Barnet, Enfield and Haringey Mental Health NHS Trust

Quality Account 2018 - 2019

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Part 1

Chief Executive's Statement

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

What is a Quality Account?

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

Our Quality Account 2018/19 is designed to:

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

About BEH-MHT

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

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

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

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

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

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

Our Vision

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

Our Values

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

Systems in place to ensure quality at all levels

BEH is an organisation that embraces continuous improvement and learning.

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

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

Our quality governance system, quality performance and

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

CQC Inspection 2017 and Quality Improvement Action Plan

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

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

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

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

Brilliant Basics

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

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

Patient Safety

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

Patient Experience

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

Effectiveness

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

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

3rd Annual Patient Safety Conference

Patient Safety: Moving Forward

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

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

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

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Blue Nile House Full Monty

By Geoff Brennan

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

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

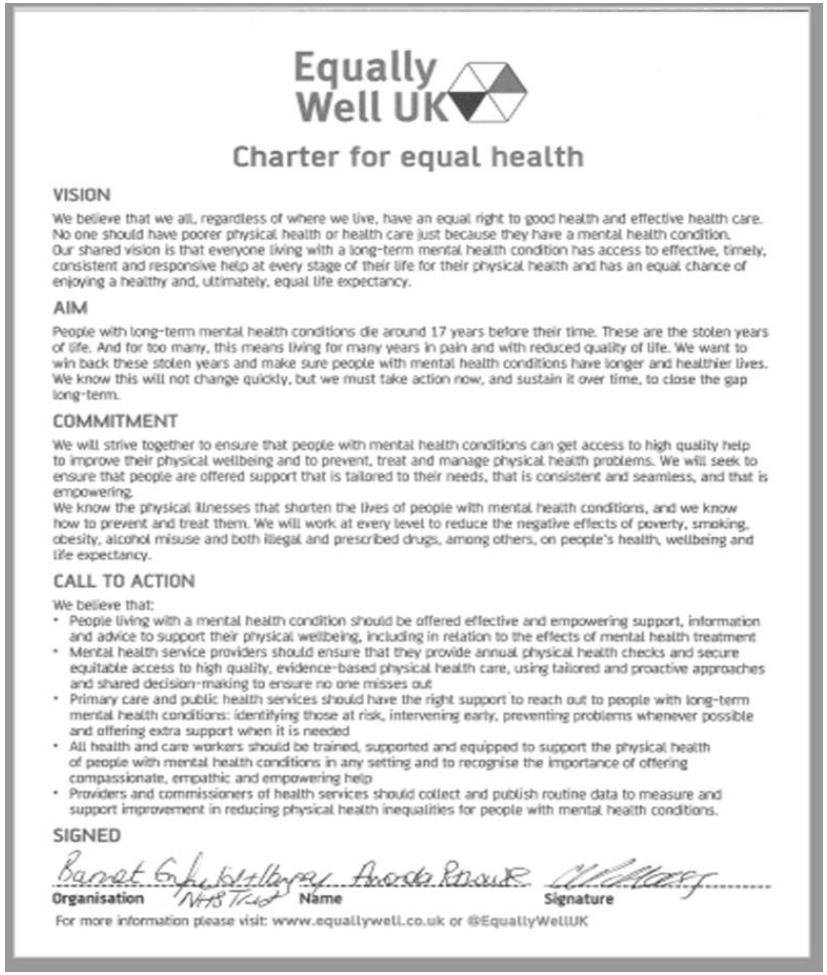
- Andy Bell, Deputy Chief Executive, Centre for Mental Health talked about how health, social care and education organisations need to work together to tackle unequal health outcomes for mentally unwell patients by understanding what causes the gaps, how to address the gaps, particularly around physical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

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

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

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

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



Equally Well UK

Charter for equal health

VISION

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

AIM

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

COMMITMENT

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

CALL TO ACTION

We believe that:

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

SIGNED

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

Organisation — Name — Signature

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

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

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

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

The Think Family Approach, Celia Jeffreys, Safeguarding Children Lead

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

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

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

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

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

Part 2

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

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

Review of Quality Performance, 2018/19

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

Examples include:

- Quality Reviews

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

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

- Staff Wellbeing Forum

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

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

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

- Staff Leadership Forums

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

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

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

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

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

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

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

resources in relation this important aspect of clinical practice.

- Table Talk

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

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

- Executive Roadshows

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

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

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

  Over 500 staff members have attended the roadshows.

- Equality, Diversity and Human Rights Forum

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

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

- Specialist Services Learning newsletter

- Let's Talk

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

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

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

- **Mobile Working**

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

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

- **Careers and Culture survey**

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

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

- **Dragon's Den**

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

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

Enablement

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

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

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

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

The partnership activities have been focussed on two key areas:

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

Workforce Development

Recruitment

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

Retention

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

Co-production - examples

Project 1: Barnet CAMHS Transformation Coproduction

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

Project 2: Barnet ADHD Awareness Campaign

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

Project 3: Enfield Pulmonary Rehab

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

Project 4: Enfield Complex Rehab QI Dialog+ CPA pilot

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

Project 5: Haringey Finsbury Ward QI Dialog+ CPA pilot

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

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

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

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

Developing Community Pathways

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

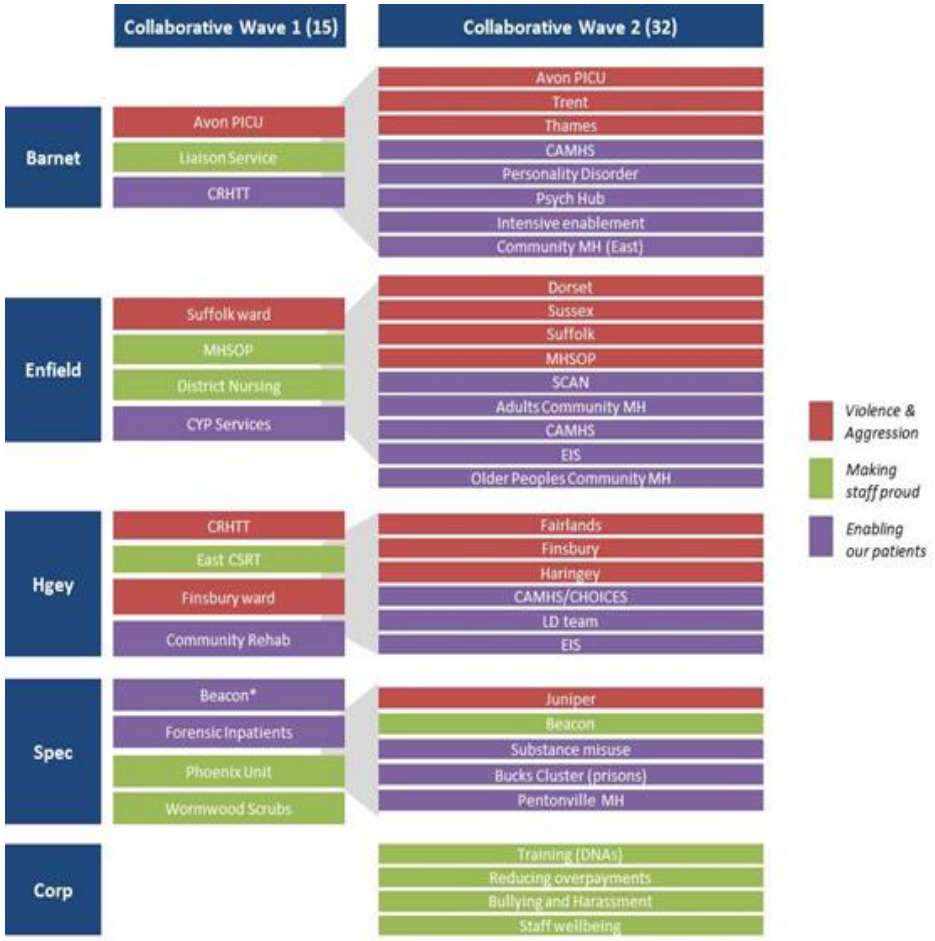
Promotion
• Created a new Trust Wide Enablement Partnership Logo.
• The Partnership engaged in the continuous internal promotion of activities such as a Peer Recruitment Event that was attended by over 100 people, and the Creative Co-production Forum that showed co-production work in the Trust.

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

Quality Improvement (QI)

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

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



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

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

For Trusts

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

For staff & teams

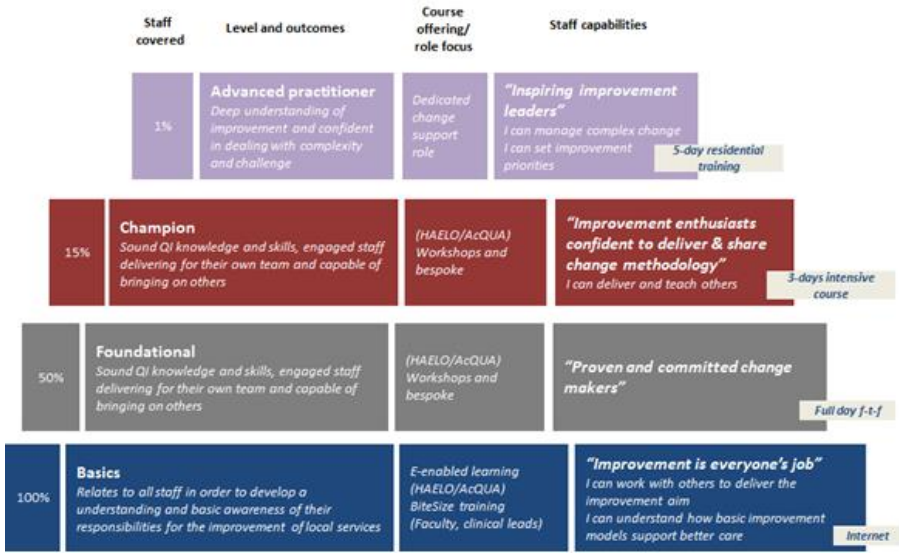
- *Motivation and retention is higher because ownership and autonomy is strengthened*
- *QI support can be used as a recruitment tool to show both internal values & how we value staff*
- *Staff can see clearly and immediately the impact of their changes through the focus on data*

For patients

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

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

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



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

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

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

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

Quality Priorities - Looking Back, 2018/19

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Physical health working group have started work on:

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

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

Physical Health Quality Assurance Audit results, 2018/19.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

North London Forensic Services

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

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

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

3) To continue to improve communication with GPs

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

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

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

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

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

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

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

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

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

Compliance by competency, 2018/19

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

Primary care communication: Enfield Health (community teams)

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

Clinical Audit and Quality Assurance Programme

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

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

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

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

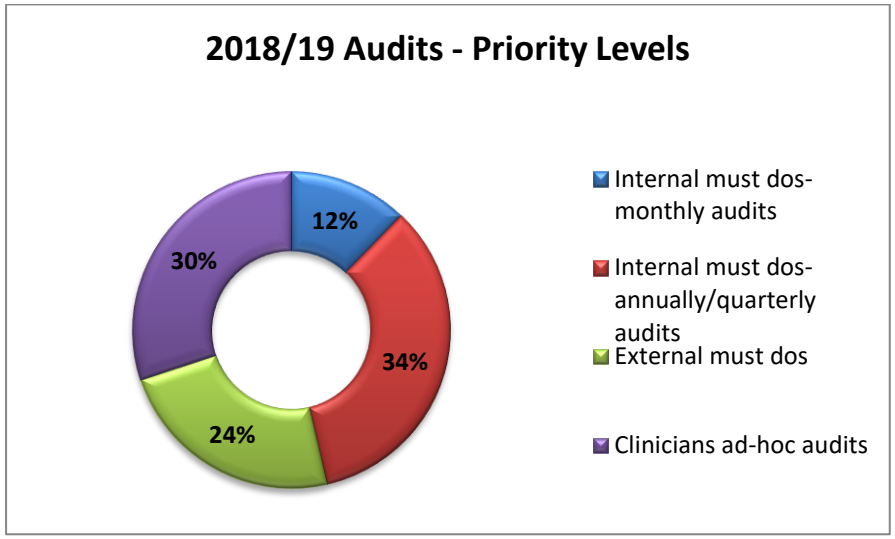
Audit Type	Definition
National Audit	An audit project funded by the Healthcare Quality Improvement Partnership (HQIP) or another national body. BEHMHT participates in all national audits where our services meet the eligibility criteria.
Priority Audits	Priority audits are mandatory audits carried out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

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

Participation in clinical audit in 2018/19

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

The chart below shows the priority level for these audits.



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

Participation in national clinical audits and national confidential enquiries

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

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

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

The national clinical audits and national confidential enquiries that the Trust participated in, and for which data collection was completed during 2018/19 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit of that audit or enquiry.
BEH participation in national audit and national confidential enquiries, 2018/19:

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

Quality Assurance Audit

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

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

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

Trust compliance with Quality Assurance Audits 2018/19

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

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

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

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

Breakdown by overall competency scores:

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

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

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

Peer Service Review Programme

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

The peer review audit tool consists of four elements:

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

Trust compliance with Peer Service Review audits 2018/19

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

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

Peer Service Reviews 2018/19: Trust Compliance

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

Local Clinical Audits 2018/19

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

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

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

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

Audit of informal patients and their rights

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

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

► Peer Service Reviews

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

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

► Quality Assurance Audit

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

► Patient and Carer Experience Survey

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

involvement in care planning under the CPA.

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

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

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

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

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

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

Priorities and Further Developments for 2019/20

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

Patient Reported Outcome Measures (PROMs)

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

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

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

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

Reporting Patient Reported Outcomes Measures (PROMs)

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

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

PROMs participation by team, 2018/19

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

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

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

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

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

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

Participation in Clinical Research

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

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

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

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

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

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

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

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

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

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

Trust performance against 2018/19 agreed CQUINS

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

CQUIN Supporting notes

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

Participation in Accreditation Schemes

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

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

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

Information Governance Toolkit compliance 2018/19

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

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

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

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

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

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

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

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

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

Data Quality

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

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

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

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

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

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

National Mandated Indicators of Quality 2018/19

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

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

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

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

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

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

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

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

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

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

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

3. Readmissions within 28 days of discharge

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

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

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

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

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

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

Patient Experience

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

The Friends and Family Test

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

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

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

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

Service User and Carer Surveys

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

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

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

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

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

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

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

The staff here are wonderful.
Finsbury Ward, June 2018

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

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

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

Complaints

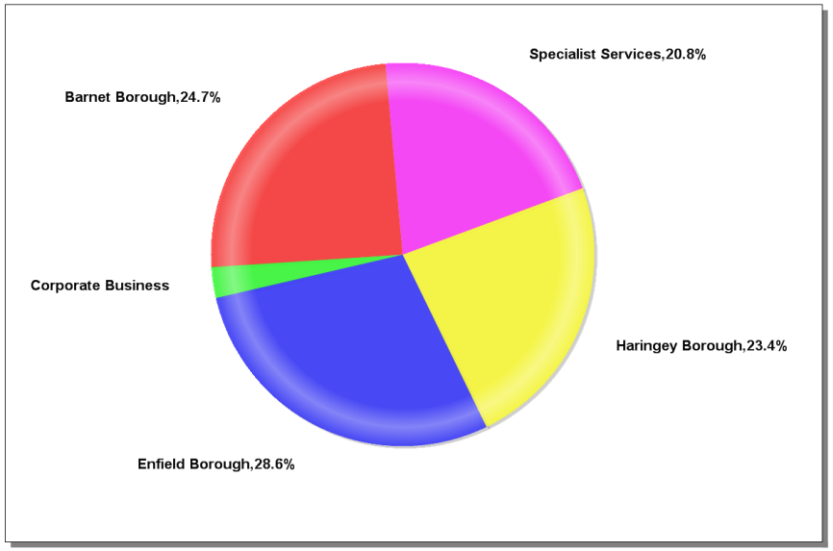
Concerns and complaints about the service received by patients and their families are taken very seriously, and the Trust seeks to address issues promptly and provide assurance of improvements made. Where possible, individuals are encouraged to seek local resolution by discussing concerns directly with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

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

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

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

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



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

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

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

Compliance

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

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

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

Community Mental Health Survey

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

What did we do well?

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

What do we need to do better?

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

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

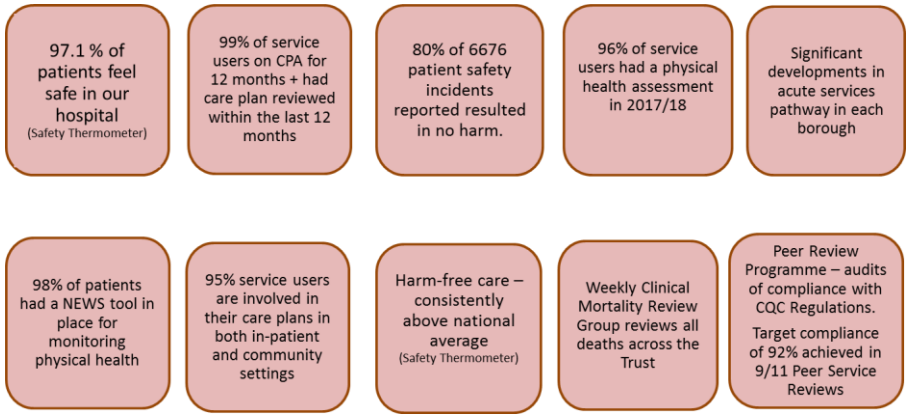
- A continued focus on recruiting Peer Workers into clinical teams, led by the Enablement Partnership. At time of report, the Trust has increased its Peer workforce to 24 employees.
- The development of a community resources database, to support individuals to find and engage with groups and networks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

Patient Safety

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

Patient Safety Indicators

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



Areas we focussed on to improve Patient Safety

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

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

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

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

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

Classic Safety Thermometer

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

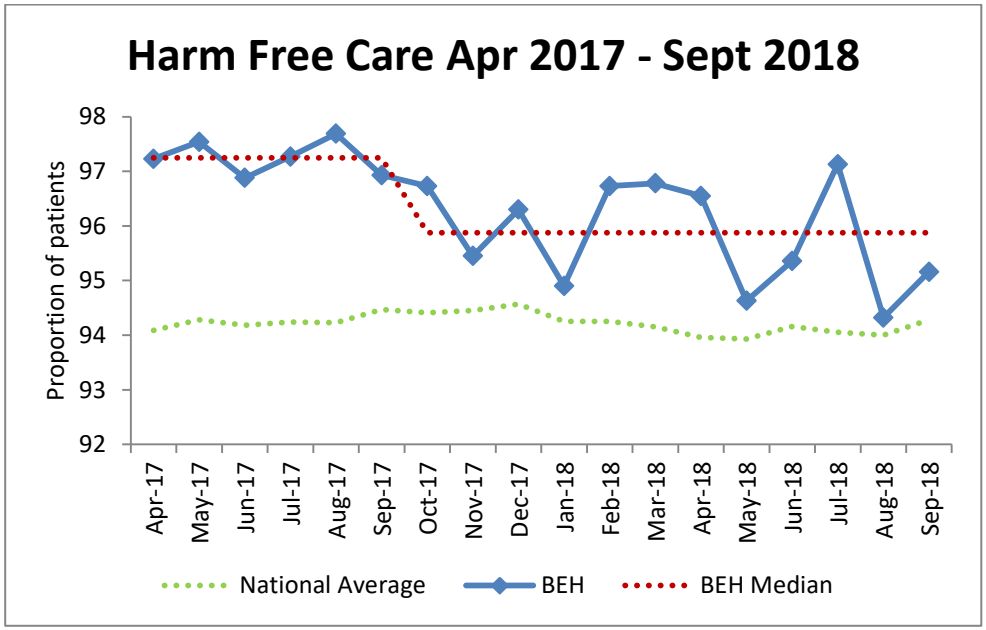
It should be noted that the national averages referred to in the following charts include data relating to all care settings (i.e. Acute, Community, Mental Health, Nursing Home, etc.). All national figures are taken from the NHS Safety Thermometer online dashboards.

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

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

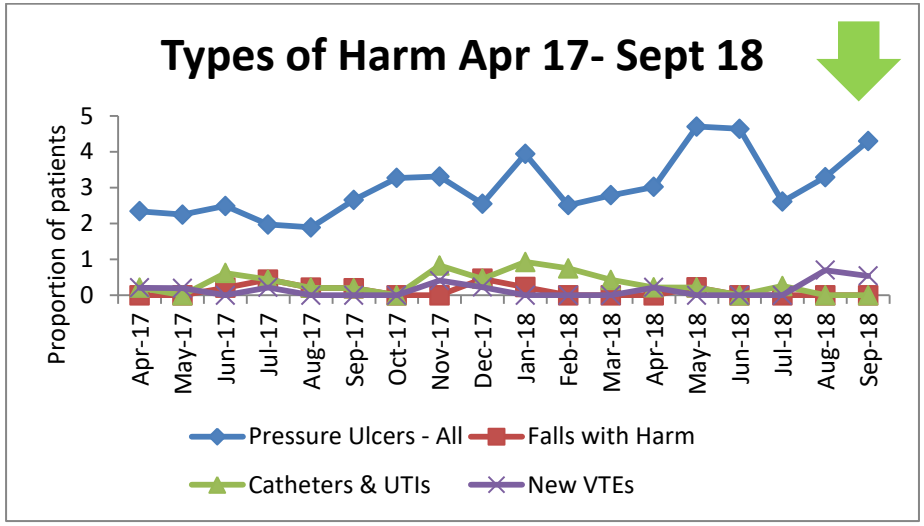
The proportion of BEH patients that experienced 'Harm Free Care' in 2018/19 remained above the national average.

Chart 1 – Harm Free Care



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

Chart 2 – Types of Harm recorded.



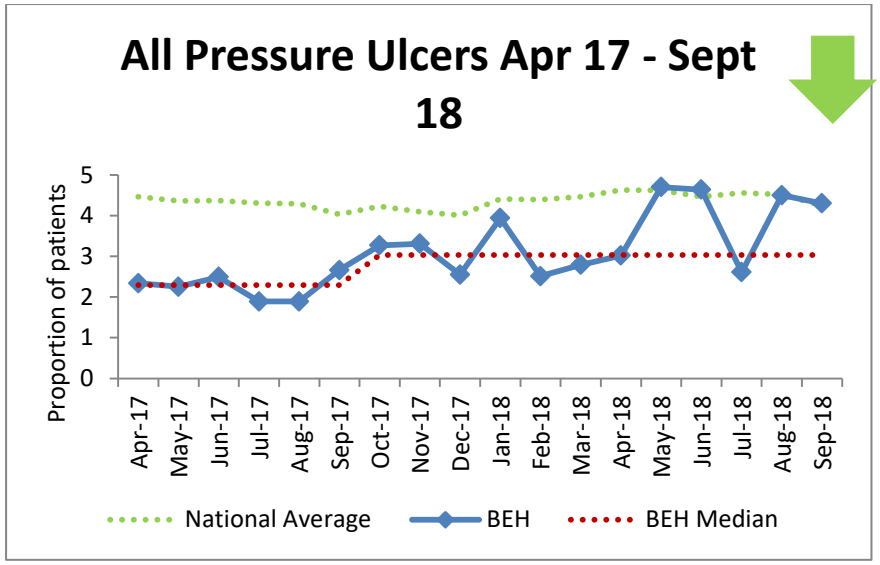
Within BEH, pressure ulcers remain the most prevalent of the harms measured by the tool.

Pressure Ulcers

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

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

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

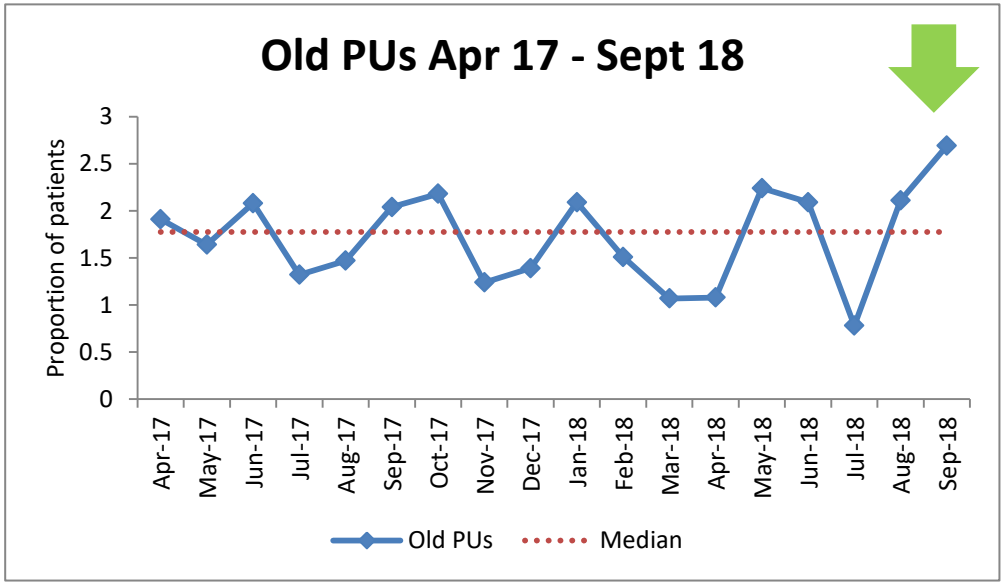


BEH was below the national average for the entirety of 2017/18 but have been above or equal to the national average for 3 out 6 months in Q1 & 2, 2018/19.

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

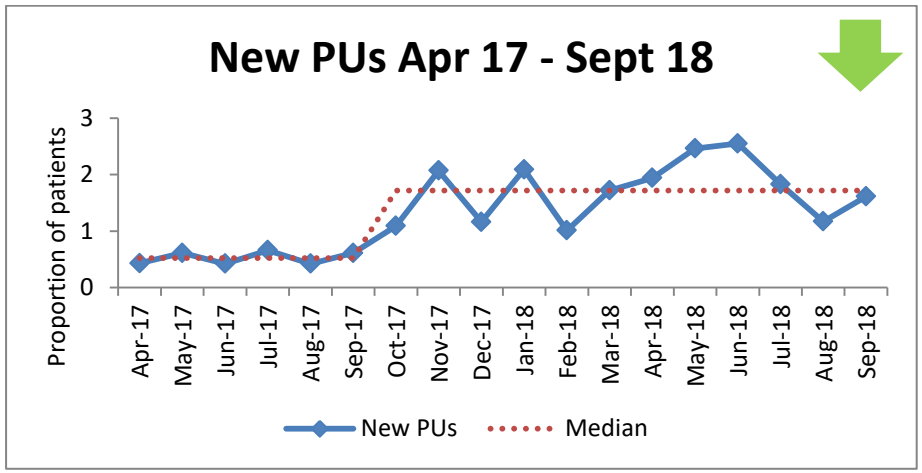
It should also be noted that the District Nurse teams may audit the same patient every month if they are scheduled to see that patient on the day of the data collection. The result being that if a pressure ulcer is not healing, it will be reported every month (regardless of the reason why the PU might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

Chart 4 – Old Pressure Ulcers (BEH)



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

Chart 5 – New Pressure Ulcers (BEH)

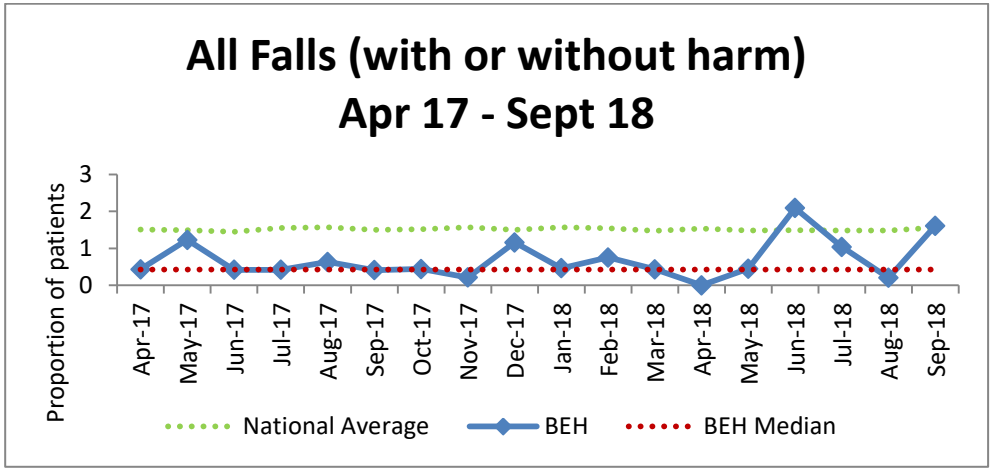


New pressure ulcer rates continue to increase compared to early 2017/18 although the numbers are still relatively low and have started to come down in quarter 2, 2018/19. National figures are not available for this indicator.

Falls

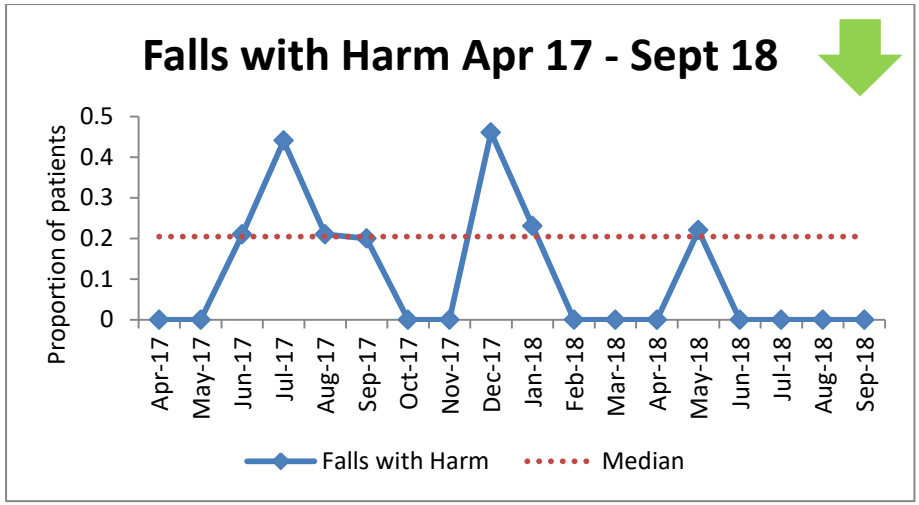
The safety thermometer measures the proportion of patients who have had a fall within the previous 72hrs. As noted above, Community teams visiting a patient once a week may not be aware of the fall until they visit. Consequently, there will be a delay in reporting the incident on the Trust incident reporting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

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



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

Chart 7 – Falls with Harm (BEH)

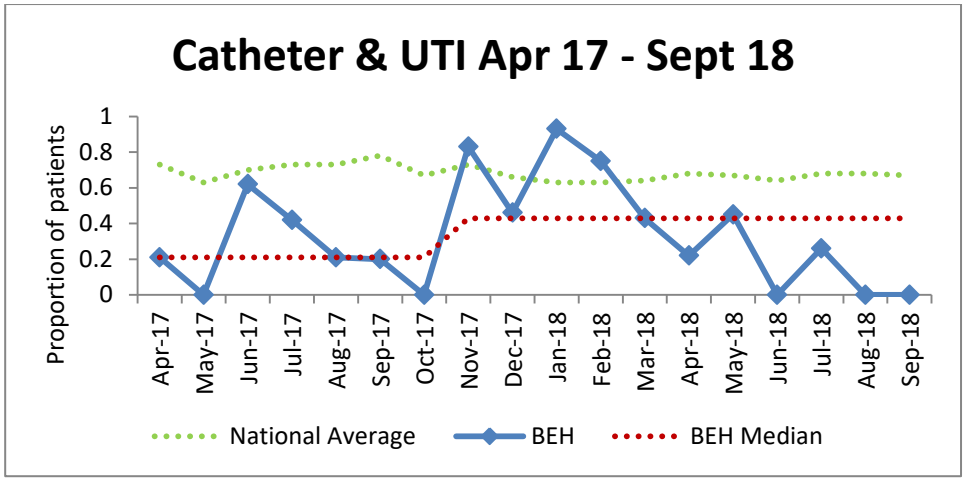


National figures are not available for this indicator.

Catheters and UTIs

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

Chart 8 – All Catheter & UTIs reported



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

Chart 9 – Catheter & New UTI (BEH)

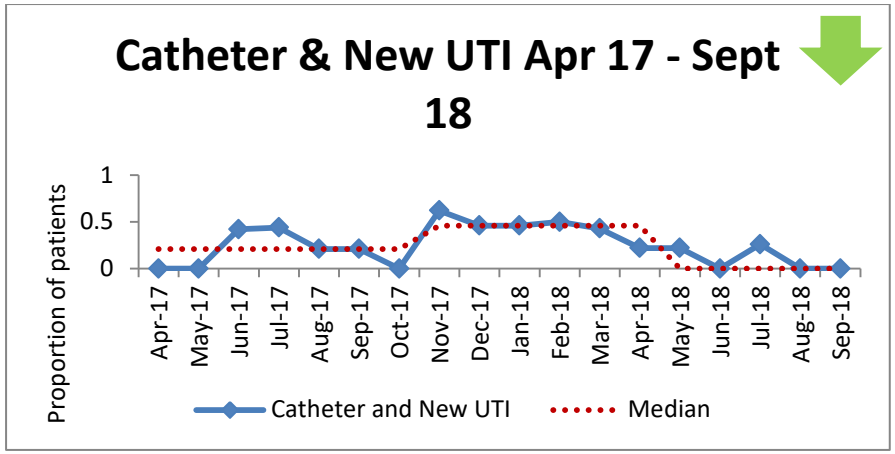
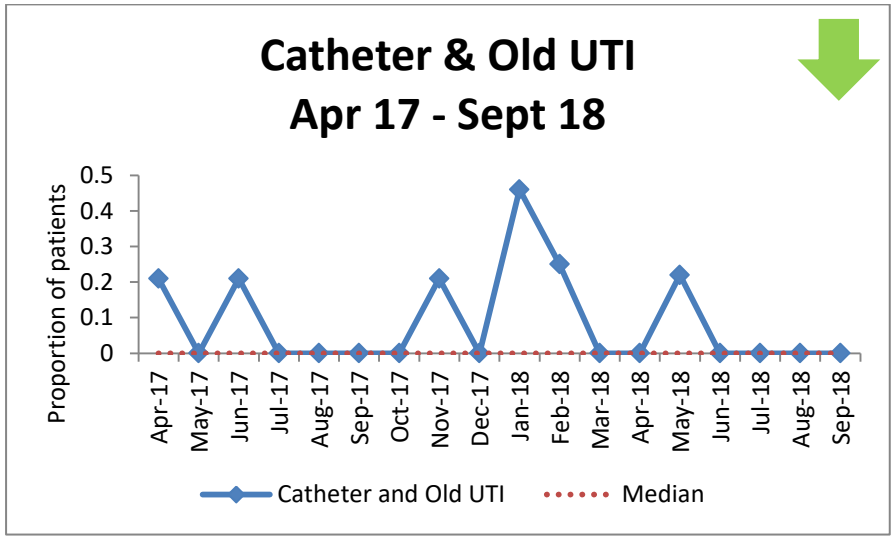


Chart 10 – Catheter & Old UTI (BEH)

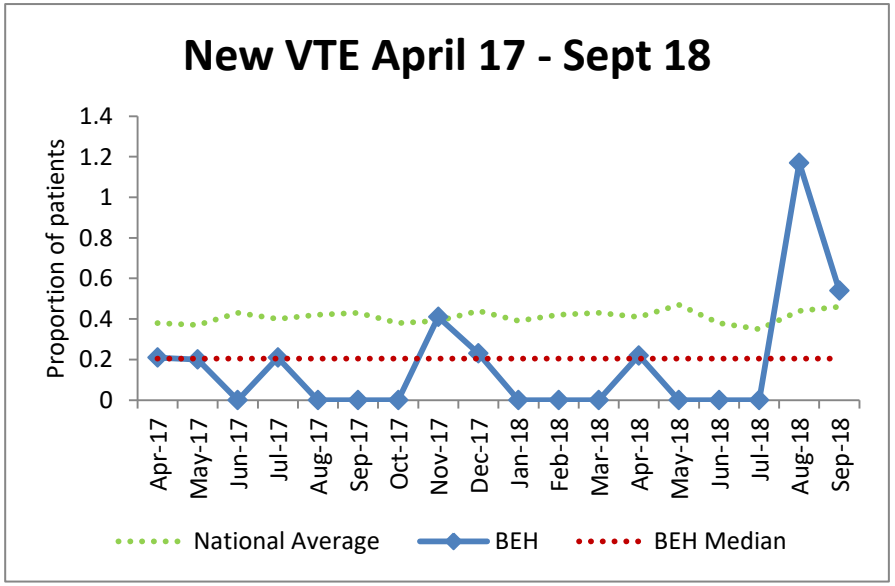


VTEs

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

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

Chart 11 – New VTEs – BEH compared to National Averages



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

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

Mental Health Safety Thermometer

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

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

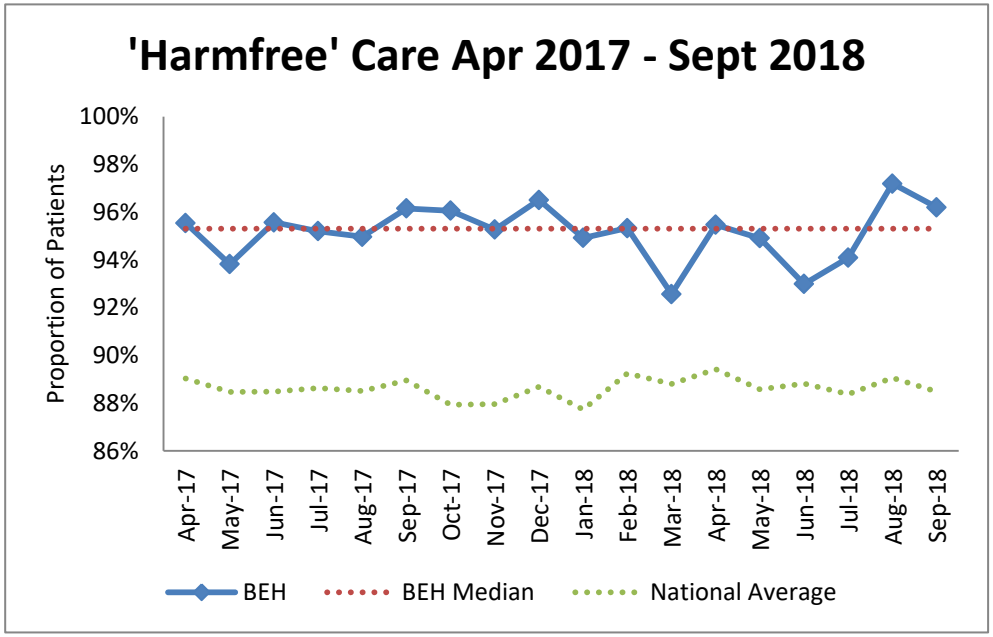
The Trust's mental health safety thermometer results have improved in 2018/19. Whilst there is not currently a formal national target, the Trust has worked towards 95% harm free. The proportion of harm free patients has increased in 2018/19 in comparison to the previous year.

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

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

Harm Free Care

Chart 12 – Proportion of patients experiencing Harm Free Care

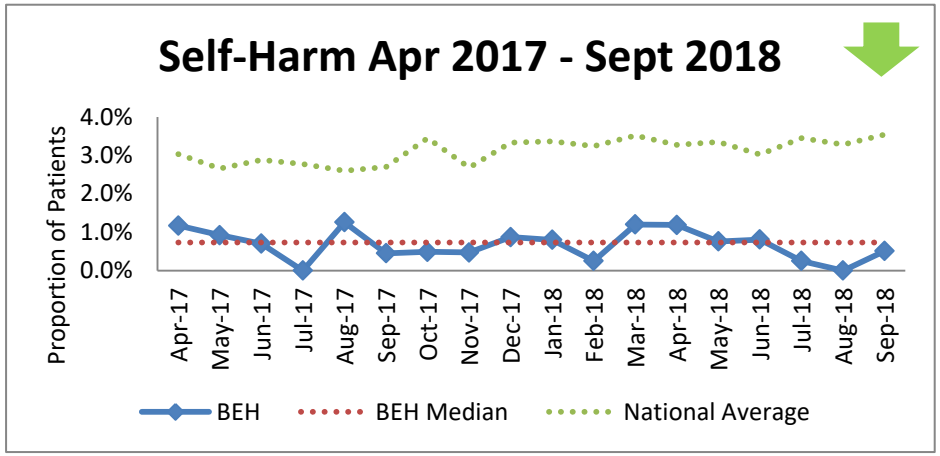


The proportion of harm free patients has increased in Q1 & 2, 2018/19 in comparison to the previous year. BEH remain well above the national figures for the period.

Self-Harm

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

Chart 13 - Self-Harms

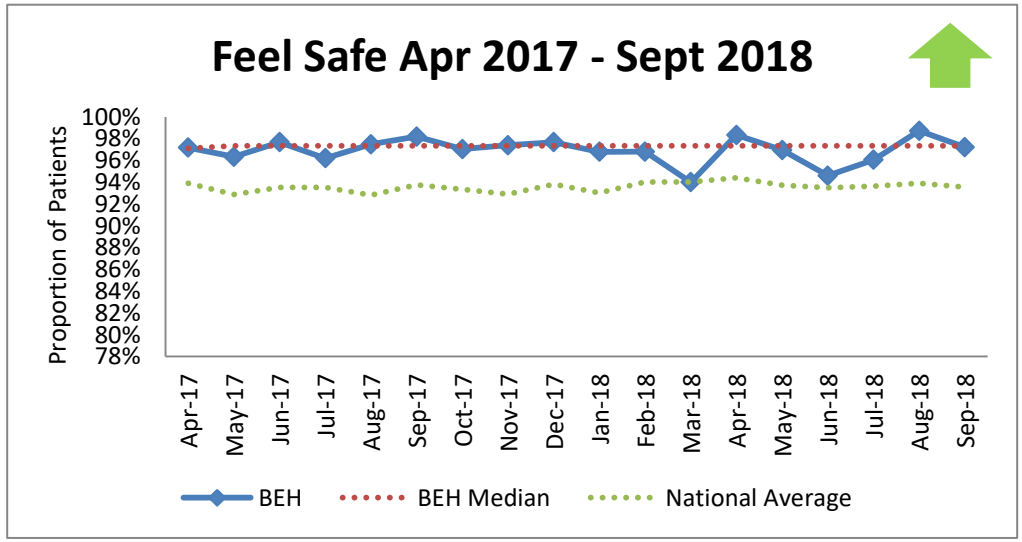


The proportion of patients that experienced self-harm has decreased in Q1&2 compared to the late 2017/18. BEH remain well below the national figures for the period.

Psychological Safety

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

Chart 14 – Psychological Safety - ‘feel safe’

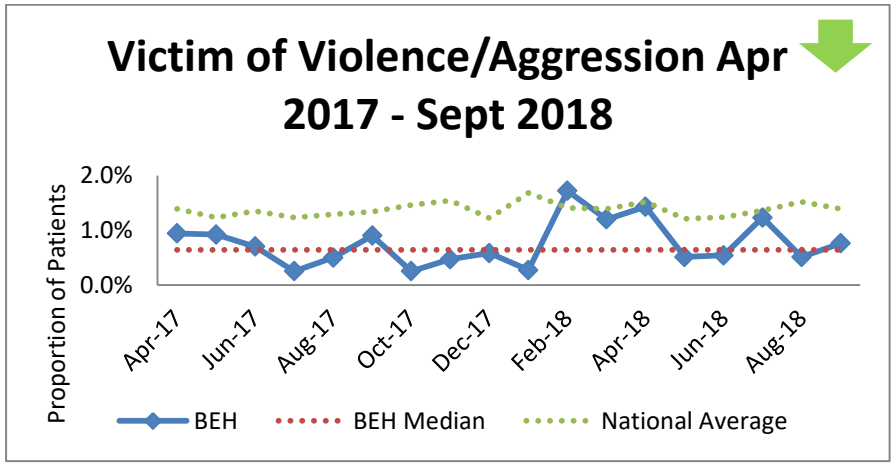


The Trusts Psychological Safety (based on responses to the question ‘Do you feel safe?’) scores have increased during 2018/19. BEH remains above the national average for the period.

Violence/Aggression

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

Chart 15 – Victim of Violence/Aggression



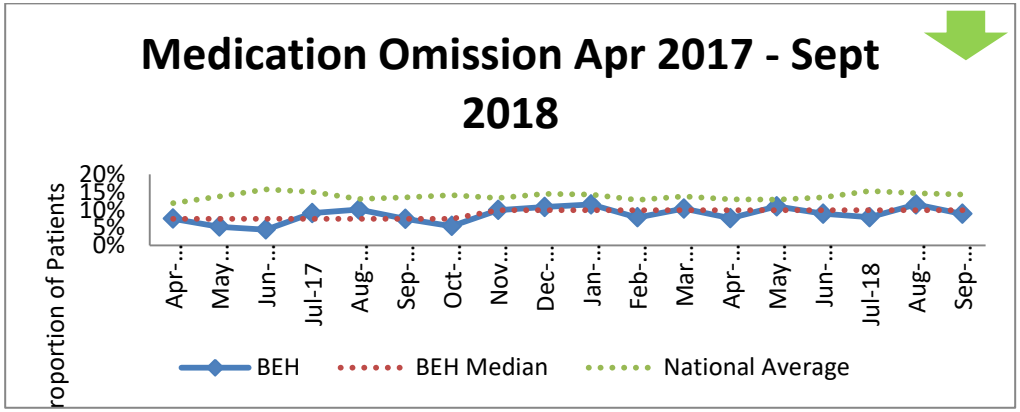
The proportion of patients that have been the victim of violence/aggression decreased from Q1, 2018/19 from Q4, 2017/18 but increased in July 2018. The numbers of harms in Q1&2 2018/19 have remained below the national rates.

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

Medication Omission

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

Chart 16 – Medication Omissions

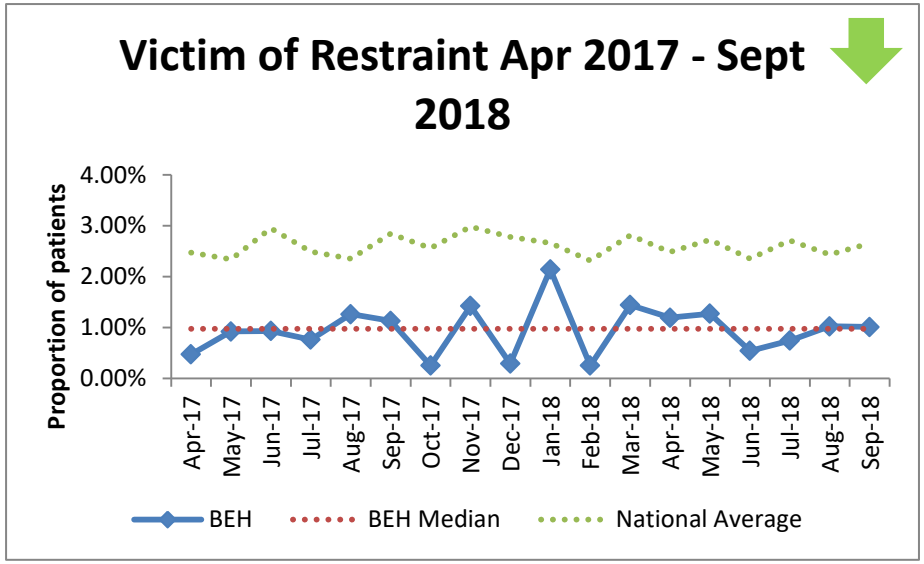


Although BEH remains below the national rates for patients experiencing a medication omission, our rate has fluctuated across Q1&2, 2018/19. Further work is required between ward staff and pharmacy to understand the resultant level of harm if any to the patient due to the omission, as well as reasons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

Restraints

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

Chart 17 – Restraints



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

Patient safety related training for staff

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

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

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

Patient Safety – Serious Incidents

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

heightened level of response is justified.

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

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

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

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

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

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

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

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

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

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

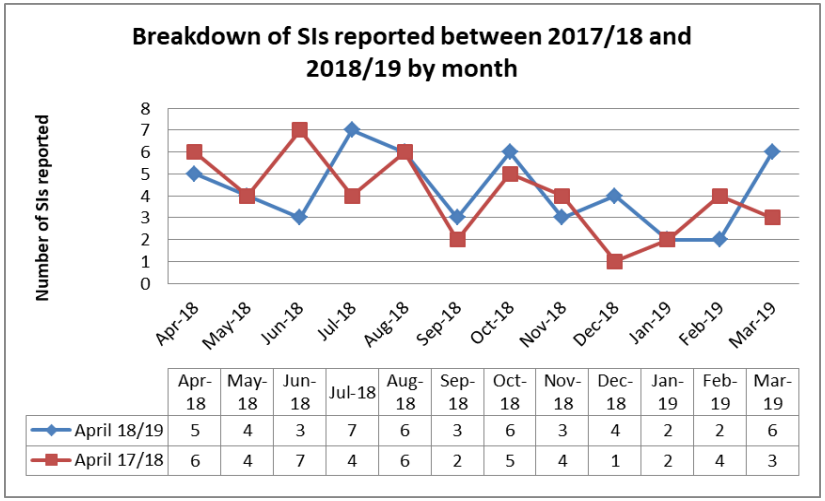
• Sharing lessons learnt: The Trust is focused on providing the appropriate resources that will facilitate learning from incident themes and investigations through Patient Safety Conferences, Serious Incident investigation learning

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

Number of Serious Incidents (SIs)

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

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



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

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

Reporting SIs within two working days

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

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

Learning from serious incidents

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

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

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

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

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

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

- Themes to be added

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

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

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

Immediate learning from AARs have highlighted the following:

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

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

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

Never Events

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

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

Regulation 28: Report to Prevent Future Deaths

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

Duty of Candour

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

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

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

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

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

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

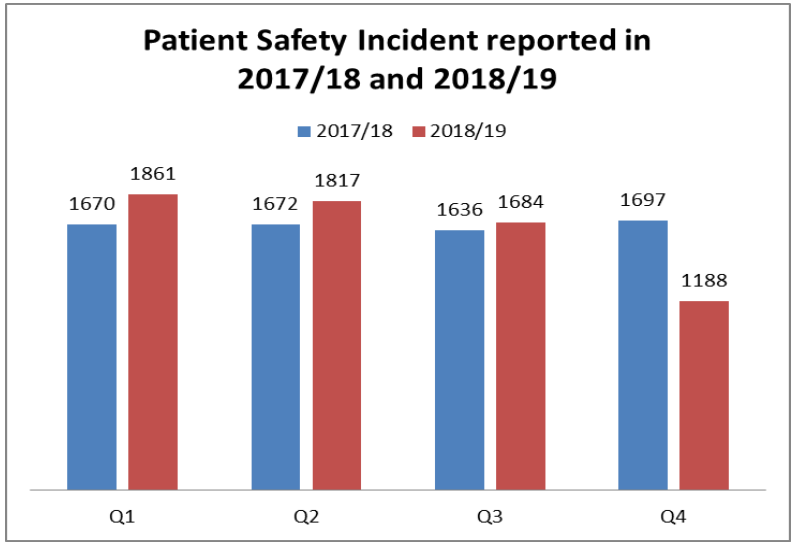
Patient Safety Incidents

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

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

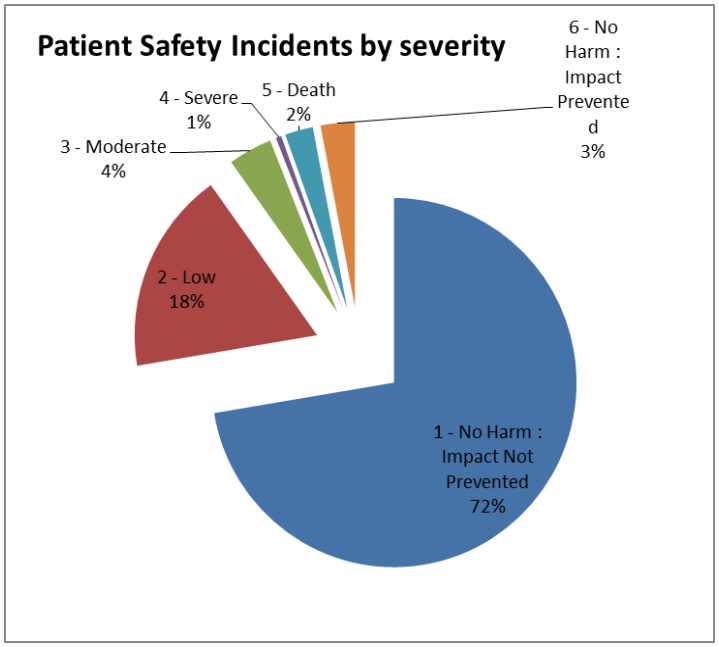
The number of patient safety incidents reported to the National Reporting and Learning System (NRLS) for the period April to September 2017 increased by 8% when compared to the same period for 2016. The number of incidents per 1,000 bed days for this period was 35.97. *(NRLS data for Oct 17 - Mar 18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

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



Patient Safety Incidents by Severity

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



Learning from Deaths

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Safeguarding

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

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

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

Key achievements over the past 12 months:

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

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

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

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

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

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

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

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

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

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

Examples of positive feedback following the day include:

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

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

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

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

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

Infection Prevention and Control

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

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

Infection Prevention and Control Training

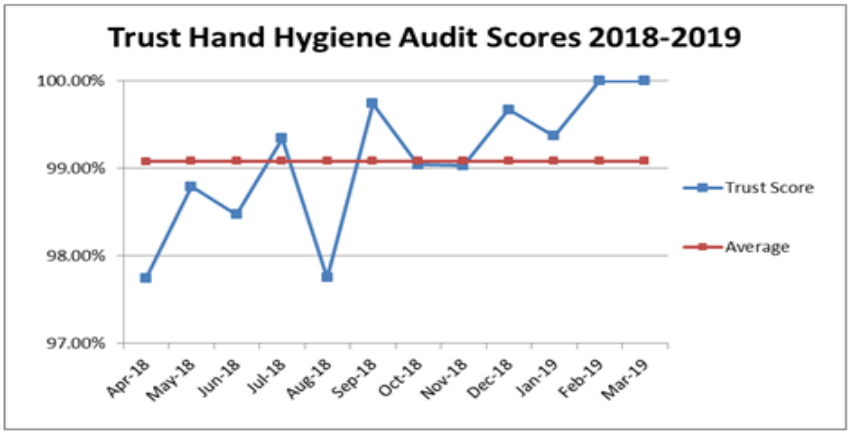
Infection Prevention and Control training is part of the Trust mandatory training programme for all staff. From 2018/19, 84.09% of staff completed the training, compared to the Trust target of 90%. To increase compliance, additional training dates have been released and notifications have been sent to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

Infection Control Audits

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

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

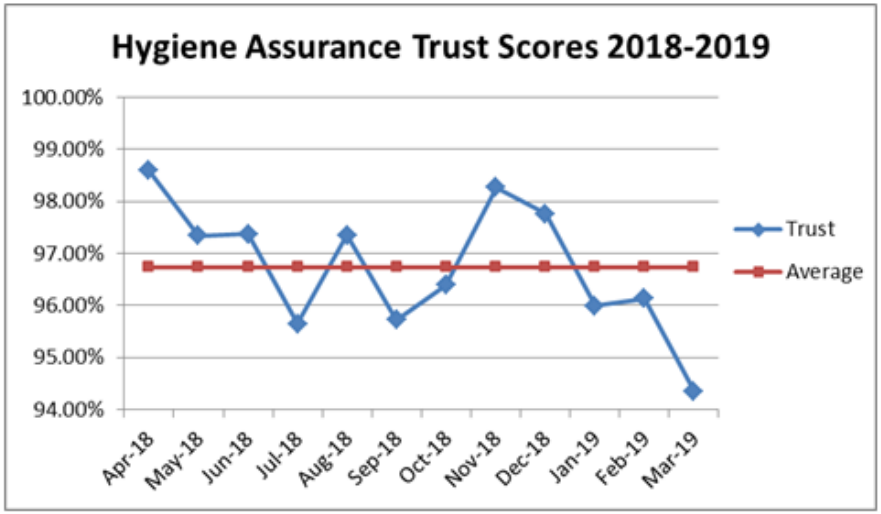
Audits are carried out monthly in inpatient areas and quarterly in outpatient services. The average hand hygiene compliance was above the Trust target of 90% in 2018/19.



Hygiene Assurance Audit 2018/19

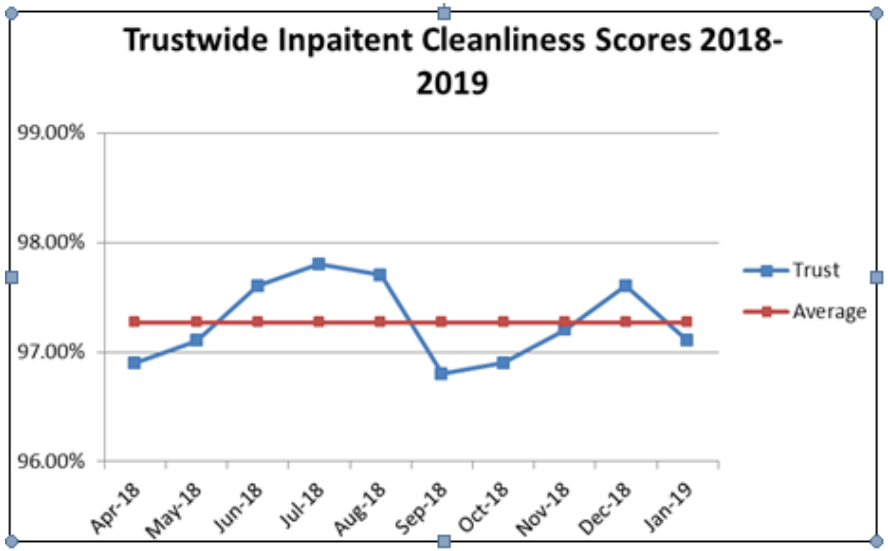
The Hygiene Assurance Audit assessed compliance against national standards in the following areas: bathrooms and showers, bedrooms, clinical room, domestic room, kitchen, laundry room, sluice room, store room, toilets, and common areas.

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



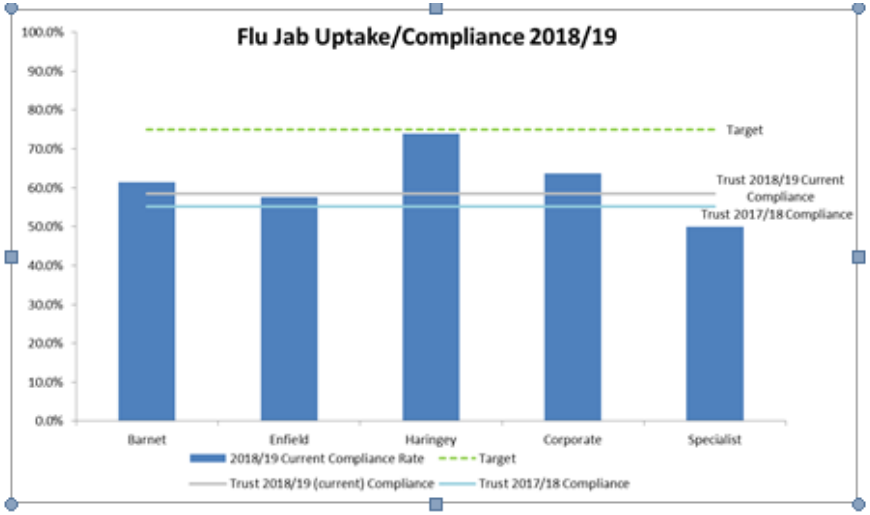
Environmental Cleanliness Audit 2018/19

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



Flu Vaccine Uptake and Compliance 2018/19

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



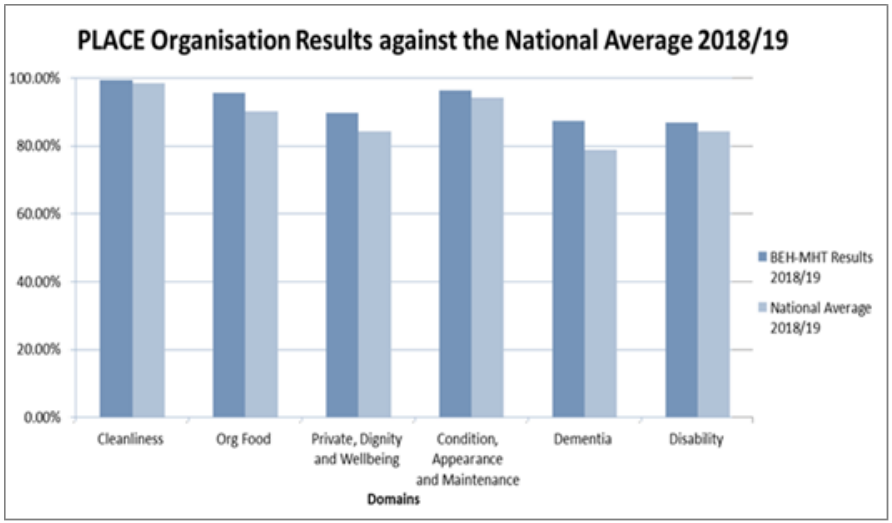
Patient-led Assessment of the Care Environment (PLACE)

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

The six domains assessed are:

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

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


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

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Staff Experience

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

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

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

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

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

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

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

2018 NHS Staff Survey

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

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

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

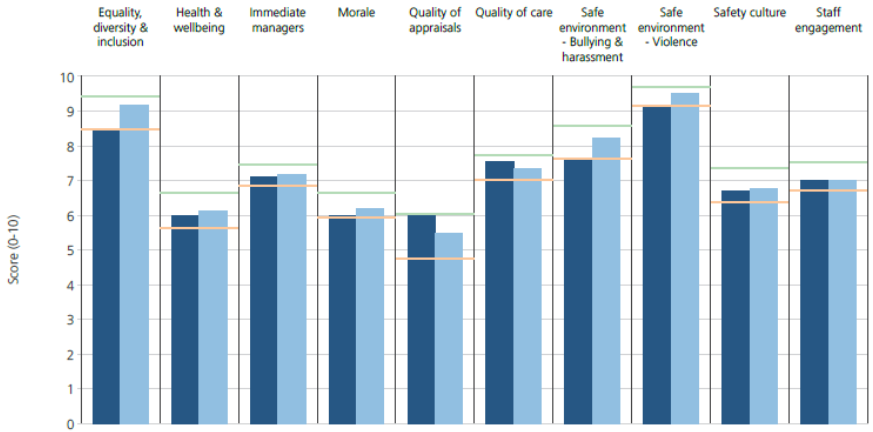
Staff survey 2018

Completed questionnaires **1,346**

2018 response rate **44%**

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

BEH Staff Survey Results 2018, comparison with similar Trusts



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

Examples of positive results from our staff survey:

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

Areas we need to improve on:

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

Staff mandatory training

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

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

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

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

Staff Appraisals

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

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

Part 3

Looking Forward: Quality Priorities for 2019/20

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

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

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

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

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

Quality Priorities for 2019/20

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

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

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

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

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

Our priority is to:

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

Reducing restrictive practices – priorities to be agreed

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

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

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

Barnet

Enfield

Haringey

Specialist Services

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

Statements from Healthwatch Barnet, Enfield and Haringey

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

Statement of Director’s responsibility

Limited Assurance report

Glossary to be updated upon completion

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

How to provide feedback

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

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

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

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