BRIEFING

BARNET, ENFIELD, AND HARINGEY NCL JHOSC SUB-GROUP

Thursday 24 June 2021, 10:00 a.m.
MS Teams (watch it here)

Contact: Fiona Rae / Robert Mack

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Councillors: Alison Cornelius and Linda Freedman (Barnet Council), Christine Hamilton and Derek Levy (Enfield Council), Pippa Connor and Khaled Moyeed (Haringey Council).

Support Officers: Tracy Scollin, Sola Odusina, Claire Johnson, Robert Mack, and Peter Moore.

AGENDA

1. ELECTION OF CHAIR

To elect a Chair for the Barnet, Enfield, and Haringey NCL JHOSC Sub-Group.

2. FILMING AT MEETINGS

Please note this meeting may be filmed or recorded by the Council for live or subsequent broadcast via the Council's internet site or by anyone attending the meeting using any communication method. 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', you are consenting to being filmed and to the possible use of those images and sound recordings.

The Chair of the meeting has the discretion to terminate or suspend filming or recording, if in his or her opinion continuation of the filming, recording or reporting would disrupt or prejudice the proceedings, infringe the rights of any individual, or may lead to the breach of a legal obligation by the Council.

3. APOLOGIES FOR ABSENCE

To receive any 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. QUALITY ACCOUNTS GUIDANCE (PAGES 1 - 10)

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

6. BARNET, ENFIELD, AND HARINGEY MENTAL HEALTH TRUST - DRAFT QUALITY ACCOUNT (PAGES 11 - 52)

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

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Fiona Alderman
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Friday, 11 June 2021

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 2020-21

Contents - to be finalised

To be added – CEO and Chief Nurse statements –
achievements for the organisation 2020/21 and managing through the pandemic

Part 1

What is a Quality Account?

Every year, all NHS Trusts are required to produce a Quality Account report. Our Quality Account includes information about the services we deliver to our local communities, how well we deliver them and our plans for the year ahead.

This report is an opportunity to reflect on the achievements that we have made and also the challenges we have encountered. Our story of improvement whilst not without challenges is a positive one, and our commitment to further improvements is strong. Through engagement with patients, stakeholders and staff we are able to demonstrate good practice and improvements in the quality of services we provide. This in turn provides us with the opportunity to identify areas we need to focus on and to agree our priorities for improvement with our stakeholders in the delivery of our services.

Our Quality Account 2020-21 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 2020-21 against the priorities identified,
- Set out for our services users, local communities and other stakeholders where improvements are needed and are planned
- Outline our key quality priorities for 2021-20 and how we will be working towards them.

The Quality Account also provides the information we are required by law to provide so that people can see how the quality of our services compares to those provided by other NHS Trusts and Stakeholder statements.

We value the views of stakeholders in the development of our Quality Account.

Our draft Quality Account 2020-21 has been shared with stakeholders both for assurance and to ensure we are reporting on the things we need to and that our focus for the year ahead is appropriate and in line with the Trust Strategy and outcomes from 2019-20.

Sharing a draft version of the report with our external stakeholders has given them the opportunity to provide feedback for consideration in the final report, and to provide a formal statement. These statements are available in Appendix 1.

This Quality Account has been reviewed by the (TBC):

- Trust Executive Leadership Team
- Trust Quality and Safety Committee
- Trust Board
- Healthwatch bodies for Barnet, Enfield and Haringey
- NCL Clinical Commissioning Group for Barnet, Enfield and Haringey
- North Central London Joint Health Overview and Scrutiny Committee

About Barnet, Enfield and Haringey Mental Health Trust

Barnet, Enfield and Haringey Mental Health NHS Trust (BEH) is an integrated mental health and community health services provider. We are the lead provider of a wide range of mental health services across the London boroughs of Barnet, Enfield and Haringey, as well as specialist mental health services to a larger population across North London, Hertfordshire, Essex and surrounding counties. Additionally, we provide a full range of child and adult community health services in Enfield. We deliver our care in the community and in inpatient settings and serve a population of well over a million people.

We have a simple and clear purpose: 'To support healthy lives and healthy communities through the provision of excellent integrated mental and community healthcare'. We aim to promote and ensure the following values exist in every area of our work. 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 We put service users at the centre of everything through living by our core values and strategic aims:

Our Values
- Compassion
- Respect Being Positive
- Compassion
- Working Together

Our strategic aims
- Excellence for service users
- Empowerment for staff
- Innovation in services
- Partnerships with others

We have been working actively towards achieving the strategic aims outlined above.

1. The 10 Brilliant Basics work streams are embedded into practice and feed into relevant governance systems, ensuring that we strive for and achieve excellence for service users at every level.
2. We are empowering our staff – the Quality Improvement approach is firmly embedded, forums and networks that support equality, diversity and inclusion regularly take place, and staff members are becoming increasingly more digitally enabled.
3. We launched a new co-produced Service User Involvement and Engagement Strategy and we have recruited 50 Experts by Experience and 43 Peer Support Workers to ensure the voices of service users and carers are heard.
4. We have been developing new partnerships with other mental health trusts, other local NHS providers, primary care, local authorities and the voluntary sector to deliver integrated care that improves the health of our population. This has led to opportunities for us to develop and sustain our services and provide better care for our service users as the healthcare landscape changes.

Our Objectives

The Trust Board recently reviewed our organisational objectives for 2020/21 to ensure they were up to date and reflected the impact of coronavirus on our services.

The Trust's objectives for 2020/21 are:

Strategic Aims	Revised Trust Objectives for 2020/21
Excellence for service users	1. Ensure the best care possible for our patients through delivering all performance and quality standards 2. Develop community-based integrated services in line with the NHS Long Term Plan 3. Make co-production with service users a key principle to ensure our services reflect the diverse needs of our communities and reduce health inequalities 4. Develop consistently safe care pathways for all patients
Empowerment for staff	5. Embed our Values across everything we do, including the development of our leaders 6. Attract and retain sufficient staff, with the right skills and values 7. Support the physical and mental health and wellbeing of all our staff 8. Actively focus on improving diversity, inclusivity and equality for all our staff, so our services respond to the diversity of our communities and we improve our Workforce Race Equality Standard position
Innovation in services	9. Meet our financial control total by March 2021 by delivering the financial plan, including cost pressures and capital programme while preparing our efficiency plans for 2021/22 10. Increase the flexibility of how we provide services to patients and how our staff work, including increased digital contacts with patients and more agile working for staff 11. Provide more useful information to help deliver high quality services through integrating our data sources 12. Achieve an Outstanding Care Quality Commission rating by December 2021 through delivering our Brilliant Basics priorities and embedding Quality Improvements

Partnerships with others	13. Increase our impact as a major employer in our local community and beyond 14. Improve the quality and delivery of our clinical and corporate services through increased working with partners across North Central London 15. Be a high-quality delivery partner and commissioner of specialist mental health services within the North London Provider Collaborative 16. Be a leader in the development of integrated health and social care partnerships in North Central London

Our Services

In 2020-21, our 3,400 plus staff helped care for more than 126,000 people; approximately 2,800 patients on our wards and over 128,300 service users in the community. We provided mental health services for young people, adults and older people, in addition to 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 systems who have mental health conditions. We provide one of the largest eating disorders services in England, as well as drug and alcohol services. Additionally, we provide mental health care to seven prisons, all sub-contracted through Care UK.

The North London Forensic Consortium has been operating as a live Provider Collaborative since October 2020. BEH is the lead contractor and is responsible for the management of a population-based budget for adult secure services covering North London. Through an integrated governance framework, providers within the consortium are able to share best practice and lessons learnt and develop innovative services. This includes the implementation of an enhanced community forensic model across North London. This will improve patient outcomes and experience.

The Trust has 569 inpatient beds which are located on our five main sites:

- St Ann's Hospital in Haringey
- Chase Farm Hospital in Enfield
- St Michael's Primary Care Centre in Enfield
- Edgware Community Hospital (Dennis Scott Unit) in Barnet, and
- Barnet General Hospital (Springwell Centre)

In August 2020, as part of the redevelopment of the St. Ann's site in Haringey, the Trust opened Blossom Court, the Trust's new mental health inpatient building.

The opening of Blossom Court means the old wards have now been replaced by brand new, state-of-the-art facilities, which are amongst the best in the country. The new facilities are already transforming the care of patients and the working conditions of staff and this is a fantastic achievement for the Trust, our patients, our staff and the people of Haringey.

Systems in place to ensure quality at all levels

In 2020-21, we recognised that now more than ever, it was essential that our quality governance reporting systems continued to support effective monitoring of key quality and performance indicators and learning from patient safety incidents, audits and service reviews and service user feedback.

The monthly Safe, Effective and Experience Group chaired by executive directors ensured divisions were operating safely and to the highest quality while delivering value for money. Key data and statistics on quality performance was also continuously monitored by our Executive Leadership Team.

Clinical care and effective quality governance is constantly improving and we must take the opportunities to improve as and when those opportunities arise.

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 patient safety. We produce a comprehensive Trust and divisional quality dashboard (including safety, experience and effectiveness); we undertake compliance checks that mirror the Care Quality Commission's essential standards; we have an active national and local clinical audit programme; we monitor themes and trends in patient experience and complaints; we monitor the standards of our inpatient wards and a number of community teams through the "Perfect Ward" audit app and through unannounced ward visits; and we have a robust risk management and escalation framework in place.

Statement of Assurance from the Board regarding the review of services 2020-21

During 2020-21, 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 2020-21 represents 100% of the total income generated from the provision of NHS services by BEH for 2020-21.

Registration with the Care Quality Commission

As a Trust, we are required to register with the Care Quality Commission (CQC) and our current registration status is that we are registered with no conditions attached to our registration.

The Trust was not inspected by the CQC in 2020-21 but we have continued to work towards embedding change and sustained improvements in areas identified as requiring improvements in our last inspection in 2019 and maintained the good or outstanding care commended by the CQC.

Brilliant Basics

The concept of Brilliant Basics, introduced in 2018-19 is to ensure we get the basics right consistently, for the good of all our patients and staff and to maximise the potential for excellence. Brilliant Basics focuses our minds on asking the right questions and finding smarter ways to work so we can deliver consistently outstanding care. There are ten workstreams under the 'Brilliant Basics' umbrella, each coordinated by a collaborative team led by a senior manager.

The Trust has continued to make progress in many of the Brilliant Basics work streams, during a time of increased acuity due to the Covid pandemic.

We believe that building strong foundations is the key to achieving excellence. We report below on the progress we've made in 2020-21.

1. Timely Access to Care

Aim: Maintain a stable position of zero out of area placements by the end of March 2021.

Progress:

- The roll out of the Pride and Joy system has continued with good feed-back from services.
- The 1st phase of the elimination of dormitories in Enfield Mental Health has been completed.
- Extension of bed capacity within the Priory remains in place.
- Due to the Covid pandemic and increases in demand and acuity, there have been challenges for capacity and out of area placements have been required.

2. Shared Learning

Aim: By March 2022 best clinical practice and lessons learnt for Patient Safety will be easily accessible to relevant staff across the Trust and have a positive impact on patient safety.

Progress:

- The Aim has been redefined to be more focused and enable measurement to be tracked.
- Patient Safety team looking at methods and measures for sharing learning relating to patient safety in each division.
- The driver diagram is at quite a high level and central to senior members of staff in the collaborative, so the focus is now around the front line staff.
- A survey is being tested with HCAs about preferred methods of accessing shared learning.
- An organisational flow chart of where to access relevant shared learning is being developed.

3. Safe and Therapeutic Environments

Aim: All inpatient ward environments in the Trust will meet national and local standards to maintain patient safety and privacy and dignity by 2022.

Progress:

- Meetings have continued on a monthly basis with divisional representation.
- A refreshed driver diagram has been developed to reflect the new approach to this collaborative and the outcome for patients.
- The violence and aggression data evidences special cause variation in Haringey since the opening of Blossom Court and proves that the environment is key to improving the overall patient experience
- The aim is to capture qualitative data from inpatients at Blossom Court especially those who were known to the former wards in Haringey.
- The data for violence / aggression in EMH will be used to test the hypothesis that improving privacy and dignity by eliminating shared bedrooms (Dorset Ward) will lead to a reduction in violence and aggression.

4: Floor to Board Information

Aim: To increase the proportion of routine management meetings where real-time business intelligence is used for decision making, to 50% of teams by the end of March 2021

Progress:

- The first phase of this work stream was around aligning system names, where 98% completeness has been achieved.
- A new driver diagram and Aim has been drafted for the second phase which is around the use of a business intelligence tool and ensuring the teams have the skills to interpret the data from live systems.
- It is recognised in the collaborative that there is a cultural shift required so that teams own their data as opposed to relying on the information/performance team to produce reports.
- Working Group to support Admin Lead/Operational staff training is going well, positive feedback received on the training so far. The group are focussing on creating simple pivot tables and run charts to support their areas. Additional support is provided to individuals via Performance Managers.

5: Assessments & Care Planning

Aim: All patients have a co-produced risk assessment that is linked to care plans and follows them throughout their patient journey, by September 2021.

Progress:

- Some peer reviews have commenced to triangulate Perfect Ward data and patient / carer / staff experience.
- Strength based assessment has been finalised after a successful pilot in single point of access.
- First meeting of the reinstated dialog+ steering group has been held. Use of dialog+ is the longer-term ambition, and forms part of the plan for rolling out care planning and risk reviews across all areas.

6: Reducing Restrictive Practices

Aim: Reduce the overall use of restrictive practices on acute inpatient wards by 30% by the end of April 2021

Progress:

- Due to the challenges of the Covid pandemic, the Aim of this brilliant basic was reviewed in November 2020 and amended to reduce the percentage and extend the timescale.
- There continues to be a lot of data to show the progress of this work stream which can now be broken down by ward and type of intervention.
- Work is now underway to calculate the percentage reduction in restrictive practices.
- The QI Project continues in Enfield Mental Health division with an aim of reducing violence and aggression and therefore having an impact on reducing restrictive practice.
- There was no physical restraint on Sussex ward in September, October and November.
- Reduction in all restrictive practices in Haringey wards since move to Blossom Court.

7: Recruitment & Retention

Aim: To reduce the WTE of ward-based vacancies by 50% by the end of March 2021

Progress:

- Work with the Occupational Health team to streamline processes and support timely recruitment.
- Intranet - recruitment platform pages updated.
- Working with IT to implement a workflow to produce basic IT accounts for new starters (without managers paperwork).
- A shortened application process for internal staff has been implemented with due governance.
- Agreement to digitalise current paper files which will improve governance and increase accessibility.

8. 132 Rights / Capacity to consent

Aim: All service users are supported to understand and exercise their rights under the Mental Health Act. All decisions around admission and treatment are made following proper assessments of service users' capacity and consent.

Progress:

- Aim and driver diagram reviewed and amended with input from Divisional representation.
- Change ideas co-produced with Head of Mental Health Law and divisional leads in response to data and CQC MHA Reviews.
- Written recording document on shared drive.
- Explanation of Rights for detained patients has been consistently over 70% since June 2020.
- Monthly Mental Health Act Q&A sessions on MS Teams starting Feb 2021.

9: Mandatory Training

Aim: Increase Mandatory Training Compliance to 90% by April 2020.

Progress:

- There have been 6 consecutive increases above the mean demonstrating a clear improvement – this is positive considering the challenges due to the pandemic.
- Safeguarding level 3 e-learning has had a positive impact on compliance.
- Face to face training has continued during 2021 despite staffing pressures. Attendance is low but courses continue to be offered.

10: Physical Health

Aim: That all people under the care of BEH receive a level of physical health monitoring and treatment that is equally suited to their individual needs, and that we are able to evidence that this is the case in over 80% of patient records by the end of March 2021.

Progress:

- eObs rolled out and embedded in Blossom Court.
- Feedback and engagement sessions with staff via Teams.
- Perfect Ward post rapid tranquilisation audit changed to support meaningful data collection.
- eObs roll out plan for rest of the Trust has now been agreed.

A review of the Brilliant Basics will be undertaken as to whether the 10 are still the most relevant areas of focus for the Trust.

Enablement

The Enablement Programme is our approach to delivering mental health services. It empowers people who use our services by increasing people's control of their mental health and aids their recovery journey. Enablement is an umbrella term for a number of evidence-based approaches, which include recovery-focused, person-centred and strengths-based approach.

The Enablement Partnership

The Enablement Partnership is a unique collaboration between BEH and peer-led charity Inclusion Barnet, which works to design, deliver and evaluate a wealth of projects across BEH under the Enablement ethos. The Enablement Partnership has completed its third year with successful activities focused on four core areas: peer worker recruitment, BEH Recovery Strategy, DIALOG+ Progression at BEH, The Crisis Prevention Houses and the Lived Experience Project.

Enablement: Year 3 Achievements

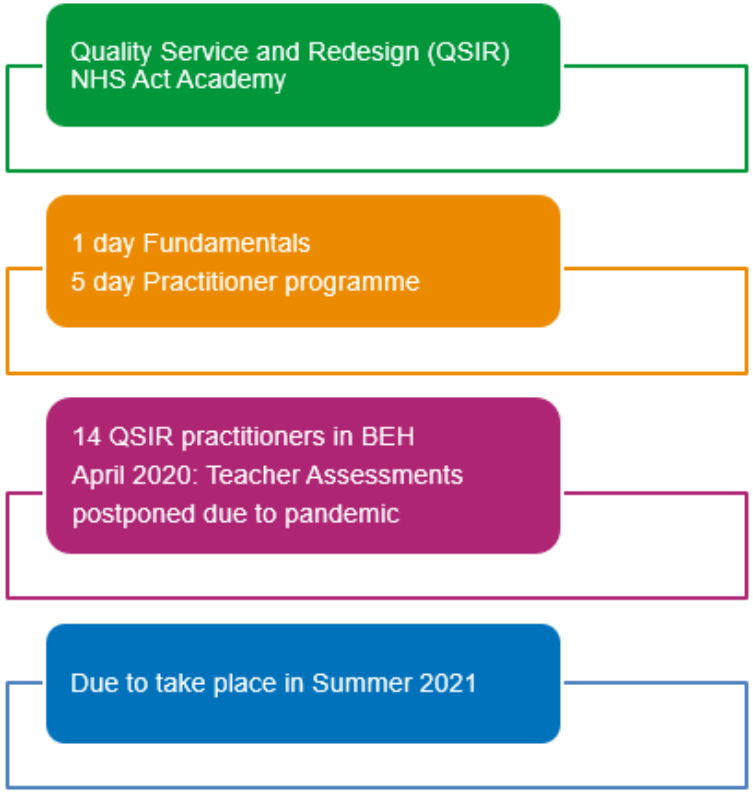
Enablement: Year 4 Aims

Quality Improvement (QI)

A key factor in improving patient care is developing a workforce that is empowered to make improvements and consistently delivers excellent care through a Quality Improvement (QI) approach. The QI approach focuses on developing changes in culture, processes and practice to improve the quality of our services. We recognise that for improvement to be sustainable, a single improvement methodology needs to be consistently embedded in the way we work in all our services, from small changes to major transformational programmes. The Trust has supported the implementation of the Model for Improvement from the Institute for Healthcare Improvement as our preferred methodology.

Training through NHS England's Quality, Service Improvement and Redesign programme had to be postponed due to the pandemic. It is still our ambition to use this programme as it allows us to train some of our staff to become trainers themselves. In the meantime, we have developed an Internal Foundations of QI training package to support teams across the Trust.

Building our capability



Embedding QI across the Trust has been underpinned by the use of LifeQI, a digital platform, which has enabled our staff to plan, measure, and report on their QI work. It also provides a central repository and source of information about all the improvements we make, which promotes collaboration and information sharing both within our Trust and with other Trusts.

Infection Prevention and Management

The last year, has been one of the most challenging years for Infection Prevention and Control (IPC) as a department, Trust-wide, nationally and worldwide. More than ever, stringent infection prevention and management has become a cornerstone in the prevention and control of communicable infections and associated morbidity and mortality. BEH is committed to infection prevention and control: it is seen as an integral part of the overall business plan and a high priority for the organisation.

Following the declaration of the COVID-19 Pandemic and subsequent development of the NHS England/NHS Improvement (NHSE/I) IPC recommendations in the management of suspected/known cases, the Trust implemented COVID-19 Guidance for the remobilisation of services within health and care settings: IPC recommendations measures to continually risk assess and provide assurance. This process was supported by the implementation of a IPC board assurance framework.

All of the 10 criteria within the Code of Practice on the prevention and control of infection (with links to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014) are regularly reviewed and discussed by the Trust's command groups and escalated to the strategic command group where necessary. This is in conjunction with the implementation of Public Health England (PHE) guidelines, Government advice and local Integrated Care Systems (ICS) best practice recommendations. The Trust has worked closely with PHE specialists and CCG in the management of outbreak situations.

A further self-assessment NHSE/I toolkit for the management and monitoring of COVID-19 within healthcare settings provided a checklist for benchmarking performance and providing assurance that the COVID-19 guidance for remobilisation of services within the Trust is based on recommended IPC measures. The self-assessment was conducted through observation of practice, questioning staff during IPC Process Improvement audits, ward rounds, staff training and drop-in sessions. Assurance has been provided that the Trust is performing to a national standard. This has been achieved and maintained through continually reviewing, risk assessing, identifying and implementing specified IPC measures to ensure:

- Systems are in place to manage and monitor the prevention and control infection.
- Provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
- Appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
- Timely accurate information on infections to service users
- Prompt identification of at risk of developing an infection individuals to facilitate timely and appropriate treatment to reduce the risk of cross infection
- All care workers are aware of and discharge their responsibilities in the process of preventing and controlling infection
- Provide or secure adequate isolation facilities to reduce risk of cross infection
- Secure adequate access to laboratory support as appropriate from identification and management of infection

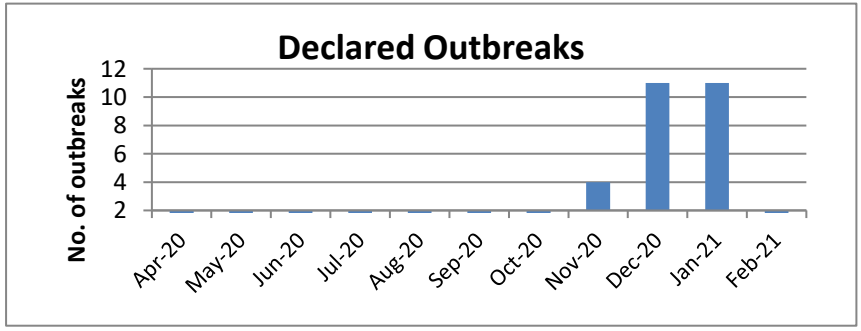
- Policies are designed to help to prevent and control infections
- A system is in place to manage the occupational health needs and obligations of staff in relation to infection

Outbreak Situation Declared

In 2020-21, there were no reported cases of bacteraemia, diarrhoeal or influenza infection reported. During the pandemic, COVID-19 outbreak situations were declared and reported to NHSE and PHE (see table 1) as per outbreak notification guidelines. Individual outbreak situation meetings led by the Trust IPC lead are held with senior staff, PHE and CCG to control further spread of infection and reduce harm.

Outbreaks are risk assessed and investigated to identify healthcare acquired infections and risk mitigation implemented to reduce the prevalence of Nosocomial (hospital acquired) infections. There were no serious incident investigations required, but After Action Reviews were carried out and learning was shared across the Trust. A daily live situation report of reported cases is monitored and discussed through the Trust command system. A monthly report of the data gathered is produced; there has been a significant drop in the rate of prevalence in the last quarter (January to March 2021).

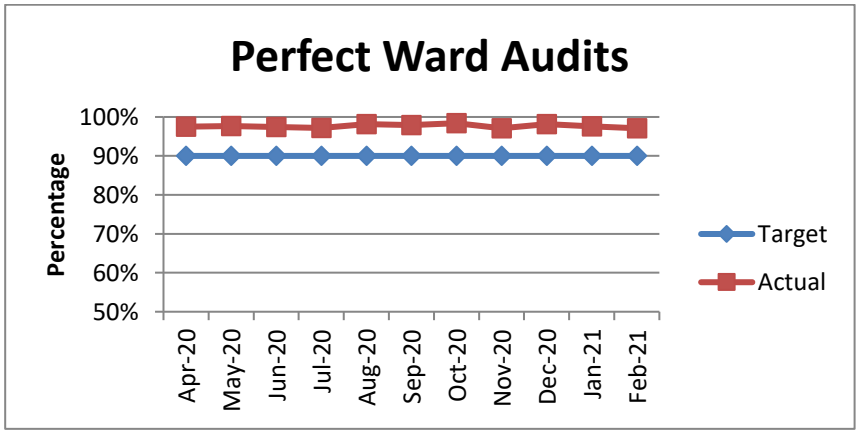
Table 1



Infection Prevention and Control Audits

IPC audits carried out during the year include the IPC Process Improvement Audit undertaken across all inpatient areas. The IPC team prioritise and work closely with wards with low compliance scores to facilitate improvement. Other audits carried out are of the ward clinical area, undertaken monthly via the Perfect Ward app. This includes general cleanliness and staff Hand Hygiene Audits which has achieved consistently above the 90% target as illustrated in table 2.

Table 2



Part 2

Quality Priorities 2020-21 – Looking Back

In early 2020, with input from our key stakeholders, four quality priorities were identified for 2020-21.

The priorities are whole programmes of work. They are aligned to the Brilliant Basics workstreams and are focussed on reducing variation in services and improve the quality of care:

1. Co-production – staff and service users working together
2. Timely access to care
3. Continuity of care (reducing variation)
4. Continuous improvement

1. Co-production

The four priorities were:

100 Experts by Experience

Despite the challenges of the pandemic, the Trust has successfully recruited 50 Experts by Experience over the last year to ensure the voices of service users and carers are heard. We are very confident that we will recruit our target of 100 by end of 2021.

As the Trust is working towards involving service users/carers in all that we do within BEH the Patient Experience Team will further recruiting to our Involvement Register. This will ensure that we have a wide range of experiences, skills and knowledge within the Experts by Experience team.

Training for Experts by Experience

Our aim was to ensure we provide adequate training and support to our Experts by Experience as there is a wide variety of involvement activities within the Trust. We had aimed to set up quarterly forums for our Experts by Experience to attend, at which training would be provided by BEH staff.

Due to the lockdown restrictions there has been a delay in establishing quarterly forums across the Trust for our Experts by Experience. With the easing of lockdown restrictions, plans are well underway to progress with this. These forums will provide training, support and a space to share experiences with others that are doing involvement work.

Experts by Experience to sit on 50% of all committees

There was great progress with establishing Expert by Experiences within our Trust wide groups before the first wave of Covid19 and we look forward to re-establishing this work. This is a key focus for the Patient Experience Team over the next 3 months.

The next steps will be to ensure job descriptions are developed for Experts by Experience to sit on Trust wide committees as members; this will help to strengthen governance processes and will ensure that service users' voices are heard.

Experts by Experience to sit on all interview panels band 8 and above

Experts by Experience have continued to have participation on many Trust interview panels over the last year which has been positive. The next steps will be to work with the recruitment team so that we are able to fully embed this priority within the Trust.

Having Experts by Experience on interview panels will ensure that people with lived experience within our services have a voice in ensuring that candidates' values and skills align with our own Trust values. They will be able to ask a range of questions to assess values, behaviours and motives in order for them to have an equal say in appointing new staff members to the Trust.

2. Timely access to care

The top three priorities were to:

- Embed consistent systems and processes across the mental health care pathway within teams/divisions.
- Ensure adequate capacity for local acute mental health beds for those who need hospital admission.
- Ensure good data capture by developing our RiO reporting process to ensure that activity is recorded and capable of reporting on all the London Mental Health Compact metrics and national requirements.

We aimed to reduce Out of Area placements to zero (where patients are placed in wards outside the Trust). We did not achieve this due to increased demand during the pandemic, however we have still significantly decreased such placements compared to last year.

There have been a number of other achievements:

- We have established a new Trust-wide Access and Flow team to focus on managing demand for beds
- We have increased capacity through a partnership agreement with an independent provider of mental health beds
- We have implemented Pride and Joy, a new electronic inpatient ward management system
- We developed new internal professional standards (IPS) for the acute mental health care pathway. The aim of IPS is to ensure timely care at each stage of the pathway
- The development of an effective discharge model
- A QI led Strengths Based Assessment model was successfully piloted in the Trust's Crisis Telephone Service
- There is a new model of Crisis Houses (formerly Recovery Houses)
- Implementation of a trusted assessment and clinical prioritisation framework.

3. Continuity of care (reducing variation)

i) Reducing variation in physical health monitoring

Until now, the Trust has been using paper charts to monitor patients' vital signs as well as a number of other physical health forms. This was then duplicated when it had to be documented on the RiO record.

As part of Brilliant Basics, a joint project between the Brilliant Basics Physical Health work stream and IM&T has seen the successful implementation of the RiO Physical Health 'eObs' (electronic patient observations) module. The new eObs module allows staff to document and record physical and visual observations using mobile devices such as tablets and save the information directly into patient notes on RiO in real time.

Our quality priority to reduce variation in physical health monitoring was to ensure that eObs is rolled out and available to 75% of all inpatient units by February 2021.

We have achieved roll out across four wards at Blossom Court. Implementation has been impacted by the pandemic, however we will continue to prioritise this programme throughout 2021. This will support BEH's vision for integrated health care, placing equal importance on mental and physical health using digital technologies to address poor mortality rates in mental health patients and improve patient outcomes. This supports our aim to work towards reducing variation in care and treatment across the Trust.

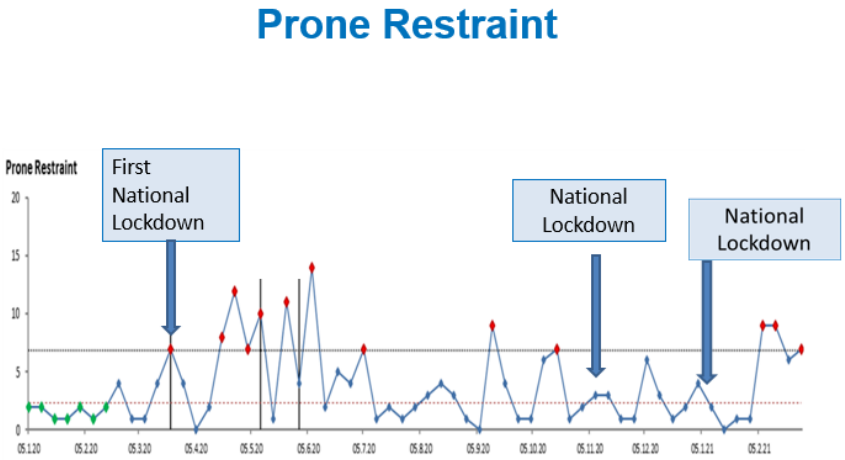
ii) Reducing variation in reducing restrictive practices

Our priority was to reduce restrictive practices by training staff in Trauma Informed Care, improving our de-escalation environments and introducing sensory rooms.

Our progress was limited by the pandemic, there was an increase in the number of restrictive interventions during the lockdown. This could be attributable to patients having less freedom and in some cases, potentially leading to increased likelihood of boredom and frustration. This increase was reflected in the number of prone restraints reported by our services – this was in line with the picture nationwide.

In addition, face masks made it more difficult for staff to communicate and effectively de-escalate situations. We also had higher levels of temporary staff due to sickness rates and shielding which caused additional challenges in building relationships.

BEH Prone Restraints during national lockdown:



Despite the challenges, improvements have been achieved:

- Sussex Ward recorded zero restraints, seclusion and rapid tranquilisation in September and October 2020
- Development of a Reducing Restrictive Practice Framework with annual priorities
- Continued focus on the Quality Improvement Brilliant Basic Reducing Restrictive Practice
- Each ward has a Quality Improvement project with specific change ideas for improvements.

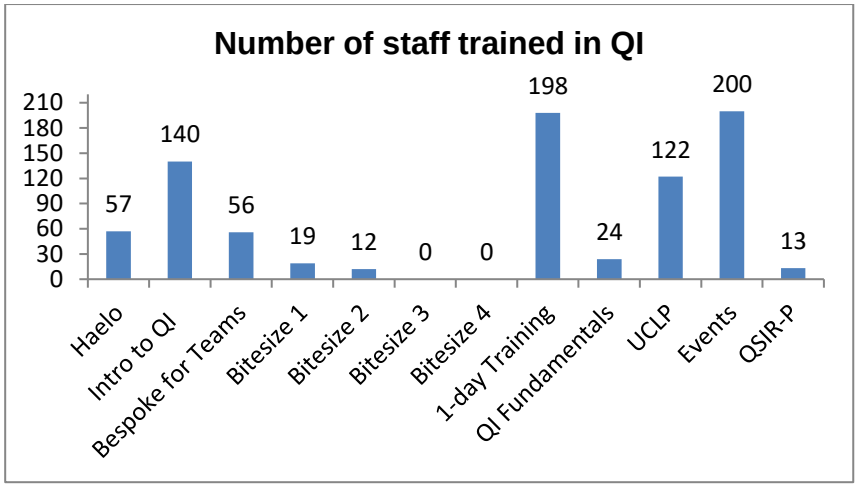
Trauma Informed Care (TIC)
Delivery of face-to-face training has been delayed during the pandemic however, staff have access to online training and resources.

We plan to roll it out face-to-face training as well as Positive Behaviour Support (PBS) training in 2021. Currently, PBS material is available to staff online.

4. Continuous Improvement

Quality improvement (QI) is the use of a systematic method to involve those closest to the quality issue in discovering solutions to a complex problem.

Our aim was to instil a culture of QI across our services, to train staff in QI and see meaningful QI projects being undertaken in all our Divisions using the LifeQI digital platform.



Digital platform – LifeQI

Barnet	• 4 projects • Example: reducing restrictive practice
ECS	• 3 projects • Example: reducing falls on Magnolia
Enfield MH	• 8 projects • Example: reducing safety breaches
Haringey	• 5 projects • Example: reducing restrictive practice
Specialist	• 19 projects • Example: reduce NPS use in forensic services
Trust -wide	• 5 projects • Further 9 projects for Brilliant Basics

Clinical Audit and Quality Assurance Programme

Clinical audit and service reviews are a way to find out if the health care and service we provide to our service users is in line with best practice standards; it lets us know which services are doing well which allows us to learn from them, and where improvements can be made.

The Trust has an extensive clinical audit programme aimed at improving the quality of services, care and treatment, patient safety and patient experience.

Participation in national clinical audits and national confidential enquiries, 2020-21

Every Trust is required to provide the following prescribed statements.

The number of national clinical audits (a) and national confidential enquiries (b) which collected data during the reporting period and which covered the relevant health services that the provider provides or subcontracts

- During 2020/21 6 national clinical audits and 1 national confidential enquiries covered relevant health services that Barnet Enfield and Haringey Mental Health Trust provides.

The number, as a percentage, of national clinical audits and national confidential enquiries, identified under entry 2, that the provider participated in during the reporting period.

During 2020-21 Barnet, Enfield and Haringey Mental Health Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in

The number, as a percentage, of national clinical audits and national confidential enquiries, identified under entry 2, that the provider participated in during the reporting period.

During 2020-21 Barnet, Enfield and Haringey Mental Health Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in

The national clinical audits and national confidential enquiries that Barnet Enfield and Haringey Mental Health Trust was eligible to participate in during 2020/21 are as follows:

National Clinical Audits

- Prescribing Valproate Topic 20a
- Use of Clozapine Topic 18b
- National Clinical Audit of Psychosis (NCAP)
- Falls and Fragility Fracture Audit programme (FFFAP): National Audit Inpatient Falls (NAIF)
- Sentinel Stroke National Audit Programme (SSNAP)
- National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)

National Confidential Enquiry

- National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)

The national clinical audits and national confidential enquiries that Barnet Enfield and Haringey Mental Health Trust participated in during 2020/21 are as follows:

National Clinical Audits

- Prescribing Valproate Topic 20a
- Use of Clozapine Topic 18b
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- National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)

National Confidential Enquiry

- National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)

The national clinical audits and national confidential enquiries that Barnet, Enfield and Haringey NHS Mental Health NHS Trust and for which data collection was completed during April 2020 to March 2021 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

BEH Participation in National Clinical Audits and National Confidential Enquiries, 2020-21

National Audit	Number of Submissions to audit	% of eligible case submitted
POMH-UK Audits		
Prescribing Valproate Topic 20a	Awaiting Report	
Use of Clozapine Topic 18b	Commenced and in progress	
National Audits		
Falls and Fragility Fracture Audit programme (FFFAP): National Audit Inpatient Falls(NAIF)	1 case identified	100%
National Clinical Audit of Psychosis (NCAP) – Early Intervention Service	226	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	Commenced and in progress	59%
Sentinel Stroke National Audit Programme (SSNAP)	Commenced and in progress	
National Confidential Enquires		
National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	5/9	56%

The reports of two national clinical audits were reviewed by the Trust in 2020-21 and we intend to take the following actions to improve the quality of healthcare provided:

National Clinical Audit of Psychosis (NCAP)

1) To improve:
   - Physical health screening and intervention
   - Clinical outcome measurement
   - Supported employment and educational programmes service set up

2) Review the model of provision for children and young people.

Use of depot/LA antipsychotic injections for relapse prevention POMH topic 17b

1) To improve processes for patients treated with depot/LAI antipsychotic medication for more than one year to ensure there is review of antipsychotic medication which includes consideration of therapeutic response at least annually by the prescriber/psychiatrist.

The reports of 2 national clinical audits were reviewed by the provider in 2020-21 and Barnet, Enfield and Haringey NHS Mental Health NHS Trust intends to take the following actions to improve the quality of healthcare provided:

National Clinical Audit of Psychosis (NCAP)

In June 2020, our three Early Intervention Services participated in the annual National Clinical Audit of Psychosis. Overall, the Trust performed very well. The following actions were identified for the Trust:

- Continued auditing of patients who have been on the caseload for 6 months or more, who received a full physical health assessment and any interventions within the last year.
- Ensure outcome measures are documented at least twice in people's baseline at 6 months, 12 months and annually thereafter until discharge.
- Improve referrals and access to carer-focused education and support programme.
- Reviews of the service to ensure teams are providing services to provide cognitive behavioural therapy (CBT) to those people identified as having At Risk Mental State.
- To review their model of provision for children and young people (CYP) and the age ranges covered by this service including:
  - Shared care protocol between this Early Intervention Psychosis (EIP) team and the CYP Mental Health service
  - Joint or reciprocal training events arranged at least annually between the CYPMH and EIP teams
  - Medication management for CY
  - The provision of Cognitive Behavioural Therapy for Psychosis and Family Intervention for CYP and who provides it Care coordinators specifically for CYP under 18.

Use of depot/LA antipsychotic injections for relapse prevention POMH topic 17b

In 2020 the Trust took part in the 5th round of this audit designed by the Prescribing Observatory for Mental Health (POMH) around the use of depot / LAI antipsychotics to prevent relapse.

The following actions were identified for the Trust:

- Improving the quality of the care plan to ensure that it is accessible in the clinical records, contains evidence that the patient was involved in the generation of their care plan, documents relapse 'signature' signs and symptoms, includes a crisis plan and a clinical plan for response to default from treatment.
- Ensure a clear rationale is provided for initiating a depot/long-acting injectable antipsychotic medication is documented in the clinical records
- Ensure an annual review of antipsychotic medication by the prescriber/psychiatrist in the responsible clinical team is carried out and medication review includes consideration of therapeutic response.

Local Audits

The Trust encourages staff to undertake audits to improve outcomes and experiences for patients and staff. Examples of local audits carried out and identified changes and improvements to practice and service delivery following audit outcomes are detailed below:

Psychiatric liaison service referral patterns during the first wave of the UK COVID-19 pandemic: an observational study

- Liaison psychiatry teams and mental health trusts to improve data collection for their routine activities, particularly for ward-based work where, after referral, patients may have repeated contacts and require intensive support.
- Further evaluation of the advantages and disadvantages of alternatives to ED for people in mental health crisis is also required.

A review of physiotherapy staff compliance with the Lone Working Policy

Physiotherapy staff were reminded of process on how to correctly document and carry out visits. Management were also informed to cascade the reminders, conduct checks on the Visit book, follow procedure if staff had not contacted after a visit and to explore a solution in the team having difficulty in contacting the admin hub and to update the lone working policy in line with the audit findings.

An exploration of whether all MSK patients receive text message reminders of their physiotherapy appointments?

To improve practices in booking follow-up appointments and documenting and checking telephone numbers are up to date at different points of contact with the service user.

How we monitor clinical practice and services across the Trust and outcomes from audits

Perfect Ward

Perfect Ward was launched in the Trust in 2019 for all of our inpatient wards. It is an app that hosts a series of bespoke clinical audits and practice reviews as well as the Quality, Effectiveness Safety Trigger Tool (QuESTT). The audit questions have been developed to provide a picture of safety and effectiveness on our wards. Perfect Ward is available on hand-held devices, making it easier for staff to undertake reviews as part of their day to day work; it has become part of the norm for our inpatient teams. In November 2020, 12 Community teams started using Perfect Ward.

The audits provided real time results to identify areas requiring attention and improvements immediately. Because the app provides real time results, staff can share and address areas requiring attention and improvement and monitor actions. The audits are reviewed at team, divisional and Trust level.

Quality Assurance Audits and Peer Service Reviews

The Trust's Community teams complete monthly Quality Assurance and Peer Service Review (PSR) audits.

The Quality Assurance audit is self-assessed and specific to each service, based on relevant national and local standards. There is a programme of spot checks of these audits to ensure robustness of outcomes. The Peer Service Reviews are based around CQC regulations and local standards. Outcomes for both audits are reviewed at team and divisional level and are monitored over time to ensure that learning and recommendations have been embedded and quality of services has improved.

Examples of improvements in practice as a result of undertaking Quality Assurance audits and Peer Service Reviews

The Paediatric Occupational Therapy team found that they needed to improve in relation to *care and treatment*. To address this the team undertook a review of their processes to ensure they were correct and suitable. Subsequently, supervisors ensured case records were reviewed during supervision. There was also a round of spot checks of cases which demonstrated compliance. When the audit was carried out again the results showed that excellent improvements had been made. The team achieved 100% compliance with standards.

For the Peer Service Review *Reg 15 Premises and Equipment*, the Personality Disorder team scored 60% in the Infection Control & Waste Management Section. The team explored where the gaps in service were and subsequently started to display on notice boards the required information on infection control checks and cleaning schedules.

Participation in Clinical Research

Each year the Research Councils invest around £3bn 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.

It was agreed by the NIHR that, for 2020-21, recruitment targets for portfolio adopted research studies at all Trusts would be suspended due to the COVID-19 pandemic. During this period, the vast proportion of BEH studies paused recruitment, and only a few studies on our portfolio were able to continue activity and remain open. This of course had an impact on our overall annual figures. Study activity did, however, pick up slightly in the second part of the year, as studies were able to restart and the Trust opened two Urgent Public Health COVID-19 studies.

The number of patients receiving relevant health services provided or sub-contracted by BEH in 2019-20 that were recruited during that period to participate in research approved by a research ethics committee is 249, across 28 different portfolio adopted studies.

Commissioning for Quality and Innovation (CQUIN) Goals agreed with commissioners for 2020-21

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.

CQUINs are part of our contractual income, subject to us evidencing delivery of the specific schemes (or indicators) as included within our contract with commissioners. Due to the pandemic, following NHSE England instruction, the commissioner-provider contracts for 2020-21 were essentially suspended and hence there is no CQUIN income for this financial year.

Quality Account 2020-21 Participation in Accreditation Schemes

The Trust's continual participation in accreditation schemes serves to enhance and improve the quality of care and services provided to our service users. Engagement in accreditation schemes and quality improvement networks encourages staff engagement and morale as well as advancing the quality of care provided.

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 2020 - 31st March 2021		
Programmes	**Participating services within the Trust**	**Accreditation Status**
ECTAS: Electroconvulsive Therapy Services	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
QED: Quality Network for Eating Disorders	Phoenix Wing	Accredited

Improving Data Quality

Our ability of the Trust to produce timely and effective monitoring reports using complete data is recognised as a fundamental requirement in order for us 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 deviations 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 the Board have improved the consistency of reporting.

The following are mandated indicators that must be reported in the Quality Account.

1) The Hospital Episode Statistics: This ceased in March 2020; the submission is now combined with the Mental Health Minimum Data Set. During 2020-21, the Trust made monthly and annual submissions to the Mental Health Minimum Data Set for all mental health service patients.

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

	NHS Number (%)	National results (%)	GP Code (%)	National results (%)
Completion of valid patient care data set	99.9%	98.3%	99.9%	99.9%

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

The Trust has exceeded this target over recent years and has been consistently above the 95% national target. Whilst the national guidance on the Quality Account stipulates that this indicator must be included in Quality Accounts of all mental health Trusts, there are no national figures for this indicator in 2020-21 and therefore, no requirement to collect this data.

The Trust replaced the 7 day follow up in 2020-21 with 72 hours follow up following discharge which is included in the Mental Health Minimum Data set. The target for this indicator is 85%; all Trust reports have been modified to capture 72 hours follow up on all reporting.

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

Average Results	2018-19	2019-20	2020-21
BEH	97.3%	97.0%	98.0%
National	100.0%	100.0%	Not Published

In 2020-21 an average of 98% of patients were reviewed prior to admission to acute wards. We consider that this data is as it is described for the following reasons: we have established, robust reporting systems through our electronic patient record system, RiO and adopt a systematic approach to data quality improvement.

4) Emergency 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.

The national target is that less than 6% 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.

	Q1 20/21			Q3 20/21			Q3 20/21			Q4 20/21		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% Emergency Re-admissions	2.3%	3.3%	6.2%	3.8%	5.8%	0.8%	3.6%	1.5%	3.8%	5.1%	3.6%	3.9%
Target %	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%

We have taken the following action to improve this percentage and so the quality of our services: we have ensured our clinicians are aware of their responsibilities to complete these reviews and this is managed and monitored by teams through daily review of discharge activities.

5) Community Mental Health Survey

The Trust took part in the national Community Mental Health Survey 2020, which captures the patient experience of community mental health services. There was a 26% response rate which is the same as last year. The overall experience has increased from 65% in 2019 to 69% in 2020 compared to the national average of 71%. This rating places BEH in the highest 80% of Trusts for outcomes relating to overall experience.

What did we do well?

- 61% of service users felt that they have been seen enough by their services for their needs.
- 69% of service users know who to contact when they are in crisis.
- 83% of service users felt they had been treated with dignity and respect.

What do we need to do better?

- A review of the demographic found that the lowest amount (36%) of responses came from service users of BAME backgrounds compared to white ethnic groups. Further exploration of this will be needed to be undertaken by the Trust Equality team.

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

- A continued focus to promote shared decision-making and self-management.
- Assess arrangements for regular review of service user medication and its effectiveness; ensure that this forms part of all reviews.
- To ensure and embed a culture of learning through service user feedback

6) Learning from Deaths

Since the launch of the national Learning from Deaths agenda, the Medical Director has led a monthly Clinical Mortality Review Group (CMRG) which looks at all deaths of people under our care, or discharged within six 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 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.

The CMRG continues to review all deaths and in addition, we continue to hold CMRGs in Enfield to review deaths under the care of Enfield Community Health Services (ECHS), in a location which makes it possible for local managers and staff to attend and maximise the opportunities for learning.

During 2020/21, 775 of BEHMHT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 250 in the first quarter; 134 in the second quarter; 165 in the third quarter; 226 in the fourth quarter.

By 31/03/2021, all case record reviews and 67 investigations have been carried out in relation to 775 of the deaths included above.

In 67 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 18 in the first quarter; 18 in the second quarter; 18 in the third quarter; 13 in the fourth quarter

None of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

Patient Experience Services

During the COVID-19 pandemic, the Patient Experience Team set up a Wellbeing Hub to call service users who were asked to shield during this time. Our aim was to be able to signpost our service users to any voluntary services that were available to them within their boroughs.

Directories were created for each borough that clearly listed voluntary services under the categories of food, social support, medication, advice and activities; these were made available on the Trust website. As well as making this information publicly available, these directories also enabled the Wellbeing Hub staff to have the information readily available to them when calling service users.

Over 2500 service users were called over a 5 months period; exceptional feedback was provided.

Feedback from service users

"Very grateful for all you are doing – thank you very much! I am 83 years old and have been asked to isolate since February. I really appreciate all the work you guys are doing to support me… thank you!"

"Thank you so much for making me feel like you care."

"Thank you for all your hard work and effort in making us feel special, NHS is a credit to the country – keep up the good work."

"You've saved me, I really needed that."

"After talking to you, I do feel like we are in this together. Thank you."

Trust wide service user involvement

Even though this year delayed many projects and some services were adjusted due to the pandemic, service user involvement has continued, albeit at a slower pace. Experts by Experience continued to be involved in many work streams, including siting on interview panels and patient and carer forums; contributing to the Clinical Strategy, the Recovery Strategy and the clinical and environmental working group for the development of the Trust's new inpatient service at Blossom Court.

Expert by Experience comments

"I felt valued and appreciated. It was a prime example of the Trust persevering to include co-production and involvement in all aspects of the Trust, from key decisions to events, from committees to interview panels. I enjoyed taking part and being turned to for advice; our lived experience and expertise provide a key insight, something which the Trust is keen to use often and consistently. I felt like - and was treated as - a valued member of the team, which in turn was very rewarding and highly motivational"

"I felt like my contribution was valued, as I was asked for my opinion on the candidates throughout, and treated equally to the other members of the team"

"I really enjoyed being involved on the interview panel and I felt that my views were listened to by staff, I cannot wait to get involved in more work within the Trust."

Service User and Carer Surveys

The Trust's Service User and Carer survey provides our services users the opportunity to give feedback under three key domains; Involvement, Information and Dignity and Respect.

During 2020/21 a total of 5,879 Patient and Carer Surveys were completed, which provided a satisfaction rate of 89.02% across our mental health and community services.

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

	Best		Worst	
Question	Do you feel the support of Peer Worker has a positive impact on you?	96.93%	Were you informed that the member of staff was going to be late?	35.71%
Section	Peer Working	96.93%	Your Experience	86.13%
Competency	Dignity & Respect	94.88%	Involvement	88.86%

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. A few examples of changes brought about from Service User and Carer feedback are:

- A brand new Service User and Carer survey was co designed with service users. The "Your Experience" survey went live in February 2021and provides a more meaningful way in which we can receive feedback about our services.

- The launch of a new three year Involvement and Engagement Strategy in September 2021. The strategy was co-produced and designed for service users by service users.

Concerns and Complaints

Concerns and complaints about services by patients and their families are taken very seriously. 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 2020/21.

Feedback Type	Total
Compliments	534
Issues and Concerns	219
Informal Complaints	190
Formal complaints	93
Members Enquiries	17
PHSO Enquiries	5

From 1st April 2020 to 31st March 2021 the Trust received 93 formal complaints, a decrease since 2019-20 (116). This is considered in part to be due to the revised Trust Complaints Policy, which introduced clearer processes for local complaint resolution and new training for frontline staff to provide greater responsiveness.

It was identified that the original timescale for formal complaints of 25 working days did not fit the nature of all complaints that came through the Trust, and as such a new grading matrix tool was produced to identify a timescale for each complaint, this may be 25, 40 or 60 working days. By having this new system in place, it works with more realistic timeframes for the completion of complex complaints and works with our complainant's expectations.

Of the total 65 formal complaints closed, 5% were upheld, 46% partially upheld, 37% not upheld, and 12% withdrawn or forwarded to the appropriate agency.

The most common categories of complaints pertain to Patient Care and Values and Behaviours.

Accessible Information Standard (AIS)

The Trust is fully complaint with the legislative requirements of the AIS 2016 and the work to address the issues presented by service users and carers who have a disability or sensory loss are continually reviewed and improved on.

Patient Safety

Our aim is to keep our patients safe and protect them from harm. We have clearly defined processes for reporting, monitoring and managing patient safety incidents and safety concerns to help prevent harm occurring to our patients.

In 2020, a Quality Improvement project to improve the timescales for completion of Serious Incident (SI) investigations and the quality of reports was commenced by the Patient Safety Team. A comprehensive review of the SI Pathway was undertaken through a series of workshops and consultation with investigators and senior service and executive leads.

Several improvements have now been implemented to the Trust SI pathway including, a centralised Patient Safety Incident Review Group (PSIRG), centralised cross-divisional allocation of SI investigators and the induction of 7-day review meeting and weekly safety huddles to monitor SI progress. The Patient Safety Team has facilitated a series of in-house training sessions for staff on SI investigations. Bringing the training in-house has enabled us to look at and explore with staff the types of serious incidents that occur in mental health and community trusts and provide valuable insight from experience to trainee investigators. It is expected that through refining our SI process, we will improve the quality of our investigations and time taken to completed of SI investigations.

One of the aims of the Trust's Shared Learning Collaborative was for lessons learnt from patient safety incidents, to be accessible by all staff and to improve practice by the end of March 2021.It is

hoped that the improvements in managing SIs will support improved learning across services.

Our fortnightly Patient Safety Incident Review Group promotes the cross-sharing of learning lessons from SI investigations between the Divisions across our Trust and key messages from this group has led in lessons being disseminated to staff through our Blue Light Bulletins, BEH news bulletin and the intranet.

Some examples of dissemination of learning and change to practice include the following:

- As a result of two serious investigations identifying the need to enhance staff awareness of the early warning signs of physical health deterioration and onset of cardiac arrest, each division will now have either a Basic Life Support (BLS) or Immediate Life Support (ILS) simulation or refresher training every 4-6 weeks.
- There is a change in Trust policy to standardise the inpatient emergency number for emergencies and ensure all inpatient teams are aware. This will ensure that duty doctors are contacted promptly.
- Due to an increase in incidents of opioid overdose, the Trust introduced naloxone (prefilled syringe) into the resuscitation bags which will assist staff during critical incidents.
- Difficulties in accessing Patient ECG examinations at local GP surgeries and acute hospitals for Patient treated on high dose psychotropic medications, has led to a planned purchase of an ECG machine to streamline and standardise a process.
- A handover pro-forma was developed and is passed between the central and divisional teams in the morning and evening to ensure seamless continuity of hand-over communication between the trust wide night crisis resolution home treatment team (CRHTT) and divisional CRHTTs
- BEH Trust are in the process of setting up an Emergency Response Team for each site, this team will assist with medical emergencies and cardiac arrests and have senior staff on the team.

The issues and learning from each investigation continue to be discussed at divisional governance meetings and shared between teams, at our Safe, Effectiveness and Experience Group (SEEG) and the Quality and Safety Committee. The Trust continues to utilise After Action Reviews to support immediate learning from incidents to improve patient care and practice. The Patient Safety Team provides training, advice and support to staff in Patient Safety.

To support the implementation of the National Patient Safety Strategy, a new Patient Safety Brilliant Basic QI workstream will commence in May 2021. There is further work to be undertaken in embedding a just and learning culture – this will be incorporated into the Patient Safety QI work. This is an exciting opportunity to further build on quality improvements made in 2020-21 in relation to the improving safety of our patients. We will develop our protocols for supporting staff following a serious incident, continue to make learning from incidents and good practice timely and as accessible as possible to all staff and continue to and strengthen our patient safety objectives.

Serious Incidents (SIs)

During 2020-21, in accordance with the National Serious Incident Framework 2015, the Trust reported 39 Serious Incidents. These include incidents of unexpected deaths, suspected suicides, and self-harm.

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 in 2020-21.

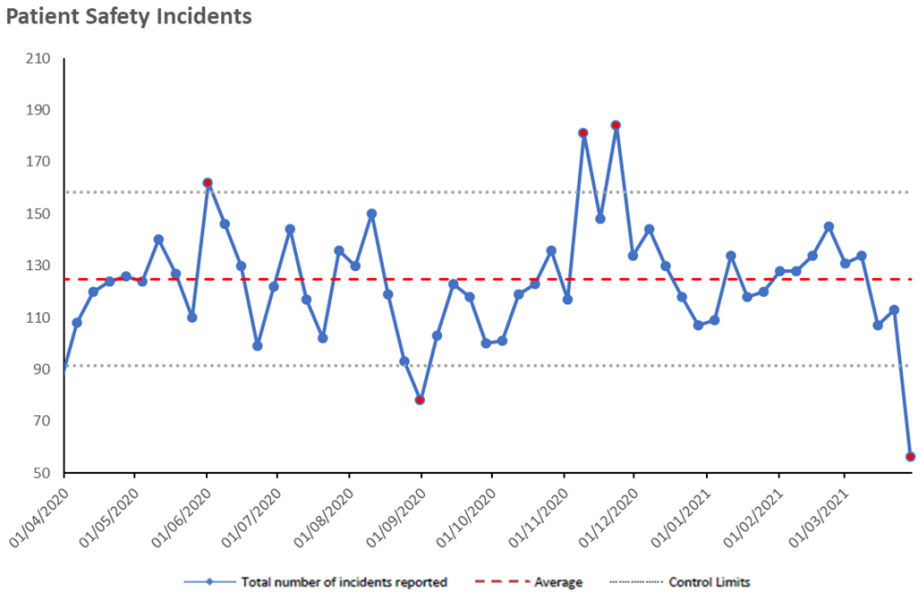
Regulation 28: Report to Prevent Future Deaths

During 2020-21, the Trust did not receive any Regulation 28: Report to Prevent Future Deaths.

Patient Safety Incidents

During 2021-21, 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.

During the year, a total of 6,535 patient safety incidents were reported. This is an increase of 3.4% in comparison to the number of patient safety incidents reported in the previous year (6,321 patient safety incidents).



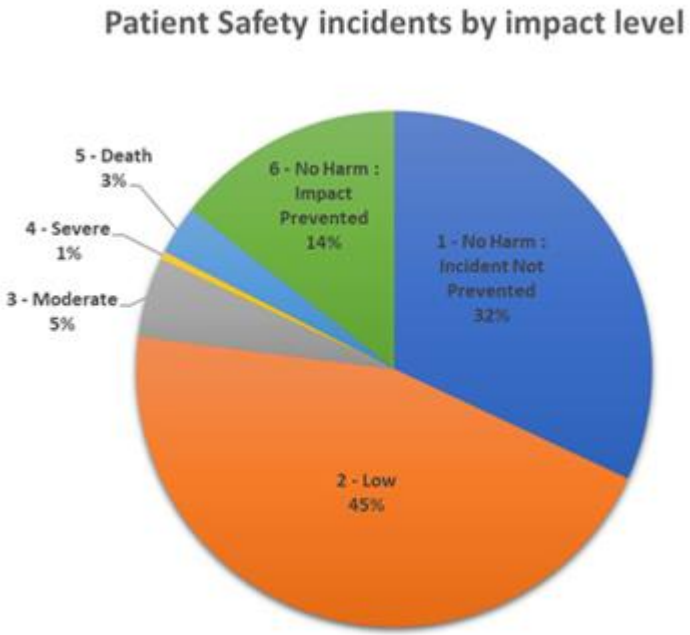
The NRLS figures for October 2019 to March 2020 were published in October 2020. The number of patient safety incidents reported by BEH to NRLS during this period decreased by 3% (174 incidents) compared to the previous six month period but increased by 6% when compared to the same period in 2018-19.

The number of incidents per 1,000 bed days for the period October 2019 to March 2020 was 32.8 (a decrease from the previous period but an increase compared to the same period in 2018-19); the Trust is ranked the seventh highest out of eight London Mental Health Trusts for the current period.

The median number of days from the date of incident to when it was uploaded to NRLS has improved significantly from 81 days on the last report (Apr 19 – Sept 19) to 24 days in the current report. This is largely due to consistent weekly submissions to NRLS being made.

Patient Safety Incidents by Severity

Of the 6,535 patient safety incidents reported to NRLS in 2020-21 by BEH services, 46% of those resulted in no harm.



The Guardian Service

In January 2021, following feedback from our staff about the Freedom to Speak Up Guardian Service, that many wanted a service with increased opening hours and availability, we launched a new Guardian Service to help all staff to raise any issues or concerns you may have about any aspect of work at BEH.

The new Guardian Service is external to the Trust and replaces the existing in-house Freedom to Speak Up Guardian service. The new service is completely independent and confidential and will provide an accessible team of guardians from a range of diverse backgrounds, to reflect our diverse staff.

The new guardians bring experience and expertise from working with staff in other NHS Trusts. Staff can continue to raise matters relating to patient care and safety and any other work-related issues. The Guardian Service is available over the telephone 24/7.

Part 3

Looking Forward: Quality Priorities for 2021-22

This section of our Quality Account describes our priorities for improvement for the year 2021-22.

In March 2021, the Trust held a stakeholder engagement event which provided attendees with an opportunity to engage with senior leaders from the Trust and share their views on the areas that we need to focus on and improve in 2021-22.

Many of the suggestions were areas that had already been identified by the Trust as requiring focus; work is already being undertaken to improve and strengthen these areas.

A number of suggestions put forward were minor changes or culture changes that stakeholders felt would improve the overall experience of service users and staff.

Quality Priorities 2021-22

While we explore quality priorities for the coming year, it is important that we look back at what we have achieved and implemented in previous years and the areas we would want to continue developing and improving in the year ahead.

Four quality priorities have been identified for 2021-22. These take into consideration suggestions from stakeholders and the strategic objectives of the Trust. The priorities are whole programmes of work. They are aligned to the Brilliant Basics and thus will be embedded into the work being undertaken by the existing working groups to reduce variation in services and improve the quality of care and service delivery across all teams and our staff health and wellbeing:

Excellence for Service User – We will successfully roll out the use of Dialog+ across key services within the Trust.

Empowering staff – We will develop a structured wellbeing programme for staff and support their psychological and physical wellbeing.

Innovation in services – We will continue to develop Quality Improvement programmes Trust wide to support innovation and continuous improvement.

Partnerships with others – We will develop integrated working with partners across North Central London.

Additionally, the Trust will continue to focus on areas identified by outcomes and experiences from last year as requiring continued efforts to improve quality.

BrilliantBasics

PART 4 – To be added

- Statement from NCL Clinical Commissioning Group for Barnet, Enfield 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

Glossary - to be finalised

AHP	Allied Health Professional
AMHP	Approved Mental Health Practitioner
BAME	Black, Asian and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CMRG	Clinical Mortality Review Group
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
DIT	Discharge Intervention Team
DoH	Department of Health
DTOC	Delayed Transfer of Care
EIS	Early Intervention Service
ECS	Enfield Community Health Services
FFT	Friends and Family Test
JHOSC	Joint Health Overview and Scrutiny Committee
KPI	Key Performance Indicator
NEWS	National Early Warning System
MDT	Multi-disciplinary Team
MHSOP	Mental Health Services for Older People
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
OAP	Out of Area Placement
PHSO	Parliamentary Health Services Ombudsman
POMH	Prescribing Observatory for Mental Health
PROMS	Patient Reported Outcome Measures
QuESTT	Quality, Effectiveness & Safety Trigger Tool
QI	Quality Improvement
RiO	Electronic Patient Care Record System
SEEG	Safe, Effectiveness and Experience Group
ULYSSES	Incident and Risk Management System

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 on the details below.

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

Or through social media:
@BEHMHTNHS
www.fb.com/behmht

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