality Account, OSCs should consider whether their reflections on the quality of healthcare provided should also be submitted to CQC.

Monitor's annual reporting guidance requires NHS foundation trusts to include a report on the quality of care they provide within their annual report. NHS foundation trusts also have to publish a separate Quality Account each year, as required by the NHS Act 2009, and in the terms set out in the Regulations. This Quality Account will then be uploaded onto NHS Choices.

Monitor's annual reporting guidance for the Quality Report incorporates the requirements set out in the Department of Health's Quality Accounts Regulations, as well as additional reporting requirements set by Monitor. This is available from Monitor's website.

Quality Accounts for OSCs - Getting started

Before you receive a draft Quality Account:

- Identify which providers will be sending their Quality Account to you and start discussions on proposed content early on in the reporting year.
- Providers have been encouraged in guidance to share early drafts of their Quality Account and useful background information on the content with stakeholders.
- Discuss the provider's proposed content of their Quality Account at an early stage to ensure that it includes areas that have been identified as being local priorities.

Once you have received a draft Quality Account (between 1 – 30 April):

- Before providing a statement on a provider's Quality Account, OCSs may wish to consult with other OSCs where substantial activity (for instance specialised services) is provided to patients outside their area.
- Write a statement (no more than 1000 words in length) for publication in a provider's Quality Account on whether or not they consider, based on the knowledge they have of the provider, that the report is a fair reflection of the healthcare services provided. The statement could include comment on for instance, whether it is a representative account of the full range of services provided.

Sending the written statement back to the provider:

- Send the statement back to the provider within 30 days of the draft Quality Account being received. Your statement will be published in the provider's Quality Account.
- If the provider makes changes to the final published version of their Quality Account after having received the statement (possibly as a result of the statement), they are required to include a statement outlining what these changes are.

Barnet, Enfield and Haringey Mental Health NHS Trust

Quality Account 2018 - 2019

Contents – to update when report complete

PART 1

PART 2

PART 3

PART 4

PART 5

Part 1

Chief Executive's Statement

Statement from Amanda Pithouse, Executive Director of Nursing, Quality and Governance

What is a Quality Account?

Our Quality Account is an annual report that allows us to report on the quality of the services that are being delivered to our local communities and our stakeholders and through engagement with patients, stakeholders and staff, allows us to demonstrate good practice and improvements in the services we provide. This in turn provides us with the opportunity to identify areas we need to focus on and agree our priorities for improvement with our stakeholders in the delivery of our services.

Our Quality Account 2018/19 is designed to:

- *Reflect and report on the quality of our services delivered to our local communities and our stakeholders*
- *Demonstrate our commitment to continuous evidence-based quality improvement across all services*
- *Demonstrate the progress we made in 2018/19 against the priorities identified*
- *Set out for our services users, local communities and other stakeholders where improvements are needed and are planned*
- *Receive support from our stakeholder groups on what we're trying to achieve*
- *Be held to account by our service users and other stakeholders for delivering quality improvements*
- *Outline our key quality priorities for 2019/20.*

About BEH-MHT

Barnet, Enfield and Haringey Mental Health NHS Trust (BEH) provides healthcare services locally, regionally and nationally. We deliver our care in the community and in inpatient settings, and serve a population of well over a million people in the three London Boroughs of Barnet, Enfield and Haringey as well as further afield. Our annual income in 2018/19 was £229.5 million.

In 2018/19, our 3300 plus staff helped care for more than 147,500 people. We provided mental health services for young people, adults and older people, and care through our full range of child and adult community health services in Enfield.

Our North London Forensic Service treats and cares for people in the criminal justice system who have mental health conditions. We provide one of the largest eating disorders services in England, as well as drug and alcohol services, and mental health liaison services at North Middlesex University Hospital NHS Trust and Barnet Hospital. Additionally, the Trust provides mental health care to seven prisons, all sub contracted through Care UK.

The Trust has 535 inpatient beds located on five main sites, St Ann's Hospital in Haringey, Chase Farm Hospital and St Michael's in Enfield, Edgware Community Hospital and Barnet Hospital.

In 2018/19, the Trust opened two new wards: Moselle House, a low secure 12 bed forensic ward for male patients with learning disabilities and Somerset Villa, a 13 bed mental health rehabilitation ward in Enfield. The new ward offers assessment and treatment to those with a range of continuing complex mental health problems and who are disabled and often distressed.

Barnet, Enfield and Haringey Mental Health NHS Trust is required to register with the Care Quality Commission and its current registration status is that it is registered with no conditions attached to its registration.

Our Vision

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

Our Values

We developed our Trust values in 2016 following trust wide engagement and input from over 500 staff. We have consciously kept these values since then as they underpin everything we do as an organisation: the decisions we make and the actions we take to improve the health and wellbeing of our population.

Systems in place to ensure quality at all levels

BEH is an organisation that embraces continuous improvement and learning.

The Board of Directors proactively focuses not only on national targets and financial balance, but places significant emphasis on the achievement of quality in all our services.

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

Our quality governance system, quality performance and

assurance are monitored by our Executive Leadership Team and the sub-committees of the Trust Board.

CQC Inspection 2017 and Quality Improvement Action Plan

Following our Chief Inspector of Hospital's Inspection in September 2017 and subsequent inspection report in January 2018, the Trust developed an improvement plan to address the gaps and shortfalls in the quality of care provided.

Trust services have worked diligently to ensure improvements continue to be made and are being sustained.

We will continue with our programme of Quality Reviews of our wards and services to check that actions have been embedded.

Additionally, taking on board the themes that emerged in both the CQC Inspections of 2015 and 2017, and building on intelligence from other sources such as complaints, staff feedback and MHA CQC reviews, the Trust introduced in January 2019, **Brilliant Basics**, key areas of long-term focus for our Trust to ensure we get the basics of care right, making them consistently right, and doing them brilliantly.

Brilliant Basics

We have excellent services and a workforce dedicated to doing what is best for our patients. The concept of having brilliant basics is that we get the basics right consistently for the good of all our patients and staff and to make our Trust fit for the future.

Ten work streams were identified under the 'Brilliant Basic's umbrella and each is being led by a senior manager:

Patient Safety

- Safe environments – Ligature reduction
- Reducing restrictive practices
- Policies
- Mandatory training
- Physical Health Monitoring

Patient Experience

- Risk Assessments and Care planning
- 132 rights / capacity to consent

Effectiveness

- Floor to Board data
- Timely access to beds
- Robust workforce data / Staffing and skill mix

We believe that building strong foundations is the key to delivering the best care possible.

3rd Annual Patient Safety Conference

Patient Safety: Moving Forward

The Trust held its third annual Patient Safety Conference in March 2019. The event was attended by over 100 staff from across the Trust. Guest speakers on the day were:

- Geoff Brennan, CEO, Star Wards discussed Star Wards, a scheme that inspires and celebrates great practice on mental health wards. Geoff gave examples of staff and service users can be engaged with and how to engage and motivated to improve the inpatient experience by inspiring patients to make the best use of their time in hospitals and allowing staff to use all their skills and personal qualities.

In November 2018, our own Blue Nile forensic ward achieved the Star Wards Full Monty award, as they were able to demonstrate to the Star Wards teams that they had implemented all 75 benchmarking ideas across the following categories: Recreation and Conversation, Physical Health and Activity, Visitors, Care Planning and Talking Therapies.

9 NOV

Blue Nile House Full Monty

By Geoff Brennan

One bite of Vincent's Almond and Vanilla cake told me I was in a special place. I can taste it now, rich, not too sweet with a perfect balance of flavours. Fabulous.

But I am getting ahead of myself. Blue Nile House, based in Chase Farm Hospital in North London was the place of divine cake – and much more. A low secure male forensic ward in Barnet Enfield and Haringey NHS Trust, the ward sits in its own little block and is chock full of amazing staff and patients. We have known about Blue Nile for some time at Star Ward HQ as the staff nurse in charge of activities, the talented Omar Limbada, is a keen and enthusiastic Star Wards champion. Omar has kept us informed of the development of the ward's work and, in September, contacted us to say they were ready to be considered for a Full Monty. Boy, was he right. They were amazing.

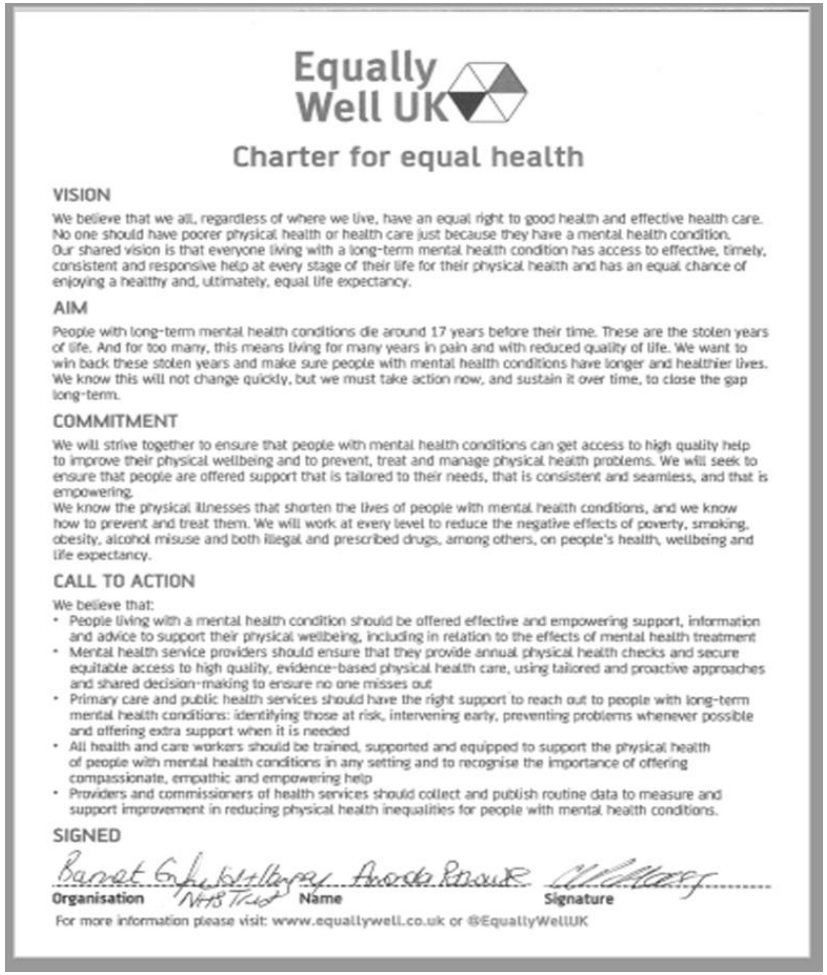
- Andy Bell, Deputy Chief Executive, Centre for Mental Health talked about how health, social care and education organisations need to work together to tackle unequal health outcomes for mentally unwell patients by understanding what causes the gaps, how to address the gaps, particularly around physical health and who's responsibility it is.

Andy highlighted the work of Equally Well UK, a collaborative of organisations to drive collective action on physical health.

Set up by the Centre for Mental Health, Kaleidoscope & Rethink Mental Illness, the aim of the collaborative is to:

- To create a nationwide learning network
- To bring people together across organisations, sectors and roles
- To establish a 'brand' for equal health
- To raise all our sights and expectations
- To enable people to enjoy better health for longer

Barnet, Enfield and Haringey NHS Trust signed the Equally Well UK, Charter for equal health. We are committed to working with our staff, service users and fellow organisations to ensure equality in physical health care and life expectancy for all of our mental health patients.



Equally Well UK

Charter for equal health

VISION

We believe that we all, regardless of where we live, have an equal right to good health and effective health care. No one should have poorer physical health or health care just because they have a mental health condition. Our shared vision is that everyone living with a long-term mental health condition has access to effective, timely, consistent and responsive help at every stage of their life for their physical health and has an equal chance of enjoying a healthy and, ultimately, equal life expectancy.

AIM

People with long-term mental health conditions die around 17 years before their time. These are the stolen years of life. And for too many, this means living for many years in pain and with reduced quality of life. We want to win back these stolen years and make sure people with mental health conditions have longer and healthier lives. We know this will not change quickly, but we must take action now, and sustain it over time, to close the gap long-term.

COMMITMENT

We will strive together to ensure that people with mental health conditions can get access to high quality help to improve their physical wellbeing and to prevent, treat and manage physical health problems. We will seek to ensure that people are offered support that is tailored to their needs, that is consistent and seamless, and that is empowering.
We know the physical illnesses that shorten the lives of people with mental health conditions, and we know how to prevent and treat them. We will work at every level to reduce the negative effects of poverty, smoking, obesity, alcohol misuse and both illegal and prescribed drugs, among others, on people's health, wellbeing and life expectancy.

CALL TO ACTION

We believe that:

- People living with a mental health condition should be offered effective and empowering support, information and advice to support their physical wellbeing, including in relation to the effects of mental health treatment
- Mental health service providers should ensure that they provide annual physical health checks and secure equitable access to high quality, evidence-based physical health care, using tailored and proactive approaches and shared decision-making to ensure no one misses out
- Primary care and public health services should have the right support to reach out to people with long-term mental health conditions: identifying those at risk, intervening early, preventing problems whenever possible and offering extra support when it is needed
- All health and care workers should be trained, supported and equipped to support the physical health of people with mental health conditions in any setting and to recognise the importance of offering compassionate, empathic and empowering help
- Providers and commissioners of health services should collect and publish routine data to measure and support improvement in reducing physical health inequalities for people with mental health conditions.

SIGNED

Barnet, Enfield and Haringey NHS Trust — Amanda Brown — [signature]

Organisation — Name — Signature

For more information please visit: www.equallywell.co.uk or @EquallyWellUK

- Caroline Sweeney, Lead for Mental Health, Guy's and St Thomas' NHS Foundation Trust gave an insightful presentation on 'Improving mental health care provision and risk management in an Acute Trust'.

  Caroline presented an overview of the challenges that are faced by an acute trust upon the presentation of a mental health patient. It was interesting and informative for BEH mental health staff to hear about the issues faced by Guy's and St Thomas' hospital, and the initiatives being put in place to minimise risk and improve patient safety.

Attendees also heard from BEH staff who had achieved some great outcomes from their quality improvement projects:

The Think Family Approach, Celia Jeffreys, Safeguarding Children Lead

Blending approaches in QI – The Oaks story, Dr Anna Mandeville, Consultant Clinical Health Psychologist & Health Foundation Fellow and Dr Kate Doukova, Consultant Psychiatrist

Reducing Restrictive Practices, Francesca Smargiassi, Marvelyn Babalola, Annette Woods, Juniper Ward

Our journey towards Clinical Excellence, Adrian Tarka, Expert by Experience and Suneel Christian, Haringey CRHTT Team Manager

Street Triage Pilot Project, Runa Bhoobun, Enfield CRHTT Manager & Michael Salfrais, Service Manager, Enfield Acute Services

Innovation in Liaison Psychiatry at North Middlesex University Hospital, Patrick Kenny, Peer Support Worker and Jay Jankee, Senior Psychiatric Liaison Nurse

Part 2

Statement of Assurance from the Board regarding the review of services, 2018/19

During 2018/19, Barnet, Enfield and Haringey Mental Health Trust (BEH) provided services across mental health and community NHS services. Our Trust Board has reviewed all the data available to them on the quality of care in all of these NHS services. The income generated by the NHS services reviewed in 2018/19 represents 100% of the total income generated from the provision of NHS services by BEH for 2018/19.

Review of Quality Performance, 2018/19

In addition to implementing a Clinical Audit and Quality Assurance programme that drives and underpins the three year Quality Strategy priorities, the Trust and its services introduced and implemented a number of quality performance and quality improvement initiatives resulting in improvements for Trust staff, service users and carers.

Examples include:

- Quality Reviews

  Members of the Nursing Directorate supported by clinical staff from the Boroughs have undertaken unannounced Quality Reviews of our wards to review the quality of care being provided. Concerns identified, as well as good practice are highlighted to Trust and Borough management for learning and action where necessary. A thematic review of themes identified from all Quality Reviews will be presented to Trust Board.

  Additionally, colleagues from Enfield Clinical Commissioning Group (CCG), our lead commissioners have undertaken Insight visits of some of our wards and community teams. To date, the visits have been positive and no significant issues have been raised with the Trust to address.

- Staff Wellbeing Forum

  The Trust is committed to improving the physical and mental health and wellbeing of its staff as it recognises that

  The purpose of the staff wellbeing forum is to improve staff engagement and wellbeing, so all Trust staff can be at their best, be energised, motivated and committed to delivering excellent care to all by:

- Developing and implementing initiatives to improve staff physical and mental health
- Reviewing staff views and feedback from surveys and focus groups and developing action plans for improvements
- Encouraging staff to take action locally to improve their working environment or seek support for major initiatives
- Developing and implementing staff social activities

- Staff Leadership Forums

- Reflective Reading Club for Nurses
  Facilitated group sessions are held for nurses approaching revalidation and are open to nurses who would like to practice reflection and stay up to date with the latest research.

- Leadership Safety Huddles
  Weekly 15 minute leadership safety huddles have been introduced to review patient safety and risk concerns that have occurred during the previous week.

  Led by the Director of Nursing, Quality and Governance, members including Trust Executive Directors, Senior management from the Boroughs and the Estates Directorate, and representative from the Patient Safety Team and Nursing Directorate come together to share with colleagues the concerns and risks in their areas and across the Trust and serious patient safety incidents.

  A weekly report from the Leadership Safety Huddle highlighting the issues discussed is presented to the weekly Executive Leadership Team

- Berwick Learning Event
  The Aftermath of Adolescent Suicide - Supporting Families, Staff, Young People and Schools

  Staff and speakers attended this dynamic afternoon learning event focusing on supporting staff, young people, families and schools after bereavement by suicide. The event was chaired by Associate Medical Director, Dr Deborah Dover, and included talks from voluntary sector partners and internal staff, plus group work on improving support structures for all.

  The event was very successful in bringing together a diverse group of staff from a broad range of our services to acknowledge the significant secondary trauma and impact suicide has on all involved. Staff talked about both personal and professional experiences of loss by suicide and there was a sharing of knowledge, understanding and

resources in relation this important aspect of clinical practice.

- Table Talk

  In the summer of 2018, the Patient Experience and Patient Safety Teams invited staff, service users and members of the public to join them at venues across the Trust, and share their views on patient experience and patient safety at BEH and how both had developed over the years.

  It was great to see so many people talking about and sharing their experiences and good practice.

- Executive Roadshows

  Since joining BEH, the Chief Executive Jinger Kandola has been keen to get out around the Trust and meet as many staff as possible. She is committed to on-going engagement with staff as well as service users at all levels.

  One of the ways that Jinjer and the rest of the Executive Leadership Team have been engaging with colleagues is through Staff Roadshows across Trust sites. The aim of the roadshows is to have an on-going honest dialogue with staff and an opportunity for everyone to feed in to the latest issues.

  The roadshows are an opportunity for staff to hear about what is going on in the Trust and to give their views. .

  Over 500 staff members have attended the roadshows.

- Equality, Diversity and Human Rights Forum

  One of the key issues emerging from the Roadshows was equality and diversity. In response to this, a series of forums have been set up so that together, staff can discuss improvements that will help all staff feel they are being treated equally and fairly.

  The Chief Executive now chairs the Trust's Equality and Diversity Forum, a new group on equality and diversity with staff from across our organisation attending.

- Specialist Services Learning newsletter

- Let's Talk

- **Mindfulness - supporting the wellbeing of our staff**

We have worked with Headspace to offer staff free access to Headspace's mindfulness app on phones, tablets and PCs for the convenience of our staff.

Teams across the Trust are having mindfulness sessions together, including senior management teams in Barnet and Specialist Services who use mindfulness at the start of senior meetings.

- **Mobile Working**

We continue to roll out mobility devices to staff in key services. Most recently Crisis Resolution Home Treatment Teams across the Trust have been issued with mobility devices.

The devices ensure staff are able to provide real time reporting into our IT systems, provide up-to-date information for staff visiting patients and to support staff to provide improved patient care. As part of future IT developments, we will be piloting handheld devices in one of our Haringey wards.

- **Careers and Culture survey**

BEH is participating in a pilot study being which is conducted by an independent staff engagement company in partnership with NHS Employers and aims to give us a better understanding of ways to improve staff career development opportunities.

The survey and analysis have been designed to provide our Trust insight that will enable us to take meaningful action on issues such as recruitment and retention, career progression for black & minority ethnic and disabled staff reducing our gender pay gap and achieving greater diversity in senior leadership roles.

- **Dragon's Den**

This year, 11 innovative projects were approved by the Dragon's Den panel which consisted of the Chief Executive, Chief Investment and Finance Officer and Interim Chief Operating Officer. The projects, put forward by front line staff were selected for their innovative and positive support of the delivery of the Trust's values, aims and objectives. The panel also believe these projects will not only make a difference, but can go on to be reproduced in other areas to improve experiences for service users or staff at BEH.

No.	Project Title	Clinical Division/Directorate
1	In-House Open Dialogue Training	Haringey Early Intervention in Psychosis
2	Working together with Experts by Experience: Developing a Trust Bank	Nursing and Governance Directorate
3	Beacon Centre Secret Garden	Specialist Services – CAMHS Inpatient
4	Live, Love, Grow – harvesting our own produce to learn to love food	Specialist Services, Eating Disorders Service
5	Inside Out – Making CHOICES that count	
6	Tovertafel – The Magic Table	Enfield MHSOP, The Oaks Ward
	Minor projects	
7	Safer Discharge & Carers Awareness Project	
8	Early Intervention Service Gardening Project	
9	Self-help libraries for the inpatient wards	
10	Use of Neuromuscular electrical stimulation as an adjunct to therapy programmes for patients following a stroke and with other neurological conditions.	
11	Grounding Kits for PTSD Clients	

Enablement

Our Enablement programme focusses on empowering people to take control of their own mental health by:

- always aiming to do with people rather than to or for people
- focusing on what people can do rather than what they cannot do
- supporting people to develop skills to help themselves stay well
- working with the whole person (not just their diagnosis) to help them build a life in which they can live, love and do.

The Trust Wide Enablement Partnership is a partnership between Barnet, Enfield and Haringey Mental Health NHS Trust (BEH) and peer-led charity Inclusion Barnet (IB).

Central to the creation of an enabling culture has been a fundamental shift in the relationship between services (and practitioners) and people using services; moving away from ‘us and them’ and towards working in partnership with people using services and their carers, from individual interventions right through to service design.

The partnership activities have been focussed on two key areas:

- Lived Experience in the Workforce: embedding effective Peer roles within the workforce and creating a workforce that is more inclusive and valuing of people with lived-experience.
- Coproduction: increasing the quantity and quality of coproduction throughout the Trust.

Workforce Development

Recruitment

- The number of Peers employed in the Trust increased from 8 to 24, and continues to rise.
- Clear roles established, including recruitment, training and supervision.
- Recruitment pack created for Managers, with tailored guidance on candidates, interviewing and on-going supportive resources for working with Peers.
- Discontinued Band 2 Peers Worker posts, created Band 3 and 4 posts.
- Designed a 6-day training course in effective peer support through consultation with existing Peers and managers.

Retention

- Uplifted all existing Peer Workers to Band 3 or 4, to develop career progression pathways for Peers.
- The Partnership inputted into the Volunteering Reimbursement Policy.
- Co-produced the Peer Information Pack
- Monthly ‘Peer-to-Peer’ supervision sessions in place to support peers
- Monthly Peer Manager meetings to support managers of Peers
- Delivery of the Enablement Partnership module in the staff induction programme.
- Formed a staff led Quality Improvement (QI) group ‘utilising lived experience’ of staff working within the Trust.

Co-production - examples

Project 1: Barnet CAMHS Transformation Coproduction

• Embedded co-production best practice in the transformation of CAMHS.

Project 2: Barnet ADHD Awareness Campaign

• Co-developed a campaign to raise awareness of ADHD (Attention deficit hyperactivity disorder) internally within referral pathways. The team are currently developing a promotional video that features people who use the service telling their story.

Project 3: Enfield Pulmonary Rehab

• Respiratory Peer Worker role developed and being recruited to use peer support principles in growing confidence, skills and motivation for people who use the PR service.

Project 4: Enfield Complex Rehab QI Dialog+ CPA pilot

• Dialog+ is a simple, evidence-based tool to improve co-production of care plans in the Care Programme Approach (CPA) process and communication between people and their clinicians. Planning groups held with East London NHS Foundation Trust (ELFT) and other colleagues were initiated and training has been completed. QI methodology is currently being scoped and the pilot will begin in April 2019.

Project 5: Haringey Finsbury Ward QI Dialog+ CPA pilot

• As described above. The QI pilot will begin in April 2019.

Project 6: Haringey PTSD (Post traumatic stress disorder) Peer Support Group Project

• Co-produced a PTSD peer support group in partnership with Mind in Haringey, to build a sustainable support network to help people manage their wellbeing in the community. The group meets regularly, with on average 10 attendees at present.

Additionally, the Enablement team has continued its work in *Developing Community Pathways*, to increase the levels of engagement with community stakeholders in order to create sustainable links to enabling resources for people using services and *Promotion*, to maximise the impact of all enablement activities through highly visible promotions of our aims and achievements.

Developing Community Pathways

• Presentations delivered to The Tavistock and Portman Trust, North London STP EBE Board, and Haringey and Enfield CCGs.
• Compiled new up-to-date borough directories of third sector organisations for BEH website and internet.
• Developed a community partnership with Mind in Haringey for a co-produced PTSD Peer Support Group.

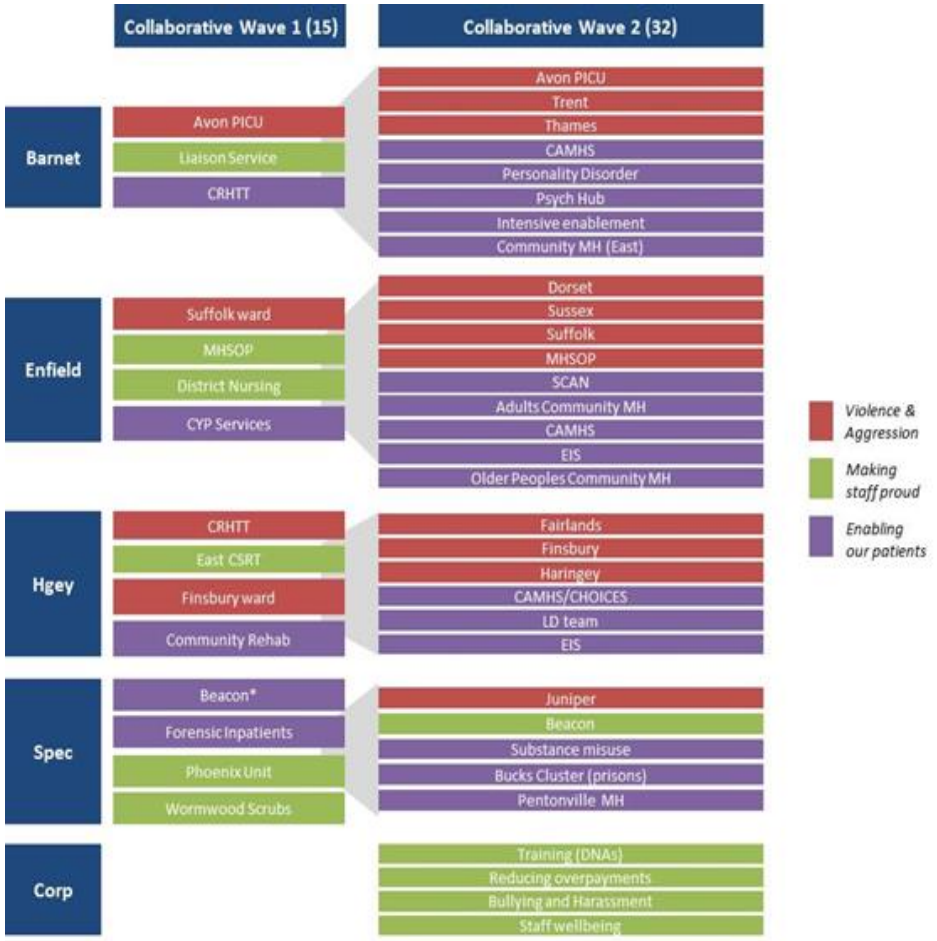
Promotion
• Created a new Trust Wide Enablement Partnership Logo.
• The Partnership engaged in the continuous internal promotion of activities such as a Peer Recruitment Event that was attended by over 100 people, and the Creative Co-production Forum that showed co-production work in the Trust.

• The Partnership present quarterly updates on Enablement's activities at each borough's Senior Manager Forum
• The Partnership attends quarterly meetings with borough Assistant Directors to problems solve, exchange updates and discuss plans.
• Trust staff were kept informed of Enablement news through its14 articles in the Trust's *Take 2* e-newsletter.
• Overall, 70 presentations on Enablement projects have been given at team meetings and to over 800 Trust employees.

Quality Improvement (QI)

Our Trust's QI Programme is led by the Medical Director, who, through the Director of Improvement, is ensuring a clinically led, bottom-up, approach to drive clinical improvements and learning across the organisation. This approach enables multi-disciplinary teams consisting of health professionals, managers, the third sector and patients, to work towards common quality improvement goals and understand each other's perspectives. All clinical teams are encouraged to implement improvements in services in line with evidence based standards and then to celebrate their successes and share their learning.

In 2018/19 the Trust continued its quality improvement journey, more than doubling the number of new projects in the second year with all remaining focused around the three Trust objectives:



Year 2 followed Year 1's collaborative model, with the central Faculty – supported by clinical QI leads – co-ordinated the 12 month training and development of the teams involved.

This model has worked well for the first two years; we have trained over 100 members of staff across our four Divisions, and launched nearly 50 improvement projects through this approach – meaning about 28% of all BEH teams have been impacted by an improvement project. The benefits for our key stakeholders are clear:

For Trusts

- *Strong correlation between Outstanding Trusts and those which use QI as a way of working*
- *Supports improved focus and productivity due to teams spending less time "boiling the ocean"*
- *Reduces complexity/inconsistency in the delivery of objectives because of the single approach*

For staff & teams

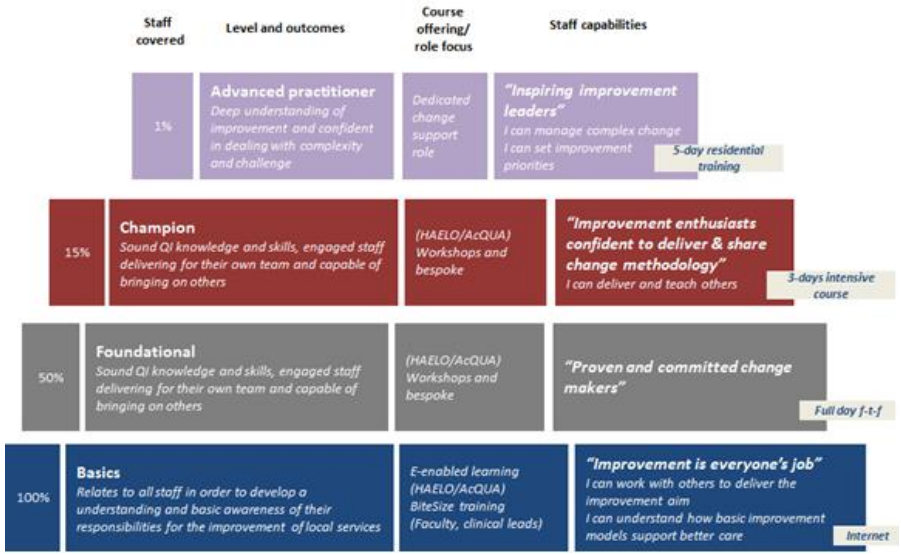
- *Motivation and retention is higher because ownership and autonomy is strengthened*
- *QI support can be used as a recruitment tool to show both internal values & how we value staff*
- *Staff can see clearly and immediately the impact of their changes through the focus on data*

For patients

- *Care-giving tends to be more stable (outcomes improved) as motivated staff stay in one place*
- *Mature QI approaches include a strong patient input throughout the application of the method*
- *Patient satisfaction, their feeling and experience of care is improved overall*

As we move into Year 3, we recognise that the scale of our ambition as well as the delivery model needs to change again. We recognise, and evidence shows, that for improvement to be sustainable, we need to embed a single, systematic improvement methodology into the way we work; from every day, informal decisions through to major transformational programmes. To date we have agreed that the MFI is "the way we think about change" but recognise that we need more work to sustain this in all that we do.

Firstly, we will be capacity-building at scale by developing further the improvement infrastructure in year one. It is an enabling strategy that supports delivery of the culture change we need to deliver our strategic direction. We are still in the early stages of embedding the wins we have achieved and this capacity-building focus will enable us to move from collaborative projects to "the way we do things round here". Bringing together the support and training offered by our proposed partner and what we are currently able to provide internally, the graphic below reflects the sort of tiered development model we are aiming for.



In comparison with our London peers and NHSI guidance, even as three-year targets, this "dosing formula" is ambitious at the more specialist end but we also are keen to begin with a stretching standard for the Trust, illustrative of the scope of our QI ambition, and reflects the foundations of staff involvement from years one and two.

Given the leadership role of the Board in setting and modelling the organisational culture, we would envisage a short programme of supported workshops to work on aligning Board development with the QI ambition; how the Board can seek to lead.

Good practice from other Trusts shows that for QI to take hold, it must work at every level including the Executive team. We will be ensuring that Executive colleagues are supported to develop a good understanding of QI and take a proactive role in the leadership and sponsorship of programmes.

Secondly, we will be looking to reflect improved outcomes for key organisational transformational priorities in year one. We need to ensure that the strategy enables us to respond to strategic operational and clinical priorities. This second aspect will be articulated in more detail through the implementation plans, with QI methodology evidencing the progress across these strategic priorities for 2019/20.

Quality Priorities - Looking Back, 2018/19

In this section we will report our progress against our 2018/19 quality priorities.

Our quality priorities for 2018/19 build on our quality priorities from 2017/18, recognising the areas that required continued focus to deliver in full.

They are part of a broad programme of quality improvement work and are part of the Trust's objectives of improving quality by continuing to improve patient safety, clinical effectiveness and patient experience.

In partnership with key stakeholders, the agreed quality priorities areas for 2018/19 were:

- To continue to improve the physical health of our service users (a quality priority in 2017/18)
- To improve the use and effectiveness of risk assessments
- To continue to improve communication with GPs (a quality priority in 2017/18).

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1) Improving the physical health of our service users, 2018/19

One of the priorities for the Trust is to integrate physical and mental health care whereby physical health checks and referrals to specialist services for treatment are carried out systematically, consistently and effectively, in order to improve the quality of Physical health monitoring and treatment for service users accessing our services.

In 2017/18, the Trust introduced a number of initiatives which led to improvements in the physical health of our patients. However, it was recognised that further work in this area was required in 2018/19 to support the successful implementation of the Trust's Physical Healthcare Policy & Strategy. In 2018/19, our physical health leads and network of champions continue to implement and embed these priorities. In March 2019, the Trust signed the Equally Well UK Charter and made a pledge to work collaboratively with other health care providers, commissioners, service user and carer groups in the UK to bring about equal physical health for people with mental health illness.

In 2018/19, Physical health care pathways for common physical healthcare conditions such as Diabetes, Coronary heart disease and Epilepsy based on NICE guidelines are being implemented to assist clinicians in the decision making process.

The effective recording and use of key cardio-metabolic parameters and the national early warning system (NEWS) are audited quarterly to ensure the physical health of our patients and outcomes are appropriately monitored and acted upon.

A programme of audit to support the physical health CQUIN continues to be implemented. Audit outcomes are reported to and monitored by the Trust's Physical Health Committee.

In order to encourage a standardised system of recording physical health checks on RIO, a consultative process was carried out involving clinicians before a RIO change proposal was successfully implemented. There is now a more user friendly RIO template available, compatible with best practice tools such as the Lester tool and NEWS, for recording physical health as well as meeting the requirements for CQUINs.

Incidents related to physical health are monitored quarterly by the Physical Health leads.

In Barnet (a BEH borough), there are areas within the borough where physical health monitoring is a normal part of service provision such as the well-being clinic, Ken Porter ward and EIS service. Community teams are in the process of establishing clinics where physical health monitoring will be carried out; this process required the purchasing of new equipment for this use.

The Physical health working group have started work on:

- A physical pre-assessment pack for all in–coming patients
- A physical health assessment pack for all patients over 65 / with deteriorating health.
- A strategy around obesity.

The Trust's Quality Assurance audit measures compliance with a numbers of physical health and well-being indicators across all of the Trust's teams. The audit showed that overall compliance with physical health standards across the Trust's mental health services was below the Trust's quality assurance audit benchmark of 90% although there was an overall increase in physical health monitoring and implementation of physical health checks and treatment within individual teams.

Physical Health Quality Assurance Audit results, 2018/19.

	Q1 (%)	Q2 (%)	Q3 (%)	Q4 (%)
Physical Health Assessment (MH)	82.08	87.77	85.12	87.81
Physical Health Intervention (MH)	74.27	78.44	79.07	80.80
Alcohol/substance misuse (MH & ECS)	81.89	87	81.33	87.42
Smoking(MH & ECS)	94	91	89.63	89.83
Physical Health (Specialist)	96.11	95.84	98.77	99.57
Physical Health (Magnolia)	100	100	100	100

The use of the National Early Warning System (NEWS), a physical observation monitoring tool on all our inpatient wards is audited via the Trust's quarterly quality assurance audit. Over 90% compliance was achieved across all inpatient wards. The results have been shared with the Trust's physical health leads and inpatient teams for learning from good practice, so that any weaknesses can be improved and strengths sustained.

NEWS inpatient ward audit results (%), 2018/19

Results	Q1	Q2	Q3	Q4	Total
24. Has **NEWS scoring** system been performed for the expected number of monitoring?	98	90	99	94	95
25. Has **NEWS scoring** system been used appropriately (all totalled up and recorded correctly)?	99	96	100	98	98
26. IF **NEWS scored** 3 or more were appropriate actions taken?	98	93	96	99	97
Total	98	93	99	97	97
Total Responses	**396**	**396**	**464**	**414**	**1670**

The Trust is committed to working with and supporting its clinical staff to implement a thorough and consistent approach to physical health monitoring and treatment through raising awareness, training and providing feedback from audit activity, incident reporting and investigations and close working with the Borough physical health leads.

Trust wide physical health standards will be driven through the Brilliant Basics physical health work stream in 2019/20 and beyond.

2) To improve the use and effectiveness of risk assessments in 2018/19

During 2017/18, several of our serious incident investigations identified that risk assessments were not completed robustly or in a timely manner. The issue was partly due to the set-up of RiO, the Trust's patient record system and how and where risks were recorded. The CQC inspection highlighted similar concerns in relation to risk assessments. The quality priority for 2018/19 is to ensure all service user risk assessments are appropriate, reflect the risk adequately and are reviewed and updated as required.

The Medical Director led a Task and Finish Group to address the difficulties in RiO which were seen to obstruct effective risk assessment. Risk assessment documentation from three other mental health Trusts was reviewed to inform our own form. The risk summary/assessment form on RiO has been adapted so that it is all on the one form and details the apparent risk at that particular time. This will assist with consistency in the recording of patient risks across the Trust's clinical teams and to allow for easier review and extraction of information.

Risk assessment standards are monitored via a review of incident investigations and quarterly via the Trust's quality assurance audit which is undertaken by all teams.

The results of the quality assurance audits to measure the quality and timeliness of patient risk assessments have shown that overall compliance is above the Trust benchmark (90%).

	Q1 (%)	Q2 (%)	Q3 (%)	Q4 (%)
Risk	98.51	97.39	96.25	98.50
Total number of Responses	396	396	456	411

Performance in one specific area was below the Trust benchmark for the Trust's mental health teams (excluding North London Forensic Services) and Enfield Health community teams. It is believed that this is in most cases a recording issue resulting in evidence not being available during the audit of the patients' electronic record of care.

Mental health teams (excluding North London Forensic Services) and Enfield Health community teams

Risk Competencies					
Question Text	Q1	Q2	Q3	Q4	TOtal
1. For long stay patients, is risk assessment reviewed at a minimum every 6 months ?(refer to this admission episode only)	100	100	100	-	100
2. For admission/MHA patients, is risk assessment reviewed at a minimum every 2 weeks?(refer to this admission episode only)	100	100	95	100	99
3. Do progress notes at admission include comment on risk?	100	100	100	100	100
4. Is the risk assessment up to date? *[within 2 days of admission to wards or within the last 12 months for community patients or since most recent review/change in care/risk incident]*	99	98	97	99	98
5. Does the risk assessment include all historical risk details including all the risks documented in the progress notes?	99	97	97	98	98
6. Is there evidence that any risks are communicated to the child's network (uploaded emails / letters on Rio / Rio progress notes)?	78	74	78	59	74
7. For identified risks, is risk management plan clearly recorded?	97	98	91	99	96

North London Forensic Services

Risk Competencies					
Question Text	Q1	Q2	Q3	Q4	Total
1. Is the **risk assessment** within the risk summary up to date (within 2 days of admission to wards or since most recent review/change in care/incident as above)	99	99	99	99	99
2. If there has been **a recent risk incident**, has the risk summary been updated following the incident?	100	97	96	99	99
3. Does the **risk assessment** clearly identify all clinical restrictions in place? (please note that this doesn't apply to general restrictions on the ward which are in community living guidelines)	100	100	100	100	100
4. Is there a Dual Diagnosis Risk Summary?	100	100	100	100	100
5. Does the risk chronology include all historical risk details relating to substance use, including particular risk?	100	100	100	100	100
6. Do the **restrictions identified in the risk assessment** all relate to those in the care plan are recorded in the care plan is there evidence of individual clinical rationale, consent, capacity and patient view recorded? If no please record individual RIO number for follow up action.	100	100	100	100	100
7. Do the **last four face to face contacts** in the progress notes (or last ward round review) **include a comment on risk?**	97	96	99	100	97
8. Has **an updated Rio risk assessment** and CPA form sent to hostel/support worker?	100	100	100	100	100
9. If there is identification of risk on the progress note, is the risk added on the Risk History (ie tick the Add to Risk History check box)?	100	100	100	100	100

There has been a reduction in the number of serious incident investigations that found issues relating to risk assessments as a contributory factor to the incident. Of the completed serious incident investigations in 2018/19, the risk assessment was found to be a contributory factor in less than a quarter of cases.

The Trust is committed to improving the timeliness and robustness of risk assessments across all teams, recognising that a fit for purpose risk assessment can help with resolving a number of challenges, such as bed management and delayed patient transfers and discharges. To this end, risk assessment and care plans is one of our Brilliant Basics work streams and is being led by the Trust's Medical Director.

3) To continue to improve communication with GPs

The Trust recognises that good engagement and timely, accurate and essential communication with primary care providers is key to ensuring patient pathways are jointly maintained and the flow of care is continued beyond hospital care.

Our priority in 2018/19 was to improve the Trust's engagement and communication with Primary Care and to seek ways to support and encourage feedback from GPs about our services.

The Trust has been working with primary care providers to strengthen feedback processes and has a number of audits in place to monitor the timeliness and relevance of communication with GPs but it is recognised that more work is required as well as support from our commissioners.

Trust services in each Borough have been restructured to align more closely with GP locality boundaries which is helping services to link their locality team staff more closely with their local practices.

Through auditing, services and areas for improvements with regard to sending discharge summaries to GPs have been identified. The audit also identified teams performing well. These teams have shared learning and good practice across other Trust services.

The results of the audit in 2018/19 to measure the effectiveness of communication between the Trust and primary care services have shown that across all quarters in 2018/19, overall compliance has been above the Trust benchmark of 90%.

Mental health (excluding NLFS wards) and Enfield Health community teams:

	Q1 (%)	Q2 (%)	Q3 (%)	Q4(%)
Communication with GP or partner agencies	93.3	92.38	93.05	91.82
Total Number of Responses	565	560	595	578

However, there are a number of indicators below the benchmark. The relevant teams have been working to address the gaps.

Compliance by competency, 2018/19

Communication with primary care	Q1	Q2	Q3	Q4	Total
27. Has **GP or referrer** been informed of patient admission (for inpatient wards) /outcome of assessment and/or plan of care?	95	100	96	99	97
28. Has referrer been informed of outcome of assessment and care plan and cc GP? (**only applicable to CAMHS)**	80	61	76	88	76
29. Has GP/referrer been sent notification of starting therapy?	91	87	92	100	93
30. Has the GP been informed within 2 weeks of last assessment / feedback / medication change? (Memory Service)	100	100	100	100	100
37. Are letters regularly sent to the family, GP and whenever necessary to the team around the child (school / social care / health)?	90	76	64	86	76
38. Has GP or referrer been informed of patient's presentation to A&E or acute ward? (Liaison Services)	-	87	100	100	95
39. Was the letter to the GP sent within 24hrs for emergency assessment?	-	93	93	100	95

Primary care communication: Enfield Health (community teams)

Enfield Health Community Services – Communication with primary care					
Question Text	Q1	Q2	Q3	Q4	Total
13. Has referrer been sent a confirmation of assessment and informed of the plan of care within 48 hours of completing the assessment?	100	69	100	75	87
14. Has referrer been sent a confirmation of assessment and informed of the plan of care within 5 working days (10 for Diabetes team) of completing the assessment?	100	98	97	100	99
16. Has discharge communication been sent to GP?	79	98	98	92	92
17. When was discharge communication sent to GP?	100	92	96	77	90
18. Has there been any communication with the GP in the past 6 months? (for DN this would include DN/GP meetings as well as written/formal correspondence communication)	87	93	100	71	86
Total	91	93		82	92

Clinical Audit and Quality Assurance Programme

All services contribute to and participate in the agreed annual audit programme through the Clinical Audit and Quality Assurance (QA) Programme. This programme is designed to assist with improving quality at a local level.

The Clinical Audit and Quality Assurance Programme is a collection of all the Trust's individual Audit programmes; Pharmacy Department Audit Programme, National audits and Confidential Enquiries Programme, Infection Control Audit Programme, CQUIN Programme and Clinical Staff Audits. The programme incorporates a significant amount of areas including: Quality Assurance Audits, Peer Service Reviews, national and local surveys and audits, monitoring of outcome measurements, patient safety, safeguarding and service user and carer experience.

Clinical audit activity is aligned to the Trust's quality and safety priorities. The Clinical Audit Programme links to the Trust's Quality Strategy and quality aims

The audit programme for 2018/19 was divided into three sections: national audits, priority audits and local service/team audits.

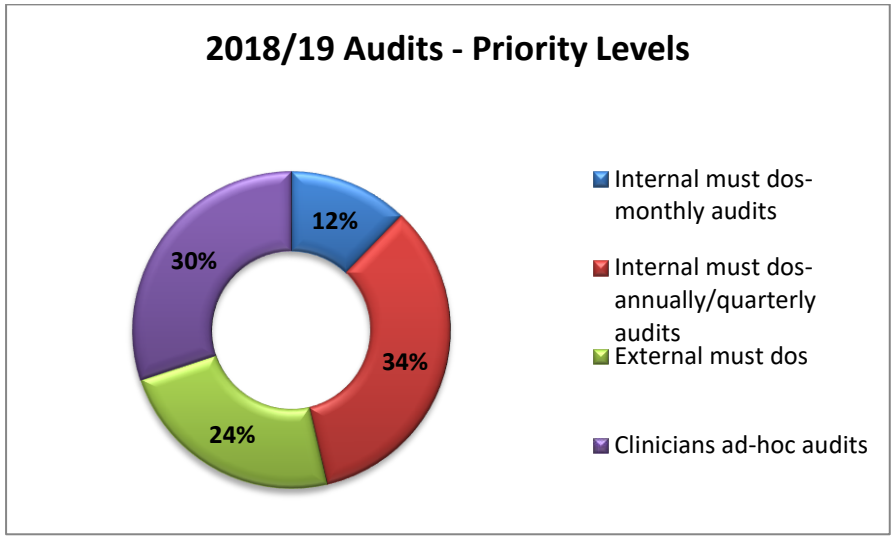
Audit Type	Definition
National Audit	An audit project funded by the Healthcare Quality Improvement Partnership (HQIP) or another national body. BEHMHT participates in all national audits where our services meet the eligibility criteria.
Priority Audits	Priority audits are mandatory audits carried out by all eligible services across the whole organisation. These audits are devised and coordinated by an identified senior lead and are commonly initiated in response to published best practice guidance or issues identified through BEHMHT Clinical Governance reporting processes.
Local Service/Team Audit	A team or specific service/topic audit designed to assess how well a service is meeting a best practice standard. Local audits are usually carried out by individual, targeted services.

Together, these assessments combine to give a total of over 100 audits, surveys and quality projects undertaken a year. The Clinical Audit & Quality Assurance Programme results are discussed in detail at local clinical governance meetings. The Clinical Audit & Quality Assurance Programme 2018/19 was approved by the Quality & Safety Committee in March 2018.

Participation in clinical audit in 2018/19

During 2018/19, the Trust participated in 86 Trust wide audits and 11 registered local audits.

The chart below shows the priority level for these audits.



"External must dos" are the national, NCEPOD / Confidential Enquiries, CQUIN, CQC and Department of Heath statutory requirements (e.g. Infection Control) audits. "Internal must dos" are audits related to clinical risk, audit of policies and local and national standards. "Clinicians' ad-hoc audits" are local topics important to the boroughs and "educational audits" are audits carried out by Junior Doctors or other trainees.
All the completed audit reports detail the level of compliance with the audit standards and highlights areas for improvement for the trust.

Participation in national clinical audits and national confidential enquiries

The Trust participates in the National Clinical Audit Patient Outcomes Programme (NCAPOP) audit process and additional national and locally defined clinical audits identified as being important to our population of service users, to help improve the quality of care and service provided to our service users.

During 2018/19, BEH participated in 11 national clinical audits and 3 national confidential enquiries covered relevant health services which covered the health services that Barnet, Enfield and Haringey provides.

During that period, the Trust participated in 100% of national clinical audits it was eligible to participate in. BEH also participated in100% of national confidential enquiries that it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust participated in, and for which data collection was completed during 2018/19 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 the audit of that audit or enquiry.
BEH participation in national audit and national confidential enquiries, 2018/19:

National Audit	Number of submissions to audit	% eligible cases submitted
POMH-UK Audits		
Topic 16b - Rapid Tranquillisation in the context of pharmacological management of acutely disturbed behaviour	24	100%
Topic 18a – The use of clozapine	14	100%
Assessment of the side effects of depot antipsychotics POMH-UK – Topic 6d	77	100%
National Audits		
Sentinel Stroke National Audit programme (SSNAP)	**Enfield Community Stroke Rehab Team** April-June 2018: Insufficient records for auditing July-December 2018: 33 records **Enfield ESD Team** April-June 2018: Insufficient records July-December 2018: 20 records	100%
National Clinical Audit of Anxiety and Depression (NCAAD)	80	100%
National Clinical Audit of Psychosis- Core Audit	150	100%
National Clinical Audit of Psychosis- EIP spotlight audit	• Barnet – 52 • Enfield - 94 • Haringey – 100	100%
NCAAD Psychological Therapies Spotlight Audit	90	100%
National Audit of Intermediate Care (NAIC)	2 (organisational and service user submissions)	100%
Falls and Fragility Fracture Audit	0 cases identified	–
National Confidential Enquiries		
National Confidential Inquiry into Suicide and Homicide	14/16	87% of NCISH questionnaires returned
Maternal, New born and Infant Clinical Outcome Review Programme	0 identified	–

Quality Assurance Audit

The Trust's primary clinical audit system for driving through improvements in practice is the monthly Quality Assurance (QA) returns from the clinical teams. The QA Audits are self-assessed and undertaken by each clinical team within the Trust. A bespoke audit tool has been produced for each team or service to assess the quality of the service user record. The audit tool is based both on national and internal Trust standards and identifies specific priority areas for specialities within the teams.

For the purpose of Trust-wide monitoring and benchmarking, 12 clinical competency areas are assessed in the Quality Assurance audit which includes; Assessment, Care co-ordination, Care plan, Carers, Communication with GPs or partner agencies, Information, Involvement, Outcomes, Physical health, Risk and Smoking.

To ensure the accuracy of the self-reported figures provided by each team, monthly spot check audits were undertaken by the corporate Clinical Audit Team. Variances are reported to team and service managers and training has been provided. Real-time information on all Quality Assurance audit compliance is made available to all teams through our online audit system.

Trust compliance with Quality Assurance Audits 2018/19

The Trust Quality Assurance (QA) Audit process was redesigned in 2018/19 to emphasise a more focused approach in achieving improvements as a result of the QA audits; the aim of this was to have succinct audits on specific areas each month which are repeated once every quarter.

From April 2018 to March 2019, 9239 patient records were assessed and reported as part of the QA audits.

Quality Assurance Audit (QA)	2017/18		2018/19	
	Score %	Number of returns	Score %	Number of returns
QA Specialist Services	97	2031	97	2121
QA ESC Services	96	1980	96	2070
QA Mental Health Services (Barnet, Enfield & Haringey Boroughs)	94	4175	91	4863
QA Prison Services	91	208	96	185
Total QA returns	95	8397	93	9239

All teams achieved above the benchmark compliance target of 90% in the Quality Assurance Audit overall.

Breakdown by overall competency scores:

Scores by Competency	
Competency	Score
Alcohol	84%
Capacity and Consent	93%
Care & Treatment	95%
Care plan	99%
Carers	96%
Communication with GP or partner agencies	93%
Health Records	97%
Information	98%
Involvement	96%
Physical Health	97%
- Physical Health Assessment	86%
- Physical Health Intervention	78%
Risk	97%
Smoking	91%

There has been an improvement in the competency scores from the previous year, particularly for Alcohol which was low due to the assessment not being documented properly.

Compliance with Physical Health assessment and intervention standards will be addressed through the Brilliant Basics physical health work stream.

Peer Service Review Programme
The Trust has an established peer service review process to assess teams' compliance with the Care Quality Commission's Regulatory Framework, and local standards as defined by Trust Policies.

The peer review audit tool consists of four elements:

General Inspection	An assessment of the team environment which requires teams to have such items as information on medicines or treatment; patient satisfaction results displayed; the names of staff who can order controlled drugs, etc.
Patient Records Inspection	An audit of patient records of the patients seen by the team. Reviewers are required to inspect three patient records as a snapshot of the team's compliance with Trust policy and procedure (i.e. patients having a copy of their care plan; patients being involved in their care planning; patients consent to medication documented, etc.)
Service User Interview	The reviewers speak with three service users to obtain their feedback on the services provided (i.e. whether service users have been involved in assessing and planning their care; agreed to treatment; have access to fresh air and exercise; are given an opportunity to feedback on their care plan).
Staff Interview	This element requires reviewers to speak to three staff members and assess their knowledge in relation to key trust policy and procedures.

Trust compliance with Peer Service Review audits 2018/19

During 2018/19, 10 CQC regulations were peer service reviewed. The Trust added three additional areas for peer service review. These were Seclusion, Restraint and Forced Care. The Trust target compliance for each peer service review is 92%; this was achieved in all13 of the Peer Service Reviews in 2018/19. Improvements were made in12/13 peer reviews.

More than 163 action plans were logged on the Trust's central database by different teams to address areas of non-compliance identified by Peer Service Reviews and Quality Assurance audits.

Peer Service Reviews 2018/19: Trust Compliance

Peer Service Reviews 2017/18 & 2018/19: Trust Compliance						
Care Quality Commission (CQC) Regulatory Outcome - Peer Service Review Topics	2017/18			2018/19		
	Score (%)	Returns	Participating Teams	Score (%)	Returns	Participating Teams
CQC Reg 11 - Need for Consent	94	526	66	96	798	104
CQC Reg 12 - Safe Care and Treatment	96	708	115	97	646	102
CQC Reg 16 - Acting on Complaints and Reg 17- Good Governance	97	406	111	97	366	100
CQC Reg 10 - Dignity and Respect	93	596	99	95	596	103
CQC Reg 14 - Meeting Nutritional and Hydration Needs	93	266	28	95	422	47
CQC Reg 13 - Safeguarding	97	592	102	98	619	103
CQC Reg 9 - Person Centred Care	96	845	92	96	784	96
Outcome 9 Reg 13 - Management of Medicine	95	371	70	97	378	65
CQC Reg 18 - Staffing	95	729	102	93	704	101
CQC Reg 15 - Premises and Equipment	92	542	103	93	527	101
Seclusion Peer Review	89	33	13	94	13	5
Restraint Peer Review	82	38	38	86	19	9
Forced Care	94	14	3	100	1	1

Local Clinical Audits 2018/19

In 2018/19, 13 local audits were registered of which 11 were completed. Data collection methods ranged from surveys to case note record reviews.

Examples of changes and improvements to practice and service delivery following local audit outcomes is listed below:

Quarterly Quality assurance audit for Therapy Groups on the 2 Acute wards and 1 PICU in Edgware:

- Therapy programmes running on Thames, Trent and Avon are perceived as being beneficial and therapeutic by service users supporting them in the acute phase of their illness. The therapy programme provides structure to the day through activity, with the aim of promoting enablement and supporting service users in working towards their recovery.
- Collection of feedback allows the OT Team to capture the opinions of service users, in order to respond to the current needs of the service within the inpatient setting.

Audit of informal patients and their rights

- Once a patient's legal status changes to informal, it is recommended to have their legal position and rights explained to them; including how they can leave the ward, their right to refuse treatment and how to make a complaint.
- Patients are to be given a copy of their rights and it has been recommended to document evidence of their capacity to consent to both informal admission and treatment.

Trustwide changes and improvements to practice and service delivery following audit outcomes

► Peer Service Reviews

- Fire Wardens identified and training to be arranged for outpatient area
- Information on the bronze command to be circulated to all outpatient staff and contingency planning to be reviewed for outpatients for fire evacuation plans
- Haringey CAHMS: For emergency numbers to be printed and distribute to all CAMHS offices to be displayed in offices.
- Eating Disorder service: Developed a risk register specifically for the outpatient team and ensured that teams within outpatients are aware of what is on it
- Enfield CYP & CAHMS services: To identify a Fire warden for the Immunisation Taskforce team and email sent out to team asking for volunteers
- Infection control board to be clearly displayed, to make sure hand washing instructions are displayed near the sinks in both clinic rooms.
- Specialist Community Services to display names and photos of staff working in team for service users to be aware of who works in the team
- For evidence daily planning of staffing in line with capacity, Specialist Inpatients Services to consider a way of communicating with all outpatient staff regarding staffing levels not just within the liaison team so that the whole team are aware and can cover for one another.
- Staff to be reminded to include venue/ mode of contact in Progress notes

- To circulate (by email) up to date information and role of Caldicott Guardian and how to access expertise. To have a Useful contacts leaflet for each desk
- For Good and smooth coordination of care, actions taken to ensure all CPA and discharge summaries are completed in timely manner and forwarded to the relevant services i.e. GP.
- All staff to be aware of risks identified on the Team Risk Assessment
- Barnet Community Services: To include Risk Assessment information in new starters induction pack and ensure understood through supervision
- For meeting nutrition & hydration needs, contact made with catering to determine whether they could increase the portion of food
- Ensure all Team Members have the knowledge of how service users would be able to obtain the information the Trust keep about them.
- GASS form to be completed liaise between DR and provider to establish who is responsible to monitor and report clients compliance with medication

► Quality Assurance Audit

- Enfield AOP & OP services: Care plans to be SMART and nurses to be reminded to complete a crisis plan and to have 1:1 discussion with service users on crisis management.
- Health Visitors to ensure their progress notes are recorded with accurate information reflecting what took place at each contact, as well as the outcome.
- Enfield Adult Mental Health Services: Service users to be encouraged bring their carers to appointments and involve in their assessment as agree and consent to, included as part of appointment letter
- Staff to discuss physical health record if complete or encourage if not completed in the past year
- Reminder to new staff to review & update risk summaries following incidents.
- Specialist Inpatient Services: For any patient identified as not having a risk management care plan, named nurses would be asked to complete one with their patient as soon as possible.
- Enfield CYP & CAMHS Services: Staff have been reminded to use abbreviations from the approved list only and operational support manager has supported the team with updated list of abbreviations. Team has been advised of updated abbreviations list.
- Enfield Adult Mental Health Services: Carers to be signposted to Carer Support agencies when identified at the point of entry and during formulation meetings

► Patient and Carer Experience Survey

- There has been a high level of uptake during 2018/19, with 10014 responses
- Satisfaction levels remain consistently high, at 90% at time of reporting
- 100% of service users report to have been explained their medication in a way they could understand
- The Trust's Patient Experience Committee are undertaking work to improve information/awareness around community organisations, including the development of a Community Resources directory led by the Enablement team.
- BEH MHT is piloting a DIALOG programme to support

involvement in care planning under the CPA.

► Seclusion & Restraint audits
- Restraint protocol circulated and patient care plan to be audited following restraint.
- Audit tool circulated to all staff to help inform them when completing documentation when a patient is in seclusion

► Safeguarding Audit
- Safeguarding leads to continue to champion the “think family” approach.
- Review process for booking appointments and recording attendance with the Insight platform worker at The Grove.
- Parenting assessment to include prompt to book appointment to see insight platform which is to be offered to all clients as part of the initial assessment process
- Managers to review action completed through monthly safeguarding supervision.

► Trust wide Safe & Secure Handling of Medicine
- Patient details were completed on the prescription charts with above 90% compliance (except for Gender).
- All patients that were subject to MHA Consent to treatment had a T2/T3 form attached to their prescription charts.
- Liaising with wellbeing clinics to ensure patients on clozapine have annual monitoring of plasma lipid and general physical examination and that clozapine is documented in the Summary Care Record for patients under the care of Community Mental Health Teams.

To ensure lessons are learnt from undertaking audits and to share good practice, we have the following arrangements:

- All clinical audit activity is centrally registered, coordinated, monitored and reported on systematically and effectively so as to maximise the potential for improvement and learning
- Managers are involved in the clinical audit project ensuring commitment at local level
- Improved timeliness of reporting to enable areas requiring improvement to be addressed and to ensure organisational learning takes place
- The Trust Quality Assurance Audit process has been redesigned in 2018/19 to have succinct audits on specific areas each month which are repeated once every quarter. This approach allows the teams to select patients to whom the measures are applicable and therefore, will give more meaningful results and allows time for the required improvements to be made between audits
- Audit activity and in particular recommendations and learning from audits, are widely disseminated and implemented. Lessons learned from clinical audit activity in one Borough are shared with the other Boroughs wherever relevant to ensure that common

themes are identified and steps are taken to improve services where necessary
- A monthly award is awarded for the best local clinical audit project and publicised Trustwide to share good practice
- A summary of lessons learned from audits are reported annually to the Trust's Quality & Safety Committee

Priorities and Further Developments for 2019/20

- On-going monitoring of action planning to ensure this process is happening across the teams for areas below the Trust benchmark.
- Building further on the collaboration of Clinical Audit and Quality Improvement (QI) and the use of QI methods to act upon the findings from the audits and make and embed the required improvements.
- Introduction of new audit tool for patient health records to ensure compliance with the relevant national and local requirements of the Records Management Policy.
- Further strengthening of lessons learnt from audits and sharing of good practice arrangements. The Corporate Clinical Audit Team will continue to support Trust teams and services to improve reporting of outcomes of clinical audit and to ensure that audit activity and in particular recommendations and learning from audits are widely disseminated.
- Implementation of the Quality and Effectiveness Safety Trigger Tool (QUESTT) to monitor key performance indicators to provide an early warning if essential characteristics of a well performing team, working within an environment that will support quality and safety, are absent or at risk. This will also act as a supportive tool that will support teams and individuals within them to provide safe and effective care and it is recognised that often factors external to the team and/or organisation have a significant impact upon a team's essential characteristics.
- Introduction of "Perfect Ward" auditing/inspection solution in the form of an app for immediate capture of information, clear view of progress, consistency for meaningful comparisons and instant report results.
- Integration of statistical process control (SPC) charts in reporting to enable visualisation of the variation in measures of quality over a defined timeframe.

Patient Reported Outcome Measures (PROMs)

The Trust currently uses nationally accredited tools to measure patient health outcomes in a range of community health and mental health services.

SWEMWBS is an outcome measure used to assess mental wellbeing within our Triage and CRHTs (Crisis Resolution Home Treatment Teams). The tool contains 7 positively worded quotes and each statement has five response categories (ranging from none of the time to all of the time), for which the patient rates their functioning.

Additionally, PROMs is linked to the electronic patient records system which our staff use routinely, to aid the recording of PROMS responses. The PROMs reporting process is routinely overviewed to ensure adequate information is available to clinicians, service users and commissioners

where it is relevant. In addition to this, work is in progress to development a system to monitor and report patient outcome information through boroughs' governance meetings.

Reporting Patient Reported Outcomes Measures (PROMs)

Showing improvements year on year is one of the priorities of the Clinical Strategy for 2018-19 and fits well with the aims of the enablement strategy, to address the service user's own presenting difficulties in a holistic manner and provide a personalised treatment plan rather than one aimed at symptoms or problems identified by professionals. For each outcome measure the Trust expects improvement in service user's and patient's functionality following intervention.
In 2018/19, 13 Trust services used PROMs as a means of measuring outcomes of care for the service user. A total of 1210 returns were received during 2018/19.

In 2019/20, PROMS outcomes will be reported at Borough Deep Dive meetings to ensure there is appropriate shared learning from patient's views of their clinical experience and expected outcomes.

PROMs participation by team, 2018/19

Team	SWEMWBS Meridian	EQ-5D	Proms ECS (KPI)	SWEMWBS RIO	POD	Other
Barnet CRHT	x					
Enfield CRHT	x					
Enfield EIS	x			x		
Total SWEMBS Meridian	268 (Q1 to Q4 2018/19)					
ICT East Team		x				
ICT West Team		x				
Total EQ-5D	286 (Q1 to Q4 2018/19)					
Stroke Rehabilitation Service			X Meridian			
Bone Health and Fracture Liaison Service			X Meridian			
Total ECS PROMS	656 (Q1 to Q4 2018/19)					
Enfield Drug and Alcohol Service						Recovery Star – TOP
Enfield Dual Diagnosis						Theseus TOP
Haringey Dual Diagnosis						DET TOP
The Grove						TOP

A number of teams across the Trust have in place other initiatives and mechanisms for monitoring and evaluating outcome measures.

In Children & Young People's specialist services, the Occupational Therapists implement COPM (The Canadian Occupational Performance Measure), an evidence based outcome measure capturing self–perception of performance in functional skills.

Our Clinical Lead Physiotherapy has developed EDON (Enfield Determination of Needs) working with the Institute of Child Health in furthering the tool's reliability. The multi–function purpose supports prioritisation, caseload weighing and outcome measurement. The tool is fully implemented within Musculoskeletal (MSK) and Neuro-Disability Physiotherapy. The tool addresses a gap in products currently available.

Co-production of goals and outcomes with children and young people, parents and support team is integral to speech and language therapy clinical care. Validated self – perception measures are part of a range of evidence based programmes extended through Talking Mats for those with speech, language and communication needs.

Outcome led interventions and provisions including a child or young person's aspiration and goals form part of their Education Health and Care Plan which is a legal document that describes a child or young person's special education, health and social care needs, and is monitored through multi agency reviews.

Participation in Clinical Research

Each year the Research Councils invest around £3billion in research. The National Institute of Health Research (NIHR) distributes £280m a year of research funding via 15 Clinical Research Networks (CRNs). The CRN provides the infrastructure to facilitate high-quality research and to allow patients and health professionals in England to participate in clinical research studies within the NHS. Our local one is the North Thames CRN.

Research support services (including research governance) are also provided through local structures, the one for north, east and central London being called 'NoCLOR' (www.noclor.nhs.uk), which supports the Trust's Research and Development Committee (R&D Committee) and provides training and support for research staff.

The recruitment target for portfolio adopted research studies within our Trust, for 2018/19 was 314. This is slightly lower than our 2017/18 target of 388. The number of patients receiving relevant health services provided or sub-contracted by BEH in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee is 327, across 24 different portfolio adopted studies. A further 3 non adoptive research studies were conducted, and the Trust also participate in 1 commercial trial.

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

Commissioning for Quality and Innovation (CQUINS) Goals agreed with commissioners for 2018/19

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

Following negotiation with commissioners, seven CQUIN schemes within BEH for community and mental health services were agreed for 2018/19. These were aligned to the national schemes and covered a broad range of quality initiatives to increase the quality of care, both physical and mental health and experience for our service users.

Our income for mental health services and Enfield Community Services was conditional on achieving quality improvement and innovation goals agreed with our commissioners through the CQUIN payment framework.

Our income for Specialist Services is paid proportionately based on performance against their agreed CQUIN schemes.

Trust performance against 2018/19 agreed CQUINS – a projection is shown for quarters 3 and 4.

Trust performance against 2018/19 agreed CQUINS

Ref	Short CQUIN Title	Q1	Q2	Q3 Confidence	Q4 Confidence
1a	Staff Survey Results	Nil submission	Nil submission	Nil submission	0%[1]
1b	Healthy food for staff and visitors	Nil submission	Nil submission	Nil submission	100%
1c	Uptake of flu vaccinations (clinical frontline)	Nil submission	Nil submission	Nil submission	75%[2]
3a	Cardio Metabolic Assessment and treatment for Patients with Psychoses	Met	Nil submission	Nil submission	25%[3]
3b	Annual health check care plans shared with GPs	Partially met[4]	Partially met[5]	100%	25%[6]
4	Managing frequent attenders at A&E	Met	Met	Nil submission	100%
5	CAMHS Transition (planning and experience of service)	Partially met[7]	Partially met[8]	Nil submission	50%[9]
9a	Preventing ill health by risky behaviours – alcohol and tobacco	Met	Partially met[10]	100%	50%[11]
10	Improving the assessment of wounds	Nil submission	Partially met[12]	Nil submission	50%[13]
11	Personalised care and support planning	Nil submission	Nil submission	Nil submission	50%[14]

CQUIN Supporting notes

CQUIN	Comment reference	
1a	1	The Trust fell just short of the targets for the 3 questions relating to health and wellbeing improvement
1c	2	75% of value forecast – Lead nurse reported in Dec that vaccine stock was critically low and there was a national shortage. Project Management Office (PMO) wrote to Commissioning Support Unit (CSU) to show projection estimated to reach 65% (which equates to 75% payment). PMO await commissioner's response
3a	3	While the audits of individual cardio metabolic parameters have looked positive, the performance against the combined completion of all parameters is much lower. A manual audit is due to take place Mar 2019
3b	4	Achieved 50% of the available award - the alignment of SMI QOF and CPA registers couldn't happen due to delay in protocol sign off. CSU awarded partial payment in recognition of work undertaken to date
3b	5	Achieved 50% of the available award – a review of shared care protocol implementation was not possible due to systems to share information was not yet in place
3b	6	25% value forecast – CSU will consider partial payment due to BEH's production of a shared care protocol and the Trust's statement of intention of commissioning new software in 2019 that will improve the sharing of information between Primary Care and BEH MHT
5	7	Achieved 75% of the available award – CSU felt transition policy document submitted did not appear to reference seeking feedback from service users pre and post transition. Document now updated
5	8	Achieved 83% of the available award – Receiving provider feedback fell short of milestone requirements. PMO now implementing an engagement plan with the 3 borough's receiving providers
5	9	50% value forecast – Receiving provider surveys/audits and reviews are less forthcoming than sending provider's. PMO striving to achieve the same level of engagement from receiving providers as they have from sending providers
9a	10	Achieved 67% of the available award – partial payment awarded against national CQUIN sliding pay scales
9a	11	50% value forecast – Quarterly submission of data enables the calculation of the 5 values (a-e). Based on comparison with the previous quarter's submission, we receive a percentage of the total value.
10	12	Achieved 40% of the available award - due to the fact an 80% baseline was set in Q2 of 2017/2018
10	13	50% value forecast - Final audit of full wound assessment due beginning April 2019
11	14	50% value forecast – Cohort to be asked the final patient activation questions end Mar 2019

Participation in Accreditation Schemes

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

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

Service Accreditation Programme, 1st April 2018 – 31st March 2019		
Programmes	**Participating services in the Trust**	**Accreditation Status**
ECTAS: Electroconvulsive Therapy Accreditation Service	Chase Farm ECT Clinic	Accredited
MSNAP: Memory Services National Accreditation Programme	Barnet Memory Assessment Service	Accredited
	Enfield Memory Service	Accredited
	Haringey Memory Service	Accredited
PLAN: Psychiatric Liaison Accreditation Network	Mental Health Liaison Service (Barnet Hospital)	Accredited
	North Middlesex Mental Health Liaison Service (North Middlesex Hospital)	Accredited
QED: Quality Network for Eating Disorders	Phoenix Wing, St Ann's Hospital	Accredited

Information Governance Toolkit compliance 2018/19

BEH's compliance for Information Quality, Information Security and Data Quality for 2018/19 was assessed using the Data Security and Protection Toolkit (DSPT). The DSPT is an online self-assessment tool allowing the Trust to measure its performance against the National Data Guardian's 10 data security standards. All organisations that have access to NHS patient data and systems must use the DSPT to provide assurance that they are upholding good data security standards and that personal information is handled correctly.

An integral part of the DSPT assessment is the annual submission of the Statement of Compliance (SoC), which provides assurance to the NHS Digital that the Trust has robust and effective infrastructure and systems in place for handling information securely and confidentially. The annual statement is necessary to obtain and maintain connection to the NHS secure infrastructure and national services.

The Trust commissioned an internal audit to help provide assurance of compliance with the requirements of the DSPT.

The scope of the audit carried out at the end of December 2018 related to:

- Personal Confidential Data
- Staff Responsibilities
- Training
- Process Reviews
- Responding to Incidents

The outcome of the audit revealed no high risk gaps requiring immediate attention.

The introduction of the General Data Protection Regulation amended the criteria for reporting information governance incidents to the Information Commissioner, the effect of this has resulted in the Trust declaring a higher number of incidents this year.

To date the Information Commissioner has been satisfied that the Trust have robust policies and procedures in place and that the majority of incidents were attributed to 'human error'.

The Trust promote information governance processes and procedures using a variety of methods, including annual information governance training, face to face presentations and awareness briefings included in the Trust's Quality Newsletter.

Data Quality

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

Monthly dashboards allow the Trust to display validated data against key performance indicators, track compliance and allow data quality issues to be clearly identified. Borough specific reports mirroring the layout of the report to Trust Board have improved consistency of reporting.

The Trust submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episodes Statistics which are included in the latest published data. We make monthly and annual submissions for Outpatient Care and Admitted Patient Care. We do not provide an Accident & Emergency service and therefore do not submit data relating to accident and emergency.

The percentage of records which included the patient's valid NHS Number and General Medical Practice code is shown below.

	NHS Number (%)	National Result (%)	GP Code (%)	National Result (%)
Completion of valid patient care data set	99.9%	98.6%	100%	99.9%

BEH was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission.

National Mandated Indicators of Quality 2018/19

We are required to report against a core set of national quality indicators to provide an overview of performance in 2018/19

1. The percentage of patients on Care Programme Approach (CPA) who were followed up within 7 days after discharge from psychiatric inpatient care.

Average Results	2015/16	2016/17	2017/18	2018/19
BEH Result	99.1%	99.4%	99.5%	99.0%
National Results	97.2%	97.2%	97.2%	95.7%

During the last three years, our compliance with following up discharged patients on CPA within 7 days has been consistently above the 95% national target. In 2018/19, 99.0 % of our patients on CPA were followed up within 7 days of discharge; the national average results were 95.7%.

BEH considers that this data is as it is described for the following reasons: we have established, robust reporting systems in place though our electronic patient record system, RiO and adopt a systematic approach to data quality improvement.

BEH has taken the following actions to improve this percentage, and so the quality of its services by ensuring clinicians are aware of their responsibilities to complete these reviews. This is managed and monitored by teams through daily review of discharge activities.

2. Percentage of admissions to acute wards for which the Crisis Resolution Home Treatment (CRHT) Team acted as a gatekeeper.

Average Results	2015/16	2016/17	2017/18	2018/19
BEH Result	97.9%	99.6%	98.9	97.1
National Results	98.2%	98.2%	98.2	98.1

In 2018/19 an average of 97.1% of patients were reviewed prior to admission to acute wards.

BEH considers that this data is as it is described for the following reasons: we have established, robust reporting systems in place though our electronic patient record system, RiO and adopt a systematic approach to data quality improvement.

BEH has taken the following actions to improve this percentage, and so the quality of its services by developing a robust system to closely monitor this activity and alert teams to any deterioration in performance.

3. Readmissions within 28 days of discharge

This indicator shows the percentage of all admissions that are Emergency Readmissions to our Trust within 28 days of discharge.

	Q1 18/19			Q2 18/19			Q3 18/19			Q4 18/19		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% Emergency Re-admissions	4.2%	2.2%	3.1%	6.5%	4.9%	3.6%	6.0%	4.4%	4.2%	3.6%	2.8%	tbc
Target %	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%

The target established by Monitor is that less than 5% of all admissions should be emergency readmissions. We have consistently met this target with an average of 4% of all Admissions being Emergency Readmissions within 28 days of discharge.

BEH has taken the following actions to improve this percentage and so the qualities of its services by ensuring our clinicians are aware of their responsibilities to complete these reviews. This is managed and monitored by teams through daily review of discharge activities.

4. Patient experience of community mental health services indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.

The results of our Community Mental Health Survey can be found on page 49 and the actions to be taken to improve the score, and so the quality of its services.

Patient Experience

The Trust provides a number of ways in which service users, carers and others can provide feedback on the care and treatment received. The information collected and collated is used to inform quality improvements and support changes in practice.

The Friends and Family Test

The Family and Friends Test (FTT) is a benchmarking tool used nationally across NHS organisations to measure patient experience.

The test asks individuals if they would recommend the service to their friends or family, and provides an opportunity for additional comment. The data is collected via paper forms, online surveys and service kiosks and reported quarterly through the Trust governance structure.

FFT score	Would Recommend	Would not recommend	Total responses
Trust overall	**90.21%**	**2.20%**	**10773**
FFT Mental Health Services	**88.01%**	**2.66%**	8248
FFT Enfield Community Services	**97.39%**	**0.71%**	2525

A total of 10,733 FFT responses were received Trust wide between April 2018 and March 2019, with 90.21% recommending the service received – a 0.58% increase from the previous year.

Service User and Carer Surveys

The Trust's Service User and Carer survey provides those using our services to give feedback under three key domains; Involvement, Information and Dignity and Respect. During 2018/19 a total of 10,105 Patient and Carer Surveys were completed, with a consistently high satisfaction rate of 90.14%.

The table below indicates that the best and worst performing areas from the survey results:

	Best		Worst
Question	Do staff clearly explain the purpose and side effects of medication in a way that you can understand?	100.00	Do staff encourage you to participate with your community by informing you about local groups, events and other organisations?
Section	Dignity and Respect	94.21	Involvement

The Patient Experience Team works closely with services across the Trust to ensure that service user and carer feedback is incorporated into service design, as part of our You Said, We Did culture. Just some of the examples of changes brought about from Service User and Carer feedback are:

- The Trust's Patient Experience Committee are undertaking work to improve information/awareness around community organisations, including the development of a Community Resources directory led by the Enablement team.
- BEH MHT is piloting a DIALOG programme to support involvement in care planning under the CPA.

Below is just a small sample of the positive feedback received via the Satisfaction Survey from patient and carers across the Trust:

***I am happy here and everybody is very kind - the team responded very quickly and was very professional*.**
Hawthorns Recovery Unit, May 2018.

The staff here are wonderful.
Finsbury Ward, June 2018

The patience the staff members have with the patients is extremely remarkable, staff are always there to support you and issues you have will get sorted with their support.
Eating Disorders Outpatients, July 2018

The Enfield 'home visits' Physiotherapist team are excellent, they treated me with the utmost dignity, respect and care, and most of all built my self-confidence with walking.
ICT West Team, November 2018

I couldn't add anything as this is the best Unit my daughter has been. She has been to 3 different Units and this by far is the best.
Barnet Liaison Psychiatry, March 2019.

Complaints

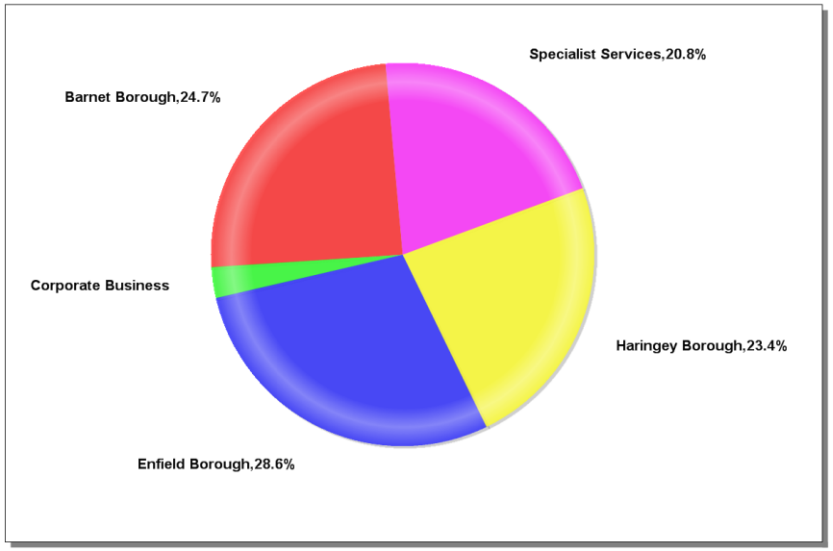
Concerns and complaints about the service received by patients and their families are taken very seriously, and the Trust seeks to address issues promptly and provide assurance of improvements made. Where possible, individuals are encouraged to seek local resolution by discussing concerns directly with the service; however, where this is not possible, the Trust implements a formal investigation process in line with national guidelines.

The table below illustrates the breakdown of compliments, concerns and complaints during 2018/19.

Feedback Type	Total
Compliments	497
Issues and Concerns	313
Informal Complaints	189
Formal complaints	77
Members Enquiries	65
PHSO Enquiries	3

From 1st April 2018 to 31st March 2019 the Trust received 77 formal complaints, a significant annual decrease since 2017/18 (163), 2016/17 (194) and 2015/16 (211). This is considered in part to be due to the revised Trust Complaints Policy, which introduced clearer processes for local complaint resolution and a new reporting system to allow for greater responsiveness by frontline services.

The chart below indicates the breakdown of formal complaints per Borough.



Of the total formal complaints received 7% were upheld, 57% partially upheld, 31% not upheld, and 3% withdrawn.
As in 2017/18, the most common categories of complaint continue to be Communication and Clinical Care. Examples of actions taken by the Trust to address lessons learnt from complaints are:

- We have worked with a group of service users to design a new induction training module which focuses on positive communication, reflecting our values of working together and respecting one another. This is delivered on a fortnightly basis to all new staff, with

plans to roll out to current staff as part of the refresher programme

- A training programme for staff within Crisis Teams has been designed and developed by a service user in receipt of care by the service in Haringey, and has been delivered to teams across the Trust. The training includes developing an understanding of the person beyond the diagnosis, engaging in personalised/individualised conversations, and delivering on best practice
- The Trust Complaints policy has been revised to ensure clear investigation routes and better equip staff with information about the escalation process
- Psychiatric Liaison teams have introduced clearer information about care pathways within A&E services, including leaflets about Recovery Houses, to ensure service users and carers are able to make informed decisions
- We've introduced a new monitoring system for wound charts within the Enfield District Nursing service, to ensure that these are completed correctly at admission.

Compliance

The Trust is required to acknowledge all formal complaints within 3 working days, and achieved a compliance rate of 92% during 2018/19. Six complaints were acknowledged outside of this timeframe due to administrative delays.

The Trust achieved a compliance rate of 60% against agreed final response dates, and this continues to be an area for improvement during 2019/20. Plans to address this include:

- Partnership working between the Patient Experience Team and Investigators throughout the complaints process
- Introduction of a Patient Experience for Managers training programme
- Introduction of a risk grade matrix for complex or lengthy investigations.

Community Mental Health Survey

The Trust took part in the national Community Mental Health Survey 2018, which captures the patient experience of community mental health services. 226 responses were received, reflecting a 27% response rate which is a 4% increase from the previous year. Results were largely positive, with the Trust scoring in the 60% intermediate range of all 52 Trusts surveyed across the majority of domains, and in the top 20% across some key areas.

What did we do well?

- 94.3% of people knew who to contact if they had a concern about their care, and 83.3% felt this person organised their care well.
- 74.6% of service users feel as involved as they want to be in planning their care, and 79.1% report to feel care is reviewed together with their team. This places the Trust in the highest 20% nationally for this question.
- 85.6% of individuals were satisfied with the therapies they were offered by the Trust.

What do we need to do better?

- Only a third of people felt they were given support with financial matters, and in finding and keeping work.
- 71.3% of respondents reported to have been given enough information about getting support from people who have the same mental health difficulties as them.
- 27.3% of individuals knew who to contact if they had a crisis out of hours.

The Trust has developed an action plan to address those areas requiring improvement, which is monitored by the Patient Experience Committee. Some of these actions include:

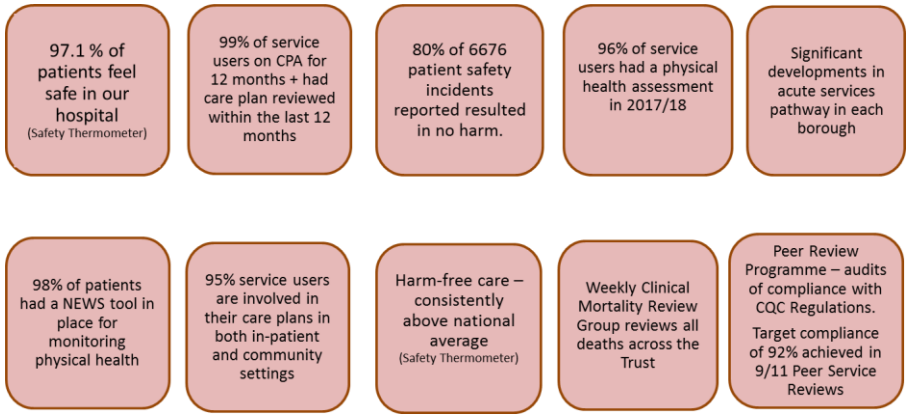
- A continued focus on recruiting Peer Workers into clinical teams, led by the Enablement Partnership. At time of report, the Trust has increased its Peer workforce to 24 employees.
- The development of a community resources database, to support individuals to find and engage with groups and networks in their neighbourhoods.
- The launch of a dedicated Night CRHT service.

Patient Safety

Our aim is to keep our patients safe and protect them from harm. The Trust has clearly defined processes and procedures to help prevent harm occurring to our patients.

Patient Safety Indicators

The Trust has performed well against key patient safety indicators in 2018/19.



Areas we focussed on to improve Patient Safety

- Timely SI investigation and Trust wide sharing of learning
- Physical health management
- Reducing violence & aggression
- Ensuring patient reporting goals reflected in care plans
- Reducing restrictive interventions

NHS Patient Safety Thermometer (Harm free care) Q3&4 data required

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

The audit is a snapshot audit of care on one day in a month. It allows teams to measure harm and the proportion of patients that are 'harm free' during their working day.

Participation in any relevant safety thermometer is a requirement of the NHS Standard Contract. The Trust has implemented both the Classic and Mental Health Safety Thermometers.

Classic Safety Thermometer

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

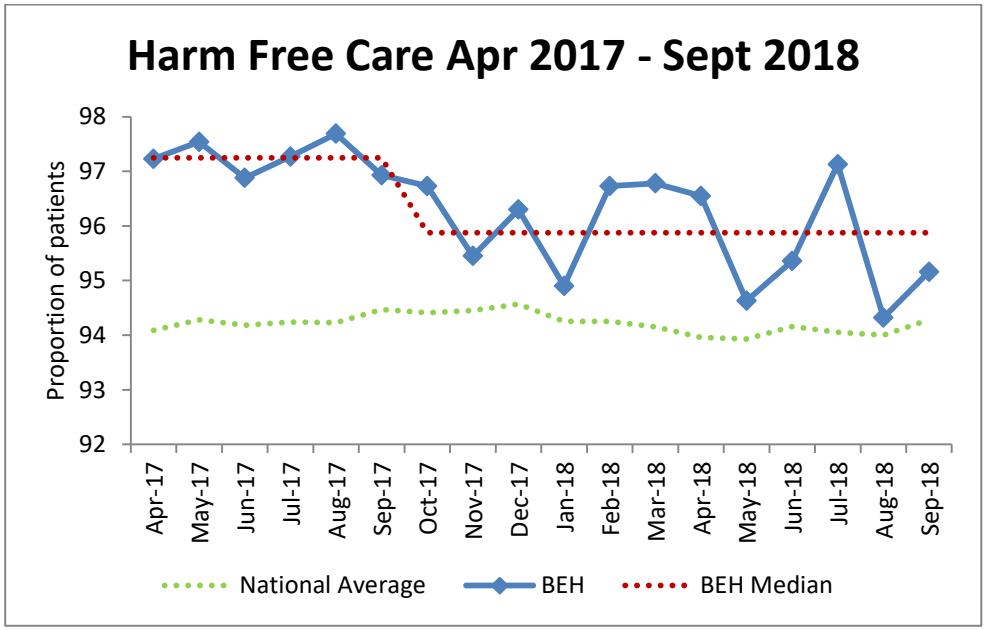
It should be noted that the national averages referred to in the following charts include data relating to all care settings (i.e. Acute, Community, Mental Health, Nursing Home, etc.). All national figures are taken from the NHS Safety Thermometer online dashboards.

Where national figures are not provided, comparisons with BEH results from 2017/18 are shown.

To ensure the accuracy of data provided by our teams, we audit the data against patient records and incident reports.

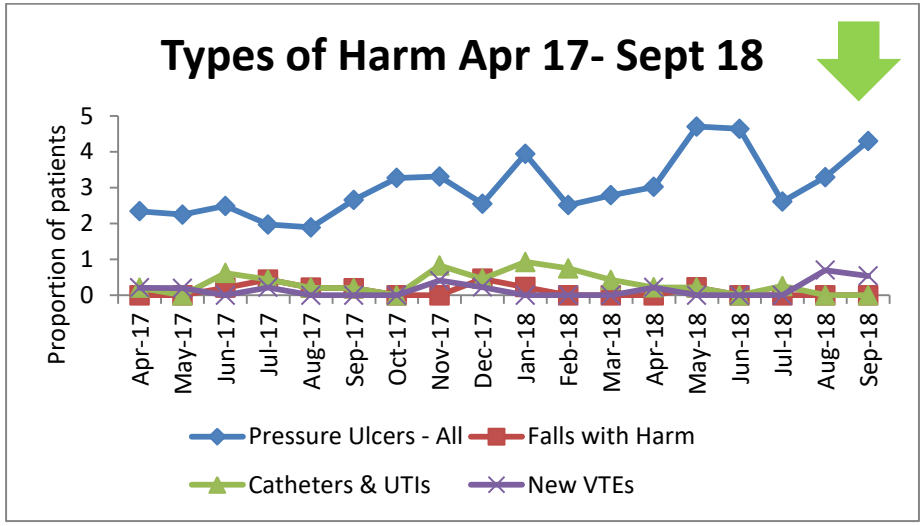
The proportion of BEH patients that experienced 'Harm Free Care' in 2018/19 remained above the national average.

Chart 1 – Harm Free Care



BEH has remained above the national average throughout the last 18 months and has only dropped below the >=95% target on 3 occasions (Jan 2018, 94.9%, May 2018, 94.6, Aug 2018, 94.3). The current median monthly average for 2018-19 (95.3%) is slightly lower than the 2017-18 figure (96.3%) but remains above the 95% target.

Chart 2 – Types of Harm recorded.



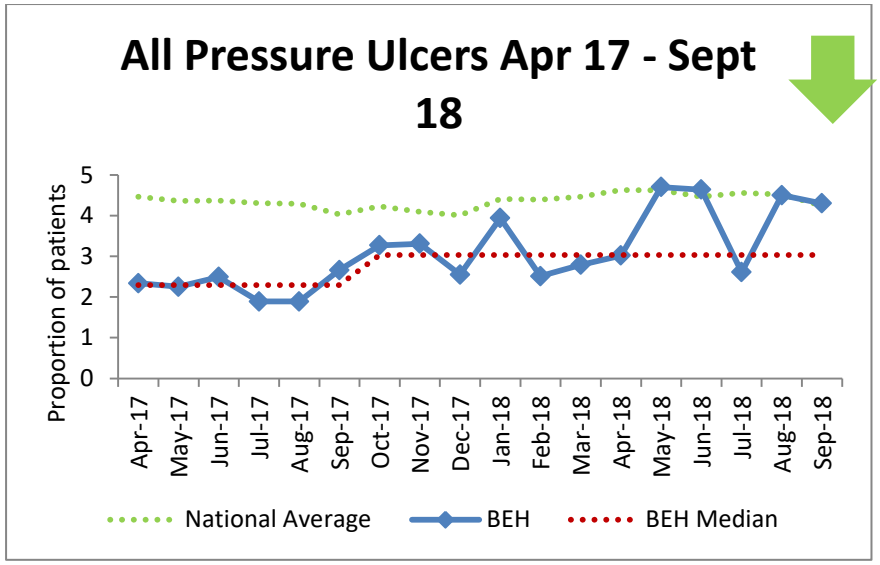
Within BEH, pressure ulcers remain the most prevalent of the harms measured by the tool.

Pressure Ulcers

This safety thermometer measures the proportion of patients with pressure ulcers at grades 2, 3, and 4. Pressure ulcers are recorded as either ‘Old’ or ‘new’. An ‘old’ pressure ulcer is defined as one that is present on admission to the organisation or develops within the first 72hrs following admission. The pressure ulcer present on admission is not normally reported on Datix as a Trust acquired pressure ulcer, but is recorded as a BEH harm on the safety thermometer tool.

A ‘new’ pressure ulcer is defined as one that occurred 72hrs or more after admission / first assessment or an old pressure ulcer which has deteriorated to a higher grade.

Chart 3 – All Pressure Ulcers recorded on safety thermometer tool.

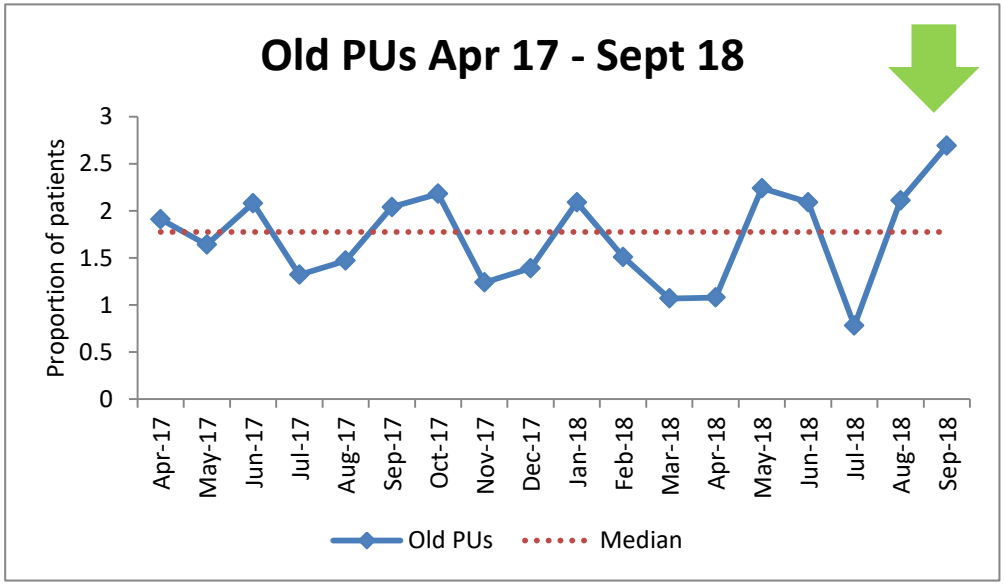


BEH was below the national average for the entirety of 2017/18 but have been above or equal to the national average for 3 out 6 months in Q1 & 2, 2018/19.

The Patient Safety Team continues to audit RiO and incident records to ensure that pressure ulcers identified in the safety thermometer audit are reported on the Trust systems so that the numbers and grades of pressure ulcers can be monitored, an assessment of care provided to the patient can be made and examples of good practice and actions taken to improve the quality of care can be taken. A review of BEH acquired pressure ulcers incidents reported in Q1&2, 2018/19 found that in two thirds of the cases, the patient and/or family were non-compliant with the care plan in place or the pressure ulcer was unpreventable due to the patient's pre-existing medical condition.

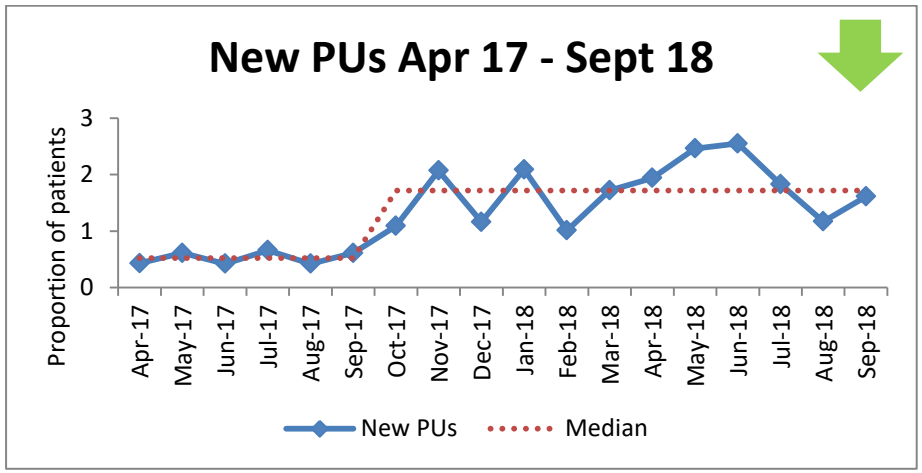
It should also be noted that the District Nurse teams may audit the same patient every month if they are scheduled to see that patient on the day of the data collection. The result being that if a pressure ulcer is not healing, it will be reported every month (regardless of the reason why the PU might not be healing).

Chart 4 – Old Pressure Ulcers (BEH)



The proportion of patients with an old Pressure Ulcer has increased in 2018/19. National figures are not available for this indicator.

Chart 5 – New Pressure Ulcers (BEH)

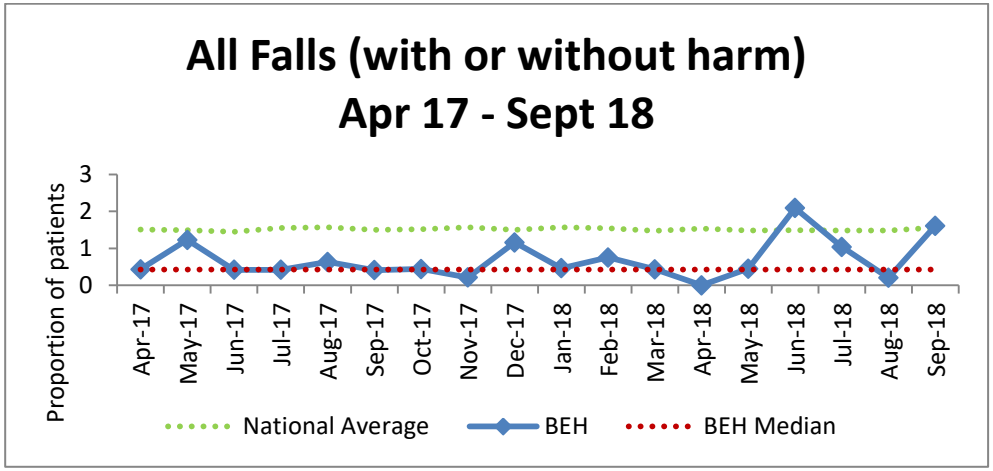


New pressure ulcer rates continue to increase compared to early 2017/18 although the numbers are still relatively low and have started to come down in quarter 2, 2018/19. National figures are not available for this indicator.

Falls

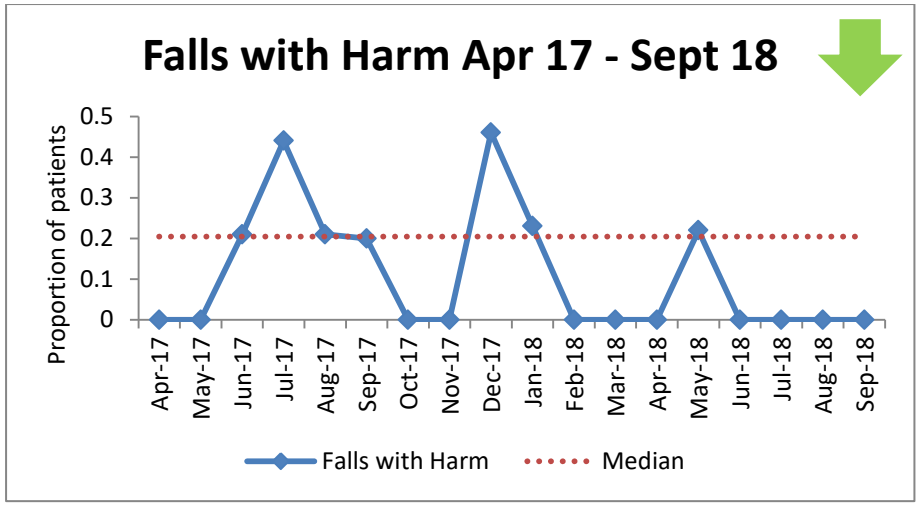
The safety thermometer measures the proportion of patients who have had a fall within the previous 72hrs. As noted above, Community teams visiting a patient once a week may not be aware of the fall until they visit. Consequently, there will be a delay in reporting the incident on the Trust incident reporting system.

Chart 6 – All Falls recorded on the safety thermometer tool.



The total number of falls recorded has increased in Q1 and 2, 2018/19, however as the chart below shows, the number of these resulting in harm has decreased and has been 0 from June to Sept 2018.

Chart 7 – Falls with Harm (BEH)

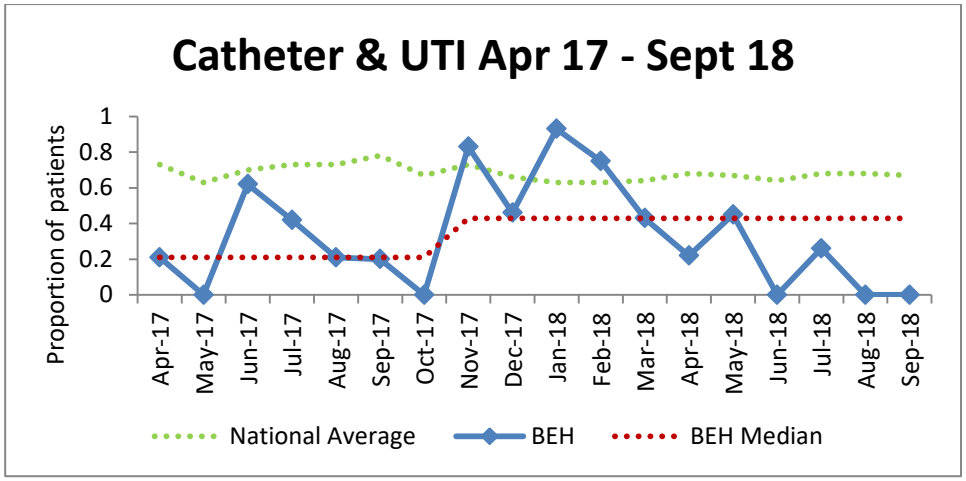


National figures are not available for this indicator.

Catheters and UTIs

The safety thermometer records harm as a patient who has a catheter is in situ *and* a urinary tract infection and whether treatment for the UTI started before admission ('Old UTI') or after ('New UTI').

Chart 8 – All Catheter & UTIs reported



After an increase of UTIs recorded at the beginning of the year, there has been a decrease in the number reported overall with 0 cases of 'New' and 'Old' UTIs reported in August and September 2018. See charts below.

Chart 9 – Catheter & New UTI (BEH)

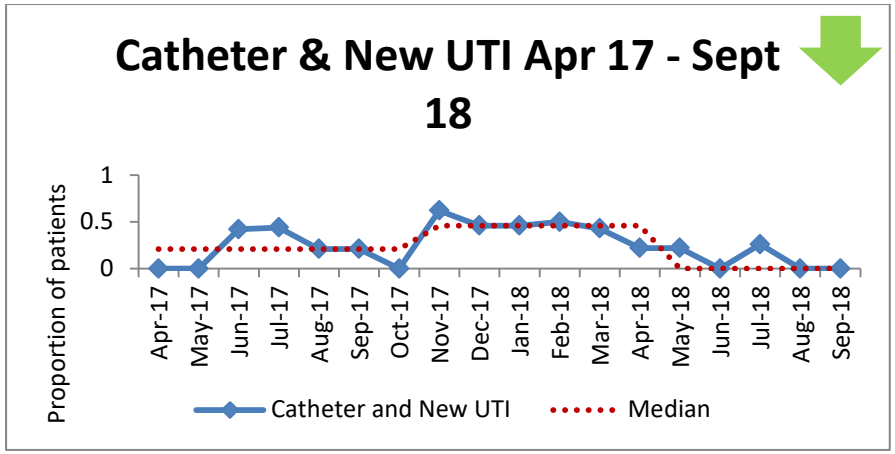
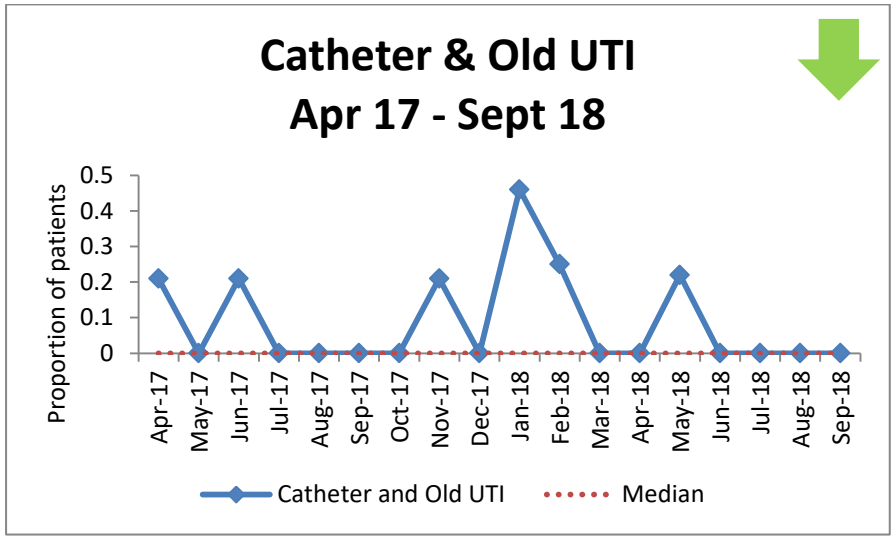


Chart 10 – Catheter & Old UTI (BEH)

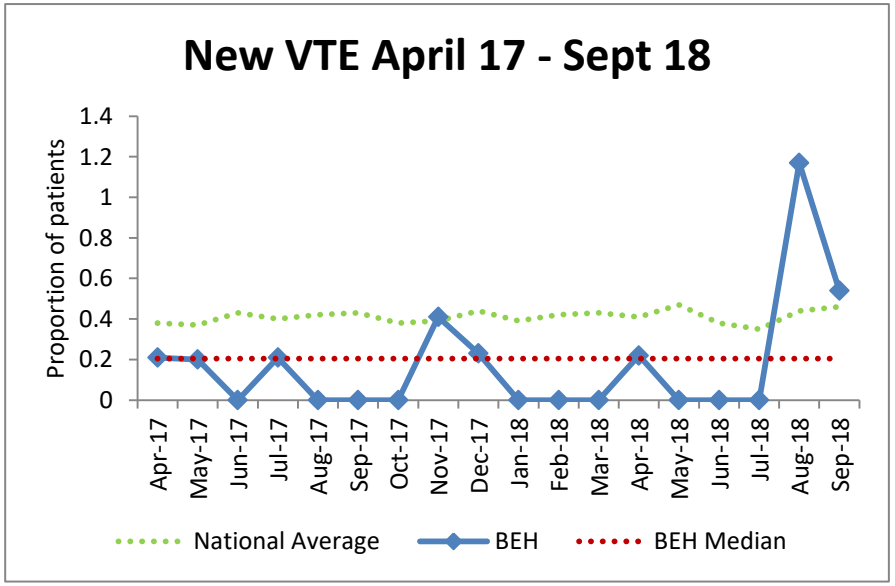


VTEs

The safety thermometer records if the patient has a documented VTE risk assessment and if an 'at risk' patient has started appropriate VTE prophylaxis. If treatment for the VTE was started after the patient's admission to BEH, this is classed as a 'New' VTE.

It should be noted that the patient may be under the GP's care for VTE treatment but will be recorded as a 'new VTE' for BEH on the safety thermometer due to the criteria noted above.

Chart 11 – New VTEs – BEH compared to National Averages



BEH has met the submission deadline for the Classic Safety Thermometer throughout Q1&2, 2018/19 and harm free care overall has been above the national average.

The assurance processes implemented by the Patient Safety Team in 2016 have greatly reduced the number of harms being reported in error. Data is audited against RiO electronic patient records and reported incident prior to submission and queries are raised with teams where the data sources don't correspond.

Mental Health Safety Thermometer

The Mental Health Safety Thermometer allows Trusts to measure the commonly occurring harms in people that engage with mental health services. Like the Classic Safety Thermometer it is a point of care survey that is carried out on one specified day each month. The tool looks at whether patients experience self-harm, are victims of violence / aggression, are restrained, if they feel safe, and whether or not they have had a medication omission.

The charts below show the proportion of patients included in the data collection that experienced 'harm free care' during 2018/19 and the proportion of patients that experienced each of the 5 harms.

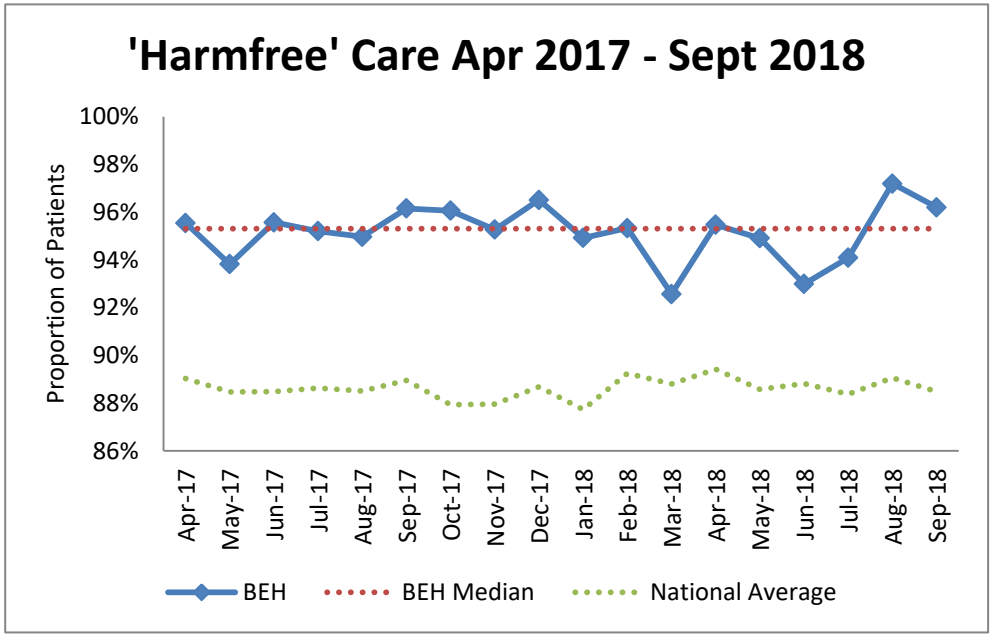
The Trust's mental health safety thermometer results have improved in 2018/19. Whilst there is not currently a formal national target, the Trust has worked towards 95% harm free. The proportion of harm free patients has increased in 2018/19 in comparison to the previous year.

Since the management of the Safety Thermometer website was taken over by the Quality Observatory Team at SCWCSU there has been a change in the way the data is interpreted in the online dashboards (access via http://www.safetythermometer.nhs.uk/). Under the former management, incomplete responses to harm indicators for particular patients were treated as 'no harm' but under the

latter they are treated as harms. The result being that the figures are negatively skewed (locally and nationally) on the current online dashboards. In light of this, all figures used in relation the MH Safety Thermometer in this report are based on data provided manually by the Quality Observatory Team which exclude these harms. Differences between the data appearing in this report and shown on the online dashboards are to be expected.

Harm Free Care

Chart 12 – Proportion of patients experiencing Harm Free Care

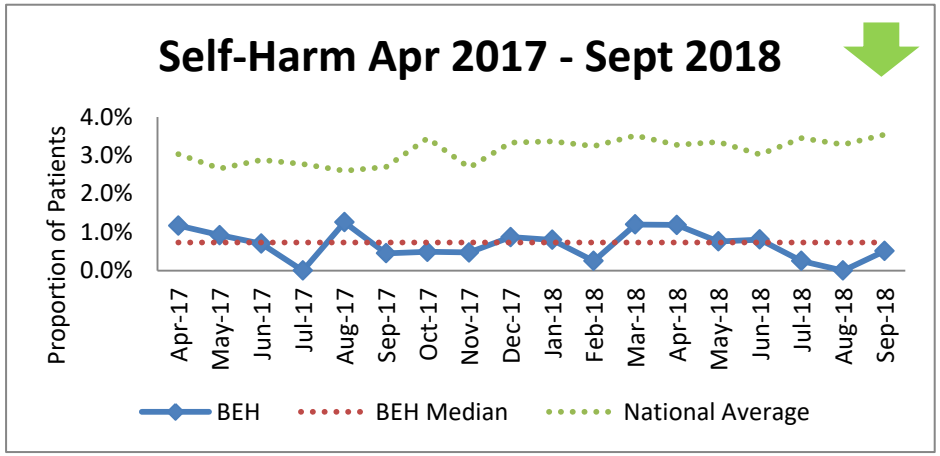


The proportion of harm free patients has increased in Q1 & 2, 2018/19 in comparison to the previous year. BEH remain well above the national figures for the period.

Self-Harm

The mental health safety thermometer records the proportion of patients who have self-harmed within the last 72 hours.

Chart 13 - Self-Harms

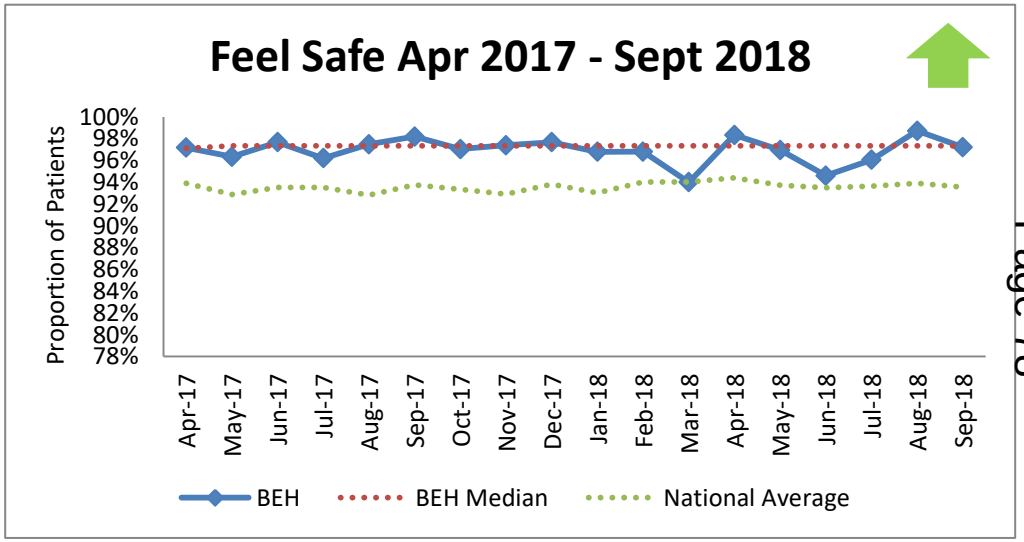


The proportion of patients that experienced self-harm has decreased in Q1&2 compared to the late 2017/18. BEH remain well below the national figures for the period.

Psychological Safety

The safety thermometer records the proportion of patients who said that they feel safe at the point of survey.

Chart 14 – Psychological Safety - ‘feel safe’

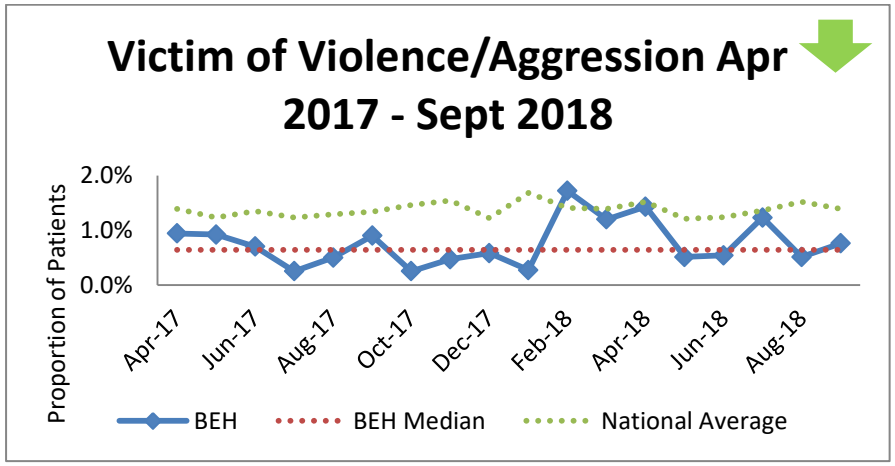


The Trusts Psychological Safety (based on responses to the question ‘Do you feel safe?’) scores have increased during 2018/19. BEH remains above the national average for the period.

Violence/Aggression

The safety thermometer records the proportion of patients that have been a victim of violence and/or aggression in the last 72 hours.

Chart 15 – Victim of Violence/Aggression



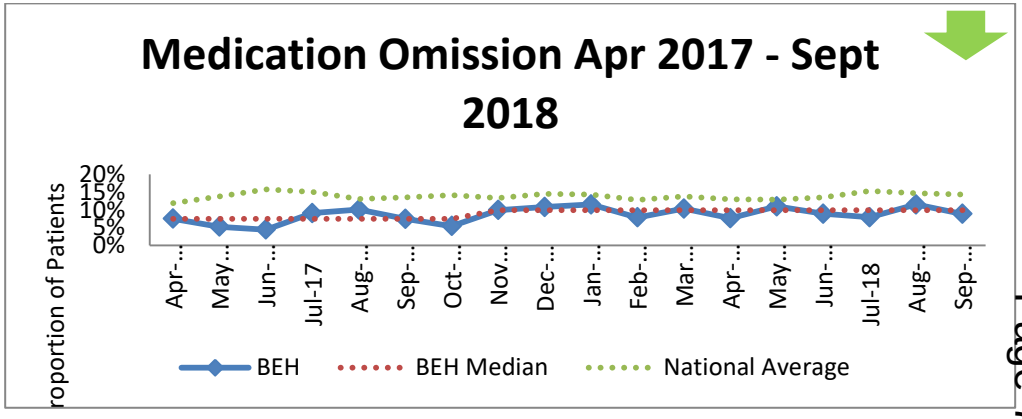
The proportion of patients that have been the victim of violence/aggression decreased from Q1, 2018/19 from Q4, 2017/18 but increased in July 2018. The numbers of harms in Q1&2 2018/19 have remained below the national rates.

A number of quality improvement initiatives have been introduced across the Trust to reduce violence and aggression on our wards.

Medication Omission

The safety thermometer records the proportion of patients that had an omission of medication in the last 24 hours.

Chart 16 – Medication Omissions

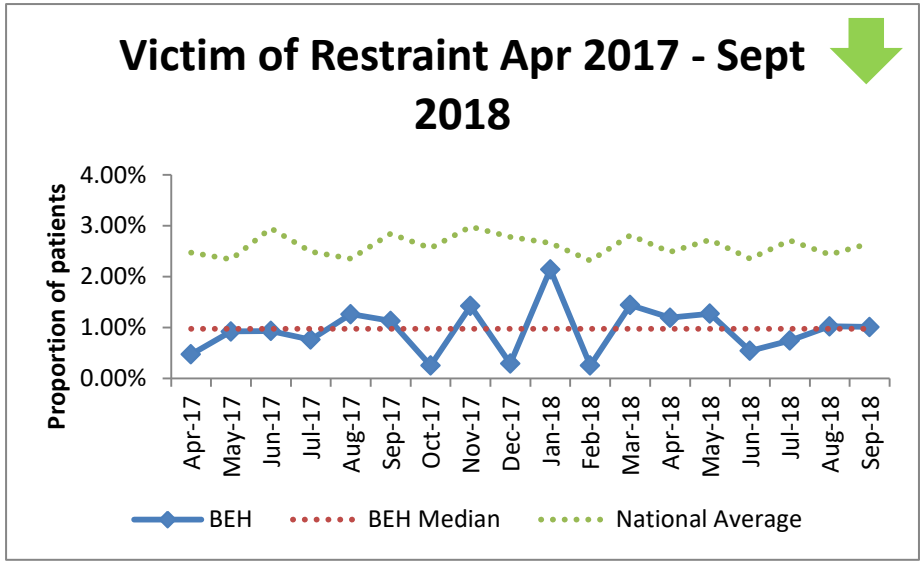


Although BEH remains below the national rates for patients experiencing a medication omission, our rate has fluctuated across Q1&2, 2018/19. Further work is required between ward staff and pharmacy to understand the resultant level of harm if any to the patient due to the omission, as well as reasons for the omission.

Restraints

The safety thermometer records the proportion of patients that were restrained or experienced restrictive practice in the last 72 hours.

Chart 17 – Restraints



4.8.2 The proportion of BEH patients that were restrained continues to be below the national rates. There are a number of initiatives in place to improve restrictive practices in the Trust.

Patient safety related training for staff

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

The Patient Safety Team has facilitated team based training on incident reporting and risk registers. This arrangement has allowed Trust staff to attend sessions for information, advice and support in specific areas identified by themselves.

The Patient Safety Team has assisted in the development and implementation of our recent transition from DATIX reporting system to Ulysses. The Patient Safety Team has facilitated training for staff on the new system to ensure incident reporting and management continues so that we can continue to learn from incidents that occur.

Patient Safety – Serious Incidents

NHS England defines Serious Incidents in health care as adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a

heightened level of response is justified.

• Serious Incidents include acts or omissions in care that result in:

- unexpected or avoidable death
- unexpected or avoidable injury resulting in serious harm
- abuse
- Never Events
- incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services
- incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

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

• The Trust Boroughs and Specialist Services have each established a Serious Incident Review Group (SIRG) that has an overview of all serious incident investigations, trends, themes and identified learning in their Borough.

• The Quality and Safety Committee, a sub-committee of the Trust Board receives regular Serious Incident reports which includes details of numbers of incidents, inclusive of deaths, comparisons of previous quarters and trends so that Trust Board can be assured that learning has been identified and is embedded in the organisation.

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

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

• The Patient Safety Team continue to work closely with Trust services, incident investigators and the Commissioners to successfully reduce the number of overdue serious incident investigations.

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

• The issues and learning from each investigation is discussed at Borough Governance meetings and shared between teams for awareness. Key learning points are included in the monthly Quality News sent to all staff.

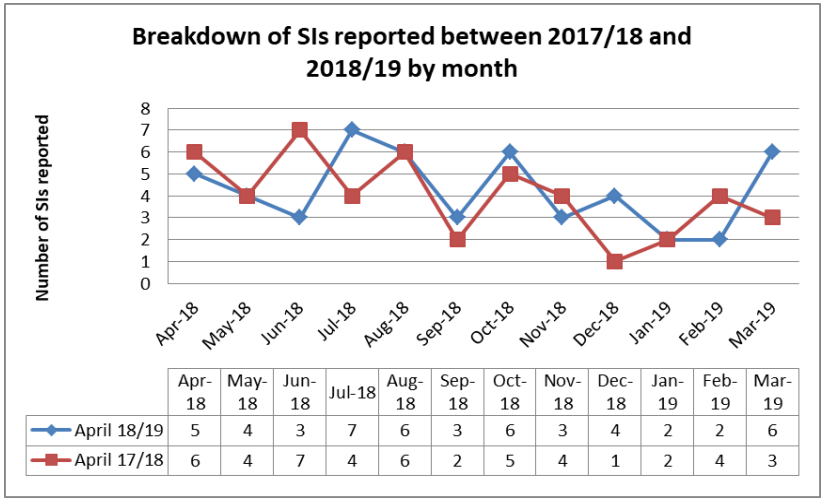
• Sharing lessons learnt: The Trust is focused on providing the appropriate resources that will facilitate learning from incident themes and investigations through Patient Safety Conferences, Serious Incident investigation learning

workshops and National Kitchen Table Week (Sign up to Safety initiative).

Number of Serious Incidents (SIs)

During 2018/19, in accordance with the National Serious Incident Framework 2015 and categorisation of serious incident cases, the Trust reported 51 Serious Incidents. This is slight increase on 2017/18 whereby 48 SIs were reported and investigated.

The chart below shows the SIs reported monthly in 2018/19 with a comparison to SIs reported in 2017/18.



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
April 18/19	5	4	3	7	6	3	6	3	4	2	2	6
April 17/18	6	4	7	4	6	2	5	4	1	2	4	3

The serious incidents reported by the Trust in 2018/19 include incidents of Information Governance Breach, unexpected death, suspected suicides and violence/aggression/assault incidents.

Reporting SIs within two working days

NHS England's Serious Incident Framework 2015 states that timely reporting is essential and that serious incidents must be reported to Commissioners within two working days of being identified.

When necessary, teams will undertake a preliminary investigation to establish facts in order for the Trust to review and agree if the incident meets SI reportable criteria. IN 2018/19, 98% (50/51) of our SIs were reported to the Strategic Executive Information System (StEIS) within two working days of the incident being confirmed as meeting SI reportable criteria. There was a delay of reporting 1 SI to StEIS during August 2018, due to an oversight by a temporary member of the Patient Safety Team.

Learning from serious incidents

Our priority was to reduce the number of Serious Incidents of slips, trips and falls which was the identified theme in 2017/18. As a result, the Trust undertook a substantive work with clinical teams to improve awareness of the risk of falls and

management from the point of admission through the Falls Collaboration project. In 2018/19, the Trust did not report any Serious Incidents related to slips, trips and falls. Work continues to reduce the number of patient slip/trip/falls through regular Safety Huddles.

One of the priorities for the Trust in 2018/19 was to strengthen the process for learning from incident investigations, sharing across the Boroughs and demonstrating changes to practice as a result of incident investigation outcomes.

To aid learning, the Trust intranet now holds all incident investigation reports since April 2015, for cross borough learning and identifying of common emerging themes and trends across the Boroughs and Trust as a whole. Key learning points are also included in the monthly Quality News Bulletin e-mailed to all staff, and are on the Trust website.

The Trust also holds Annual Patient Safety Conferences and Berwick Events, which all staff are invited to attend. Our recent Patient Safety Conference 'Moving Forwards' highlighted good work that staff are embedding for example, the 'Think Family Approach and 'The Oaks patient ideas board', which is being embedded into practice.

A review of completed SI investigations has been undertaken to identify themes and emerging trends. A recent review found the following reoccurring themes:

- Themes to be added

Risk assessments and care plans are audited via the monthly Trust Quality Assurance audits. The Patient Safety Team will continue to review completed SI investigations to identify any themes and trends.

To enhance the learning and assess appropriateness of action taken, we introduced and piloted After Action Reviews (AARs) in February 2018. This has been successful due to the open and honest engagement from teams in the reviews and willingness of teams to want to learn and improve patient care and practice to level of detail now analysed and due to its success, it has been rolled out Trust wide.

The Trust have now trained 28 members of staff in facilitating AARs. The Patient Safety Team in conjunction with the Service leads, scrutinise potential incidents which meet criteria for AAR learning. Examples of incidents in which AARs have been used include: an incident related to a baby miscarriage on an inpatient ward, a Medication Error and incidents related to unexpected events (violence against staff assaults).

Immediate learning from AARs have highlighted the following:

- The violence challenges that clinicians face which are outside of their role which allows for a greater awareness of risk.
- A greater understanding of how clinicians fit within a process of providing care for patients.

- Clinical curiosity regarding medication: following process and assuring checks are done from prescribing to administering medication to patients.

The learning from each investigation is discussed at Borough Governance meetings where recommendations and actions are noted; cross-borough learning is shared at the Trust wide SI Assurance Meeting (chaired by the Medical Director) on a bi-monthly basis.

Never Events

'Never Events' are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been implemented by a Trust.

BEH did not report any Never Events during 2018/19.

Regulation 28: Report to Prevent Future Deaths

During 2018/19 the Trust did not receive any Regulation 28: Report to Prevent Future Deaths (PFD).

Duty of Candour

The Duty of Candour is a legal duty on us to inform and apologise to people who use our services if there have been mistakes in their care that have led to significant harm. The Trust takes seriously its responsibilities to be open and honest with its patients and service users and has implemented a Trust wide training programme and implemented robust processes to ensure that the Trust complies with the Duty of Candour legislation.

When a serious incident has occurred and throughout any subsequent investigation, support to and communication with service users, their families and carers is a key priority for our Trust services. We actively encourage input into investigations by services users, their families and carers. Clinical Directors or senior management will meet with families and carers to discuss events, what the investigation has found and how we will learn from our mistakes.

Our compliance with Duty of Candour, part 1 for 2018/19 was 100% that is, the Trust informed the relevant person in person as soon as reasonably practicable after becoming aware that a safety incident had occurred, and provided support to them in relation to the incident within 10 days of the incident being identified.

Our Duty of Candour part 2 compliance for 2018/19 is 91%. At the time of writing 35 SI reports have been submitted to the Commissioning Support Unit for review. In 3/34 cases, Trust services did not contact the patient or next of kin within 10 working days of the Trust approving the investigation into the serious incident.

In all 3 cases, Duty of Candour was completed but not within 10 working days of the report being approved.

Part 2 Duty of Candour compliance is an improvement on 2017/18 where our compliance was at 83%. We have strengthened our processes Trust wide and will continue to strive to liaise with our patients or next of kin in a timely manner once the approved investigation report is ready.

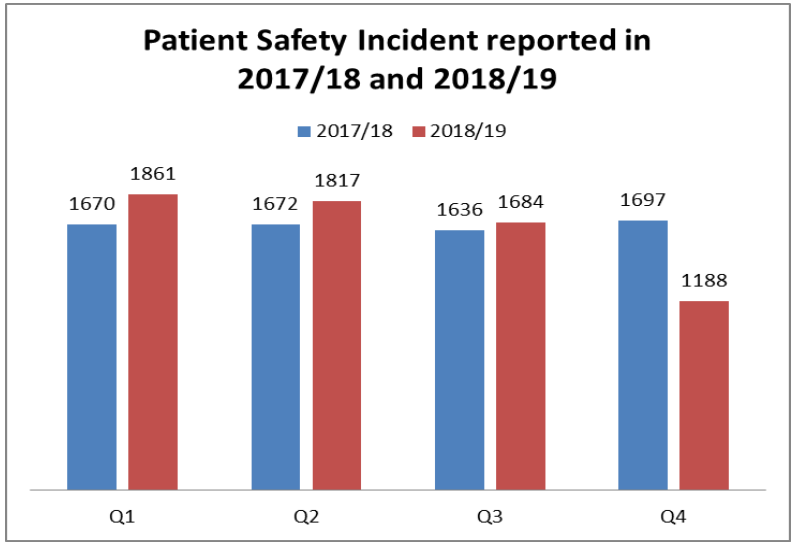
Patient Safety Incidents

During 2018/19, the Patient Safety Team continued to work with clinical teams to ensure potential patient safety incidents were identified and to improve incident reporting, the identification of themes and trends and learning from incidents.

Patient safety incident reporting in 2018/19 decreased by 2% compared to patient safety incident reporting in 2017/18 (6,675 patient safety incidents reported).

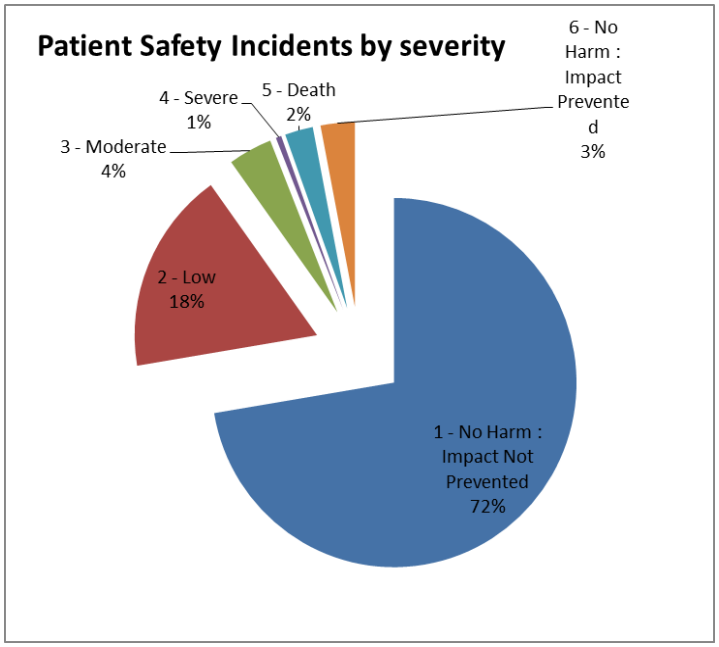
The number of patient safety incidents reported to the National Reporting and Learning System (NRLS) for the period April to September 2017 increased by 8% when compared to the same period for 2016. The number of incidents per 1,000 bed days for this period was 35.97. *(NRLS data for Oct 17 - Mar 18 is not yet available).*

Patient Safety Incidents reported in 2017/18 and 2018/19



Patient Safety Incidents by Severity

Of the 6,550 patient safety incidents reported to NRLS in 2018/19 by BEH services, 72% of those resulted in no harm.



Learning from Deaths

The National Learning from Deaths Agenda required the Trust to review its approach to investigating deaths of people under the care of Trust services and to report these from April 2017. The Trust has always investigated deaths which meet serious incident criteria, but since April 2017 the Medical Director has led a weekly Clinical Mortality Review Group (CMRG) which looks at all deaths of people under our care, or discharged within 6 months of death, including deaths which are regarded as 'expected' or deaths which are from natural causes. This is to see whether lessons can be learned, and to ensure that the Duty of Candour (which requires us to engage transparently with carers and relatives of anyone who dies) is properly carried out.

The Mortality Reviews provide an important opportunity to review the duty of candour in its widest sense and ensure that we offer support to families which goes well beyond the initial communication and includes opportunities to be involved in investigations and to meet and discuss their findings, and any other issue of concern to bereaved families.

This year we have started holding CMRGs in Enfield to review deaths under the care of ECS, in a location which makes it possible for local managers and staff to attend and maximise the opportunities for learning.

During 2018/19, 495 deaths of our service users were reported. A breakdown by quarters is provided below:

2018/19	Q1	Q2	Q3	Q4
Number of deaths reported	137	101	116	141

The CMRG reviewed all 495 deaths, 255 of which were 'expected', most of whom were patients of our Enfield Health District Nursing services, who care for people in their last days and weeks. The Mortality Reviews provide an important opportunity to review the duty of candour in its widest sense and ensure that we offer support to families which goes well beyond the initial communication and includes opportunities to be involved in investigations and to meet and discuss their findings, and any other issue of concern to bereaved families.

For all 495 deaths a case record review or investigation was carried out.

Of the 240 'unexpected' deaths 80 were of natural causes and 136, though of unknown cause, were judged not to require investigation, pending a coroner's decision. Nine deaths were likely to be caused by suicide and all of these were investigated. A further 15 unexpected deaths were investigated using root cause analysis (RCA). The Trust provides limited learning disability services. One death of a person with a learning disability was reviewed and concluded to be from choking. A section 42 enquiry with the Local Authority is underway.

A review of all deaths reported during 2018/19 found that none were deemed to have been avoidable, although there is no consensus about how this judgment should be made in mental health and community services. However, we did identify a range of care and service delivery problems while investigating deaths, which were addressed by action plans in each case. The action plans were reviewed by our commissioners, and led to learning and reflection for staff and services across the Trust.

As an organisation we are keen to learn from all deaths of people under our care, and from all of our serious incidents. Clinical Directors and other clinical staff attend the mortality review group, and learn from the discussions and take learning back to their teams. In addition we learn from our case record reviews in a range of ways including direct feedback to staff and teams, discussions at local Serious Incident Review Groups, quality news bulletins, and a range of learning events, including the Berwick programme of Trust wide learning events, which takes a thematic approach to learning from incidents.

Below are examples of learning by services from death incident investigations:

- The investigation into three serious incidents involving Barnet Crisis Resolution Home Treatment Team (CRHTT) found that the RAG rating tool designed to indicate the level of risk a patient poses to themselves and others and the perceived level of support a patient needs was not being used as intended.

  The investigations showed that due to the pressures of new referrals and high caseloads, patients who should have been gradually downgraded RED-AMBER-GREEN after a period of engagement, before being discharged back to the community team or GP, were downgraded from RED – GREEN if deemed not to be in crisis, and discharged, sometimes without the rationale detailed to support the decision.

  The learning has been shared with all CRHTTs to ensure practice is in line with protocol and any issues that may affect process must be escalated in order to reduce the risk.

  In Haringey CRHTT learning days have taken place to help embed the process of ensuring that risk is managed adequately in the differing stages of treatment from the CRHTT.

- Learning from deaths in Haringey Community Locality Teams. A number of incidents, including two deaths of patients showed that patients present with differing levels of risk but referrals for psychological treatment are placed on a waiting list.

  An assurance review audit is now conducted on a monthly basis to ensure the patient is being monitored effectively against the level of risk changes and the reviewed more urgently if required. Patients are also advised to contact the team if they feel the level of risk to themselves or others increases so that the patient can receive the help they need.

Safeguarding

During 2018 /19, our Safeguarding Team have continued to strengthen and improve the arrangements in place within the Trust to safeguard our most vulnerable patients, and are continuing to develop and embed a culture that puts safeguarding at the centre of care delivery.

Our quarterly Integrated Safeguarding Committee is chaired by the Executive Director of Nursing, Quality and Governance. This committee leads and supports all safeguarding activity in line with our Safeguarding Strategy and underpinning work plan, and ensures that the Trust executes its statutory duties in relation to safeguarding of children and adults at risk. The Trust Board takes safeguarding extremely seriously and receives an Annual Safeguarding Report as well as update reports to the Quality and Safety Committee, a sub-committee of the Board.

We recognise that effective safeguarding requires a multi-agency response. Our team continues to work proactively and collaboratively with our partner agencies across all three boroughs.

Key achievements over the past 12 months:

In order to ensure we remain responsive and committed to ensuring best practice in relation to issues such as domestic abuse we have developed a self-help handbook for service users who may be experiencing domestic abuse. In addition we have formed a Domestic Abuse Steering Group as sub-group in of our Integrated Safeguarding Committee.

We are now delivering level 3 safeguarding adult training to clinical staff in line with the Intercollegiate Document Safeguarding Adults (2018). The feedback from training is very good and we have seen an increase in safeguarding adult referrals as staff become more aware and responsive to safeguarding issues that they identify in the clinical areas.

Following the CQC report “Sexual Safety on Mental Health Wards” (September 2018) we are reviewing our understanding and responses to sexual safety incidents on the inpatient wards. As part of this work we have completed an inpatient staff survey which will help us identify areas where improvements can be made.

We recognise that our staff need easy access to information to support them in practice. The previously developed pocket sized safeguarding adult handbook for staff has been very well received and staff tell us they use it often. Due to the success of this we have recently completed the development of a safeguarding children handbook for our staff and this will be available over the next few weeks. In addition we have

updated the safeguarding pages on our intranet so that they are more accessible and easier to navigate.

Following a quality improvement initiative we have improved the way we monitor and support clinician's attendance at child protection case conferences. This means more staff are aware of, and attend child protection case conferences ensuring the needs of the child are recognised and met.

Each quarter we undertake safeguarding audits that not only demonstrate our staff are responsive to safeguarding but also help us to identify areas where improvements can be made. Examples of positive change to practice include:

- Following a quarterly audit at the inpatient CAMHS unit (Beacon) it was clear that the staff at the Beacon unit had limited safeguarding supervision which is essential for them considering the high risk caseloads that they work with. The Trust's safeguarding children lead has implemented a regular group supervision session with the Beacon staff to support them in the safeguarding work that they are undertaking and to provide challenge in complex cases.

- An audit on one of the adult inpatient units demonstrated that practice could be improved by better use of the body maps when patients are admitted.

We have strengthened the role of safeguarding champions ensuring that safeguarding really is everyone's business. The champion's network has also been expanded to include our prisons provision. The safeguarding team hosted the Trust's first Safeguarding Champions away day in February 2019, attended by 58 champions from across different services within the Trust.

Examples of positive feedback following the day include:

"The away day was very useful and informative to my role"

"The away day was excellent; it supported networking and really made me feel part of BEH"
(Prison Champion)

"Very useful to have a space dedicated to thinking about safeguarding"

"Very helpful to network and meet other champions from across the Trust!"

"Glad I attended, I now feel clearer about my role!"

Infection Prevention and Control

The Trust is committed to preventing and controlling the risks associated with healthcare infections in its managed services and to provide a safe clean environment for everybody who use our services. Assurance is provided by performing regular audits to evaluate compliance against control best practice guidelines. The infection control audit assesses hand hygiene practice, infection prevention, and control measures in clinical areas using audit tools based on national guidelines and standards.

In 2018/19, there were no occurrences of MRSA, MSSA or E.Coli bacteraemia. The Trust reported six cases of Carbapenemase-Producing Enterobacteriaceae (CPE) colonisation. All six cases were transfers from a different hospital. Two cases of shingles, three outbreaks of Norovirus and two cases of scabies were reported in 2018/19. In all of these cases, all precautions were put in place with good effect.

Infection Prevention and Control Training

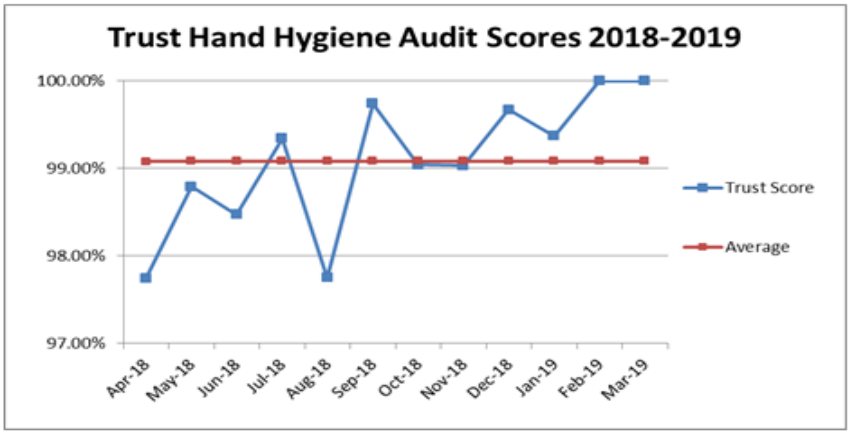
Infection Prevention and Control training is part of the Trust mandatory training programme for all staff. From 2018/19, 84.09% of staff completed the training, compared to the Trust target of 90%. To increase compliance, additional training dates have been released and notifications have been sent to all staff to self-book training sessions in subjects and courses that they are not complying with.

Infection Control Audits

Hand Hygiene Audit 2018/19
The hand washing audit monitors compliance with the hand washing policy. Standards within the audit tool include:

- Whether staff are wearing nail varnish, wrist watches and rings (except for a plain band ring)
- Whether staff are washing their hands before and after delivering an episode of care
- The hand washing technique of our staff.

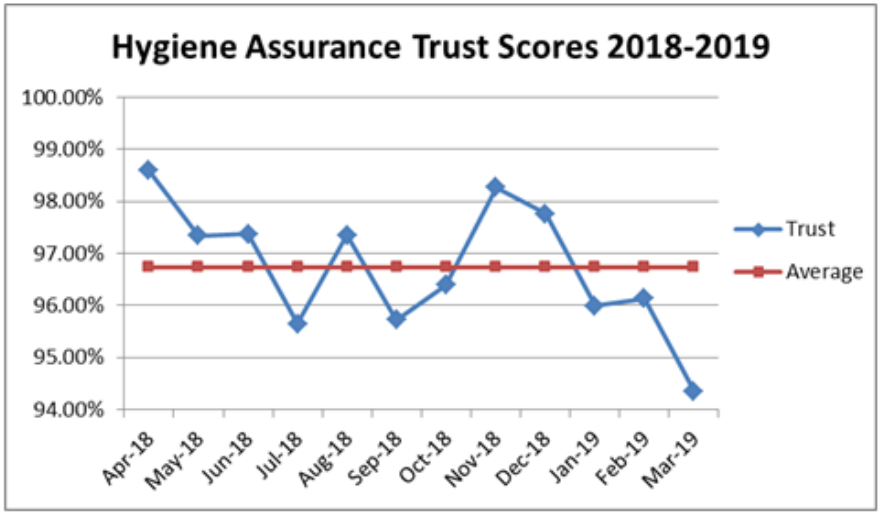
Audits are carried out monthly in inpatient areas and quarterly in outpatient services. The average hand hygiene compliance was above the Trust target of 90% in 2018/19.



Hygiene Assurance Audit 2018/19

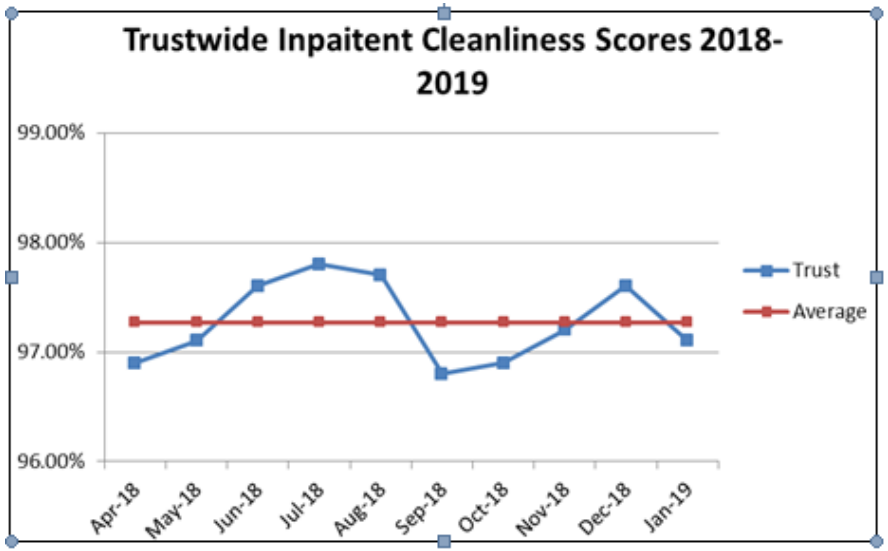
The Hygiene Assurance Audit assessed compliance against national standards in the following areas: bathrooms and showers, bedrooms, clinical room, domestic room, kitchen, laundry room, sluice room, store room, toilets, and common areas.

Ward infection control link nurses performed monthly audits in inpatient areas. Unannounced spot checks were completed by the Infection Control Team on audited areas to check the accuracy of reported compliance data.



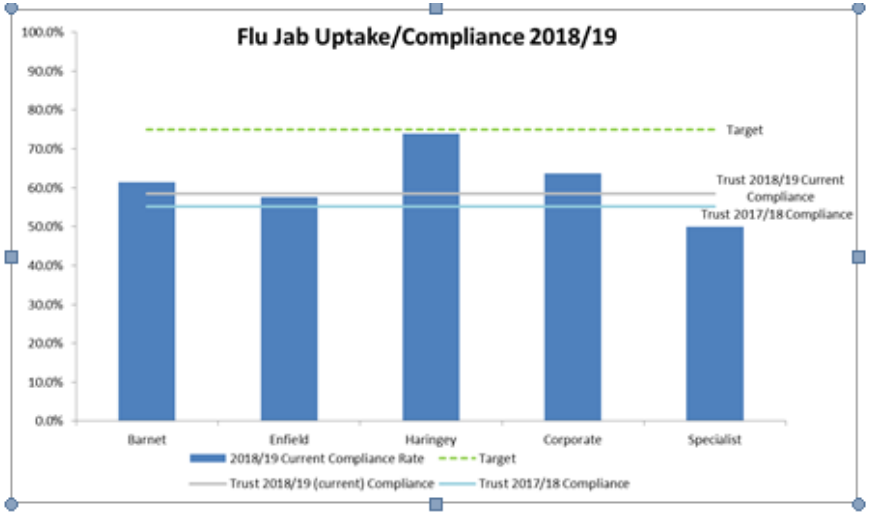
Environmental Cleanliness Audit 2018/19

The Cleaning Audit assesses the cleanliness of the clinical environment using the national standards for cleanliness tool. All 49 elements of the National Specifications for Cleanliness in the NHS (2007) are checked. The Trust scored consistently above the 95% Trust target compliance rate.



Flu Vaccine Uptake and Compliance 2018/19

All eligible Trust staff and patients below 65 years old are offered the quadrivalent vaccine under the Trust flu campaign. Peer vaccinators and Occupational Health department ran table top flu clinics and continue to run flu clinics in each borough. In addition, peer vaccinators and occupational health visited the wards, community clinics, meetings, and the Trust induction days to make it more convenient for staff wanting to have the vaccine. These exercises were well received by staff and the Trust flu uptake closed at 58.4% for 2018/19, compared to 48.7% in 2017/18.



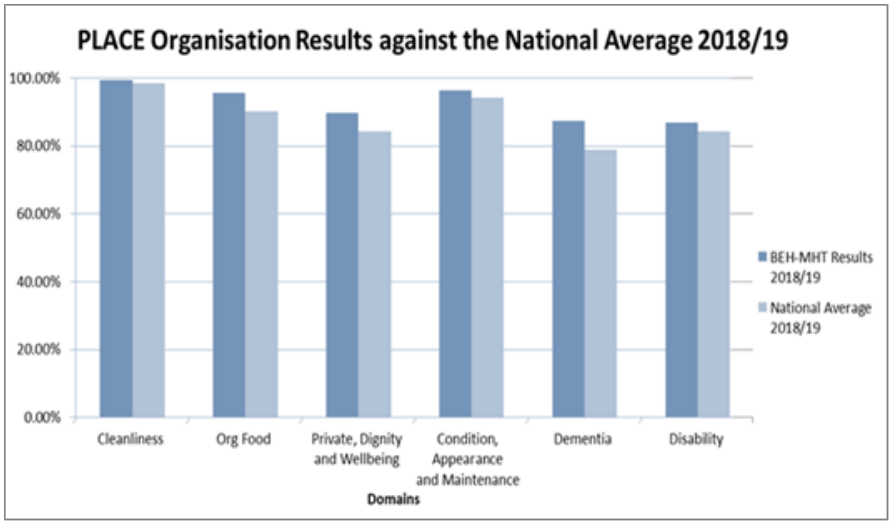
Patient-led Assessment of the Care Environment (PLACE)

Patient-led Assessment of the Care Environment inspections are voluntary self-assessments covering a range of non-clinical activities and services which impact on our patients' experience of care. This provides a snapshot of our performance.

The six domains assessed are:

- Cleanliness
- Food
- Privacy, dignity, and wellbeing
- Condition, appearance, and maintenance of building facilities
- Dementia
- Disability

The 2019 PLACE assessment took place in May 2018. Data was submitted to NHS Digital for analysis June 2018. The results were published in August 2018. Our overall scores in each domain were above the national level for 2018/19. Following the PLACE assessments, an action plan to address all areas of non-compliance and shortfalls was devised and actioned by the relevant departments, units and wards.


PLACE Organisation Results against the National Average 2018/19
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
Cleanliness
Org Food
Private, Dignity and Wellbeing
Condition, Appearance and Maintenance
Dementia
Disability
Domains
BEH-MHT Results 2018/19
National Average 2018/19

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Staff Experience

For the last two years, one of the Trust's Objectives has been 'Happy Staff' because we recognise that staff who enjoy what they do, in a positive and rewarding environment are motivated to do well and support patients and colleagues.

As a Trust, we recognise that good staff experience means allowing staff the freedom and security to raise and share concerns in confidence, and for the concerns to be acted upon professionally and adequately.

Our Freedom to Speak up Guardians are well known and respected across the Trust. Although their role primarily involves supporting and listening to staff who wish to raise issues about patient safety and the quality of care, they are often approached by staff wishing to raise HR issues, such as bully and harassment claims.

The Freedom to Speak up Guardians have developed relations with a number of key personnel within the Trust and work closely with them to ensure matters are dealt with adequately and in confidence and without any retribution for the staff member raising the concern.

Additionally, we encourage staff to have open discussions with members of the Patient Safety Team whose role is to work with clinical teams to keep our patients safe.

The Chief Executive operates a confidential hotline for anyone wishing to raise any concerns of any nature anonymously.

The Trust's whistleblowing policy is available on the Trust intranet and clearly supports a 'no blame' culture and defines the expectations of senior individuals to support the whistle-blower without prejudice.

2018 NHS Staff Survey

We participate in the annual NHS staff survey which provides valuable insight into staff morale and their personal experience of working at the Trust. During 2018 following the 2017 Staff Survey, the Workforce Directorate worked with colleagues across the Trust and introduced a number of initiatives to improve staff experience in 2018.

The final results of our Staff Survey 2018 were published in March 2019.

The response rate for the 2018 staff survey decreased from 44% from 46.9% in 2017.

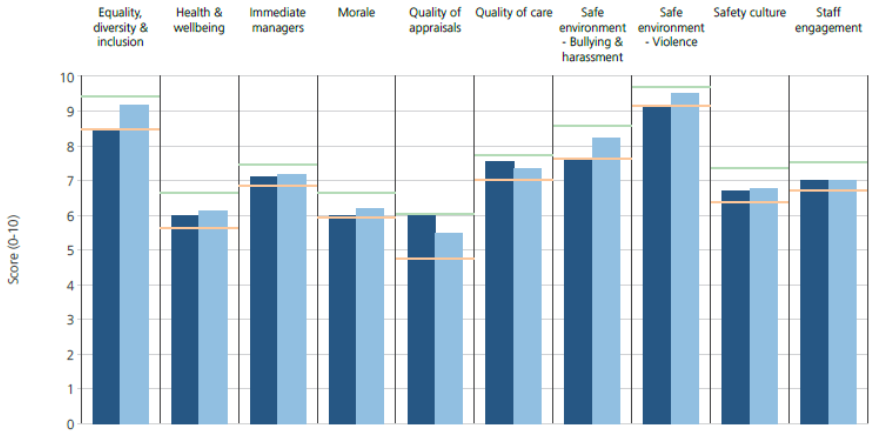
Staff survey 2018

Completed questionnaires **1,346**

2018 response rate **44%**

The survey highlighted some good areas of staff experience but it is evident that our staffs' experience of our Trust should be better and we are determined to improve.

BEH Staff Survey Results 2018, comparison with similar Trusts



Best	9.4	6.6	7.4	6.7	6.0	7.7	8.6	9.7	7.4	7.5
BEH	8.5	6.0	7.1	6.0	6.0	7.5	7.6	9.2	6.7	7.0
Average	9.2	6.1	7.2	6.2	5.5	7.4	8.2	9.5	6.8	7.0
Worst	8.5	5.6	6.9	6.0	4.8	7.0	7.6	9.2	6.4	7.7
No. of Responses	1,308	1,325	1.330	1,307	1,170	1,155	1,295	1,287	1,315	1,337

Examples of positive results from our staff survey:

- 82% of our staff feel that BEH looks after your training, learning and development needs and invests in you to help build your career
- The majority of our staff feel we use service user feedback to help make better decisions within services and departments
- 73% of our staff feel secure raising concerns about unsafe clinical practice, which is an improvement compared to last year

Areas we need to improve on:

- 43% of our staff said that if a friend or relative needed treatment, they would not be happy with the standard of care provided by our organisation.
- 21% of our staff said they faced harassment or abuse from their colleagues over the last year
- We need a greater focus on wellbeing and to improve internal career progression and promotion

Staff mandatory training

In 2018/19, we continued to provide a variety of training and development opportunities for staff, ranging from leadership development to physical health skills and motivational interviewing. This complemented the full range of mandatory training.

Our compliance at the end of March 2018 was slightly below our target of 90%. We continue to focus on areas that are below compliance by sending reminders to staff, offering bespoke sessions and a choice of face-to-face and E-learning to enable staff to become compliant. We have worked with colleagues across North Central London STP to streamline the suite of mandatory training programmes as well as enhance quality and improve portability of training. This means that NHS staff moving between Trusts, do not need to repeat training that they have already completed with another NHS employer.

The figures below demonstrate that we have done well in relation to most topics. Resuscitation, information governance and Moving and Handling training remain a challenge. We have been offering additional and bespoke courses for departments, as well as outreach support to team managers to plan their training, and learning and development drop in clinics across all Trust sites each month to further support all our colleagues to achieve their compliance.

MANDATORY TRAINING – 10 CORE SKILLS COURSES				
Course Name	TNA	Trained	Compliance	Target
Conflict resolution	3147	2541	80.74%	90%
Equality and Diversity	3156	2885	91.41%	90%
Fire Safety	3156	2644	83.78%	90%
Health and Safety	3156	2733	86.60%	90%
Infection Control	3156	2799	88.69%	90%
Information Governance	3156	2420	76.68%	95%
Moving and Handing - High Risk	301	172	57.14%	90%
Moving and Handing - Medium Risk	98	82	83.67%	90%
BLS/AED Level 2 (Adult and Paed)	216	168	77.78%	90%
BLS/AED Level 2 (Adult)	1703	1060	62.24%	90%
Immediate Life Support Level 3 (ILS)	542	333	61.44%	90%
Safeguarding Adults Level 1&2	3156	2743	86.91%	90%
Safeguarding Children Level 1&2	3156	2837	89.89%	90%
Safeguarding Children Level 3	1084	860	79.34%	90%
Safeguarding Children Level 4	8	7	87.50%	90%
Total	29191	24284	83.19%	90%
MANDATORY TRAINING - ALL COURSES PLUS 3 MENTAL HEALTH SPECIFIC				
Course Name	TNA	Trained	Compliance	Target
Breakaway	858	609	70.98%	90%
CPA and CRA	873	578	66.21%	90%
PMVA (Ward Approaches)	518	430	83.01%	90%
Total	2249	1617	71.90%	90%

Staff Appraisals

The Trust continues to promote the importance of appraisals for all of our staff. In 2018, 93% of staff reported in the staff survey that they had participated in the appraisal process. They also reported high quality of appraisals (above the

national average), covering performance as well as an opportunity to discuss their development and career aspirations.

Part 3

Looking Forward: Quality Priorities for 2019/20

This section of our Quality Account will describe our priorities for improvement for the year 2019/20.

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

In February 2019, BEH staff from across the Trust including the Trust Chairman, Chief Executive Officer and Medical Director were joined by service users, peer workers, commissioners and representatives from other statutory and voluntary organisations to reflect on our quality improvements during 2018/19, to receive feedback from our service user feedback survey, to hear about the progress we have made against our quality priorities of 2018/19, our challenges and plans going forward at a Trust and Borough level, and to openly consider areas of focus for our quality priorities in 2019/20.

The Trust will maintain the overarching objectives of improving quality by continuing to improve patient safety, clinical effectiveness and patient experience. The quality priorities will support the Trust with implementation of our Brilliant Basics priorities.

The Trust identified quality indicators that can be monitored and reported in a meaningful and beneficial way to our service users and staff.

Quality Priorities for 2019/20

We have agreed four quality priority areas for 2019/20. These will encompass a range of activities and forms of monitoring and will be reported through the Brilliant Basics work streams and at the relevant meetings at Trust, divisional and team level.

- Timeliness of beds
- Risk assessments and care plans (embedding a sound culture across all teams)
- Reducing restrictive practices
- Learning & improving from Patient & Carer feedback, clinical governance systems and staff feedback

Timeliness of beds
Our priority is to:
1. Reduce the number of service users being admitted to inpatient beds outside of the Trust due to there being no bed available.
2. Reduce bed occupancy rates so that beds are always available.
3. Reduce the number of service users who are admitted to our beds outside of their home locality.
4. Monitor the feedback we receive from inpatients about their experience of being cared for on our wards.

5. Ensure risk assessments are utilised appropriately to inform bed management decisions.

Risk assessments and care plans (embedding a sound culture across all teams)

Our priority is to:

1. Improve the quality and timeliness of risk assessments
2. Ensure risk assessments are appropriately used to inform all decisions regarding the patient
3. Improve the quality of patient care plans by increasing collaboration and shared decision making with the patient, carer and appropriate clinical team
4. Ensure care plans are individualised and reflect the patient's specific needs
5. Ensure the management and documentation of care plans is in line with the CPA policy.

Reducing restrictive practices – priorities to be agreed

Learning & improving from Patient & Carer feedback, clinical governance systems and staff feedback – priorities to be agreed

Specific measures, monitoring and reporting will be agreed for all four quality priorities.

BEH Borough and Specialist Services quality improvements, initiatives and achievements, 2018/19

Barnet

Enfield

Haringey

Specialist Services

Statement from our lead Commissioner, Enfield Clinical Commissioning Group on behalf of themselves and our Clinical Commissioning Groups in Barnet and Haringey

Statements from Healthwatch Barnet, Enfield and Haringey

Statement from Barnet, Enfield and Haringey Scrutiny Committee, a sub group of North Central London Joint Overview and Scrutiny Committee

Statement of Director’s responsibility

Limited Assurance report

Glossary to be updated upon completion

AHP	Allied Health Professional
ADHD	Attention deficit hyperactivity disorder
ASD	Autistic Spectrum Disorder
BME	Black and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Service
CAPA	Choice and Partnership Approach – a continuous service improvement model that combines personalised care and collaborative practice with service users
CCG	Clinical Commissioning Group
CIP	Cost Improvement Programme
CMHOT	Community Mental Health Occupational Therapist
CPA	Care Programme Approach
CQC	Care Quality Commission
CRHTT	Crisis Resolution Home Treatment Team
CQUIN	Commission for Quality and Innovation. (Quality improvements agreed during the annual contracting negotiations between BEH and its health commissioners)
CYP	Children and Young People
Dashboard	A presentation of collective information on a number of key areas of performance and quality for the Trust.
DoH	Department of Health
DTOC	Delayed Transfer of Care
ECS	Enfield Community Services
FTAC	Fixated Threat Assessment Centre
FNP	Family Nurse Partnership
HENCEL	Health Education North Central and East London
HMP	Her Majesty's Prison Service
HSCIC	Health and Social Care Information Centre
HTAS	Home Treatment Accreditation Scheme (Royal College of Psychiatrists)
IAPT	Improved Access to Psychological Therapies
ICAN	A system of recording service user outcomes in CAMHS
JHOSC	Joint Health Overview and Scrutiny Committee
KPI	Key Performance Indicators
LGBT	Lesbian, gay, bisexual and transgender
NEWS	National Early Warning System
MHS	Mental Health Services
MRSA	Type of bacterial infection that is resistant to a number of widely used antibiotics
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCL	North Central London
NICE	National Institute for Health and Clinical Excellence
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning System
NRES	National Research Ethics Service
OT	Occupational Therapist
PLACE	Patient-led Assessment of the Care Environment
POMH	Prescribing Observatory for Mental Health
PROMS	Patient Reported Outcome Measures
QI	Quality improvement

How to provide feedback

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

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

Or through social media:
communications@beh-mht.nhs.uk
@BEHMHTNHS
www.fb.com/behmht

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

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Quality Account 2018/19

North Middlesex University Hospital
NHS Trust

What is a Quality Account

- An annual report (statutory) about the quality of services offered by an NHS Healthcare Provider

- The account must include the Trust's commitment to Quality Priorities for the year ahead, and progress against priorities from the previous year.

- Available to the public

Auditors Report

Auditors are required to produce a limited assurance report over the NHS trust's quality account. It will cover:

- compliance with the Regulations;
- consistency with specified documentation; and
- two indicators in the quality account which have been tested.

Indicators 2019/2020

- For acute NHS trusts, the following indicators required by the Regulations are currently considered suitable for substantive testing:

Acute NHS trusts

Two of the following four indicators, for auditors to agree with the NHS trust's management team:

- Percentage of patients risk-assessed for venous thromboembolism (VTE);
- Rate of clostridium difficile infections;
- Percentage of patient safety incidents resulting in severe harm or death;
- and FFT patient element score.

Quality Priorities

- Quality Priorities must be set out under the following headings:
  - Patient Safety
  - Clinical Effectiveness
  - Patient Experience
  - The Trust has also opted to include Staff Experience in previous years

2018/19 Quality priorities progress

Priority	Objective	RAG (Q1- Q3)
Patient Safety **Reduce hospital-acquired harm**	Implementation of NEWS2	On track
	Development, implementation and evaluation of Local Safety Standards in Invasive Procedures (LocSSIP's)	Target will not be met Whilst some progress has been made towards the development of LocSSIPs across the organisation, it is certain that the aspiration for 80% of procedures to be covered by a LocSSIPs will not be achieved.
	Develop human factors understanding and capability	On track

2018/19 Quality priorities progress

Priority	Objective	RAG (Q1- Q3)
Patient Experience Improve Patient Experience Outcomes through improved FFT results	Improve patient experience in the emergency department resulting in an improved performance in the Friends and Family Test (FFT) so it meets or exceeds the London Benchmark	In progress (Improvement on previous years' performance, but not meeting London benchmark)
	Improved patient experience in maternity resulting in an improved performance in the Friends and Family Test (FFT) so it meets or exceeds the London Benchmark	In progress (Improvement on previous years' performance, but not meeting London benchmark)
	Improve patient experience in Outpatients resulting in an improved Friends and Family Test (FFT) which meets or exceeds the London benchmark	In progress (Improvement on previous years' performance, but not meeting London benchmark)
	Improve the experience of inpatients using cancer services resulting in improved performance in the 2017 national cancer inpatient survey in comparison to the 2016 national survey results.	In progress
	Develop a Patient Experience Strategy using Always Events as a methodology to implement the strategy	On track Patient Experience Strategy published. Implementation in progress

2018/19 Quality priorities progress

Priority	Objective	RAG (Q1- Q3)
Staff Experience	Improve the experience for staff working at the Trust so that there is an increase in the percentage of staff who would recommend the Trust as a place of work to their friends and family	In Progress
	Improve the experience for staff working at the Trust so that there is an increase in the percentage of staff believing that the Trust provides equal opportunities for career progression or promotion	In Progress
	Embed Just Culture principles and framework as part of the Incident, Serious Incident and HR processes.	On track

Quality Priorities 2019/2020 - Engagement

Internal Stakeholders

- Kitchen Table Event Patients, Public and Staff
- Senior Leadership
- Internal committees

External Stakeholders

- External stakeholder event – CCGs, HealthWatch, CSU

Patients, Public & Staff – Sign up to Safety (1) Suggested Areas for Improvement/Focus

Patient Safety

- NEWS 2
- Communication
- Embed human factors training
- Robust learning cycle to ensure we are closing the loop
- Review and follow up of patients

Clinical Effectiveness

- Implement QI across the Trust
- Learning from excellence to be used to shape our values, systems and processes

Patients, Public & Staff – Sign up to Safety (2) Suggested Areas for Improvement/Focus

Patient Experience

- Signposting around the hospital through the use of Way finders
- Self registration cubicles where appropriate
- More interpreters on site.
- Listen more to our patients and families
- Privacy, dignity, violation, vulnerable

Staff Experience

- Visibility of leaders on the ward
- Training compliance, giving staff time to complete training
- Standardise documentation
- Professional behaviours – Trust values

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Patients, Public & Staff – Sign up to Safety (4) Suggested Areas for Improvement/Focus

Other Feedback Received

- Improve Staff Car Park – Provision & Lighting
- Improve IT as it can be slow sometimes and frustrating for staff
- Improve portering provision and service
- Cancellations and waits for appointments
- Tracking and storage of patient's notes
- Improvements to physical environment
- Improve re-cycling throughout the hospital

Quality Priorities for 2019/2020 (1)

Patient Safety - LocSSIPS

- Local Safety Standards for Invasive Procedures are a mechanism of ensuring consistent application of safety critical interventions for high risk procedures.
- This priority is carried over from 2019/20.

Success:

- We will have evidence of 80% of procedures carried out in the trust covered by a LOCSSIPs
- We can demonstrate the adherence through audits
- 0 Surgical procedure never events
- A reduction in the number of incidents relating to surgical invasive procedures with a moderate – severe level of harm

Patient Safety - Human Factors

- Improve patient safety, by enhancing clinical performance through an understanding of human factors
- This priority is carried over from 2019/20.

Success:

- Increased number of staff trained in HF Continue to embed the use of SBAR and Safety huddles across the organisation demonstrated through audits
- HF considered in the redesign of clinical pathways, standard operating procedures, IT systems and devices

Quality Priorities for 2019/2020 (2)

Patient Safety - NEWS2

- Building on our work over the last 2 years through our work in regards to deteriorating patients implementation of the
- Continued implementation of National Early Warning Score 2 as a key patient safety priority. (Patient Safety Alert)
- This priority is carried over from 2019/20.

Success:

- Maintain levels of good compliance with NEWS2 (target of 80%)
- 50% reduction in the number of serious incidents where NEWS2 is a contributory factor - a baseline will be taken in quarter 1 of 19/20 baseline.
- As part of the trust's digital programme - successful rollout of an electronic mobile system for nurse documentation of NEWS2 scores, for team handover and communication

Clinical Effectiveness

- Implementation of an effective approach to quality improvement to support successfully and timely delivery in all areas of trust business.
- Build QI capability within the organisation

Quality Priorities for 2019/2020 (3)

Success (Clinical Effectiveness)

- Provide targeted training for all staff (ward to Board)
- Support the Board and Senior Management teams to understand the organisation's QI approach and its components and know how data is analysed in a QI context
- Provide indepth training for identified QI Champions in the uses of the organisation's chosen methodology
- Appointment of an improvement team
- Development of coaching and expertise
- Development of a North Mid Improvement Faculty
- This priority will be delivered over 2 years.

Patient Experience

- We want all our patients to have a positive experience of receiving care at North Middlesex Hospital. This will be achieved through implement and embed Patient Experience Strategy.
- This priority is carried over from 2018/19

Success

- Improve Staff, Inpatient and A&E FFT, and cancer patient survey scores in line with the London Benchmark
- Implementation of the co produced action plan developed using the NHS Improvement Patient Experience Improvement Framework Assessment Tool

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Quality Priorities for 2019/2020 (4)

Staff Experience

- The summary of results of the 2018 Staff Survey, the trust lowest scores were in the following 2 areas:
  - Equality, diversity and inclusion
  - Bullying and harassment

Success

- increase in the percentage of staff believing that the Trust provides equal opportunities for career progression or promotion from Q3
- 100% application of the just culture framework
- Introduction of First Step management/leadership skills programme based on collective/compassionate leadership
- Trust refresh of the values and introducing a set of leadership behaviours to inform a leadership development programme
- Continue to realise improvements through the LiA programme

Is there more to include?

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North Middlesex University Hospital NHS Trust

Draft 2018/19 Quality Account

Quality Account contents

Comment [EK1]:

Foreword from the chair and chief executive – To be completed

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

TBC

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

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

Peter Carter
Chair (Interim)

SIGNATURE

Maria Kane
Chief executive

SIGNATURE

Introduction

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

About Us

North Middlesex University Hospital NHS Trust (North Midd) is a single site, medium-sized hospital, located in Edmonton and is the local acute hospital for the boroughs of Enfield and Haringey, which have a combined population of approximately 590,000.

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

We provide high quality care across a full range of secondary care services and some specialist tertiary services that reflect the needs of the local population.
We provide services in collaboration with a range of partners, including local GPs, acute, mental health and community health service providers.

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

On average each day North Mid cares for:

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

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

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

We are a major local employer – by the end of March 2019 we had a headcount of 3,381 staff, over 60% of whom live locally in Enfield and Haringey.

The Trust services are organised across three clinical divisions

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

Our vision and strategy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Quality delivery through our digital strategy – to be updated

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

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

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

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

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

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

The aims of the programme are outlined below:

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

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

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

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

Improvements included:

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

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

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

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

The programmes remit was delivered through 8 work streams:

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

With the focus of:

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

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

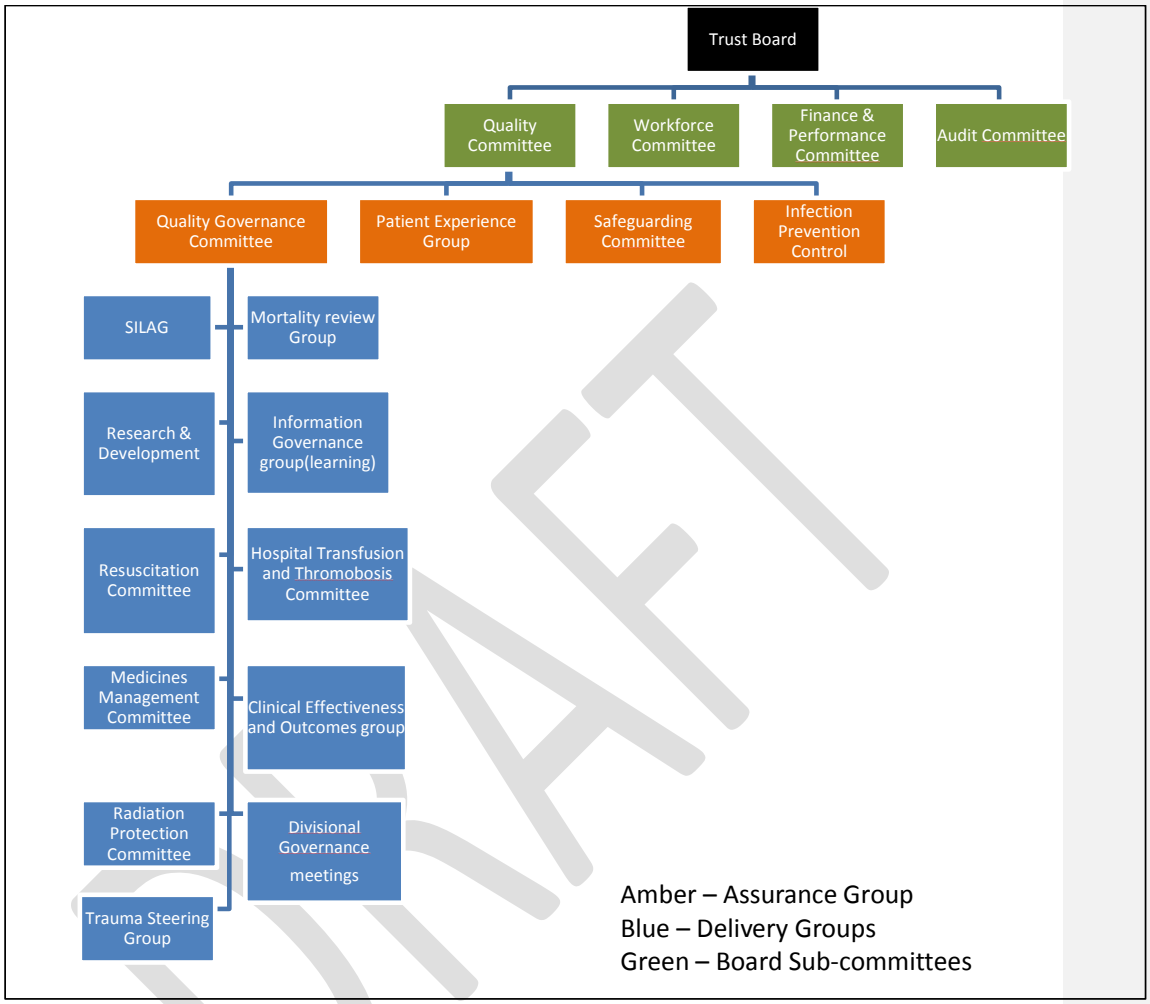
Outcome measures for the programme

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

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

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

See below updated committee structure for 2019/20.



#DigitalNorthMid

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

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

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

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

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

The joint programme with RFL will:

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

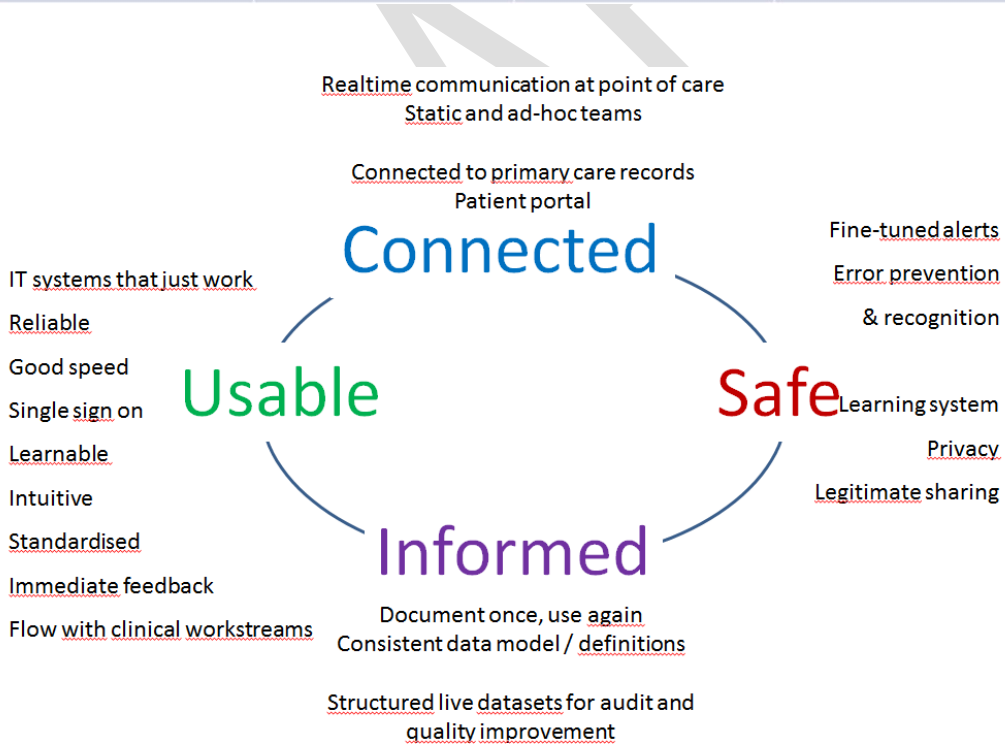
- Enable NMUH to benefit from broader experience gained by RFL as part of the Provider Digitisation Programme (reducing both our costs and the time it will take to implement new systems and technologies)

Our digital vision

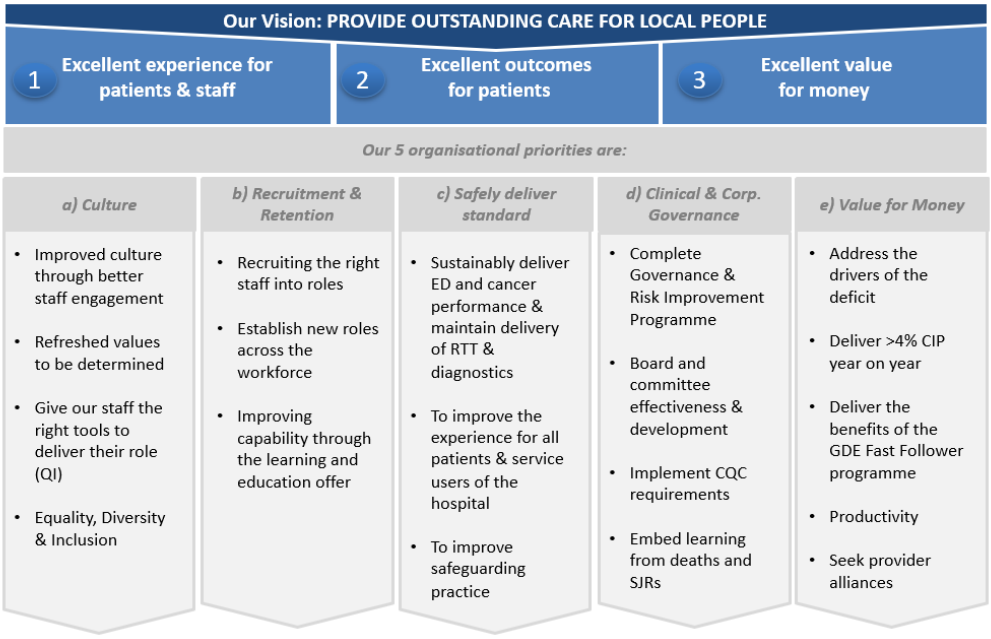
Use Technology and data to

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

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



Trust vision for Quality Improvement



The Quadruple aim of quality improvement is:

Good for patients

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

Good for the population

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

Good for the taxpayer

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

… and staff

- Teamwork
- Involvement
- Joy in work

Why we have chosen to do this

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

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

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

Current quality improvement programmes

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

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

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

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

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

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

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

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

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

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

Implementation of Priority Clinical Standards for Seven Day Hospital Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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2. Clinical Standard 5 and 6

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

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3. Clinical Standard 8

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

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

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Freedom to Speak Up

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

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

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

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

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

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

Staff may also raise their concern with their union representative.

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

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

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

Annual Report – Rota Gaps and Improvement Plans

Awaiting

Learning from Deaths
Mortality rates

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

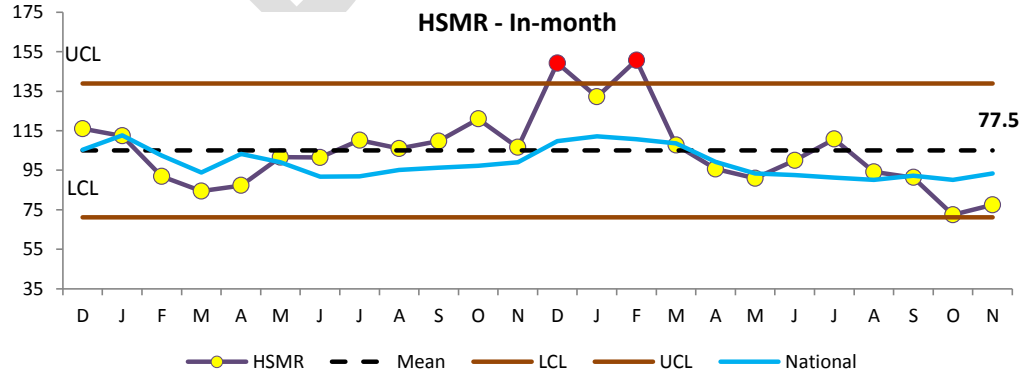
The table below shows the Trust's mortality rates for the last year. For both indicators HSMR and SHMI, the expected level of mortality is 100, with scores between 90 and 110 representing statistically expected levels of mortality. Scores below 90 represent better than expected levels of mortality, and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

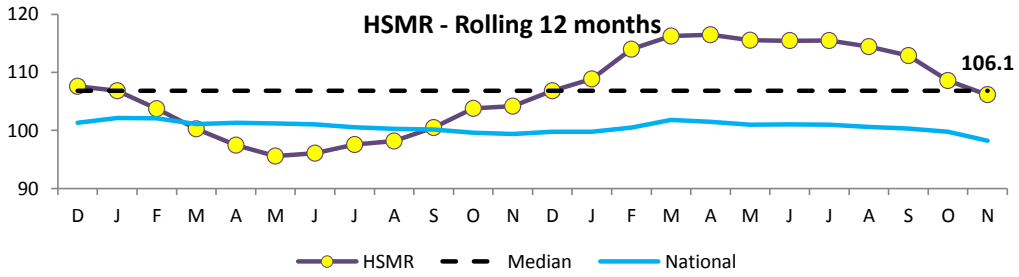
Category	Indicator name	Benchmark	17-18 Target	Q4		Q1			Q2			Q3			Q4			Q1			
				Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
HSMR	Hospital Standardised Mortality Ratio in-month	National	100	84.5	81.0	63.2	83.7	102.0	95.3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

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

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

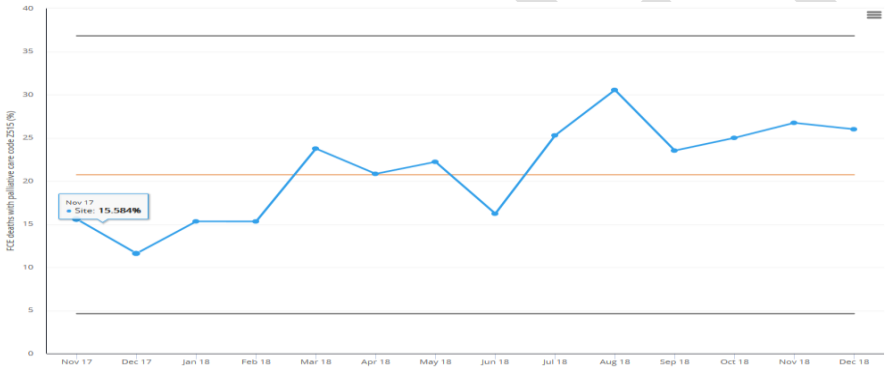
Hospital standardised mortality ratio (HSMR)





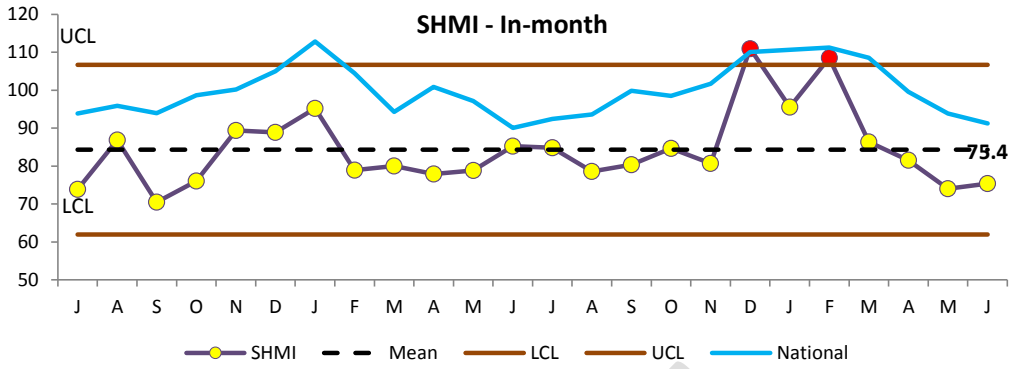
The Hospital-Standardised Mortality Rate (HSMR) for November 2018 (in month) is within the control limits and below the national mean. The rate has declined over the past four months and is currently below the Trust mean performance (105%). The data is available usually 2 months in arrears. The rolling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

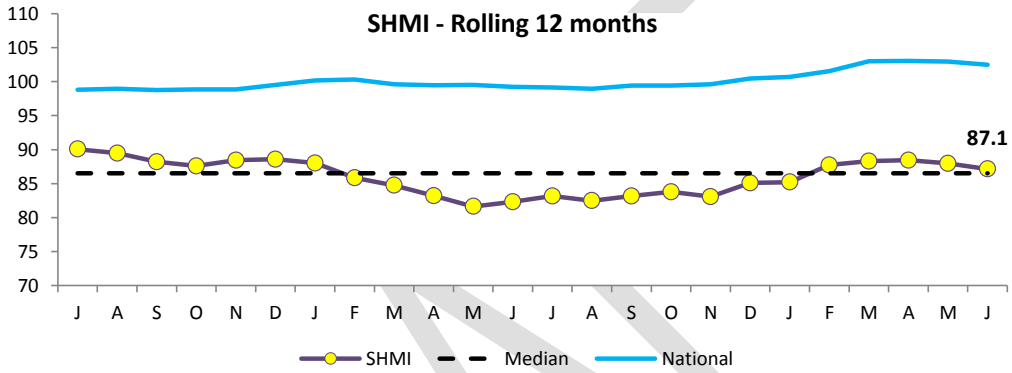
HSMR can be adversely affected by a lack of palliative care input or palliative care coding. The SPC chart below shows the percentage of patients who died with specialist palliative care input. It shows an increase over the last 6 months but is still below the national mean of 32% of cases.



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

Summary Hospital Level Mortality Indicator (SHMI)





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

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

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

Disease specific alerts

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

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

Action taken

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

Results

Therapeutic operations on jejunum and ileum procedures

Total deaths identified - 17 cases, 10 analysed

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

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

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

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

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

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

Areas for improvement:

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

-
Conclusions

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

5.

Action plan

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

Disseminating Learning form mortality reviews

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

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

Medical Examiner

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

The stated aims of the role are to:

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

-

This is achieved by a

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

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

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

Supporting bereaved families

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

◊ Infection control

MRSA Bacteraemia

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

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

Clostridium difficile Infection (CDI)

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

◊ Patient Safety Incidents

The Trust is committed to providing care that is safe and high quality. However, on rare occasions, patients will regrettably come to significant harm as a result of a patient safety incident. All patient incidents are reviewed at a daily meeting. Where significant harm may have been caused to patients, further root cause analysis investigation is undertaken.

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

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

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

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

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

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

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

Duty of Candour

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

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

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

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

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

Becoming a learning organisation

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

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

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

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

Quality Learning Days

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

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

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

Quality Improvement Celebration Day

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

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

Patient Experience

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

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

2018/19 Performance Friends & Family Test and Complaints

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

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

2017/18 Performance Friends & Family Test and Complaints

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

Complaints

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

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

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

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

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

Listening into Action (LiA)

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

LiA Pulse Check

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

LiA Leadership Audit

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

Improvements at the hospital thanks to Listening into Action

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

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

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

Delivery of the 2018/19 Quality Priorities

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

How did we do?

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

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

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

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

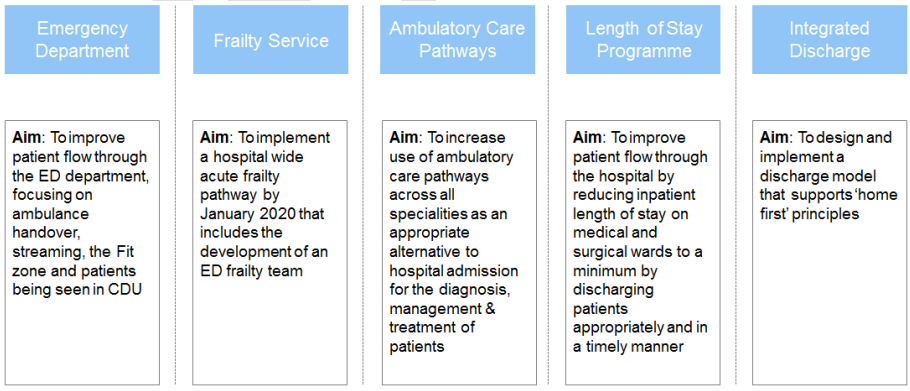
Other related QI initiatives during this period	Human factors training – have liaised with the leads to remain updated about the launch of this training, so local LocSSIPs leads can be directed to it and encourage team participation
Quality Priority: Achieved	**Develop human factors understanding and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

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

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

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

Clinical Effectiveness

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

Patient Experience

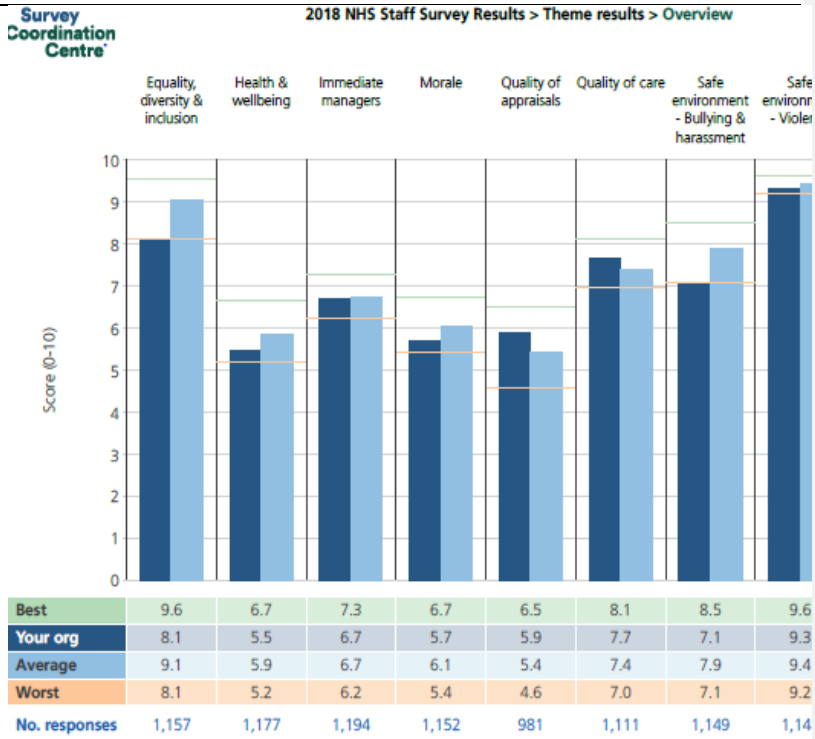
Quality Priority: Partially achieved	**Improve Patient Experience Outcomes through improved FFT results** 1. Improve patient experience in the emergency department resulting in an improved performance in the Friends and Family Test (FFT) so it meets or exceeds the London Benchmark 2. Improved patient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

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

Staff Experience

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

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

	 Best 9.6 6.7 7.3 6.7 6.5 8.1 8.5 9.6 Your org 8.1 5.5 6.7 5.7 5.9 7.7 7.1 9.3 Average 9.1 5.9 6.7 6.1 5.4 7.4 7.9 9.4 Worst 8.1 5.2 6.2 5.4 4.6 7.0 7.1 9.2 No. responses 1,157 1,177 1,194 1,152 981 1,111 1,149 1,14
Achievements (notable)	Out of the 44 comparable questions the Trust improved in 32. When benchmarking against the 43 acute hospital Trusts that used Picker, the Trust is the second most improved.
What we're going to do next to continue improvement	Based on the results of this year's staff survey, the trust will prioritise and invest in initiatives to improve: a) Equality, diversity and inclusion **b)** Bullying and harassment

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

Quality priorities for delivery in 2019/20

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

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

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

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

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

Patient Safety

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

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

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

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

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

Clinical Effectiveness Priorities

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

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

Patient Experience

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

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

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

Staff Experience

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

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

Statements of assurance from the board

1. During 2018/19 the North Middlesex University Hospital NHS Trust provided 35 relevant health services.

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

1.2 The income generated by the relevant health services reviewed in 2017/18 represents 89.5% of the total income generated from the provision of relevant health services by the North Middlesex University Hospital NHS Trust for 2017/18.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Comment [EK2]: TBC

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

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

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

5. North Middlesex University Hospital NHS Trust is required to register with the Care Quality Commission and its current registration status is registered with the CQC with no conditions attached to the registration.
The CQC has not taken enforcement action against North Middlesex University Hospital NHS Trust during 2018/19.

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

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

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

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

- Safe
- Effective
- Caring
- Responsive
- Well led

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

Ratings for North Middlesex University Hospital NHS Trust

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

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

The next scheduled CQC inspection is in summer 2019.

8. North Middlesex University Hospital NHS Trust submitted records during 2018/19 (April 2018 to January 2019) to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

NHS Numbers Percentages are

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

General Medical Practice Codes was:

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

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

Comment [EK3]: Colour and percentage to be added

10. Not applicable for 2018/19.

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

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

Some of the notable highlights were:

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

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

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

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

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

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

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

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

27. Learning from deaths

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

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

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

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

Lessons learned: Treatment escalation issue

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

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

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

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

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

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

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

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

Next steps for 2019/20:

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

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

Domain 1 - Preventing people from dying prematurely

Summary Hospital-Level Mortality Indicator (SHMI)

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

Publication Date	Reporting period	Measure	NMUH Value	National Average	National Lowest	National Highest
March 2018	October 2016 - September 2017	Value	**0.8363**	1.0000	N/A	N/A
		Banding	**3**	N/A	N/A	N/A
December 2017	July 2016 - June 2017	Value	**0.8241**	1.0000	N/A	N/A
		Banding	**3**	N/A	N/A	N/A

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

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

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

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

Ensuring that all deaths that occur in the hospital are closely reviewed as routine in line with the trust's revised procedure for learning from deaths to assure that the best possible care was given to patients in all cases. Any subsequent learning events are shared within the organisation as appropriate.

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

(ii) Percentage of deaths with palliative care coding.

Publication Date	Reporting period	Measure	NMUH Value	National Average	National Lowest	National Highest
March 2018	October 2016 - September 2017	Specialty coding	**0.0**	1.9	0.0	18.3
		Diagnosis coding	**25.0**	31.2	11.5	56.3
		Combined	**25.0**	31.5	11.5	59.8
December 2017	July 2016 - June 2017	Specialty coding	**0.0**	1.9	0.0	18.6
		Diagnosis coding	**28.9**	30.8	11.2	58.3
		Combined	**28.9**	31.1	11.2	58.6

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

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

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

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

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

Not applicable to the North Middlesex University Hospital NHS Trust

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

PROMS; patient reported outcome measures.

(i) Groin hernia surgery

Publication Date	Reporting period	Measure	NMUH Value	National Average	National Lowest	National Highest
February 2018 (provisional)	April 2016 - March 2017	EQ VAS	**2.205**	-0.241	-6.507	3.273
		EQ-5D Index	**0.082**	0.086	0.006	0.135
August 2017	April 2015 - March 2016	EQ VAS	**0.268**	-0.817	-4.644	4.966
		EQ-5D Index	**0.072**	0.088	0.021	0.157

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

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The Trust's performance against both measures has improved between the reporting periods shown above, but performance against the EQ-5D Index remains slightly below the national average.

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

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

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

(iii) Hip replacement surgery

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

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

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

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The Trust's performance improved between the two reporting periods against the EQ VAS measure, but remained below the national average. The Trust's performance against the EQ-5D Index and Oxford Hip Score worsened between the two reporting periods, and was the lowest in the country in 2016-17.

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

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

(iv) Knee replacement surgery

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

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

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The Trust's performance improved against the EQ VAS and IQ-5D Index measures between reporting periods, while the Trust's performance against the Oxford Knee Score measure worsened. The Trust's performance against all three measures remained below the national average.

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

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

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

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

Domain 4 - Ensuring people have a positive experience of care

Responsiveness to the personal needs of patients

Publication Date	Reporting period	NMUH Value	National Average	National Lowest	National Highest
August 2017	2016-17	**63.6**	68.1	60.0	85.2
August 2017	2014-15	**59.3**	68.9	59.1	86.1

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

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The Trust's performance improved over the previous reporting period against this measure, but it has historically been below the national average.

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

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

Staff who would recommend the trust to their family or friends

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

Comment [EK4]: Awaiting performa

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

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The Trust's performance improved slightly over the previous reporting period against this measure, but it has historically been below the national average.

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

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

Patients who would recommend the trust to their family or friends

A&E

Publication Date	Reporting period	NMUH Value	National Average	National Lowest	National Highest
May-18	Q4 2017-18	**tbc**	tbc	tbc	tbc
Feb-18	Q3 2017-18	**63%**	86%	63%	99%
Nov-17	Q2 2017-18	**51%**	87%	51%	99%
Aug-17	Q1 2017-18	**47%**	87%	47%	99%

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

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. Reporting on this measure within the Quality Accounts this year is optional. The Trust has improved against this measure during 2017-18, but has remained worse than the national average.

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

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

Inpatients

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

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

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

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. Reporting on this measure within the Quality Accounts this year is optional. The Trust's performance during 2017-18 has fallen slightly, but continues to show a positive inpatient experience, albeit slightly below the national average.

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

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

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

Patients admitted to hospital who were risk assessed for venous thromboembolism

Publication Date	Reporting period	NMUH Value	National Average	National Lowest	National Highest
June 2018	Q4 2017-18	**tbc**	tbc	tbc	tbc
March 2018	Q3 2017-18	**95.1%**	95.3%	76.1%	100.0%
December 2017	Q2 2017-18	**95.4%**	95.2%	71.9%	100.0%
September 2017	Q1 2017-18	**95.4%**	95.1%	51.4%	100.0%

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

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The Trust has consistently achieved the 95% standard against this metric, and has been above or close to the national average throughout 2017-18.

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

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

Rate of C.difficile infection

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

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

The data is consistent with the hospital's own internal monitoring and reporting of performance against this indicator. The Trust continues to review all cases of c.difficile infection to determine whether infection was cause by a lapse in care. The Trust has an agreed target with commissioners for this measure, which was met during 2016-17.

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

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

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

April 2017 – March 2018

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

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

Annex 1: Statements from Commissioners, local Healthwatch organisation

Statement from Haringey Clinical Commissioning Group

Statement from Haringey Healthwatch

Annex 2
Statement of directors' responsibilities for the quality report

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

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

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

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

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

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

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

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

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

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

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

By order of the board:

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

Appendix 1 – National Clinical Audits and National Confidential Enquiries

See page **.

Appendix 2

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