# TRUST BOARD MEETING IN PUBLIC (Part 1)

To be held on Thursday 23 May 2019, 9.00 – 12.00,
Lecture Theatre, St Ann’s Hospital, St Ann’s Road, London N15 3TH

## A G E N D A

<table>
<thead>
<tr>
<th>Item no</th>
<th>Item</th>
<th>Purpose</th>
<th>Page number</th>
<th>Lead</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>PATIENT FOCUS</strong></td>
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</tr>
<tr>
<td>1.</td>
<td>Presentation from the Trust’s Community Home Assessment Team (CHAT)</td>
<td>Learning</td>
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<td></td>
<td>9.00 – 9.20</td>
</tr>
<tr>
<td>2.</td>
<td>Welcome and apologies for absence</td>
<td>Noting</td>
<td>Verbal</td>
<td>Mark Lam</td>
<td>9.20</td>
</tr>
<tr>
<td>3.</td>
<td>Declaration of interests (to note the register and declare any conflict of interests on items on the agenda)</td>
<td>Noting</td>
<td>3 - 4</td>
<td>Mark Lam</td>
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</tr>
<tr>
<td>4.</td>
<td>Minutes of the previous meeting held on 25 March 2019</td>
<td>Approval</td>
<td>5 - 20</td>
<td>Mark Lam</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Action Log and matters arising from the minutes</td>
<td>Noting</td>
<td>21</td>
<td>Mark Lam</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Chairman’s report</td>
<td>Noting</td>
<td>Verbal</td>
<td>Mark Lam</td>
<td>9.25</td>
</tr>
<tr>
<td>7.</td>
<td>Chief Executive’s report</td>
<td>Noting</td>
<td>23 - 26</td>
<td>Jinjer Kandola</td>
<td>9.35</td>
</tr>
<tr>
<td></td>
<td><strong>QUALITY AND PATIENT SAFETY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Safe staffing levels</td>
<td>Assurance</td>
<td>41 - 52</td>
<td>Amanda Pithouse</td>
<td>10.00</td>
</tr>
<tr>
<td>10.</td>
<td>Inpatient nurse staffing and skill mix report</td>
<td>Assurance</td>
<td>53 - 70</td>
<td>Amanda Pithouse</td>
<td>10.15</td>
</tr>
<tr>
<td></td>
<td><strong>STRATEGY AND PLANNING</strong></td>
<td></td>
<td></td>
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<td></td>
<td>No items at this meeting</td>
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<td></td>
<td><strong>OPERATIONAL, PERFORMANCE AND WORKFORCE</strong></td>
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<td></td>
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<tr>
<td>11.</td>
<td>Integrated Performance Report</td>
<td>Noting</td>
<td>71 - 86</td>
<td>Stanley Riseborough</td>
<td>10.25</td>
</tr>
<tr>
<td>13.</td>
<td>Workforce update</td>
<td>Noting</td>
<td>97 - 102</td>
<td>Jackie Stephen</td>
<td>10.50</td>
</tr>
</tbody>
</table>
## GOVERNANCE AND REGULATORY

<table>
<thead>
<tr>
<th></th>
<th>Draft Quality Account 2018/19</th>
<th>Approval</th>
<th>103-194</th>
<th>Amanda Pithouse</th>
<th>11.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Board Assurance Framework</td>
<td>Assurance</td>
<td>195-216</td>
<td>Andrew Wright</td>
<td>11.15</td>
</tr>
<tr>
<td>15</td>
<td>Summary Report on Corporate Risk Register</td>
<td>Assurance</td>
<td>217-224</td>
<td>Amanda Pithouse</td>
<td>11.20</td>
</tr>
<tr>
<td>17</td>
<td>Mental Health Act Annual Report</td>
<td>Approval</td>
<td>244-257</td>
<td>Amanda Pithouse</td>
<td>11.40</td>
</tr>
<tr>
<td>18</td>
<td>ANY OTHER URGENT BUSINESS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>QUESTIONS FROM THE PUBLIC</td>
<td></td>
<td></td>
<td></td>
<td>11.55</td>
</tr>
<tr>
<td>20</td>
<td>DATE OF NEXT MEETING</td>
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**Exclusion of the Press and the Public**

To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).
# BOARD OF DIRECTORS’ REGISTER OF INTERESTS

<table>
<thead>
<tr>
<th>Board Member:</th>
<th>Interest Declared:</th>
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| Mark Lam     | • Non-Executive Director, Social Work England  
| Trust Chairman | • Non-Executive Director, Airedale NHS Foundation Trust.  
|               | • Private business consultant  
|               | • Former Chief Technology and Information Officer, Openreach, a BT Group business |
| Jonathan Bindman | • Unpaid adviser to Raphael, a Jewish counselling service based in Barnet.  
| Medical Director | • Wife’s interests are:  
|               | o Works as a GP currently working at St Stephens Health Centre, Bow  
|               | o Independent Clinical Adviser for Out of Hours Primary Care Service, City and Hackney CCG  
|               | o GP Clinical Lead for Medicines Optimisation at Tower Hamlets Clinical Commissioning Group  
|               | o Chair of the North East London Faculty Board of the Royal College of General Practitioners |
| Neil Brimblecombe | • Member of Thrive London, Suicide Prevention Reference Group since 2016  
| Non-Executive Director | • Member of London Review of Mental Health Bed Based Care Steering Group  
|               | • Professor of Mental Health, London South Bank University – Role to develop research programmes and collaborative links between LSBU and other organisations (one day per week)  
|               | • Clinical Lead Mental Health, London Urgent and Emergency Care collaborative, Healthy London Partnership – supporting NHS services to deliver care in ways that reduced pressure on urgent and emergency capacity (four sessions per month – equivalent to two days)  
|               | • Chair, Policy and Practice Committee, Mental Health Nurse Academics UK |
| Cedi Frederick | • Owner of Article Consulting Ltd, a health and social care consultancy (not currently working with the NHS).  
| Non-Executive Director | • Owner/Chief Executive Officer of La Nova Group, which delivers events, programmes and experiences which optimises health, wellbeing and personal performance.  
|               | • Board member of CommonAge, a Not for Profit organisation established to promote positive aging across the Commonwealth.  
<p>|               | • Board Member of Basketball England (Governing Body of Basketball) |
| David Griffiths | • Wife is Director of Finance at East Suffolk and North Essex NHS Foundation Trust. |
| Chief Finance and Investment Officer |</p>
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<tr>
<th>Board Member:</th>
<th>Interest Declared:</th>
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| Catherine Jervis             | • Non Executive Director for First Community Health and Care, a not for profit company (social enterprise) which provides community health services (primarily to the NHS) in East Surrey. Registered in England No: 07711859.  
• Non Executive Director for Achieving for Children, Community Interest Company Registered in England and Wales as a Private Limited Company, Registration Number 08878185.  
• Non-Executive Director for the Independent Office for Police Conduct.  
• Non-Executive Director, Hillingdon Hospital NHS Foundation Trust                                                                                                                                                                                                                     |
| Jinjer Kandola                | • None                                                                                                                                                                                                                                                                                                                                            |
| Amanda Pithouse              | • None                                                                                                                                                                                                                                                                                                                                            |
| Stanley Riseborough          | • Owner and Director of SHR Health consulting – small consulting company  
• Wife works for Sussex Partnership NHS Trust                                                                                                                                                                                                                                                                                                    |
| Paul Ryb                     | • Managing Director, The BIGilittle Co. Ltd.  
• Non-Executive Director of SpareRyb Global Alliance Ltd.  
• Co-Owner Anytime Fitness Mill Hill 24/hour Gym, North London  
• Trustee for The Macular Society  
• Finance Committee member for the Thomas Pocklington Trust                                                                                                                                                                                                                                                                                   |
| Ruchi Singh                  | • Director, Kaleidoscope Transformations Ltd, a strategy consulting company                                                                                                                                                                                                                                                                        |
| Jackie Stephen               | • None                                                                                                                                                                                                                                                                                                                                            |
| Charles Waddicor             | • Director / Owner of SAMRO health and social care solutions  
• Chair / Trustee of The Primary Care Respiratory Society UK  
• Small shareholding in Ventura Group  
• Chair of a Board, operated by Social Finance, overseeing projects running in Haringey, Tower Hamlets, and Staffordshire, supporting people with mental health problems into employment  
• Chair of Herefordshire and Worcestershire Sustainability and Transformation Partnership                                                                                                                                                                                                      |
DRAFT
Minutes of the Board Meeting held on Monday, 25 March 2019 in the Lecture Theatre, St Ann’s Hospital, St Ann’s Road, London, N15 3TH

Present:
Mark Lam Trust Chairman
Jinjer Kandola Chief Executive
Dr Jonathan Bindman Medical Director
Neil Brimblecombe Non-Executive Director
Cedi Frederick Non-Executive Director
David Griffiths Chief Finance and Investment Officer
Catherine Jervis Non-Executive Director
Amanda Pithouse Executive Director of Nursing, Quality and Governance
Paul Ryb Non-Executive Director
Stanley Riseborough Interim Chief Operating Officer
Ruchi Singh Non-Executive Director
Jackie Stephen Executive Director of Workforce and OD
Charles Waddicor Non-Executive Director

In attendance:
Ellie Coulbeck Patient Experience Lead (for Patient Focus presentation)
Jenny Service User (for Patient Focus presentation)
Christopher George CQC (observing)
Soraya Boloorsaz-Mashadi Deloitte (observing)
Katia Louka Trust Board Secretary (minutes)

9 members of the public and staff attended

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Minute Item</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patient Focus Presentation – Patient Experience</td>
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Ellie Coulbeck introduced the presentation. The Trust had recently held a series of Roadshows where staff and service users had provided their views on priorities in setting the Trust’s strategic direction and the new Trust Strategy. It was important for service users to have a voice in such discussions and she introduced Jenny, who would provide an overview of the overarching themes.

Service Users had provided views on the positive things about the Trust. This included:
- The importance of individualised personal care based on service user needs.
- The dedication of staff who were keen to go the extra mile.
- Services that learnt from the experience of complaints and incidents and were responsive
- Co-production and peer working

Areas that could benefit from changes were:
- More holistic joined up care with housing and social care
- Shorter waiting times
- Being able to access the right services at the right time
- Improving staff understanding that life goes beyond diagnosis
- The need for young people in crisis to access services
- Stronger connections to the community to make the Trust more visible
- Increased communications from staff to patients and carers
- Improvements in inpatient food

The final question posed was what would make a really great Trust from a service user perspective:
- Increased working opportunities such as co-designed services in the Trust
- Tailored responses when contacting crisis teams
- Recruitment and retention of staff
- The importance of staff helping patients to recover
- Service users had also highlighted the need for robust and greater sharing of information so that they did not have to repeat their stories to different services.
- More integrated care including a joined up system with GPs linked to electronic systems
- More garden spaces for inpatients

Jenny said she had attended the Haringey roadshow and had volunteered to support the Patient Experience Team to pull together and identify key priorities. These will be considered with the Trust’s Strategy in going forward.

Mark Lam thanked Jenny for sharing her experiences and delivering a powerful message to the Board.

In response to a question from Neil Brimblecombe, Jenny said that around 30 service users had attended the Haringey roadshow, however further responses were captured from face to face meetings, online surveys and feedback forms.

Paul Ryb referred to the views about reaching out to the community and how peer support as a strategy could be better used. He asked whether using social media could take this to the next level. Jenny replied that there was better use of social media within the Trust and she knew more about what was going on in the Trust through her use of social media. She agreed that peer support would be helpful. She had considered becoming a peer supporter and was working with Ellie Coulbeck and involved in activities within the Patient Experience Team.

Chares Waddicor asked whether Jenny would stay involved to ensure that the Trust delivered on these issues and she confirmed that she would.

Ruchi Singh referred to the comments about CAMHS and asked if there was a good proportion of young people represented at the roadshows. Jenny said that there were around 30 per cent represented through relatives, however the feedback had been captured anonymously.

JK said that there had been strong messages coming across from young people regarding food such as catering for different age groups and for different cultures. These messages had also been highlighted in the patient surveys.

In summary, Mark Lam, as Chair, thanked both Ellie Coulbeck and Jenny attending the meeting. This was a great initiative driven through the roadshows and presented a great opportunity to get messages out.

Jinjer Kandola added that the Trust had a commitment to act on these issues and
further reinforced that the more the Trust engaged with its service users the better feedback it received.

1. **General Business**

1.1 **Chairman’s Welcome**
The Chairman welcoming staff and members of the public to the meeting of the Trust Board.

1.2 **Apologies for Absence**
No apologies of absence were received.

1.3 **Declarations of Interest and Declarations of any Conflicts of Interest**

David Griffiths reported that his declarations had been omitted from the current Register of Interests. He confirmed that there were no changes to his existing declaration that his wife was a senior manager at North Essex Foundation Trust.

Mark Lam stated that he would be stepping down from his non-executive directorship at Barking Havering and Redbridge NHS Trust at the end of March and from Airedale Foundation Trust at the end of May.

Ruchi Singh confirmed she no longer had an interest to declare at the Ministry of Housing and was no longer providing advisory support to the Department of Works and Pensions.

The Trust Board agreed to note:
1. That there were no conflicts of interest declared in relation to items on the agenda.
2. The Board of Directors Interests would be updated for the next meeting.

1.4 **Minutes of the Meeting held on 28 January 2019**
The Trust Board confirmed the minutes of the last meeting as a true record subject to the following amendment:

Page 7 – The wording “external provision required to support the work on the Workforce Strategy” to be changed from Workforce Strategy to the OD Strategy.

1.5 **Actions and Matters Arising from the Minutes**

Min ute 3.1- Jonathan Bindman confirmed that data presented in the Clinical Quality and Safety Report did not include deaths in prisons involving patients under the care of the Trust. These were not reported on StEIS. 24-hour reports of deaths in custody were received by the forensic service. All prisons actively report this data but the reporting line is not through the Trust.

Charles Waddicor queried how the Board was sighted on any such incidents. Jonathan Bindman clarified these were discussed at the Serious Incident Review Group within the North London Forensic Service as well as the Trust wide SI group.

Mark Lam said that it was important that the Board discussed learning from serious incidents. He emphasised the importance of learning from deaths and the need for assurance that the Trust had acted upon these through more frequent reporting. Jonathan Bindman responded that he and Amanda Pithouse had discussed the need to triangulate reports to the Board at least three times a year.

Charles Waddicor said it was necessary to distinguish data from prisons. Jinjer
Kandola said this was a complex issue and as the lead provider of prison mental health care the Trust took a lead. The Quality and Safety Committee should receive a proposal for reassurance and escalation to the Board if necessary. Therefore this action will be redirected to the Quality and Safety Committee.

Minute 1.4 - It was noted that more information had been provided in the Safe Staffing Report and this action was closed.

Minute 2.1 - The Skill Mix Review report had been considered by the Executive Leadership Team and had required more work on the financial modelling. This work was in progress and the report would be reviewed at the Quality and Safety Committee in May before being presented to the Trust Board.

The Trust Board noted the written update on the actions arising from the minutes.

1.7 Chairman’s Report

Mark Lam reported that the agenda had more key decisions on strategy and planning than usual due to the end of year financial reporting. This changed the balance of the Board discussion however he reminded the Board that patient safety and staff issues were still paramount to the discussions.

Since the last meeting he had attended many stakeholder meetings. The publication of the NHS 10 Year Plan had been discussed in many of these forums. There had been clear signals from the North Central London sector that integrated care systems would be key in the way forward. The Trust was keen to play a lead part in these discussions and maintain good relationships with its partners.

Mark Lam said that he had spent more time visiting services on different sites since the last Board meeting and had shadowed teams in the community. He remained incredibly impressed with the dedication and warmth of staff.

The Trust Board agreed to note the Chairman’s verbal report.

1.8 Chief Executive’s Report

Jinjer Kandola presented the Chief Executive’s report and highlighted the key points:

Recent changes had been made within NHS England (NHSE) and NHS Improvement (NHSI) as outlined in the report. In addition the new joint organisation had announced the appointment of Simon Stevens as the Chief Executive.

The Trust was delighted that Project Future had been shortlisted for HSJ awards in three categories and was keen to support them for their work with the Police and other partners such as Haringey Council and the charity, MIND.

The Trust had hosted a series of internal events including the BAME forum chaired by Jinjer Kandola. The forum was open to all staff and the first meeting had generated 10 actions that they felt could improve equality in the Trust.

Jinjer Kandola thanked Nina Van Markwijk, Deputy Director of Finance for setting up the BEH Women’s Network. This was launched on International Women’s Day and had discussed issues on gender and supporting women in the workplace.

Paul Ryb referred to item 6 in the report on engagement with stakeholders to forge stronger relationships and said he was keen that something of substance would
emerge from these meetings. Jinjer Kandola responded that there were a number of key work streams and she would be meeting with John Wardell, from Enfield CCG about the next stages and how to support partnership working.

Cedi Frederick referred to the new Equality and Diversity forums and the relationship with other Committees. Jinjer Kandola said that the Trust had established the architecture so that individuals on the front line could have a voice if they were interested in BAME issues. Upward reporting would be through the People and Culture Committee as well as more regular reporting to the Board.

Cedi Frederick said that the Board should do more to challenge and hold to account in terms of contribution and outcomes with colleagues around the Trust rather than have arms-length contact. He welcomed the challenge that the new Board Committee and Forum would bring.

Catherine Jervis said that she had attended an STP group consisting of Audit Chairs from the North Central London providers. There had been a very positive discussion around strategic directions and aspirations which were beginning to resonate and receive support.

The Trust Board agreed to note the Chief Executive's report on recent Trust matters since the last Trust Board meeting.

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<tr>
<th>2. For Discussion and Decision</th>
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<td><strong>2.1 Trust Annual Plans for 2019/20</strong></td>
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Jinjer Kandola presented the Trust’s Annual Plan for 2019/20. It set out the Trust’s corporate objectives for the year ahead. This was a new approach within the Trust that would set the key priorities and enablers to facilitate the delivery of the first year of the Trust Strategy. It will provide a clear line of sight on the priorities at corporate level and how these were translated down to ward level.

In formulating the key priorities, Jinjer Kandola said that the Executive Leadership Team had set five key areas of focus to address underlying issues within the organisation. These were:

- Ensuring that clinical services and the care and treatment of individuals focused on brilliant basics
- Strengthening borough leadership
- Focussing on staff experience to make the patient experience even better
- Strengthening governance processes
- Progressing the transformation programme

Paul Ryb said that this was a very clear and concise approach. He referred to the earlier presentation about empowering staff in digital transformation and social media. He was mindful that there were gaps in IT and communications and felt that these were not included in the commentary or being used to the best advantage.

Jinjer Kandola said that there was a need to connect with patients but not specifically included within corporate priorities. She would be happy to discuss this with the team further.

Cedi Frederick said that he was pleased to see references to “Team BEH” over the last few months on social media and that it was good to engage on a grass roots level to encourage staff and provide them with the opportunity to be part of one organisation.

Jonathan Bindman said it would be helpful to look at the clinical strategy and review this in light of the Trust’s strategy once it was signed off.
Catherine Jervis said that it was positive to discuss the Annual Plan together and welcomed the rigour around this. It would be interesting to see how the strategy was addressed over the next couple of months and it was very positive to see the long term vision translating into medium term as this was important for purposeful activity.

Jinjer Kandola said the next stage would be to think about the outcomes. There would be more scrutiny by Board Committees to provide assurance to the Board.

Charles Waddicor acknowledged the challenges ahead and asked if there was a role for Non Executives in this. Jinjer Kandola said that the focus on integrated care systems would require more NED involvement.

Cedi Frederick said he welcomed the reference to strengthening leadership. He advised caution in embedding a cultural change as this would be very difficult to achieve in the first year but welcomed the tone and commitment to this.

Jinjer Kandola said that the Board would be discussing the OD Strategy at its meeting in July which included developing and nurturing the culture of the organisation. However she pointed out that cultural changes took five years to take effect.

Cedi Frederick said that he would like to see more in the strategy around community engagement. Jinjer Kandola acknowledged this and would take this on board.

Ruchi Singh said that community engagement would make a difference and a clear set of priorities was necessary. She was interested to know how this would be managed when there were other things that came to the fore.

Jinjer Kandola said that this was building in flight. The year 1 priorities would be the foundation and there were some initiatives such as “brilliant basics” which were a priority. The Board would be provided with regular quarterly updates.

In summary, Mark Lam as Chair said this was the first time this approach was being taken and it was important for the Board to recognise that this was a challenge. He welcomed the exchange and feedback and was happy to approve the plan and proceed to the next stage.

**The Board agreed to approve the Trust Annual Plan for 2019/20.**

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<th>2.2 Patient Safety Report</th>
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<td>Jonathan Bindman presented the Patient Safety report. It had previously been agreed that the former Medical Directors report and the Clinical Quality and Safety report be reformatted to address the need to present data to the Board on Learning from Deaths as well as summary information on all serious incidents reported on StEIS.</td>
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<td>In response to a query on the breakdown of data, Jonathan Bindman said that the data could be further broken down into expected and unexpected deaths.</td>
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<td>Neil Brimblecombe said he was interested seeing the thinking on long term deterioration and where it may have made a difference.</td>
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<td>Mark Lam added that the Board required assurance on methodology and what was an expected or unexpected death. He would like more Board time spent on having</td>
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assurance on the integrity such as at a board workshop as this was a technical area.

Charles Waddicor said it would be useful to see if there were any clusters such as where deaths were occurring even if they were not avoidable.

Jinjer Kandola said that it would be useful to have a deep dive discussion around this at a Quality and Safety Committee meeting and bring back to the Board.

David Griffiths said that there were no equality and diversity implications and whether it was possible to track these. Jonathan Bindman stressed that this report was about deaths under the care of the Trust and not representative of the population as patients were over-represented in these areas.

Jonathan Bindman said that the data presented was in response to the Learning from Deaths agenda and was not intended to look at trends and themes. He reported that since the last Board meeting three serious incidents had been reported, one of which would be discussed in Part 2 of the meeting.

With regard to the serious incident regarding an assault on a member of staff he said that as a consequence of this and a number of other recent incidents of staff assaults, Amanda Pithouse was working with staff across the Trust to share practices and develop guidelines for supporting staff and make sure that action was being taken.

In summary Mark Lam, as Chair, requested that:
1. The Board spend more time on deep dive on methodology and process around safety measures.
2. The Quality and Safety Committee have an annual review of all incidents in detail to assure the Board.

The Trust Board agreed to note the report and the action.

### 2.3 Workforce Strategy

Jackie Stephen introduced the draft Workforce Strategy which set out the direction for the development of the workforce for the next three years and outlined a prioritised action plan for 2019/20. It recognised national priorities such as the NHS Long Term Plan and on a more local level the priorities set out in the Trust Strategy.

She drew attention to the high level activity plans set out during the year around the following themes:
- Attract and Select
- Develop and Deploy
- Support and Wellbeing
- Engage and Retain
- Expertise, Innovation and Best Practice

The proposed establishment of the People and Culture Committee would enable the Trust to focus on delivering these activities.

Paul Ryb said he was concerned about the commentary on pathways and the time taken to formulate it. He asked whether there were any barriers to this and was mindful that the Trust should not wait too long to develop this and what was being done to utilise pathways. He asked whether this was due to lack of confidence or any impediments that staff felt in putting themselves forward.
Jackie Stephen agreed and whilst there were no formal pathways these would be publicised to help people be more creative. Locally the Workforce department were working very hard on flexibility but this needed to be developed further in a more structured way.

Amanda Pithouse referred to the nursing career pathway. Conversations across the North London sector had started on this however some of the challenges were around funding.

Neil Brimblecombe noted the action on retaining staff but queried whether the strategy was radical enough to attract new recruits and he wondered how the Trust was going to respond to this as all organisations were getting better at recruiting staff. Jackie Stephen said the Trust would have to look at MDTs and where staff were working to the top of their registrations and to have more radical and challenging conversations around this.

Cedi Frederick queried what was different when comparing this strategy to past ones. He acknowledged the need to work with other partners, but not at the expense of staff leaving to go to another organisation. He suggested that the Trust should go outside the NHS and look at other sectors to bring in new and fresh ideas, however he recognised that this would be a challenge.

It was queried whether the Trust analysed reasons when staff left the Trust. Jackie Stephen responded that it tended to be a mixture of staff going to another Trust, going outside of the NHS or doing something different. The challenges were that the Trust was located just outside inner London where pay scales were higher.

Jackie Stephen said that the age profile needed to be tackled urgently with more flexibility at the end of careers. Another issue was that there could be four generations working within one organisation and one size did not fit all. Young people were more prone to leaving the organisation early.

In summary, Mark Lam as Chair, said he welcomed the fact that this was the first Workforce Strategy for a number of years however it required further work. He had picked up from the discussion that there was an appetite to do something more radical that would make a difference.

Jinjer Kandola said she welcomed the systematic approach to workforce. It had focused on important areas such as attracting and selecting the best staff. It was important to engage and retain those individuals once they were in the organisation. More staff left because of experiences with line managers. She highlighted page 42 and the fours strands on which the Trust will be delivering its strategy.

The Trust Board reviewed and endorsed the strategy and the prioritised actions for year one, and acknowledged that it would be monitored through the People and Culture Committee which was in the stages of being set up.

### 2.4 2018 Staff Survey Analysis

Jackie Stephen introduced the analysis of the staff survey results. In summary the results had been disappointing and did not reflect where the Trust wanted to be as an organisation. Despite interventions deployed by the Trust, these had not resulted in significant change from previous years and it was proposed to focus on a small number of key areas to facilitate greater impact and sustainability of change.

The following themes were highlighted:
- Continued high level of bullying and harassment experienced by staff
- High levels of perceived unfair treatment regarding career progression/promotion.
- Low perceived focus on staff wellbeing.
- Low advocacy of BEH as a place to receive treatment or to work.

In response to a query on whether there had been an analysis of responses made, Jackie Stephen said that there had been discussions within focus groups and team meetings on a wide range of issues and it was difficult to pin this down as no root cause had been identified as to why the results were not improving.

Cedi Frederick said that this was an organisational issue and changing perceptions would take a long time especially when working with the same managers as the previous years. Trust and understanding between managers was needed to motivate staff as it was clear they were not engaged in these conversations.

Jinjer Kandola commented that as a fresh pair of eyes she had seen limited improvement in the last five years and therefore a more radical approach was needed to address these issues.

She referred to the table on page 66 regarding workplace culture and highlighted that the managers had the greatest span of influence on developing the staff experience. The focus should be on developing Managers especially those at Band 7 to focus on leading their teams.

Cedi Frederick said that there should also be a focus on teams not just managers.

In summary, Mark Lam, as Chair said it was disappointing that the organisation had not materially improved around this for several years. He agreed that it was necessary to do something radically different and report back to the People and Culture Committee instead of waiting for next year’s survey to see if there was any improvement.

The Trust Board agreed the approach of focusing on the themed areas, combined with parallel action planning at corporate and divisional levels using a range of for a to give staff opportunities to contribute actionable suggestions to improve working life in the Trust.

2.5 Quality Improvement Strategy

Jinjer Kandola introduced the report. The Trust had been working towards quality improvement as a priority in the Trust and was now working to develop a QI Strategy. Richard Milner, Director of Improvement was leading this work.

This was a three-year strategy which focused on the development of the Trust’s capabilities and change in culture as well as noting those strategic priorities that would be delivered in 2019/20.

Years 1 and 2 were collaborative projects with a clear delivery around patient focus outcomes, empowering staff and ensuring that teams were best placed to deliver solutions.

There had been significant investment in QI and this had been based on internal resources and capacity of staff but also recognising that external organisations could provide additional support and expertise.

Neil Brimblecombe said that Communications aspect was referred to but needed to be further expanded.
Charles Waddicor said he welcomed the report and that there should be more emphasis on staff who could not access the intranet such as those working in prisons.

Jonathan Bindman referred to the three half day workshops and queried whether this was adequate to understand the methodology. Richard Milner said that this was based on the initial proposal received.

In response to a query about underpinning Trust values, Amanda Pithouse said that the Trust was very much at the start of this process and it was work in progress. She said some organisations had taken five years to embed QI into their culture.

Catherine Jervis said it was not a dis-service in describing where we are on this journey. It was a very important milestone and must not miss out what we have gained from current activities.

In summary Mark Lam, as Chair, said that the strategy included what the Trust was focussing on, however it needed to be simplified and communicated in a way that all staff were fully engaged and on board. He welcomed the feedback and suggestions made.

The Trust Board agreed the Quality Improvement Strategy.

<table>
<thead>
<tr>
<th>2.6</th>
<th>Revenue Budget Approval 2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Griffiths introduced the report. This was the first time in the last four years that a balanced budget had been set at the start of the new financial year, however it had not been without its challenges. The plan aimed to break even for a number of years. The Executive Leadership Team and the Finance and Investment Committee had reviewed the plan prior to Board approval.</td>
<td></td>
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<tr>
<td>He highlighted the key financial risks within the proposed financial plan which included:</td>
<td></td>
</tr>
<tr>
<td>• Disappointing progress in the delivery of the CIPs, and the Trust was starting the new financial year with a higher percentage of unidentified CIPs than in the past.</td>
<td></td>
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<tr>
<td>• Management of agency expenditure</td>
<td></td>
</tr>
<tr>
<td>• Resolution of the Enfield Universal Children’s Services contract for 2019/20</td>
<td></td>
</tr>
<tr>
<td>• Any impact arising from the Director of Nursing, Quality and Governance’s review of ward staffing levels.</td>
<td></td>
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<tr>
<td>To mitigate against the risks the plan included a contingency reserve. In addition the existing controls would continue to be operated rigorously with regular monitoring of the CIP and overall financial performance.</td>
<td></td>
</tr>
<tr>
<td>Charles Waddicor highlighted that out of area placements had been capped at 14 beds and hoped that the measures in place would deliver this however he thought that this was still a risk. He added that the Trust should celebrate the fact that after four years a balanced budget had been set and the medium term measures in place had helped this.</td>
<td></td>
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<tr>
<td>Mark Lam agreed that the break-even position was a significant milestone and asked whether it would have any undue impact on patient quality and safety.</td>
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<tr>
<td>David Griffiths responded that the Trust had set a lower target for CIPs than in previous years. Quality impact assessments had been signed off by the Medical Director and Director of Nursing, Quality and Governance. However the impact of</td>
<td></td>
</tr>
</tbody>
</table>
mobility was still a key issue.

Stanley Riseborough added that quality impact assessments were associated with the deployment of the Mobility programme and that the service changes being made would provide an opportunity to improve these.

Catherine Jervis referred to the audit report on CIPs which was discussed at the March Audit Committee meeting. She said that there was mitigation of the risk to quality and had provided a small number of mitigations around transformation of processes. It was to be discussed at the Quality and Safety Committee to build in more robustness around managing these.

In summary Mark Lam, as Chair, said he was satisfied with the diligence and questions posed around the impact of risk and on this basis proposed to approve the revenue budget for 2019/20 as long as the Trust was clear that there would be no compromise on patient safety.

The Trust Board agreed to:
- approve the Trust’s budget for 2019/20 and
- noted that the final plan submission to NHS Improvement was due on 4 April 2019 and delegated authority to the Chief Executive and Chief Finance and Investment Officer to make the final submission subject to there being no material change to the assumptions described in the report.

### 2.7 Capital Investment Programme

David Griffiths presented the Capital Programme for 2019/20. The draft programme was reviewed by the Finance and Investment Committee at its meeting on 18 March and had recommended it for approval by the Board.

The Finance and Investment Committee had raised one issue for the Board to consider. The Capital Programme sought permission to utilise £1.4m of the £4.8m unallocated capital receipt remaining from the sale of St Ann’s site to fund the refurbishment of Eden Ward, a low secure mental health ward which had been identified as high priority. This decision was dependant on agreement with NHSI to increase the Capital Resource Limit by £1.4m as capital funding within the NHS was highly restrained. At the meeting on 18 March the F&I Committee requested the Executive Leadership Team to review the Capital Programme to identify what further works could be deferred, should NHSI not agree to increase the Capital Resource Limit by £1.4m. This was to be considered at the next Capital Review Group in April.

Catherine Jervis queried whether there was a significant amount of backlog maintenance projects. David Griffiths said that there is a significant number of projects but did not have the detailed information to hand and agreed to circulate details to provide assurance to the Board.

The Trust Board agreed to approve the proposed Capital Programme for 2019/20.

### 3. Assurance

#### 3.1 Board Assurance Framework (BAF)

Katia Louka presented the latest version of the Board Assurance Framework. The BAF was being revised to reflect the new Trust corporate objectives for 2019/20 to be agreed by the Board.
The revised BAF would also reflect the outputs of the current review of the Trust’s corporate governance processes as well as aligning it with the Corporate Risk Register.

In summary Mark Lam, as Chair, said that the Board accepted the current format and going forward the BAF would reflect the strategic priorities of strong governance arrangements.

**The Trust Board agreed to note the latest Board Assurance Framework and that it will receive an updated report at the next meeting.**

### 3.2 Summary Report on Corporate Risk Register

Amanda Pithouse presented the new version of Risk Register following the transfer of data from the Datix system to Ullyses.

The Risk Register was discussed at the March meeting of the Quality and Safety Committee and lengthy discussions and areas for improvement had been highlighted.

A number of recommendations had been identified to improve the Corporate Risk Register which included aligning it to the Board Assurance Framework so that there was a clearer relationship between the two.

The Trust was working through a number of emergent risks which would be presented to the Executive Leadership Team and the Quality and Safety Committee by May 2019 for discussion and agreement.

David Griffiths referred to paragraph 23 which did not reflect the role of the Audit Committee as they would have oversight of the Risk Register to provide a further assurance measure on the process. The Quality and Safety Committee would continue to oversee each risk and present the Risk Register to the Board.

Catherine Jervis added that the intention was for the Audit Committee to oversee processes and provide comfort to the Board that consideration of risks was taking place in some of the other Committees.

In response to a query about the content and wording of each risk, it was noted that Deloitte were currently undertaking a review of the Corporate Governance processes which included the BAF and Risk Register. Part of the review would be to look at policies and culture and how risks were managed within the Trust. Amanda Pithouse referred to paragraph 1.9 which identified and summarised the high level risks one expected to see on a Corporate Risk Register. These had been raised through various committees.

Stanley Riseborough refereed to risks in the Register which had scored 20 (catastrophic) on pages 152 and 153. and He queried the process of these as the mitigation did not correlate with the risk score. It highlighted that whilst these were high risks on a local level, they had been escalated up in the organisation unnecessarily.

Johnathan Bindman said that both risks had been discussed at the Quality and Safety Committee and these would be reconsidered alongside some of the other risks which were due to teething problems when transferring from one management tool system to another.

**The Trust Board noted the Risk Register and agreed the recommended areas for improvement and timeframe for completion.**
### 3.3 Trust Quality and Performance Report

Stanley Riseborough introduced the report which provided a summary of performance against the NHSI Single Oversight Targets and the Trust’s key performance indicators (KPSs) up to January 2019.

He referred to the last Board meeting and the discussion on the high number of reported cases of pressure ulcers. He had discussed this further with colleagues within the Enfield service and they had confirmed that three cases were within the service, two were receiving terminal care and one was not receiving the care they wanted. There was a continued focus to look through this through the next quarter.

He highlighted the following areas:

The 7 day follow up for patients discharged from inpatient wards continued to be above target. This was pivotal to ease the pressure on inpatient bed flows. Services had done well to bring down out of area placements and these were being tracked through the Finance and Investment Committee.

The improvement in podiatry waiting times continued and this was due to the service nearing completion of recruitment of staff.

IAPT services in Enfield continued to maintain good performance reporting and whilst there was good performance in Barnet IAPT services, the 6-week target had not been met due to the high volume of referrals entering treatment.

Jonathan Bindman referred to NHSI national benchmarking of bed usage across London and all Trusts had shown vacancies except BEH who had out of area placements. He would share this data with colleagues.

Mark Lam said that the Trust’s bed base was based on historical and demographic factors and this needed to be reviewed.

Charles Waddicor said that there was a trend on missing the targets on pressure ulcers and queried what was being done to understand why this was the case.

Stanley Riseborough said that 10 out of the 13 patients admitted were those that were referred to the Trust with pressure ulcers and the Quality and Safety Committee would be receiving a further detailed report for discussion at the next meeting.

Board members referred to the 13 breaches of Section 136 in January and that the target had been missed since last April. Stanley Riseborough commented that this reflected the bed pressures and managing the system of bed flows across urgent care pathway. These were priority areas for the Trust to resolve.

Jinjer Kandola said that a lot of work had been done on delayed transfers of care yet the impact was limited. She said she would welcome a Deep Dive in this area to establish the route cause and this would provide clarity around the S136 suite.

In summary Mark Lam, as Chair, said that whilst bed management had improved over the last six months it was harder to sustain this.

**The Trust Board agreed to note the update on the Trust’s Quality and Performance Report as at January 2019**

### 3.4 Proposed New Version of the Trust Dashboard
Stanley Riseborough reported that following a review of the current dashboard options a workshop had been held in February to discuss a new format for a revised Board report.

The Trust Board had previously asked that the number and format of the reports be reviewed in order to enhance decision making and focus attention on key issues within the Trust. It had been agreed to reduce the current number of 90 KPIs to 49 overarching KPIs. He stressed that any KPIs moved from the Board Dashboard would still be available and would be formally reviewed by their respective Committee. In response to a query about the targets being removed, he said that he and Amanda Pithouse had gone through the list and removed multiple targets and there was assurance that none were removed inadvertently. The new format would consist of core indicators and there was assurance that ones taken out were reported elsewhere.

In summary Mark Lam, as Chair, said that the recommendation was to move forward to a new reporting system which he supported. He asked members of the Board to feedback to Stanley individually on any specific details by 3 April.

Catherine Jervis also agreed with this recommendation and the direction of travel.

The Trust Board agreed the new format of the Trust Dashboard and the first report in this format would be presented to the May Trust Board meeting.

### 3.5 Financial Performance: Month 11 (February 2019)

David Griffiths presented the update on the year to date financial performance. He highlighted the following key messages:

- The I&E deficit was £0.9m better than plan and £1.1m better than NHSI Plan profile.
- The I&E forecast outturn was a deficit of £3.3m and this was in line with the Control Total set by NHSI.
- The key risks to achieving the forecast were the continued use of private beds, the delivery of savings plans and the requirement for further savings with the cost pressure inherited form the Agenda for Change pay award.
- The Cost Improvement Plan (CIP) delivery was £1.0m behind plan year to date, with a forecast outturn of £7.6m.
- Cash balance was £53.1m against a plan of £54.7m. Capital expenditure is £7.7m against a plan of £16.7m year to date.
- The NHSI Single Oversight rating was currently 3 and forecast to stay as a 3 for the rest of the year.

With six days remaining to the end of the financial year, subject to the year-end processes, the Trust was on track to manage all cost pressures.

In summary Mark Lam, as Chair, said this was a welcomed report and thanked the Finance team for their hard work.

The Trust Board agreed to note the year to date financial performance for 2018/19.

### 3.6 Information Governance Annual Report

Stanley Riseborough introduced the Information Governance Annual Report which provided an update to information governance processes. He highlighted the following:

The Data Security and Protection Toolkit (DSPT) had replaced the Information
Governance Toolkit. It enabled organisations to measure performance against the National Data Guardian’s 10 date security standards. The DSPT submission was due on 31 March 2019.

As this was the first submission of its kind, public sector organisations would be able to publish their assessment if they were approaching a level of “standards met” in all but a few areas, accompanied by an improvement plan. The Trust was expected to achieve “Standards Met” with an improvement plan relating to mandatory training compliances and contractual agreements with 3rd party providers.

The Trust had reported a mandatory training compliance of 75% against a target of 90%. The Board discussed how to improve compliance and acknowledged that there were pressures in the system and it was necessary to encourage and support staff to meet their mandatory training requirements. A pilot had been undertaken where teams were asked to peer review other teams and this had proved very helpful.

The Board requested a further report at the July meeting and expected to see a marked improvement.

The Trust Board noted the Annual Report on Information Governance.

### 3.7 Inpatient Safe Staffing Report

Amanda Pithouse presented the exception report on inpatient safe staffing and reported that vacancy rates continued to be variable across the Trust and overall there was a slight increase from 12.8% in December 2018 to 13% in February 2019.

In response to a query on sickness rates having reduced to 2.9%, Jackie Stephen reported that overall sickness rates were under increased management scrutiny including Back to Work interviews taking place.

Stanley Riseborough highlighted that there were three wards which had averaged a sickness rate of 7% and these needed to be monitored as staff sickness rates were an early indicator of impacting on other issues.

In summary Amanda Pithouse said that vacancy rates continued to be a challenge for the Trust in in-patient areas and the Trust was working hard to recruit registered nurses and healthcare assistants in a number of areas, targeting those with the highest vacancy rates first. In the meantime Bank and Agency staff were being used to fill the gaps.

The Trust Board agreed to note the inpatient safe staffing report.

### 4. For Noting

#### 4.1 Trust Preparations for “No Deal” Brexit in seven areas

Stanley Riseborough introduced the report. All NHS organisations had been required to have a plan in place in the event of a “No Brexit” deal. A review had been carried in seven key risk areas and an initial assessment had been made. This was presented in Appendix 1 of the report. So far, no issues of concern had been raised.

The Trust had engaged with European nationals working in the Trust over the last two years giving EU staff the opportunity to share their experiences and ask any questions. There had not been any significant concerns raised other than uncertainties around partners/family situations.
The Trust Board agreed to note the update report.

4. Other Items

5. Any other Urgent Business

There was no other urgent business.

6. Date and Time of Next Meeting

The next meeting will take place on Thursday 23 May 2019 at 9am in the Lecture Theatre, St Ann’s Hospital.

Exclusion of the Press and the Public

The Trust Board resolved that representatives of the press and other Members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).
<table>
<thead>
<tr>
<th>Action Ref No</th>
<th>Minute No</th>
<th>Action</th>
<th>Assigned to</th>
<th>Assigned from</th>
<th>Assigned date</th>
<th>Due date</th>
<th>Status</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB11/18-1</td>
<td>3.1</td>
<td>Clarify whether data presented in the Clinical Quality and Safety Report included deaths in prisons involving patients under the care of the Trust.</td>
<td>Jonathan Bindman</td>
<td>Trust Board</td>
<td>28/11/2018</td>
<td>25/03/2019</td>
<td>Closed</td>
<td>The data did not include deaths in prisons.</td>
</tr>
<tr>
<td>TB01/19-1</td>
<td>1.4</td>
<td>Safe staffing levels - Consider showing the data to indicate the highs and lows by each specialty to make comparisons between wards</td>
<td>Amanda Pithouse/ Jackie Stephen</td>
<td>Trust Board</td>
<td>28/01/2019</td>
<td>25/03/2019</td>
<td>Closed</td>
<td>Completed.</td>
</tr>
<tr>
<td>TB01/19-2</td>
<td>2.1</td>
<td>Safe staffing - Bring skill mix review report to a future board meeting.</td>
<td>Amanda Pithouse</td>
<td>Trust Board</td>
<td>28/01/2019</td>
<td>22/07/2019</td>
<td>Closed</td>
<td>On the agenda.</td>
</tr>
<tr>
<td>TB03/19-1</td>
<td>5</td>
<td>The Quality and Safety Committee to receive a report with data on deaths in prisons involving patients under the care of the Trust (for assurance and if necessary escalation to the board)</td>
<td>Jonathan Bindman</td>
<td>Trust Board</td>
<td>25/03/2019</td>
<td>01/07/2019</td>
<td>Open</td>
<td>Due in July.</td>
</tr>
<tr>
<td>TB03/19-2</td>
<td>2.2</td>
<td>Patient Safety - the board to spend more time on deep dives on methodology and process around safety measures</td>
<td>Jonathan Bindman</td>
<td>Trust Board</td>
<td>25/03/2019</td>
<td>tbc</td>
<td>Open</td>
<td>To be scheduled.</td>
</tr>
<tr>
<td>TB03/19-3</td>
<td>2.2</td>
<td>Patient safety - the Q&amp;S committee to receive an annual review of all incidents</td>
<td>Jonathan Bindman</td>
<td>Trust Board</td>
<td>25/03/2019</td>
<td>tbc</td>
<td>Open</td>
<td>To be scheduled.</td>
</tr>
<tr>
<td>TB03/19-4</td>
<td>2.7</td>
<td>Capital investment programme - Circulate to the Board details of the number of backlog of maintenance projects</td>
<td>David Griffiths</td>
<td>Trust Board</td>
<td>25/03/2019</td>
<td>23/05/2019</td>
<td>Open</td>
<td>To be circulated.</td>
</tr>
<tr>
<td>TB03/19-5</td>
<td>2.8</td>
<td>Information Governance training - update on compliance with mandatory training</td>
<td>Sarah Wilkins/ Jackie Stephen</td>
<td>Trust Board</td>
<td>25/03/2019</td>
<td>22/07/2019</td>
<td>Open</td>
<td>Scheduled in July.</td>
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</table>
# Chief Executive’s Report

**Report to:** Trust Board  
**Date:** 23 May 2019  
**Security Classification:** Public Board Meeting

**Purpose of Report:**  
This is a regular report to the Board, intended to provide an update on recent Trust matters, since the last meeting held on 25 March 2019.

**Recommendations:**  
The Trust Board is asked to note the update on recent Trust matters since the last Trust Board meeting.

**Sponsor:** Jinjer Kandola, Chief Executive  
**Report Author:**  
- **Name:** Georgia Denegri  
- **Title:** Interim Trust Secretary

**Report History:** Regular Report

**Budgetary, Financial / Resource Implications:** No particular matters to highlight

**Equality and Diversity Implications:** No particular matters to highlight

**Links to the Trust’s Objectives, Board Assurance Framework and / or Corporate Risk Register**  
None

**List of Appendices:**  
- None
1. **Introduction**

This report sets out key issues and developments since the last report to the Board on 25 March 2019.

2. **External Update**

The Trust has continued to work closely with our local Clinical Commissioning Groups and local authorities around the development of local Integrated Care Systems, following the series of InterGreat events over the last few months.

On 29 April, the Trust formally announced the proposal to develop a Strategic Alliance with neighbouring Camden and Islington NHS Foundation Trust. This is very similar to the successful mental health provider alliance in South London. The proposed Alliance with Camden and Islington is not a merger; both Trusts will remain distinct organisations with individual authority and control. However, both organisations believe closer collaboration will produce a range of benefits for patients and staff and be a stronger voice for mental health locally.

3. **New Trust Strategy**

The organisation recently published its new Trust Strategy, following approval by the Trust Board at the last Board meeting. This has been widely circulated to staff and external stakeholders. The Strategy is clear, bold and ambitious and sets out the Trust’s vision for the next five years. The Strategy was developed with a wide range of contributions from service users, carers, staff and wider stakeholders. The Strategy provides clarity around the Trust’s future direction and confirms the focus on service users, staff and the wider communities the Trust serves.

4. **Internal Events**

The National Clinical Director for Dementia and Older People's Mental Health, Prof. Alistair Burns, visited the Enfield Care Home Assessment Team (CHAT) in April. The CHAT service is a national example of best practice in dementia care. The Trust Board are receiving a patient focussed presentation from the CHAT Team at this board meeting.

The Trust Board were very pleased to welcome Baroness Claire Taylor of Enfield to meet informally with Board members on 29 April. Baroness Taylor is the Liberal Democrat spokesperson on mental health in the House of Lords and Board members had a very helpful discussion about the provision of mental health services locally and some of the opportunities and challenges ahead.

On 13 May, the Trust welcomed Baroness Dido Harding, NHS Improvement Chair, who visited services at St Ann's Hospital in Haringey with our CEO, Chairman, Mark Lam and Dr Karen Townend, Service Lead for Eating Disorders. She also visited Fairland's Ward and Finsbury Ward.

The Chief Executive led two events on 9 and 17 May for Team Leaders across the Trust. The all-day events focused on developing Team Leaders, recognising their importance to patient care and service delivery. The events covered the new Trust Strategy, our focus on ‘Brilliant Basics’, the Quality Improvement Programme and a range of developmental topics.

The Chief Executive has also visited a number of services across the Trust, including the new PICU Ward (see below), the inpatient wards at St Ann’s Hospital and the Phoenix Unit, the Eating Disorders inpatient ward at St Ann’s Hospital.
5. **Relocation of Psychiatric Intensive Care Ward**

The Trust’s male Psychiatric Intensive Care (PICU) Ward relocated from the Dennis Scott Unit at Edgware Community Hospital in Barnet to much improved facilities in the Chase Building on the Chase Farm Hospital site in Enfield, opening on 2 April. The move allowed significant improvements for patients and staff. Following the move, the new PICU is now known as Devon Ward.

6. **Appointment of Chief Operating Officer**

The Trust has recently appointed Natalie Fox as its new substantive Chief Operating Officer, commencing on 1 July. Natalie will take over from Interim Chief Operating Officer, Stanley Riseborough. Natalie has over 28 years operational experience gained within acute, mental health and community providers as well as the prison service.

7. **Executive Roadshows**

Throughout May and June, a number of Executive Roadshows are being held and will focus on the discussing the new Trust Strategy with staff locally and supporting staff in preparation for the CQC inspection in June / July.

8. **International Nurses Day: Sunday 12 May**

International Nurses Day saw a number of table top stalls set up across the Trust to celebrate this important day and provided an opportunity to share people stories and celebrate nurses.

9. **Mental Health Awareness Week: 13 - 19 May**

The theme for this year was body Image – How we think and feel about our bodies. The Trust’s Mental Health Liaison Team based in the North Middlesex University Hospital organised a stall in the hospital for patients, visitors and staff on Thursday 16 May and the Trust supported a range of initiatives to help promote mental health awareness.

10. **Use of Trust Seal**

Since the last report The Trust Seal has been affixed to the following documents:

<table>
<thead>
<tr>
<th>Seal no.</th>
<th>Description of the document</th>
<th>Date sealed</th>
<th>Names of those attesting Seal</th>
</tr>
</thead>
<tbody>
<tr>
<td>286</td>
<td>Deed of Novation of Contract between BEHMHT and Blenheim CDP, Human Kind Charity in respect of Haringey Integrated Drug Services</td>
<td>5.3.19</td>
<td>David Griffiths and Stanley Riseborough</td>
</tr>
<tr>
<td>287</td>
<td>Deed of Novation of Contract between BEHMHT and Blenheim CDP, Human Kind Charity in respect of Enfield Drug and Alcohol Services</td>
<td>5.3.19</td>
<td>David Griffiths and Stanley Riseborough</td>
</tr>
</tbody>
</table>
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## Overview of the report:
The purpose of this paper is to provide the Board with assurance concerning quality and patient safety issues since the last Board, set in the context of details of a summary of serious incidents and complaints received in 2018/19. The quarterly statutory reporting of trainee medical staffing issues from the Guardian of Safe Working is also included.

## Key issues to bring to the attention of members:
There are clear common themes across SI and complaint investigations, including communication/information sharing, and quality of documentation. The PET and PST continue to promote and strengthen learning from investigations, with the introduction of governance trend analysis reporting and Blue Light Bulletins this quarter.

## Key supporting documents:
None

## Decisions / actions required:
As this is the second combined report, feedback from the Committee would be welcomed to inform subsequent reports.

## Report History:
This report is the first in this format.

## Links to the Trust’s Objectives, Board Assurance Framework and / or Corporate Risk Register
The action taken will help us deliver out trust objectives of:
- Value for Money
- Excellent Care
- Happy staff

## List of Appendices:
- GSWH report
1. **Introduction and Background**

This report updates the Board on the full range of quality and safety information and actions since the last Board. It sets this in the context of a summary of trends and themes arising from the management of serious incidents, complaints, and coroners’ inquests during 2018/19, the full detail of which was discussed at the Quality and Safety Committee on 7th May.

2. **Serious Incidents**

2.1 **Serious Incidents update**

Eleven serious incidents have been reported on StEIS since the last Board (all between 20.3.19-5.5.19). Four of these are deaths possibly due to suicide and all have been reviewed at the Clinical Mortality Review Group (CMRG) and are subject to an SI investigation. A further patient under the care of IAPT was found dead at home and the cause of death is yet to be established.

A patient sustained two fractures to the lower limbs from jumping in front of an underground train, and another sustained a serious head injury after jumping from a bridge and being struck by a car; both incidents are subject to an SI investigation.

A female patient reported the death of her baby in the community; this was established as a still birth but she was unwell and awaiting a Mental Health Act assessment which had been delayed, and the delay is the subject of an investigation together with safeguarding and Local Authority colleagues.

An incident was reported in which a patient receiving palliative care was administered an oral preparation of a sedative medication subcutaneously, which is a ‘never event’ and will be the subject of a Board level panel inquiry (BLPI).

An alleged assault by a patient will also be the subject of a BLPI. In addition, a patient with a persisting eye infection had a surgical enucleation of the eye; this was reported as an SI but de-escalation has been requested by the Medical Director.

2.2 **Blue Light Bulletins**

A new process of ‘blue light bulletins’ has been introduced since the beginning of April. A standard template is used to format immediate learning from incidents of any kind, which is then disseminated to the entire organisation marked as a priority. The information is intended to be simple, clear, and focused on immediate actions, and is suitable for discussion in team meetings.

Three bulletins have been issued in the first 6 weeks of its operation. The first was issued on 5.4.19 and concerned the medication never event described above with simple advice on how to avoid future errors. The second, on 18.4.19 described a fall in incident reporting following the transfer of the reporting system from datix to Ulysses, with advice on using the new system. The third, on 10.5.19, was based on one of the injuries by jumping referred to above, and noted the risks arising when patients are identified as in need of admission to hospital but remain under the care of a CRHT while waiting to be admitted.

2.3 **Safety Huddles**

BEH commenced a corporate Safety Huddle focusing on incidents in November 2018. In March 2019 safety huddles have been rolled out across the organisation and staff in all clinical teams have been asked to establish safety huddles in their areas. Research in this area states that safety huddles are individual to the area and team but must be multidisciplinary and be no longer than 20 minutes in length. They offer an opportunity for multidisciplinary teams to coordinate care, delegate tasks and trouble shoot issues that have arisen in the shift for purpose of collaborating, exchanging
information and bringing awareness to patient safety concerns. They improve communication, foster a sense of empowerment, autonomy and accountability, improve efficiency, quality of information sharing and safety. Lubinensky (2015) found that safety huddles heightened awareness of staff and patient needs throughout shifts and implemented “proactive” huddles prevented patient safety issues and staff concerns and were shown to improve teamwork and safety.

Problems which cannot be resolved locally can be escalated to divisional management, or to the weekly corporate safety huddle. This is chaired weekly by the Executive Director of Nursing Quality and Governance, and reviews real time data on a range of incident types derived from Ulysses, in the form of SPC run charts which allow an evidence based approach to identifying trends and meaningful variation. In addition to data on incidents of self-harm, aggression, rapid tranquillisation, and a number of other patient safety indicators, the executive safety huddle triangulates and discusses a wide range of other issues such as those related to environment or IT which have safety implications, and ensures prompt escalation and resolution.

2.4 Serious Incident Data in 2018/19

Number of incidents

The Quality and Safety Committee received a detailed report in May 2019, covering serious incident, complaint and claims data for the full year 2018/19. A summary of key findings is included here for the attention of the Board.

The total number of serious incidents reported to StEIS in 2018/19 was 51. In comparison, there were 61 reported in 2015/16, 65 reported in 2016/17 and 48 reported in 2017/18. The figures do not appear to indicate any trend. The process of investigation was also described, and it was noted that while 50 of 51 SIs were reported within the 2 day time frame, the Trust continues to struggle to achieve the 60 target for the completion of investigation reports and submission to the Commissioning Support Unit (CSU), and 26 of the 37 reports for 2018/19 which were due by the end of the year were reported after the 60 day period. While most overdue reports are submitted shortly after the due date, at the year-end 6 reports had been overdue for more significant periods, the reasons for which have been discussed with the CSU at our quarterly meetings with them, and escalated within divisions.

Analysis and learning from Serious Incident Investigations

It is important to note the limitations of SI data for analysis. SIs represent a small, highly selected proportion of overall incidents. While they are each of significance for individual patients and services, the small numbers mean that they are not a reliable means of identifying differences between divisions, or trends over time. For this reason, the rates of all incidents reported on Ulysses, divided into subcategories, are now routinely reported at safety huddles in an SPC run chart format, which allows for prompt identification of meaningful trends, which can then be acted on. However, because SIs receive a rigorous analysis based on RCA methodology, useful learning can be identified from the individual cases.

There were 9 investigations of suspected suicides in 2018/19, a decrease in relation to the same period of 2017/18, when 24 were investigated. This is unlikely to reflect a true decrease given data from NCISH over a 10 year period, which shows suicide rates change only by a few per cent each year when rigorously measured over representative populations. None occurred within an inpatient unit though one met national criteria for an ‘inpatient suicide’ in that the subject was on agreed leave from inpatient care.

Of 15 unexpected deaths, 11 were of patients under the care of CMHTs, of which 9 were found unresponsive at their home address. Two occurred on adult inpatient units. In each case patients were found collapsed in communal areas, and resuscitation attempted without success. Resuscitations carried out in our services are all subject to a review process which considers
whether staff were trained and followed correct procedures, and also whether equipment was available and functioning; these reviews are reported by exception via the physical health care committee and learning this year has included the necessity to upgrade heads for oxygen bottles, which has been completed. The general lesson that BLS and ILS training is a practical necessity for all staff, who will encounter collapsed patients in wards and the community, has also been widely disseminated.

One death occurred under the District Nursing Team, whereby a male patient with high blood glucose the previous day had refused to go to hospital. The patient passed away the following evening. The importance of capacity assessments when patients decline treatment was noted by the team. One death occurred under the care of the Eating Disorder Outpatient Team. The patient was reportedly admitted to The Royal Free Hospital and died of a cardiac arrest.

Information governance (IG) incidents investigated as SIs are also reported separately to the Information Commissioner, and are the subject of a separate IG report.

2.5 Learning from Deaths

The total number of deaths of patients under our care in 2018/19 was 495. All were reviewed at the trust CMRG. However, since September 2018 deaths occurring under the Enfield Community Services, which make up the majority of deaths under our care, are reviewed locally by a CMRG which enables learning to be identified locally and changes made; cases are also reviewed by exception at the trust CMRG, and quarterly audits of samples of cases provide additional assurance. To date the principal learning from the new arrangement has been in relation to processes of reporting, but at both CMRGs we also place a strong emphasis on ensuring that the duty of candour is fulfilled, not just in the narrow sense of the formal definition, but also actively seeking assurance that relatives and carers have been involved in care at the end of life. We often receive feedback of positive comments made by relatives and carers about our ECS services in the last days of life, and Ulysses now provides a formal route by which positive comments can be more effectively captured.

No deaths of patients under ECS were reported as SIs in 2018/9, but following CMRG review, 24 deaths occurring under mental health services were reported as SIs and investigated.

The CMRG continues to note a number of deaths which reflect the well understood problem referred to as ‘the stolen years’, in which people with a long history of severe mental illness die of apparently natural causes such as chronic cardiac or respiratory disease in their 50s or 60s, substantially below the normal life expectancy for the general population. We do not subject these to RCA investigation, though we subsequently seek information from coroners or GPs about cause of death, and the coronial process provides a further opportunity to identify cases requiring investigation if the coroner identifies issues which we are not aware of at the time of the CMRG. The learning from these deaths largely relates to the importance of supporting smoking cessation, and of delivering the highest possible quality of physical health care throughout our mental health services and throughout the many years people are under our care. We have a better opportunity to influence people’s physical health in the early years of their care than we do when chronic ill health has become established, as it does in too many cases.

3. Complaints

We received 77 formal complaints in 2018/19, and this continues a sustained falling trend in the numbers (from 211 received in 2015/16, 194 in 2016/17 and 163 in 2017/18). This reflects an increased emphasis over time on the effective use of a staged process in which at stage 1 ‘issues and concerns’ are identified and resolved where possible; complaints may then be regarded as informal, with the agreement of the complainant, and only if unresolved at this stage is a formal complaint investigated. Figure 1 illustrates the working of the staged process, with more issues being resolved in the early stages. The figure also includes members inquiries (from MPs on behalf
of their constituents) which require a formal response to the MP within 10 days, but are otherwise addressed in the same manner as other complaints.

**Figure 1: Complaints by stage, 2018/19**

Thematic analysis of all stages of complaints is carried out and reported in detail to the Quality and Safety Committee. The themes have been broadly consistent across time, area and complaint stages, with the largest categories of complaint being ‘communication’ (39% of formal complaints in 2018/19), and ‘clinical care’ (36%); the remainder fall into a range of categories (each with three or less formal complaints in 2018/9) including access to treatment or medications, loss of property, staff attitude, or assault. Each formal complaint is fed back to teams and individuals involved, and where appropriate, action plans are compiled and shared via quarterly Deep Dives and local governance committees.

Complaints provide an important opportunity for individual reflection and learning, and revalidation and appraisal processes, which are well established for doctors and in development for nurses, provide further assurance of this learning.

All complainants are advised of their right to appeal to the Parliamentary and Health Service Ombudsman (PHSO) within the standard complaints response letter and other information provided. During 2018/19, three formal complaints were escalated via the PHSO for investigation, one of which was upheld. This concerned a service user who raised concerns regarding a delay in assessment of care and support needs, and the PHSO recommended a payment of £1000 to be paid jointly between Trust and the Local Authority.

Trust policy stipulates formal complaints will be acknowledged within three working days, with a Trust benchmark of 100%. This was achieved in 92% of cases in 2018/19, vacancies in the patient experience team resulting in 6 cases not being acknowledged in time.

Final responses should be issued within 25 working days, unless otherwise agreed with the complainant, with a Trust benchmark of 90%. The overall rate in 2018/19 was only 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.
A number of stages within the investigation process have been identified as potential contributing factors to additional delays within both SI and complaints investigations, including allocation of investigators, completion of investigations, and also potential delays in the processes of management oversight and sign off.

4. Coroner’s Inquests

In 2018-19, 27 Coroner’s cases were heard in respect of people known to our services, 18 of them at the North London Coroner’s Court in Barnet, which covers all of our boroughs. Given the low numbers, data by division is unrevealing, and NCIS and ONS data are a better guide to the prevalence of suicide (which shows that London has a lower rate of suicide than the average for England, that all our boroughs have broadly similar rates to those in London as a whole, though Enfield has the lowest of our boroughs, and that there has been a slight falling trend in recent years).

In 2018-19, the Trust received the following conclusions from Coroner’s cases: narrative 15, natural causes 4, suicide 3, open 1, unascertained 2, drug related 1, RTA 1. Among the narrative verdicts were some number which were subject to investigation on the presumption that suicide was likely.

In 2018-19 38 Trust staff provided witness statements and attended court for full Coroner’s Inquests. With the new ‘fast track’ approach within certain jurisdictions it is likely that fewer Trust clinicians will be required to attend Court and give live witness evidence, and SI investigation reports are also no longer routinely required prior to the inquest. North London Coroner’s Court is now fully running this system and a larger number of ‘read only’ inquests are being listed following pre-inquest reviews in Court with the Coroner and interested parties.

5. Safe Working for Trainee Medical Staff

The Trust employs a Guardian of Safe Working hours (GSWH), a statutory role required as part of the implementation of the current trainee medical contract of employment. Dr. Gareth Jarvis handed over the role to Dr. Matthew King in September 2018 and Dr. King’s first report is appended. A notable point is that the out of hours workload for trainees is markedly higher at the Enfield site than other sites, due to the larger number of beds and the presence of the 136 suite on the site, and the disproportion has been exacerbated in recent months by new developments including the opening of Moselle Ward and the move of our intensive care ward to Devon ward. A possible option for addressing this would be to relocate the trainee currently covering the Barnet (Edgware) site to Chase Farm after 9pm. This raises a number of patient safety issues which would need to be addressed and discussions are taking place with Clinical Directors.

6. Themes and Trends

Triangulation of data arising from complaints and serious incident management identifies a number of common themes:

Effective Communication

Whilst a common theme within complaints data, issues pertaining to communication were also evident within serious incident reviews. These more specifically include ensuring information is shared with family members and carers, both as part of routine communication and post incident, and information sharing with key partnerships such as the police, GPs, the CQC, external providers (drug & alcohol services) and third party agencies.

Documentation

Several investigations were impeded by unclear, or absent, documentation, particularly around risk assessment and incident management. Subjective language, such as ‘settled’ or ‘appeared’ was
commonplace within both RiO entries and observation reviews, and led to confusion in handover of information.

Within SI investigations, it was highlighted that crisis and contingency plans should be developed by inpatient services in conjunction with the patient, and that the patient and any involved family members should have a copy. This is reflected within complaints data with service users and staff expressing confusion around crisis plans.

**Risk Assessment & Management**

In several SI investigations it was found that Risk Summaries on RiO did not contain up to date relevant information considering the full clinical formulation and risk history, nor updated systematically.

**Information Governance**

There have been seven SI investigations in 2018/19 regarding breaches of confidentiality, and 13 concerns or complaints. Specifically, these pertained to sharing information with a family without express consent, and disclosure of records to the wrong address or recipient.

**Dissemination of learning**

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

Where actions are identified these are input onto the Ulysses reporting system, and allocated to an appropriate manager/staff member for completion by members of the Patient Experience and Safety Teams. Evidence of completion is uploaded directly onto the system by the allocated manager, and outstanding action plans reviewed via Borough Governance Meetings and the Trust wide Patient Experience Committee.

Incident and complaint reports are reviewed at quarterly Borough Deep Dive meetings to provide thematic analysis of investigations; highlighting trends and themes identified and actions being taken by the teams to address any concerns. The Boroughs report on changes to practice as a result of incident and complaint investigation outcomes at their Deep Dive meetings and in their six-monthly governance report to Quality and Safety Committee.

The Patient Experience Team have developed new quarterly Borough Governance reports to support the dissemination of learning across services and divisions, which is compiled into a Trust Wide report for Patient Experience Committee.

The Patient Safety Team in partnership with the Patient Experience Team produce a monthly Quality Bulletin, emailed to staff and placed on the website, which includes key learning points from investigations and complaints.

**7. Implications**

**Budgetary / Financial Implications**

Budgetary / financial implications arising from management of incidents relate to the cost of commissioned Independent reviews. The costs of the reviews are paid out of the budget for the Nursing Directorate.

At present there is no dedicated budget for the Patient Experience Team. Costs associated with variance from the standard complaints process (i.e. co-production) are absorbed by service lines and managed within departmental budgets.
Equality and Diversity Implications

This report is inclusive and does not affect any group more favourably than another. The patient experience team are working closely with colleagues in Equalities and Communications to deliver a representative feedback tool, which captures the diversity of the patient experience.

QUARTERLY REPORT ON SAFE WORKING HOURS FOR DOCTORS IN TRAINING

Executive summary

Overall the Trust continues to have a low level of reporting of exceptions to working hours. As noted by the previous Guardian, Dr Gareth Jarvis, there were only 10 reports in the 6 month period April to August 2018.

This report covers September 2018 to March 2019 during which there have been 16 exception reports submitted with all closed bar 5 (see Qualitative Information/Issues below).

On taking over the role of Guardian of Safe Working Hours (GSWH) I was concerned about the low level of reporting. I have previously worked as a trainee within the Trust and therefore aware of some of the issues around the Enfield on call rota. I went to trainees and clinical supervisors to explore why they weren’t reporting. It was apparent that there was a lack of knowledge and understanding about the exception reporting process. Some trainees and consultants didn’t know their logins.

Given previous concerns about work load (see issues below) at certain sites and medical HR no longer being able to complete diary card monitoring, it is vital that trainees use the exception reporting system to highlight concerns around safety and workload. I have provided all trainees with information on the reporting system, had face to face meetings at local academic programs and attended the February 2019 Trust Induction. Medical HR has also emailed all trainees and supervisors to remind them/set up logins for the exception reporting process. It is hoped that with raised awareness and understanding of exception reporting the Trust will be able to capture a more accurate picture of working patterns for trainees and review of work schedules where appropriate to ensure safe working.

Introduction

The New Junior Doctor Contract 2016 was implemented by the Trust on 01.02.17. The Terms and Conditions of the contract stipulate that the Trust appoint a Guardian of Safe Working Hours (GSWH). The Trust appointed Dr Matthew King to the role as of 01.11.18. The T&Cs of the contract also stipulated that the GSWH must provide quarterly and annual summative reports to the Board.

High level data

| Number of doctors in training (total): | 89 |
| Number of doctors in training on 2016 TCS (total): | 89 |
| Amount of time available in job plan for guardian to do the role: | 0.5 PAs per week |
| Admin support provided to the guardian (if any): | 0 WTE |
| (Medical HR log in everyday and check for exceptions and ensure they are dealt with in a timely manner) |
| Amount of job-planned time for educational supervisors: | 0.25 PAs per trainee |

a) Exception reports (with regard to working hours)

<table>
<thead>
<tr>
<th>Rota</th>
<th>No. exceptions carried over from last report</th>
<th>No. exceptions raised</th>
<th>No. exceptions closed</th>
<th>No. exceptions outstanding</th>
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<tbody>
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<td>1</td>
<td>0</td>
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<td>6</td>
<td>6</td>
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</tr>
<tr>
<td>Grade</td>
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<td>Addressed within 7 days</td>
<td>Addressed longer than 7 days</td>
<td>Still open</td>
</tr>
<tr>
<td>---------------</td>
<td>--------------------------</td>
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<td>------------</td>
</tr>
<tr>
<td>FY2-CT3 Barnet</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>FY2-CT3 Enfield</td>
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<td>0</td>
<td>3</td>
<td>0</td>
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<tr>
<td>FY2-CT3 Haringey</td>
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<td>0</td>
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<td>5</td>
</tr>
<tr>
<td>ST4-6</td>
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</tr>
<tr>
<td>Total</td>
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**Exception reports - response time: Sep 2018 – March 2019**

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<tr>
<th>Grade</th>
<th>Addressed within 48 hours</th>
<th>Addressed within 7 days</th>
<th>Addressed longer than 7 days</th>
<th>Still open</th>
</tr>
</thead>
<tbody>
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<td>0</td>
<td>0</td>
</tr>
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<td>FY2-CT3 Enfield</td>
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<td>0</td>
<td>3</td>
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<td>3</td>
<td>5</td>
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<td>ST4-6</td>
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<tr>
<td>Total</td>
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**Hours monitoring exercises (for doctors on 2002 TCS only): Sep 2018 – March 2019**

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<thead>
<tr>
<th>Rota</th>
<th>Grade</th>
<th>Rostered hours</th>
<th>Monitored hours</th>
<th>Banding</th>
<th>WTR compliant (Y/N)</th>
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<td>NA</td>
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</tr>
<tr>
<td>FY2-CT3 Haringey</td>
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<td>NA</td>
<td>NA</td>
<td>NA</td>
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<td>ST4-6</td>
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**b) Work schedule reviews**

**Work schedule reviews by Grade: Sep 2018 – March 2019**

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<th>Grade</th>
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<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>FY2-CT3 Haringey</td>
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<td>NA</td>
<td>NA</td>
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</tr>
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<td>ST4-6</td>
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**c) Locum bookings**

**i) Bank**

**Locum bookings (bank) by Rota and Grade: Sep 2018 – March 2019**

<table>
<thead>
<tr>
<th>Rota</th>
<th>Grade</th>
<th>Number of shifts requested</th>
<th>Number of shifts worked</th>
<th>Number of shifts given to agency</th>
<th>Number of hours requested</th>
<th>Number of hours worked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet Rota</td>
<td>FY2-CT3</td>
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<td>28</td>
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<td>336</td>
<td>336</td>
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<td>Enfield Rota</td>
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<td>444</td>
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<td>264</td>
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<tr>
<td>ST4-6 Rota</td>
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<td>27</td>
<td>0</td>
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<td>324</td>
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<td>Total</td>
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<td>91</td>
<td>82</td>
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<td>1368</td>
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**Locum bookings (bank) by reason: Sep 2018 – March 2019**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number of shifts requested</th>
<th>Number of shifts worked</th>
<th>Number of shifts given to agency</th>
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<th>Number of hours worked</th>
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<td>Sickness</td>
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ii) Agency

<table>
<thead>
<tr>
<th>Rota</th>
<th>Grade</th>
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<th>Number of hours worked</th>
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<td>Enfield</td>
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<td>Haringey</td>
<td>FY2 - CT</td>
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<td>ST4-6</td>
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<tr>
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<th>Number of shifts worked</th>
<th>Number of hours requested</th>
<th>Number of hours worked</th>
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<tbody>
<tr>
<td>Vacancy</td>
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<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Sickness</td>
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<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Other</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Increase in workload - FY2s taken off Enfield Rota</td>
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<td>NA</td>
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<td>NA</td>
</tr>
<tr>
<td>Total</td>
<td>NA</td>
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d) Fines

<table>
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<th>Directorate</th>
<th>Grade</th>
<th>Number of fines levied</th>
<th>Value of fines levied</th>
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Qualitative information

On starting the post of GSWH in November 2018, I noted that there were 4 exception reports submitted in the previous period still active:

- **August 2018**: 3 reports related to the same LTFT trainee working a set of 3 night shifts who had significant disruption to their working pattern and on calls due to an error in a wrong on call rota being distributed by HR. The trainee also raised concerns that allocation of on call shifts was not fair across trainees. My predecessor, Dr Jarvis, spoke with medical HR who maintained the hours were technically safe. Dr Jarvis noted that this issue
remained unresolved and was unclear on the GSWH’s involvement in fair distribution of shifts if it was not impacting on safety. **Exception reports remains ‘open’**

- **August 2018**: 1 report related to trainee leaving late from a long day shift due to a serious incident with a forensic patient which required medical attention. The trainee had to stay late to complete necessary documentation. From the exception report it is evident that the trainee discussed this with their clinical supervisor and advised to complete an exception report however no initial review was then completed. Medical HR have chased the clinical supervisor to do this. **Exception report remains ‘open’**

Since September 2018 there have been 16 exception reports, 6 of which remain open:

- **September 2018 (Enfield Rota, core trainee)**: 2 reports related to the same trainee leaving 30mins – 1 ½ late from a day shift due to heavy workload. One report did not have an initial review with the clinical supervisor. The second review did and advice was given on managing workload during the day and handing over jobs to be able to leave on time. Of note, during the initial review for the second report the clinical supervisor raised an unrelated issue regarding a discrepancy in time off after working on calls due to being a part time trainee. **Exception reports remain ‘open’**

- **September 2018 (Enfield Rota, core trainee)**: 2 reports related to the same trainee working on call shifts and unable to take natural break and had to leave 30 minutes late. Both reports were discussed with the clinical supervisor with an agreed outcome for these difficulties to be brought to the trainee forum. **Exception reports ‘closed’**

- **January 2019 (Barnet Rota, core trainee)**: Trainee who was second on call was asked by HR to cover an on call shift. The trainee was due to handover to a locum doctor who arrived 35 minutes. It was agreed with the clinical supervisor that the trainee would take 35 minutes in toil. **Exception report ‘closed’**

- **January 2019 (Enfield Rota, core trainee)**: Trainee had to stay 45 minutes late on call due to late arrival of colleague for handover. Agreed with clinical supervisor to take 45 minutes in toil. **Exception report ‘closed’**

- **January 2019 (Enfield Rota, core trainee)**: Trainee who was second on call was asked by HR to cover an on call shift. The trainee was due to handover to a locum doctor who arrive 30 minutes late. It was agreed with clinical supervisor that the trainee would take 30 minutes TOIL. Of note, the trainee raised concern that the locum had not had appropriate rest breaks between locum shifts. **Exception report ‘closed’**

- **January 2019 (Higher trainee): Immediate Safety Concern**. Higher trainee struggled to get access to senior support for a Section 136 assessment. It was apparent that there had been a change in the consultant rota which had not been communicated effectively leading to some confusion. Issue was resolved with assistance from the on call consultant. Higher trainee discussed this with their clinical supervisor and the correct rota was located. **Exception report ‘closed’**

- **February 2019 (Enfield Rota, core trainee)**: Two reports completed by the same trainee due to have stay 30 minutes late because of a locum not arriving on time. Unfortunately the trainee has changed rotations and therefore unclear if TOIL was possible. **Exception reports ‘closed’**

- **March 2019 (Enfield Rota, core trainee)**: Two reports completed by the same trainee due to having to stay late because of a busy on call shift and not being able to take natural
breaks due to work load. This was discussed with supervisor and TOIL agreed. Exception report ‘closed’

- **March 2019 (Haringey Rota, core trainee):** Three reports from two trainees relating to exceeding normal working hours due to busy daytime jobs. Exception reports remain ‘open’.

**Issues arising**

Exception reports largely refer to the on call Enfield Rota (Chase Farm Site) which has been monitored for some time due to reports of heavy workload (this has been a historical issue). This has sometimes lead to trainees being unable to complete their work within expected hours and/or not being able to take necessary breaks.

There is anecdotal evidence that workload on the Chase Farm site is heavy. I was therefore surprised to see so few exception reports being completed when I compared reporting rates with GSWH in other Trusts.

I note several exception reports refer to locums not arriving promptly for handover resulting in trainees leaving up to 45 minutes late from their shift. I was concerned to see that one locum ended a night shift at 9am and then started a shift at 5pm meaning they did not take the necessary 11 hours rest between shifts.

One immediate safety concern was raised relating to information about consultant on call rota’s not being distributed. On further investigation I have found that the consultant body changed their pattern of working but there was a breakdown in communication with trainees.

Although improved slightly, there continues to be a difficulty in exception reports being closed by trainees when the issue has been resolved. This has meant that some exception reports remain open.

At the last Junior Doctors Forum concerns were raised by HR about several vacant on call shifts on the CT rota’s. Trainees stated that the locum rates (approx. £28/hour) were too low and did not reflect what other Trusts were paying so unhappy to fill the vacant slots.

**Actions taken to resolve issues**

To address suggestions of increased workload at Chase Farm I commissioned real time recording of trainees workloads whilst on call. Collating evidence of workload was also important in establishing a baseline as there are likely future changes to services provided on the Chase site (e.g. increased ward numbers with PICU moving). As diary card monitoring no longer exists I asked trainee reps, in collaboration with HR, to draw up a simple way of recording activity, breaks etc. whilst on call. Information has now been collected over a 3 month period which demonstrates that whilst the average on call is manageable, there are an increasing number of shifts where trainees feel that the workload is too much resulting in patient safety concerns.

As stated, I was concerned about the low level of reporting. I therefore visited trainees and clinical supervisors at the various hospital sites to establish why this might the case. The response was a lack of knowledge and understanding about the reporting process. I provided relevant information, asked HR to reissue login details and have attended the Trust induction to raise awareness of exception reporting. I plan now to attend all future Trust inductions and provide training where required.

With regards to locums, I have sought assurances from HR that they were unaware of a locum not taking necessary rest breaks between shifts and that they will monitor to ensure this does not happen again.
The issue of a change in a consultant on call rota has been resolved and there has been close liaison with the trainee reps to ensure that there is no impact on their working pattern. Feedback from trainees is that they are happy with this arrangement.

Following discussion with HR we negotiated a higher rate of locum pay for trainees to cover vacant shifts. Following this all vacant shifts have since been filled resulting in no use of agency staff.

**Summary**

Overall, the Trust continues to have low exception reporting and these largely relate to workload at the Chase Farm site, handovers and issues with locum cover. The majority of exception reports are resolved and closed with no fines to date being issued.

Due to anecdotal evidence and some data of increased workload on the Enfield rota, it is important that any issues are captured in real-time by trainees through the exception reporting process.

**Questions for consideration**

The main questions I have for this quarter is how to get trainees and supervisors more engaged with the exception reporting process and how does the Trust prepare for likely future difficulties on the Enfield rota?

A solution to the Enfield rota has been put forward by to all Clinical Directors by the Junior Doctors Forum. It has been suggested that we utilise the Barnet on call doctor to assist with the Chase Farm doctor. We are not proposing that the doctor is withdrawn from Barnet, rather they would act as ‘floating cover’ on night shifts. This would help reduce the workload and therefore limit patient safety issues at Chase Farm. It is also an opportunity for Barnet trainees to get some important clinical experience (e.g. assessment of S136’s) as well as easier access to senior supervision from the Specialist Trainee who is based at Chase Farm. It was also suggested that the large number of GP trainees on the Barnet rota might also benefit as a lack of senior supervision and experience has been raised by them in the past.

The new on call pattern would be as follows:

- Haringey remains the same as there is an acute admissions ward (plus eating disorders which requires medical input)

- Enfield remains the same

- Barnet remains the same 9am-9pm. During the night shift the Barnet doctor starts their shift at Chase Farm where they will have a handover with the Core Trainee and Specialist Trainee on call. The Barnet trainee would then assist at Chase Farm unless called to the Edgware site or Barnet A&E for CAMHS patients.
# Safe Staffing Levels

**Report to:** Trust Board  
**Date:** 23 May 2019  
**Security Classification:** Public Board Meeting

## Purpose of Report:


This is an exception report that demonstrates both the planned level of staff and the actual level achieved.

The Board can be assured there is local monitoring and oversight of staffing.

## Recommendations:

The Trust Board is asked to agree:

1. To note the Safe Staffing report.

2. That managers to be kept fully informed of newly recruited staff and when they are coming into post and to what areas, to be targeted at areas of highest vacancy rate.

3. That the Executive Management Team continues to monitor the impact of the recruitment and retention strategies.

4. That the Executive Management Team continues to support an improved use of e-Rostering in order that the available resource can be used more efficiently and effectively.

## Report Sponsor:

Amanda Pithouse, Executive Director of Nursing, Quality and Governance

## Comments / views of the Report Sponsor:

Vacancy levels remain variable across all wards; the overall Trust wide vacancy rate for inpatient wards has decreased slightly from 13% in February 2019 to 11.7% in April 2019. 

Recruitment and retention of skilled staff remains a high priority with continued recruitment and retention initiatives both locally, across London with Capital Nurse and partnership universities. Overall, the wards have met their planned number of hours worked for registered and care support staff.

The Care Hours Per Patient Day (CHPPD) is presented in this report.
| Report Authors: | Name: Amanda Pithouse  
Title: Executive Director of Nursing, Quality and Governance  
Tel Number: 020 8702 3032  
E-mail: Amanda.pithouse@nhs.net  
Name: Clare Scott  
Title: Deputy Director of Nursing  
Tel Number: 020 8702 6051  
E-mail: clare.scott@nhs.net |
<table>
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<tr>
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<td>Regular Report.</td>
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| Budgetary, Financial / Resource Implications: | Numerous financial implications associated with safe staffing including:  
- costs associated with use of temporary staffing or savings from reduced usage |
| Equality and Diversity Implications: | Planning of staff is taken into account across all Trust services and is compliant within our Equality and Diversity duty. |
| Links to the Trust’s Objectives, Board Assurance Framework and / or Corporate Risk Register | Links to Trust objectives: Happy Staff, Excellent Care and Value for Money and is in accordance with regulatory standards |
| List of Appendices: |  
- Appendix 1 – Barnet, Enfield, Haringey, Specialist Indicator Data Sets March and April 2019  
- Appendix 2 – Care Hours Per Patient Day, March and April 2019 |
1. **Introduction**

1.1. The purpose of this exception report is to advise the Board of fill rate across the 29 of the Trust’s 30 in-patient areas where nurse and health care assistant staffing levels fell below planned requirements and actions taken to address this where required.

1.2. 29 of the 30 in-patient areas within the Trust have reported the details of their staffing levels on a shift by shift basis for March and April 2019. The Trust acquired Capetown Ward in April 2019 and will commence reporting on safe staffing in May 2019.

1.3. This report is provided in accordance with the expectations set out in the National Quality Board Guidance (2013, 2016) that Trust Boards take full responsibility for nursing and care staffing capacity and capability.

1.4. Managers are required to report their planned numbers of registered nurses and health care assistants on duty, against the numbers actually present on shift.

1.5. This work has included the daily monitoring and robust management of planned and actual staffing of both registered and unregistered staff across all 29 in-patient areas. The analysis allows for any emerging challenges to be addressed in a timely manner to ensure the delivery of planned staffing levels, to support the provision of safe and high quality care to service users and improved patient experience.

1.6. This exception report provides details of all shifts where the fill rate fell below 100%, therefore not meeting their planned numbers. Borough teams continue to flex their approach and increase staffing to support acuity/dependency and enhanced observations where appropriate, this approach has ensured that staffing levels have remained safe throughout the reporting period.

2. **Fill Rate**

2.1 Table 1 gives an indication of overall fill rate for March and April 2019 across all inpatient wards, which shows little variance between both Registered and Care staff during this period. For detailed rates per ward in both March and April 2019, see Appendix 1.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Registered Nurses Average Fill Rates - DAY (%)</th>
<th>Registered Nurses Average Fill Rates - NIGHT (%)</th>
<th>Care Staff Average Fill Rates - DAY (%)</th>
<th>Care Staff Average Fill Rates - NIGHT (%)</th>
</tr>
</thead>
<tbody>
<tr>
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<td>March</td>
<td>99</td>
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</tbody>
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Trust Board Page 43
2.2 Of the 29 inpatient wards reported on, in March 2019 a number of wards fell below the planned numbers for both registered nurses and care staff, they were not able to fill all of the shifts with either registered nurses or care staff. Of these 1 ward (Juniper) fell below 95% for the day shift across the month for registered nurses and health care assistants but was supported by the ward manager and staff from other wards where required. This has been explored with the teams and it is due to unplanned sickness absence and inability to get bank staff to cover at short notice, the service has an onsite manager to support the ward if required.

2.3 In the month of April 2019, 6 of the 29 wards reported fill rates below 95% for registered nurses during the day; with no wards reporting a fill rate below 95% for both registered nurses and health care assistants. For all wards, the ward manager confirmed that they support the ward but that this is not reflected in the safe staffing returns.

3. **Vacancy Factor**

3.1 The overall vacancy rate for our inpatient areas fell slightly from 13% in February 2019 to 11.7% in April 2019.

3.2 Vacancy rates continue to be variable across the Trust, the three wards with the highest vacancy rates are Thames, Magnolia and Derwent. There are a number of wards that are over established; Cornwall Villa, the Oaks, Finsbury and Eden.

3.3 The Trust provides clinical placements to a high number of students in partnership with a number of Universities and has student nurses working across all areas. The recruitment campaign for student nurses due to qualify in September 2019 commenced in February; those that complete their final placement with the Trust have been offered an automatic contract. Interviews with students completing training in other Trusts were held throughout March 2019 and follow on interviews continue for late applicants.

3.4 The Trust is currently recruiting for the next cohort of Trainee Nursing Associates due to commence this year.

4. **Sickness Rate**

4.1 The overall sickness rate across the Trust in-patient wards has increased from 2.9% in February to 6.4% in April 2019, above the Trust target of 4%. Sickness rates vary across in-patient wards; with some long term sickness impacting on specific areas.

4.2 The three wards with the highest sickness rate in April 2019 were Finsbury, Suffolk and Fennel; some of this is due to long term sickness. The monitoring and discussion of both vacancy and sickness rates in monthly meetings with workforce.

5. **Care Hours per Patient Day (CHPPD)**

5.1 The care hours per patient day (CHPPD) metric was developed to provide a consistent way of recording and reporting deployment of nursing staff providing care in inpatient ward settings. The metric was designed initially for acute hospitals but has since been tested and adapted for use in mental health and community inpatient wards. The Trust has been reporting the CHPPD information to NHSI since April 2018 when it became a mandatory requirement. Since November 2018 a submission for allied health professionals included in minimum staffing numbers has been provided.
5.2 From January 2019 this information will be published on ‘My NHS’ and ‘NHS Choices’, see Appendix 2 for current submission of nursing, health care assistants and allied health professionals for March and April 2019.

6. Conclusion

6.1 Vacancy rates continue to be a challenge for the Trust on in-patient areas with an overall vacancy rate of 11.7%.

6.2 The Trust is working hard to recruit registered nurses and health care assistants and there is on-going recruitment for a number of areas. The nursing directorate will work with workforce to develop a rolling programme of recruitment for registered nurses in mental health, learning disability and general specialisms, for both substantive rolls and bank.

6.3 The nursing directorate are contributing towards a Trust wide recruitment and retention programmes led by workforce and staff from across the Trust.

6.4 Safe staffing reports are published on the Trust website monthly; promoting transparency and providing assurance in relation to the Trust monitoring of safe staffing. Our fill rates are reported via monthly UNIFY submission; a requirement of all NHS providers.

7. Recommendations

7.1 In order to deliver on NHSI publication ‘Developing Workforce Safeguards’ the Director of Nursing has commenced a formal nursing establishment and skill mix assessment across all inpatient wards; this will include the consideration and development of new roles to include the Nursing Associates. A full report with recommendations to be brought to Trust Board in May 2019

8. Budgetary / Financial Implications

8.1 Financial costs associated with the procurement of electronic IT solutions to record and track staff usage.

8.2 A reduction in the reliance on temporary staff, and associated savings.

9. Risk Management

9.1 Consistency in high calibre, well trained and competent staff will contribute to risk reduction and improved quality of care and patient experience. Investment in staff development will also assist in retaining high quality staff and assist in the recruitment of staff in the future.

10. Equality and Diversity Implications

None
**Appendix 1 – Barnet, Enfield, Haringey, Specialist Indicator Data Sets March 2019**

### Barnet - March 2019

<table>
<thead>
<tr>
<th>Hospital site name</th>
<th>Ward name</th>
<th>Speciality</th>
<th>Staffing Day</th>
<th>Staffing Night</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Average Fill Rate - registered nurses</td>
<td>Average Fill Rate - care staff</td>
</tr>
<tr>
<td>Edgware Community Hospital</td>
<td>Avon</td>
<td>Psychiatric Intensive Care Unit</td>
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<td>Trent Ward</td>
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<td>Barnet General Hospital</td>
<td>Ken Porter</td>
<td>Adult Mental Illness, Old Age Psychiatry</td>
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</table>

### Enfield - March 2019

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<th>Speciality</th>
<th>Staffing Day</th>
<th>Staffing Night</th>
</tr>
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<td></td>
<td></td>
<td>Average Fill Rate - registered nurses</td>
<td>Average Fill Rate - care staff</td>
</tr>
<tr>
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### Haringey - March 2019

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<th>Staffing Day</th>
<th>Staffing Night</th>
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<td>Average Fill Rate - registered nurses</td>
<td>Average Fill Rate - care staff</td>
</tr>
<tr>
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<td>Ward name</td>
<td>Speciality</td>
<td>Staffing Day</td>
<td>Staffing Night</td>
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<td>100.0%</td>
</tr>
<tr>
<td>St Ann’s Hospital</td>
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</tr>
<tr>
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<td>Moselle House</td>
<td>Forensic Psychiatry</td>
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<td>99.2%</td>
</tr>
<tr>
<td>St Ann’s Hospital</td>
<td>Eden House</td>
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### Barnet - Reporting April 2019

<table>
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<th>Ward name</th>
<th>Speciality</th>
<th>Average Fill Rate-registered nurses</th>
<th>Average Fill Rate-care staff</th>
<th>Average Fill Rate-registered nurses</th>
<th>Average Fill Rate-care staff</th>
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<tr>
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<td>Thames Ward</td>
<td>Adult Mental Illness</td>
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<td>100.0%</td>
<td>98.4%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Edgware Community Hospital</td>
<td>Trent Ward</td>
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</tr>
<tr>
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### Enfield - Reporting April 2019

<table>
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<td>Suffolk Ward</td>
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<td>101.7%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Chase Farm Hospital</td>
<td>Sussex Ward</td>
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<td>105.7%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
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<td>Complex Rehab Ward (formerly Somerset Villa)</td>
<td>Old Age Psychiatry</td>
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<td>97.3%</td>
<td>95.1%</td>
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<tr>
<td>Chase Farm Hospital</td>
<td>The Oaks</td>
<td>Old Age Psychiatry</td>
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<td>95.8%</td>
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<td>94.5%</td>
</tr>
<tr>
<td>Chase Farm Hospital</td>
<td>Cornwall Villa</td>
<td>Old Age Psychiatry</td>
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<td>102.5%</td>
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<tr>
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### Haringey - Reporting April 2019

<table>
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<th>Average Fill Rate-care staff</th>
<th>Average Fill Rate-registered nurses</th>
<th>Average Fill Rate-care staff</th>
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<td>Haringey Ward</td>
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</tr>
<tr>
<td>Hospital site name</td>
<td>Ward name</td>
<td>Speciality</td>
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<td>Average Fill Rate - care staff</td>
<td>Average Fill Rate - registered nurses</td>
<td>Average Fill Rate - care staff</td>
</tr>
<tr>
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</tr>
<tr>
<td>Chase Farm Hospital</td>
<td>Blue Nile House</td>
<td>Forensic Psychiatry</td>
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</tr>
<tr>
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<td>101.1%</td>
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<td>97.9%</td>
<td>93.3%</td>
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</tr>
<tr>
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<td>Juniper</td>
<td>Forensic Psychiatry</td>
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<td>100.0%</td>
</tr>
<tr>
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<td>Mint</td>
<td>Forensic Psychiatry, Learning Disability</td>
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<tr>
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</tr>
<tr>
<td>Chase Farm Hospital</td>
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<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
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</tr>
<tr>
<td>Chase Farm Hospital</td>
<td>Severn</td>
<td>Forensic Psychiatry</td>
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<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
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<td>Forensic Psychiatry</td>
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<td>100.0%</td>
<td>100.0%</td>
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</tr>
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</tr>
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<td>96.9%</td>
<td>98.8%</td>
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</tr>
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<td></td>
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<td><strong>Appendix 2 - Care Hours per Patient Day March 2019</strong></td>
<td></td>
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<tr>
<td><strong>Cumulative count over the month of patients at 23:59 each day</strong></td>
<td><strong>Registered midwives/ nurses</strong></td>
<td><strong>Care Staff</strong></td>
<td><strong>Registered allied health professionals</strong></td>
<td><strong>Non-registered allied health professionals</strong></td>
<td><strong>Overall</strong></td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------------------</td>
<td>----------------</td>
<td>---------------------------------</td>
<td>---------------------------------</td>
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<tr>
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<td>Cumulative count over the month of patients at 23:59 each day</td>
<td>Registered midwives/nurses</td>
<td>Care Staff</td>
<td>Registered allied health professionals</td>
<td>Non-registered allied health professionals</td>
<td>Overall</td>
</tr>
<tr>
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# Title:
Inpatient Nurse Staffing and Skill Mix Report

## Report to:
Trust Board

## Date:
23 May 2019

## Security Classification:
Public Board Meeting

## Purpose of Report:
This report provides an overview of in-patient nurse staffing levels, outlining the current position and recommendations. It is provided to assure the Board that:

- there is good oversight of inpatient staffing establishments.
- the Trust is meeting its obligations to assess the safety and suitability of inpatient nurse establishments in accordance with the standards published by the National Quality Board (2013, refreshed 2016).

## Recommendations:
The Trust Board is asked to consider the recommendations of any uplift in budget and note recommendations for further review of shift pattern on acute mental health wards

## Report Sponsor:
Amanda Pithouse, Executive Director of Nursing, Quality and Governance

## Comments / views of the Report Sponsor:
This report provides an update on existing work but also serves as information about other initiatives which are aimed at making the wards safe by providing appropriate staffing. Mindful of the demographics of the workforce and the pressures faced by all NHS organisations in terms of nurse recruitment, the Trust is engaged in the development of new roles and alternative routes into nurse training. This means that we will be well placed to address short and medium term staff risks

## Report Author:
Name: Clare Scott  
Title: Deputy Director of Nursing  
Tel Number: 020 8702 6051  
E-mail: clare.scott3@nhs.net

## Report History:
This is the fourth skill mix report to the Board.

## Budgetary, Financial / Resource Implications:
The recommendations will result in an uplift of £150k if the headroom remains at 24%. If the Board considers a reduction to headroom to 22% the recommendations and budget adjustments to support the current minimum staffing levels the budget would be reduced by nearly £200k.
### Equality and Diversity Implications:

The Trust has a duty to promote equality and diversity in the recruitment of the nursing workforce; the planning of staff is taken into account across all Trust services and is compliant within our Equality and Diversity duty.

### Links to the Trust’s Objectives, Board Assurance Framework and / or Corporate Risk Register

Action taken will assist in delivering our Trust objectives; providing excellent care, happy staff and value for money.

### List of Appendices:
- Appendix 1 – Shift pattern by ward
- Appendix 2 – Staffing levels comparison
1. Introduction and Background

1.1 The Francis Enquiry (2013) and subsequent Government response ‘Hard Truths’ (2014) emphasised the need to get staffing levels right; with seminal papers from Keogh (2013) and Berwick (2013) clearly linking nurse staffing levels to patient safety, outcomes and experience.

1.2 In 2013 the Chief Nursing Officer and the National Quality Board (NQB) published guidance setting out clear expectations for providers for safe nursing staffing. The NQB set out expectations in terms of Board ownership and public visibility. The guidance identified expectations for reporting:
   - Monthly workforce reporting to the Trust Board
   - Annual establishment review using evidence based tool and clinical discussions led by Director of Nursing; report to the Board.
   - Six monthly establishment reviews
   - Displaying planned versus actual staffing numbers in clinical areas.
   - Submission of the above fill rates through unify and publication on the Trust website.

1.3 The calculation of appropriate staffing levels is more complex in mental health settings than acute settings for a number of reasons as highlighted by NHS England in the Mental Health Staffing Framework; they identified that mental health services require a higher number of interventions, that are often reactive and unplanned; the length of stay tends to be longer with higher numbers being detained to hospital rather than being there by choice; with around half of service users requiring a higher degree of security.

2. Methodology

2.1 Nationally there are a range of tools in circulation to assist in the calculation of nursing establishments. It has been recognised that these do not capture the complexities in mental health inpatient services.

2.2 In 2017 NQB and National Health Service Improvement (NHSI) guidance advised a flexible, pragmatic approach to safe staffing, using evidence-based tools where available. Guidance included the use of flexible staffing strategies, triangulation and comparisons with similar services, along with recommendations of the implementation of care hours per patient day (CHPPD) in acute and community hospitals.

2.3 To address the absence of an evidence based tool for mental health and learning disability inpatient services, NHSI have been working with provider organisations nationally along with Keith Hurst (Shelford Safer Care Nursing Tool) to develop and evidence based acuity and dependency tool to support with the review of staffing numbers and skill mix requirements. Barnet Enfield and Haringey were involved in this piece of work and the tool is due to be published.

2.4 In the absence of the tool a nursing acuity and dependency audit was commissioned by the Executive Director of Nursing using a combination of Safe Care data and the draft acuity and dependency tool over a period of 15 days in January 2019. The audit covered the inpatient ward areas within the acute Trust and community hospital.

2.5 To ensure the review was in line with the NHSI document – Developing Workforce Safeguards published in October 2018, there was a triangulated approach to the review. The review engaged clinical staff who manage the wards; the Director of Nursing, Deputy Director of Nursing, supported by a representative from finance and workforce (where possible) held engagement events where each ward manager attended with the service lead
and assistant director or clinical director. At the meetings the following areas were discussed and reviewed:

- Ward specialism, number of beds and whether ward is mixed
- Budget WTE, including staffing versus actual staffing, vacancy rates and any other absence, including suspension or restricted practice.
- Training for breakaway and PMVA, emergency team response arrangements
- Minimum staffing levels per shift
- Shift pattern
- Observation data, including where observations are absorbed in minimum numbers
- Safe staffing fill rate
- Number of students at any one time
- Additional challenges such as high level of leave, high admission rates
- Complaints, patient experience and serious incidents
- Other professionals not included in the nursing budget

2.6 The meetings were used to hold constructive challenge conversations in relation to safety and quality issues on the wards and any suggestions to improve safety and experience for patience carers and staff. Discussions also explored the introduction of new roles such as trainee nursing associates and how these could be incorporated into the current establishment.

2.7 This level of scrutiny involving clinical judgement strengthened the approach and counterbalanced the potential flaws in using a tool that is currently in draft which, if used alone may have resulted in recommendations that could not be validated. The data and proposed staffing levels and skill mix were discussed thus enabling an opportunity to further interrogate intelligence regarding clinical demands and staff competency; this will form a vital part of any future review.

2.8 In addition to this, a benchmarking exercise was carried out against other similar services in London for acute wards. A further exercise was supported by finance with financial modelling for current minimum staffing numbers carried out.

2.9 Care hours per patient day (CHPPD) have been collected and reported in April 2018. In addition to the staff hours, patient count at 23.59 is recorded and used in the calculations of care hours per patient day (CHPPD). As the CHPPD is related to bed occupancy it will provide additional assurance that Safe Staffing is maintained when bed occupancy is low or enhanced 1:1 nursing observations are required.

3.0 Acute Wards

3.1 The Trust has 9 acute wards including 1 psychiatric intensive care unit (PICU). All wards were reviewed using the approach outlined in section 2. Within the budget headroom was set at 24.2%. All the wards (acute and PICU) were budgeted to absorb the first 1:1 observation in their minimum staffing level, there was no additional reserve to cover 1:1 observations.

3.2 The ward establishments included staff from band 3 to band 6. The 3 wards in Haringey have a Band 6 bleep holder rota and are supernumerary for this role (approximately two days a week each). Two of the wards have a trainee nursing associate (TNA) who started training in December 2018. None of the wards had an activities coordinator within their budget, however Finsbury Ward were recruiting to a post as a cost pressure and considering adopting the same approach for Haringey Assessment Ward to improve patient experience and quality of interventions.
3.3 The Enfield wards work with the same establishment as Haringey, ranging from Band 3 to Band 6; they do not currently have any trainee nursing associates. All three wards have an activity coordinator shared between them budgeted for outside of the nursing budget. The financial model for Haringey wards supports the current minimum staffing rota.

3.4 The 3 wards in Barnet (including PICU) have ward establishments between band 3 and 6, none of the ward have trainee nursing associates. The band 6 nurses do not have any supernumerary time due to the pressures of the ward. The PICU is due to relocate to Enfield in March 2019, their bed base will reduce from 16 to 14 patients with minimum staff numbers remaining at the current level. In addition to the minimum numbers the PICU ward have budgeted activities staff.

3.5 The other two Barnet wards have a bed base of 20 (Thames) and 21 (Trent); both wards explained that the bed numbers had increased approximately 3-4 years ago but the staffing levels had not been reviewed at the time. For both wards the first 1:1 observation is budgeted to be absorbed in minimum staffing numbers, in practice this is not happening on Trent ward, the rationale for this decision being that it did not feel safe to have 4 staff for the remaining 20 patients and that this would impact on quality and safety of patient care. Current practice is that the ward books an additional staff member for the first 1:1 observation; this is a cost pressure for the ward, approved by the Clinical Director. Thames ward identified the same concerns regarding patient safety and quality of care but continued to absorb the first 1:1 observation in their minimum staffing numbers. Following the clinical discussion a decision was made between the Director of Nursing and Assistant Director to book an additional member of staff for the first 1:1 observation as an interim measure. Neither ward raised concerns with staffing levels at night as the clinical activity, leaves and attendance at meetings is less during the night. When comparing minimum staffing numbers to similar wards, both in size and acuity, to that of other Trusts, it was found that other Trusts are working with an additional member of staff during the day shift. A recommendation from the staffing review would be to uplift the minimum staffing numbers for both Trent and Thames to 6 staff on a day shift (3 registered nurses and 3 health care assistants). Both wards are due to reduce to 18 beds during 2019/20 when a new acute ward is opened; it is anticipated that the minimum staffing levels can return to the current level when the bed base reduces.

3.6 Wards were managing sickness and reviewing staff unable to undertake prevention and management of violence and aggression (PMVA). All acute wards work a two shift pattern, consisting of a long day (0.700hrs – 19.30 hrs.); managers explained that this can make it difficult to find time to facilitate supervision and team meetings; in addition to this it should be noted that for 5 hours of the day, the staffing will be reduced by 1 member of staff while breaks are taken.

Specialist Services

Adult eating disorder service

3.7 Phoenix Ward – As part of the staffing data benchmarking taking place for mental health inpatient services by NHSI and Keith Hurst; in October 2017 a research team carried out a comprehensive mental health dependency/acuity, activity, quality and staffing review over a 14 day period. As Phoenix ward is only the second eating disorder ward to be included in the database, there are few benchmarks so was compared mainly to acute admission wards. In summary the main findings were that Phoenix staff were more patient centred; the amount of time that staff spent working indirectly with patients was almost half that of an acute ward and that quality scores were excellent which indicates that staffing is appropriate. The recommendation was for a slight uplift of staffing if temporary staff are excluded from the analysis, however if any additional staff are to be appointed the recommendation was for proportionately more support staff to be considered which could lower registered staff’s associated work time. The recommendations were reviewed by
finance and the Director of Nursing in August 2018 and a budgeted uplift in staffing was agreed.

CAMHS in-patient

3.8 The Trust has 2 CAMHS ward, The Beacon. There has been an improving picture with regards to a reduction in vacancy rate for registered nurses; the vacancies for health care assistants is at 5 but the financial model highlights that the ward may be over budgeted for health care assistants in comparison to agreed minimum staffing numbers. This will be reviewed further with finance. The ward is committed to supporting the nursing associate role and currently has a trainee nursing associate in their establishment. During the meeting the service manager highlighted that due to levels of acuity with the young people there is a risk that this could impact on staff morale and staff may leave. The management team are focused on supporting staff and working to retain them. The ward is a standalone ward and rely on the adult acute mental health wards based on the Edgware community hospital site to support with emergency response when required.

Low and medium secure forensic wards

3.9 When analysing the scores calculated using the draft acuity and dependency there was no discrepancy between current minimum numbers and approximate calculated numbers. When considering this alongside the qualitative narrative from the clinical meetings the minimum numbers were overall assessed to be appropriate. There was however variation in minimum numbers depending upon the purpose of the ward, i.e. Rehabilitation or admission, with some of the wards describing higher levels of acuity and additional funding from NHSE for 1:1 or 2:1 observations. Mint ward the medium secure learning disability ward reported that many of the patients on the ward require a high level of support, although they do not have a high level of 1:1 observations as they support patients with positive behaviour support plans (PBS).

3.10 Three of the lows secure wards highlighted that they were away from the main forensic services and as such were less likely to be supported by other wards during a night shift or when emergency assistance is needed. Six of the wards worked on 1 registered nurse on night shift; two of these wards (Mint and Moselle House, low and medium secure learning disability wards) reported that their minimum staffing was for 2 registered nurses on a night but they had carried out a review and made a decision that the ward could be safely managed on one registered staff on a night shift and it was more beneficial to have additional registered staff in the day.

3.11 Vacancy rates vary across the wards but there is a continued focus on recruitment and retention. The service supports both the new nursing associate role and the graduate mental health worker role and has a number of staff training to be a nursing associate and is also recruiting a number of graduate mental health workers. Levels of challenging behaviour were reported as high on some wards with some sickness being attributed to assaults on staff; however staff were supported and sickness rates were managed through Trust processes.

Older People's mental health

3.12 The Trust has 3 wards specifically to care for older people with mental health conditions. The Oaks (21 bedded assessment ward) carried out a review of their minimum staffing numbers in November 2018 following concerns around the quality of care on the ward and identified gaps in the ability to provide high quality care. The review consisted of piloting the draft acuity and dependency tool in conjunction with a number of clinical discussions with ward staff and management. The recommendations were to increase the minimum staffing by 1 registered nurse during the day; this was introduced as an interim measure immediately along with a number of other interventions to ensure that there is robust
oversight of the rota and shifts are filled in advance. A further quality review carried out found improved staff morale, a reviewed team nursing approach and improved fill rate.

3.13 A recommendation from the skill mix review is to increase the full time establishment to support the current minimum staffing rota on a permanent basis.

3.14 For both of the other wards for older people, when taking into consideration the calculations from the draft acuity and dependency tool along with the clinical discussions, the full time equivalent supports the minimum staffing numbers indicated. However Cornwall Villa did highlight that the purpose and admission criteria of the ward changed in 2018 and at that time the needs of the patient group and the acuity changed; a recommendation is that when changes are made to the purpose or specialism of a ward a full skill mix review is carried out.

Rehabilitation wards

3.15 The Trust has two rehabilitation wards, one at Enfield for work age adults (male) and a mixed ward for longer stay patients with the majority being in the older age range, although the ward is not specifically for older people with mental health issues.

3.16 Somerset Villa in Enfield is newly opened ward and runs a hybrid model of staff on the rota to include a mixture of a three shift pattern and a two shift pattern. The clinical discussions highlighted that although the ward is for the rehabilitation of patients, they have some challenges with acuity, facilitating leave and appointments. Ken Porter Ward in Barnet are a standalone ward caring for patients with a high level of physical health needs, through clinical discussions they highlighted additional pressures where patients are admitted from acute Trusts and require barrier nursing; although overall they felt that their minimum staffing numbers were appropriate for the bed numbers and type of patient.

Acute community wards

3.17 Magnolia ward is the Trust's only acute community ward, providing care and treatment for people following transfer from acute general hospital or to prevent an admission; this is a nurse led service with a nurse consultant who is not included in the minimum staffing numbers. The ward completes Safe care online and is due to use the safer nursing care tool once the licencing agreement is complete. The ward previously worked on 28 beds, there was an agreed increase to 33 beds last year and the budget to support additional staffing has been increased to reflect this. Magnolia has experienced difficulties recruiting to registered nurse posts as a standalone ward and have been involved a number of recruitment activities as well as supporting the overseas nursing in their preparation for the overseas structured clinical examinations (OSCEs).

3.18 Capetown ward – The Trust acquired Capetown ward from the Royal Free Hospital in March 2019. A full face to face clinical review of the staffing skill mix took place in April 2019; the financial modelling has been calculated using the same formulation as for Magnolia ward but has been uplifted to reflect the increased acuity of a combination of stroke neuro and general rehabilitation patients admitted directly from acute wards. The agreed minimum staffing levels are within the current budget for 22 beds.

4.0 Shift Pattern

4.0 The previous paper referred to 12 hour shifts; this remains a matter for consideration; currently there is variety across wards of either a two shift pattern or three shift pattern (Appendix 1). There have been a number of reports published exploring the possible negative impact on patient care of 12 hour shifts. In 2015 the National Nursing Research Unit, King’s College London published research that found that 12 hour shifts did have some degree of negativity either for nursing staff or patients which could potentially impact
on patient safety. The adverse effects highlighted were around fatigue, although it was acknowledged that other factors such as working shift patterns and number of days worked without a break are a contributory factor.

4.1 The reviewers found the quality of evidence as weak to moderate so findings cannot be generalised with confidence. Nurses working 12 hour shifts were more likely to rate the quality of care where they work as poor and give a lower patient safety rating. Nurses working 12 hour shifts were no more or less satisfied with their working pattern than those working shorter shifts. Anecdotally nurse’s views were mixed, with some finding greater flexibility with travel costs, more rest days and childcare with 12 hour shifts, while others reported fatigue, supporting the fact that risks and benefits differ for individual nurses.

4.2 Many hospitals continue with 12 hour shifts based on an untested assumption that is a cost-effective system. The review and analysis of data presented in the report raises a significant challenge to the assumption that 12-hour shifts can reduce costs without any deleterious effects. The review pointed towards an increase in needle stick injuries and musculoskeletal disorders with nurses who work 12 hours or longer more likely to rate the quality care as poor, and give a lower patient safety rating to the environment and few reported benefits; it is noted that the review focused on acute hospitals and it is acknowledged that the type of work and the experience of staff may be very different in mental health settings.

4.3 The Royal College of Nursing (RCN) survey found that the majority of nurses working 12 hour shifts preferred this length of shift for the reasons mentioned above, however guidance focuses on managers ensuring a suitable shift pattern, ensuring that all of the working hours are not grouped together to avoid fatigue and, where possible, to be flexible in allowing staff to choose a rotating shift pattern or fixed pattern.

4.4 A recommendation of the review is to consult with nursing staff across the acute wards about proposed changes to the shift pattern and make recommendations for the most appropriate shift pattern accordingly. Any recommendations will weigh up the evidence on length of shift and correlation to patient safety alongside staff satisfaction and shift pattern to ensure flexibility and maintain staff retention and will include a number of short days.

5.0 Challenges Highlighted During the Review

5.0 Set out below are the key challenges:

- **Violence and aggression** – numbers and nature of violence and aggression has been considered in line with staffing. Local managers are able to flex staffing according to acuity and needs of the ward. There was no direct reference to violence and aggression during clinical review, although there was reference to increasing levels of acuity and higher levels on 1:1 observations, especially on acute wards. There is a continued focus to reduce levels of violence and aggression and restrictive interventions through both the positive and safe work stream and Quality Improvement collaboratives. In addition to this there is a focused piece of work led by the Trust lead for psychology to develop a Trust wide critical incident support system to ensure that there is a consistent approach to supporting staff following incidents.

- **Recruitment and retention** – A number of wards reported challenges with recruiting to vacant posts despite an active recruitment programme, the main areas of concern are the women’s medium secure ward (Juniper), PICU (Avon) and the community hospital ward (Magnolia). Juniper has been supported by the other secure wards to ensure that the ward is suitably staffed; Avon have a healthy bank of staff that have supported the ward and have also contracted agency staff when required. Magnolia ward has been supported by the overseas recruitment programme and has long term contracted agency staff to provide consistency and quality of care. The Trust has
continued focus on recruitment and is successful in recruiting more than 95% of newly qualified nurses who were students with the Trust. There is a need to improve retention and this is supported by quality improvement work with NHS Improvement and a work stream with Capital Nurse.

- **Number of 1:1 observations and escorts off ward** – For all wards the first 1:1 or escort off ward is absorbed in the minimum staffing numbers and can result in additional pressures on staff to deliver care to the remaining patients; however this is factored into acuity and dependency tools and Safe Care when calculating optimum staffing levels.

- **Emergency response** – the system to provide emergency assistance to wards when required varies across the Trust, a recommendation resulting from the review is for the process for emergency response to be reviewed to provide a standardised approach across the Trust.

- **Exemptions to prevention and management of violence and aggression (PMVA) training** – The review highlighted that there were a number of staff across the Trust are currently exempt from practicing PMVA techniques due to physical health issues. There are currently 26 staff exempt, all are being reviewed through occupational health. Managers were advised to ensure that the risk assessment and management plan clearly identified how this would be managed on relevant wards.

- **Shift pattern** – a consistent theme arising from the face to face discussions with ward managers from the acute wards was the challenge that the long day shift presents when facilitating supervision and team meetings; it was also described as having an impact on levels of motivation and tiredness towards the end of the shift; a review of shift patterns will be undertaken with full staff engagement.

### 6 Benefits

6.1 The Trust has participated in the development and piloting of the acuity and dependency tool, once published this will provide the evidence base required by NQB

6.2 There are a number of benefits that have been identified through the comprehensive review of the staffing for inpatient wards:

- Improve the quality of the patient experience by ensuring that the nurse to patient ratio is at optimum level for each specific patient group.
- Improve staff wellbeing – in respect of skill mix, supervision and support.
- Transparent and appropriate rota.
- Enable ward managers to have accountability for establishments that ensure they are able to flex staffing to meet the changing needs of the clinical area.

6.3 It should be acknowledged that safe staffing is much more than just looking at the number of staff on wards. Any review will provide the Trust with the opportunity to grow more peer support worker roles, consider how apprenticeships can be introduced at every level and expand the use of new roles to support existing teams or invest in Advanced Clinical Practitioners to lead them; all of which is outlined in the NHS document ‘Stepping forward to 2020/21’.

### 7 Nursing Associates

7.1 As part of a Capital Nurse bid with HEE and Capital Nurse, the Trust trained 3 nursing associates as a pilot. The 3 trainee nursing associates qualified in February 2019 and entered the nursing midwifery council (NMC) and have taken up substantive posts in their new roles within the Trust. This year the programme has changed to apprenticeship training without the financial support from HEE to backfill their post while on placement or at university. The Trust is, however committed to supporting staff development through this
route as a local pipeline to nursing associates and registered nurses. A further 19 trainee nursing associates started the training in December 2018 with recruitment underway for a further 20 trainees to commence the programme between October and December 2019.

7.2 Services have been proactive and forward thinking in their desire to support staff through this training and create posts for them on completion. This approach will require workforce planning with a clear robust governance process in place to assess the quality impact of any proposed changes to establishment and skill mix.

8 Financial Modelling

8.1 Finance have carried out a comparison of 2019/20 budget to the cost of current shift pattern. Initial findings are that the budget needs uplifting by approximately £152k to meet the minimum staffing numbers that wards are currently rotered for. A deep dive with finance and nursing directorate is recommended for scrutiny and accuracy.

8.2 The financial modelling is calculated based on the current agreed headroom of 24%. A comparison using headroom of 22% has been calculated (appendix 4)

9 Headroom

9.1 Uplift, also known as headroom, is a judgement about additional staff to cover time spent out of the clinical area. This covers activities such as annual leave, study leave, sickness absence, parenting leave and emergency or carer’s leave.

9.2 The RCN (2013) recommends minimum headroom of 25%. However, there is variation reported in literature, ranging from 21.6% to 25.3% (Hurst 2016); for the acuity and dependency tool and calculator it is recommended that headroom should not fall below 22%. The headroom in a benchmarking telephone survey of trusts across England (Jones et al 2016) ranged from 15% (plus a percentage for real time maternity leave) to 25% (plus a percentage for real time maternity leave).

9.3 The National Quality Board (NQB 2018) recommends that the percentage uplift allocation must be based on historical data, future staffing projections and the staffing profile. This should be reviewed annually to ensure an adequate allocation. The historical percentage can be built into the prospective workforce plan.

The Trust calculates the current headroom of 24.2% based on:

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9.4 The current calculation of annual is above that of maximum annual leave allowance according to Agenda for Change, at 33 days. The majority of mandatory training is now available via e-learning, some of which requires less time away from clinical areas. However with the introduction of apprenticeships there are additional requirements for time out of the clinical area which may add to training days.

9.5 For comparison, an example of calculations for 22%, this can be altered to reduce annual leave to reflect annual leave at 33 days, although the sickness may need to be increased as the average for the last financial year was 4.27%.

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10 **Proposed Changes to Establishments**

10.1 Currently two of the acute wards (Thames and Trent) have a higher bed base than the other acute wards across the Trust, the recommendation is for an increase by 1 health care assistant to the day shift only to support with the acuity and dependency levels and provide a staff to patient ratio in line with the other acute wards in the Trust. When the new ward opens later in the year and the bed base for both Thames and Trent reduces back down to 18 per ward, the staffing requirements will be reviewed, it is anticipated that the minimum staffing and thereby full time equivalent will revert back to the current level.

10.2 As outlined in section 3.17 there was an uplift to the minimum staffing numbers on the Oaks (OPMH) following a quality review; a recommendation from the skill mix review is to increase the full time establishment by 1 registered nurse during the day to support the current interim minimum staffing rota on a permanent basis.

11 **Recommendations**

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<td>1. Staff consultation on shift pattern for acute wards, to consider hybrid model of both 2 shift and 3 shift pattern</td>
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<td>2. Make full use of current systems, both e-roster and Safe Care module to streamline processes and develop a flexible workforce that is responsive to the needs of the service.</td>
<td>Underway. External consultant presented an options paper to the executive leadership team in April 2019.</td>
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<td>3. Review emergency response teams across the Trust</td>
<td>Clinical Directors to work with nurse consultant for positive and safe and lead for non-clinical risk to review and standardise the approach to emergency support across the Trust – complete December 2019</td>
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<tr>
<td>4. Consider and agree proposed changes to establishments</td>
<td>Paper to Trust Board May 2019</td>
</tr>
<tr>
<td>5. Nursing Directorate and Finance to review the modelling and any cost variance</td>
<td>Completed April 2019. Beacon budget and allied health professionals under review by finance.</td>
</tr>
<tr>
<td>6. Workforce planning to develop new roles and support governance structures with regards to quality impact assessments for any change to establishments.</td>
<td>Pilot in two specialist wards commenced April 2019</td>
</tr>
<tr>
<td>7. A recommendation is that when changes are made to the purpose or specialism of a ward a full skill mix review is carried out.</td>
<td>Service leads and assistant directors to involve Director of Nursing at the outset of any skill mix establishment review.</td>
</tr>
<tr>
<td>8. Recommendation for Trust Board to consider and agree headroom</td>
<td></td>
</tr>
</tbody>
</table>
12 Summary

12.1 The Trust continues to monitor and report nurse staffing levels to provide assurance that we deliver safe, effective and high quality care.

12.2 The Trust has measures in place to manage, monitor and escalate concerns around safe staffing on a shift by shift basis with senior staff providing appropriate support toward teams.

12.3 Changes to three wards existing staffing establishments are proposed, outlined in section 8.

12.4 The Trust has received a safe staffing report at each public meeting which has provided the Trust Board with information in respect of planned versus actual staffing numbers both for registered and unregistered staff.

12.5 The acuity and dependency calculator tools will be useful to provide a consistent national approach to calculating baseline levels to support good practice. However no guidance can or should replace the ability and professional judgement of nursing leaders, managers and healthcare professionals in supporting the framework with clinical and professional guidance to support the decision making.

13 Action being requested

13.1 The Trust Board is asked to note the processes and plans in place to monitor safe staffing levels.

13.2 In addition to the work on staffing numbers, it is recommended that a review takes place on skill mix, to consider such roles as the nursing associate and carry out competencies mapping exercise.

13.3 The Oaks - Uplift of minimum staffing numbers by 1 registered nurse per morning shift, Monday to Friday

13.4 Trent and Thames wards – uplift of 1 health care assistant on each ward during the day shift only; this will be for an interim period and will be reviewed when the bed base reduces to 18 for each ward.

Implications

14 Financial

14.1 The additional cost for uplift to The Oaks is £85k, although the ward is currently working to these minimum numbers outside of budget, resulting in a cost pressure to the service.

14.2 The proposal for an uplift to Trent and Thames wards would mean costs of £190k, although is reduced to £93k when offset by a reduction in budget to wards resulting from financial modelling (appendix 3)

14.3 Band 7 nurses on the ward will continue to be considered to be ‘supervisory’ and although included in the ward budget will not form part of the staffing review in terms of inclusion in the shift pattern.
15 Risk Management

15.1 Consistency in high calibre, well trained and competent staff will contribute to risk reduction and improved quality of care and patient experience. Investment in staff development will also assist in retaining high quality staff and assist in the recruitment of staff in the future.

16 Equality and Diversity Implications

16.1 None
## Inpatient Nurse Staffing and Skill Mix

### Appendix 1

#### Wards with a 2 shift pattern (12 hour shifts)

<table>
<thead>
<tr>
<th>Unit (acute wards)</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avon (PICU)</td>
<td>07:00-19:30</td>
<td>19:00-07:30</td>
</tr>
<tr>
<td>Dorset</td>
<td>07:00-19:30</td>
<td>19:00-07:30</td>
</tr>
<tr>
<td>Fairland’s</td>
<td>07:00-19:30</td>
<td>19:00-07:30</td>
</tr>
<tr>
<td>Finsbury</td>
<td>07:00-19:30</td>
<td>19:00-07:30</td>
</tr>
<tr>
<td>Haringey Assessment Ward</td>
<td>07:00-19:30</td>
<td>19:00-07:30</td>
</tr>
<tr>
<td>Suffolk</td>
<td>07:00-19:30</td>
<td>19:00-07:30</td>
</tr>
<tr>
<td>Sussex</td>
<td>07:00-19:30</td>
<td>19:00-07:30</td>
</tr>
<tr>
<td>Thames</td>
<td>07:00-19:30</td>
<td>19:00-07:30</td>
</tr>
<tr>
<td>Trent</td>
<td>07:00-19:30</td>
<td>19:00-07:30</td>
</tr>
</tbody>
</table>

#### Wards with a 3 shift pattern

<table>
<thead>
<tr>
<th>Unit</th>
<th>Early</th>
<th>Late</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beacon (CAMHS)</td>
<td>07:00-15:00</td>
<td>13:30-21:30</td>
<td>21:00-07:30</td>
</tr>
<tr>
<td>Blue Nile House (low secure)</td>
<td>07:00-15:00</td>
<td>13:30-21:30</td>
<td>21:00-07:30</td>
</tr>
<tr>
<td>Cardamon (medium secure)</td>
<td>07:00-15:00</td>
<td>13:30-21:30</td>
<td>21:00-07:30</td>
</tr>
<tr>
<td>Eden (low secure)</td>
<td>07:00-15:00</td>
<td>13:30-21:30</td>
<td>21:00-07:30</td>
</tr>
<tr>
<td>Derwent (medium secure)</td>
<td>07:00-15:00</td>
<td>13:30-21:30</td>
<td>21:00-07:30</td>
</tr>
<tr>
<td>Moselle House (low secure LD)</td>
<td>07:00-15:00</td>
<td>13:30-21:30</td>
<td>21:00-07:30</td>
</tr>
<tr>
<td>Fennel (medium secure)</td>
<td>07:00-15:00</td>
<td>13:30-21:30</td>
<td>21:00-07:30</td>
</tr>
<tr>
<td>Juniper (medium secure female)</td>
<td>07:00-15:00</td>
<td>13:30-21:30</td>
<td>21:00-07:30</td>
</tr>
<tr>
<td>Ken Porter (rehabilitation)</td>
<td>07:00-15:00</td>
<td>13:30-21:30</td>
<td>21:00-07:30</td>
</tr>
<tr>
<td>Magnolia (community hospital)</td>
<td>07:00-15:00</td>
<td>13:30-21:30</td>
<td>21:00-07:30</td>
</tr>
<tr>
<td>Mint (medium secure LD)</td>
<td>07:00-15:00</td>
<td>13:30-21:30</td>
<td>21:00-07:30</td>
</tr>
<tr>
<td>The Oaks (OPMH)</td>
<td>07:00-15:00</td>
<td>13:30-21:30</td>
<td>21:00-07:30</td>
</tr>
<tr>
<td>Paprika (medium secure)</td>
<td>07:00-15:00</td>
<td>13:30-21:30</td>
<td>21:00-07:30</td>
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<tr>
<td>Phoenix (eating disorder)</td>
<td>07:00-15:00</td>
<td>13:30-21:30</td>
<td>21:00-07:30</td>
</tr>
<tr>
<td>Sage (medium secure)</td>
<td>07:00-15:00</td>
<td>13:30-21:30</td>
<td>21:00-07:30</td>
</tr>
<tr>
<td>Severn (medium secure)</td>
<td>07:00-15:00</td>
<td>13:30-21:30</td>
<td>21:00-07:30</td>
</tr>
<tr>
<td>Silver Birches (OPMH)</td>
<td>07:00-15:00</td>
<td>13:30-21:30</td>
<td>21:00-07:30</td>
</tr>
<tr>
<td>Cornwall Villa (OPMH)</td>
<td>07:00-15:00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tamarind (medium secure)</td>
<td>07:00-15:00</td>
<td>13:30-21:30</td>
<td>21:00-07:30</td>
</tr>
<tr>
<td>Somerset Villa – rehabilitation (hybrid model)</td>
<td>08:00-15:15 (L/D – 08.00 – 20.30hrs)</td>
<td>13:45-21:00</td>
<td>20:00-08.30</td>
</tr>
</tbody>
</table>
Total cost for rolling year Feb 18-Jan 19 is £4.1m. Graph 1 shows cost for all wards including older people’s mental health, secure, eating disorders, CAMHS and acute community ward.
### Appendix 3 - Headroom at 24.2%

<table>
<thead>
<tr>
<th>Ward</th>
<th>Budget 2019/20 (VTE)</th>
<th>Recommended VTE</th>
<th>Variances VTE</th>
<th>Budget 2019/20 (£000)</th>
<th>Uplift / Reduction (£000)</th>
<th>Breakdown</th>
<th>New posts</th>
<th>Budget 2019/20 (VTE)</th>
<th>Recommended VTE</th>
<th>Variances VTE</th>
<th>Budget 2019/20 (£000)</th>
<th>(Reduction) (£000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dorset</td>
<td>25.00</td>
<td>27.67</td>
<td>2.67</td>
<td>1,061</td>
<td>-</td>
<td>Basset</td>
<td>£15.54</td>
<td>£15.45</td>
<td>£0.91</td>
<td>£4,607</td>
<td>-</td>
<td>97</td>
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<tr>
<td>Evesfield</td>
<td>25.00</td>
<td>27.66</td>
<td>2.67</td>
<td>1,060</td>
<td>-</td>
<td>Evesfield</td>
<td>£252.74</td>
<td>£251.36</td>
<td>£1.38</td>
<td>£3,357</td>
<td>-</td>
<td>99</td>
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<tr>
<td>Thomas</td>
<td>24.44</td>
<td>27.87</td>
<td>3.23</td>
<td>1,030</td>
<td>-</td>
<td>Haringay</td>
<td>£75.00</td>
<td>£75.03</td>
<td>£0.03</td>
<td>£3,224</td>
<td>-</td>
<td>0</td>
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<tr>
<td>Area PICU</td>
<td>34.50</td>
<td>32.07</td>
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<td>1,427</td>
<td>-</td>
<td>Specialist Services</td>
<td>£381.46</td>
<td>£371.31</td>
<td>£10.15</td>
<td>£15,640</td>
<td>-</td>
<td>190</td>
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<tr>
<td>KIn Porter</td>
<td>31.60</td>
<td>29.04</td>
<td>-2.56</td>
<td>1,268</td>
<td>-</td>
<td>-</td>
<td>£824.15</td>
<td>(£9.39)</td>
<td>-</td>
<td>£152</td>
<td>-</td>
<td>190</td>
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<tr>
<td><strong>Total</strong></td>
<td>115.54</td>
<td>116.45</td>
<td>-0.91</td>
<td>4,807</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

**Evesfield**
- Dorset: 25.00
- Suffolk: 25.00
- Sussex: 25.00
- Cornwall Villas: 18.30
- Silver Birch: 31.00
- Somerset Villas: 23.56
- The Oak: 30.40
- Magnolia: 41.77
- Cape Town: 32.11

**Haringay**
- Fairlands: 25.00
- Finchley: 25.00
- Haringay Assessment: 25.00

**Specialist Services**
- Cardiology: 31.70
- Mint: 23.43
- Paprika: 25.00
- Janitor: 25.50
- Blue Nile: 22.50
- Sage: 34.50
- Fanal: 22.50
- Tansind: 25.00
- Phoenix: 29.20
- Sevens: 22.50
- Beacon Centre: 44.57
- Eden (Sold East): 24.19
- Morrell House: 21.50
- Downeast: 27.00

**Total** 381.46

**GRAND TOTAL** 824.74

---

Trust Board Page 68
### Appendix 4- Headroom at 22%

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Brent</td>
<td>25.00</td>
<td>24.58</td>
<td>-0.42</td>
<td>1.08</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Trent</td>
<td>25.00</td>
<td>24.58</td>
<td>-0.42</td>
<td>1.08</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Thames</td>
<td>25.00</td>
<td>24.58</td>
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<td>1.08</td>
<td>-</td>
<td>-</td>
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<td>1.08</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Kent Porter</td>
<td>25.00</td>
<td>24.58</td>
<td>-0.42</td>
<td>1.08</td>
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<td>Total</td>
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<td>Enfield</td>
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<tr>
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<td>-0.42</td>
<td>1.08</td>
<td>-</td>
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<tr>
<td>Trent</td>
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<td>-0.42</td>
<td>1.08</td>
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<tr>
<td>Thames</td>
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<td>24.58</td>
<td>-0.42</td>
<td>1.08</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Avon Park</td>
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<td>24.58</td>
<td>-0.42</td>
<td>1.08</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Kent Porter</td>
<td>25.00</td>
<td>24.58</td>
<td>-0.42</td>
<td>1.08</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Total</td>
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<td>256.92</td>
<td>-4.18</td>
<td>9.57</td>
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<td>Haringey</td>
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<td>Feilds</td>
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<td>24.58</td>
<td>-0.42</td>
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<td>-</td>
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<td>1.08</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Haringey Assessment</td>
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<td>24.58</td>
<td>-0.42</td>
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<td>Specialist Services</td>
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<td>need to check</td>
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<tr>
<td>Cardiac</td>
<td>31.70</td>
<td>33.42</td>
<td>1.72</td>
<td>1.31</td>
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<tr>
<td>MHT</td>
<td>23.49</td>
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<td>0.96</td>
<td>0.94</td>
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<td>10</td>
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<tr>
<td>Pepple</td>
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<td>0.55</td>
<td>1.035</td>
<td>59</td>
<td>59</td>
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<tr>
<td>Junior</td>
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<td>24.58</td>
<td>0.55</td>
<td>1.035</td>
<td>59</td>
<td>59</td>
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<tr>
<td>Blue Nile</td>
<td>22.50</td>
<td>21.04</td>
<td>1.46</td>
<td>0.970</td>
<td>49</td>
<td>-</td>
</tr>
<tr>
<td>Sage</td>
<td>34.58</td>
<td>33.42</td>
<td>1.16</td>
<td>1.384</td>
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<td>-</td>
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<tr>
<td>Fenial</td>
<td>22.50</td>
<td>21.04</td>
<td>1.46</td>
<td>0.970</td>
<td>49</td>
<td>-</td>
</tr>
<tr>
<td>Tamarin</td>
<td>25.00</td>
<td>24.48</td>
<td>0.54</td>
<td>1.035</td>
<td>59</td>
<td>59</td>
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<tr>
<td>Phoenix</td>
<td>22.50</td>
<td>21.04</td>
<td>1.46</td>
<td>0.970</td>
<td>49</td>
<td>-</td>
</tr>
<tr>
<td>Seven</td>
<td>22.50</td>
<td>24.48</td>
<td>0.54</td>
<td>1.035</td>
<td>59</td>
<td>59</td>
</tr>
<tr>
<td>Beacon Centre</td>
<td>44.57</td>
<td>35.14</td>
<td>11.43</td>
<td>1.766</td>
<td>314</td>
<td>-</td>
</tr>
<tr>
<td>Eden (Seacolls East)</td>
<td>25.00</td>
<td>24.48</td>
<td>0.54</td>
<td>1.035</td>
<td>59</td>
<td>59</td>
</tr>
<tr>
<td>Moslate House</td>
<td>25.00</td>
<td>24.48</td>
<td>0.54</td>
<td>1.035</td>
<td>59</td>
<td>59</td>
</tr>
<tr>
<td>Derwent</td>
<td>25.00</td>
<td>24.48</td>
<td>0.54</td>
<td>1.035</td>
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<td>59</td>
</tr>
<tr>
<td>Total</td>
<td>361.46</td>
<td>365.11</td>
<td>15.35</td>
<td>16.640</td>
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<tr>
<td><strong>GRAND TOTAL</strong></td>
<td><strong>824.74</strong></td>
<td><strong>810.24</strong></td>
<td><strong>14.50</strong></td>
<td><strong>33.028</strong></td>
<td><strong>470</strong></td>
<td><strong>825</strong></td>
</tr>
</tbody>
</table>

Trust Board Page 69
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Title: Trust Integrated Performance Report – update on April 2019

Report to: Trust Board

Date: 23 May 2019

Security Classification: Public Board Meeting

Report Author: Jayshree Pindoriya
Assistant Director of Information & Performance

Report Sponsor: Stanley Riseborough
Interim Executive Chief Operating Officer

Comments / views of the Report Sponsor: The Board is recommended to note the content of this report.

Overview of the report:
This report provides a summary of performance against both NHSI Single Oversight (SOF) Targets and the Trust Key Performance Indicators (KPIs) update for April reporting.

This report provides an overview of April performance, assessed against the indicators under the CQC domains, Safe, Effective, Caring and Responsive.

Key issues to bring to the attention of members:

The Board is asked to note:

The key challenges on service performance is mainly on NHSI and National targets:

- Accident and Emergency – 1 hour response at North Middlesex Liaison Service performance fell by 7.9% reporting at 77.0%. Achievement of the target will continue to be challenging. There have been on-going issues of 1 hour breaches occurring when multiple referrals present to the service. This tends to occur during out of hour (5pm-9pm) when there is a reduced staffing compliment and assessments cannot be completed within the 1 hour.

- Accident and Emergency – 1 hour response at Barnet Hospital performance in April fell by 1.4% reporting at 89.8%. The main reason for the number of breaches each month is constantly recognised as multiple referrals received at a time delaying the nursing staff to see all referrals within the 1 hour target.

Areas of above target or improved performance in NHSI and National Targets:

- 7 day follow up for patients discharged from Inpatient wards seen within 7 days continues to be above target month on month, weekly monitoring is place to ensure compliance - reporting month at 98% (118/120) against target of 95%. The Trust continues to be ranked top performing against London Trusts.
The benchmarking information indicates the Trust is reporting at 99.4% above the National and London Average.

- Podiatry waiting times has been achieved and is reporting at 100% for the second month against the 95% target. The improvement is due full establishment of staff.

- The 2-week access standard for Early Intervention in Psychosis continues to be above target – reporting month increased to 86%, the national target for 19/20 has increased to 55%.

The benchmarking information indicates that the Trust is reporting above the National and London Average.

- Enfield’s ‘Let’s Talk’ IAPT service recovery rate has continued to maintain good performance reporting at 51.82% against the national target of 50%. The service has sustained all waiting times standards.

- Barnet’s ‘Let’s Talk’ IAPT service has met all waiting times standards apart from 6 weeks target, this is due to high volume of referrals entering treatment against the 348 target. Expansion funding was not agreed in writing until April 2019. All posts have now been advertised, with shortlisting and interviews scheduled for the next 4 weeks. Band 5 positions take approximately 8 weeks from offer to start date and band 7 positions 16 weeks, due to an increased notice period for the latter. Agency backfill at 60% has been agreed and these positions are currently being filled, thus some clinical work will start from the current month. Supporting measures particularly the number of people who enter first treatment appointment continues to improve reporting at 53.08% against national target of 50%.

**Key supporting documents:**

- Trust Integrated Performance Report

**Decisions / actions required:**

The Quality and Safety Committee is asked to highlight any areas of performance requiring additional assurance or investigation before presentation to the Trust Board.

**Likely onward reporting:**

Once approved by this committee, or once feedback has been incorporated, this report will be submitted to the Trust Board.

**Report History:**

This is a regular report, produced monthly.

**Implications of the decision / actions:**

Performance improvement activity will be guided by comments and feedback from this committee.

**Links to the Trust’s Objectives, Board Assurance Framework and / or Corporate Risk Register**

Performance against these metrics informs the Board and the Quality and Safety Committee of the extent to which that we are providing excellent services for patients.

**List of Appendices:**

- Integrated Performance Report
This report provides a summary of performance against both NHSI Single Oversight (SOF) Targets and the Trust Key Performance Indicators (KPIs) for 2018/19.

**Effective & Responsive**

**TARGET: 95%**

The % Gatekept by the Crisis Resolution Home Treatment Team has been above target throughout the year, the chart shows there was a period of 12 consecutive months where there was a period of special cause variation. In the recent three months the SPC chart shows a period of common cause variation. The reporting month shows all patients admitted were gatekept (99%).

The CRHTs have been asked to review the process to ensure all cases are gatekept prior to admission. Fortnightly data quality report are monitored by the Performance Managers in order to address any under recording.

**TARGET: 53%**

The SPC chart for the Early Intervention in Psychosis indicates that the level of variation in the process is of common cause, the 2 weeks to treatment has remained above target of 53% in all three boroughs.

There are not concerns in sustaining this target.

The benchmarking information indicates that the Trust is reporting above the National and London Average.

Special Cause Variation Improvement (7 or more consecutive data points better than the mean, or a single point outside the control limit)
Special Cause Variation Concern (7 or more consecutive data points worse than the mean, or a single data point outside the control limit)
Common Cause Variation
RECOVERY RATE TARGET: 50%

The SPC chart indicates that the level of variation in the process is of common cause. The performance in the reporting month is at 59.3% against the target.

WAITING TIMES TARGET - 95%

The service has continued to meet all waiting times standards - 6 weeks and 18 weeks respectively and there are no concerns in sustaining the target.

RECOVERY RATE TARGET: 50%

The SPC chart indicates the level of variation in the process is of common cause. The performance in the reporting month is at 58.1% against the target.

WAITING TIMES TARGET - 95%

The SPC chart for the 6 weeks treatment indicates the level of variation in the process is of concern. This is due to high volume of referrals entering treatment every month. In the last quarter the average number of referrals reported by the service had increased by 59% against the referral target 348.

The CCG have released additional funds to reduce these but more funds are required to make an
TARGET: 95%

The SPC chart for 7 day follow up indicates that the performance has consistently been above target of 95% with reporting month at 98%.

This indicator is monitored by the Performance team on a fortnightly basis, liaising with the ward to ensure accurate recording of follow up and allowable exceptions ie. AWOL, deported, remanded in custody or MH hospital transfer.

The benchmarking information indicates the Trust is reporting at 99.4% above the National and London Average.

The CQUIN scheme for 19/20 will require follow up within 72 hours of discharge with 80% target. As part of the CQUIN this will change in Q3 reporting.

TARGET: 95%

The SPC charts indicates the 1 hour response time in A&E Liaison Service at North Middx has been a period of special cause variation (improvement) for six consecutive months. However, in the reporting month the performance is showing 84.9% showing a reduction in last two months.

Achievement of the target will continue to be challenging. Performance fell by 0.6% for the third consecutive month. The service saw the number of referrals increase in the month by 5.4% including an increase of 3.5% in the number of referrals pertaining to the over 65 age group. The Horizon project funded for 2-3 months is coming to an end in March as well as the cash injection of 150k Winter Resilience funding from Enfield CCG. The funding has helped to fund additional resources required to support staff pressures in the service.

The SPC chart for A&E Liaison for 24 hour response time shows a period of special cause (common) the last two consecutive months reported below mean 86%.
Special Cause Variation Improvement (7 or more consecutive data points better than the mean, or a single point outside the control limit)

Special Cause Variation Concern (7 or more consecutive data points worse than the mean, or a single data point outside the control limit)

Common Cause Variation

**TARGET: 95%**

The SPC chart indicates variation of common cause, the Performance in March improved, but still remained under target at 91.2%.

Performance in March improved by 7.9%. The number of referrals to A&E increased by 30% with a corresponding increase in the number of over 65s referrals. The split between patients seen in A&E and on the wards have remained approximately 60% & 40% respectively. The main reason for the number of breaches each month is constantly recognised as multiple referrals received at a time delaying the nursing staff to see all referrals within the 1 hour target.

The SPC chart for A&E Liaison for 24 hour response time shows a period of special cause (common) the last two consecutive months reported below mean 93.9%.
The Trust Key Performance Indicators (KPIs) for 2018/19 based on National and Local Targets

**TARGET: 95%**

The SPC chart for patients on CPA reviewed in the last 12 months indicates the level of variation in the process is of common cause.

Overall CPA reviews have remained on target for 18/19. Two of the three borough have experience set backs in achieving the target during the year. Haringey due to transitional changes to locality teams and relocation of services to the central site. Barnet due to internal staffing issues within the service. Enfield manage to remain on target for most of the year.

**TARGET: 95%**

The SPC chart for Memory Service referral to diagnosis within 6 weeks shows variation in the common cause above the lower process limit. The reporting month shows improvement at 60.3% above the mean level of 52.2%.

In the last two months the boroughs have been working towards the backlog of patient waits over 7 weeks. The service is provided with weekly detailed waiting list to ensure patients appointments are booked and follow up telephone reminder. The services have been providing fortnightly recovery plan for the Tri-borough monitoring meeting.

In the reporting month Barnet achieved 83%, Enfield 38% and Haringey 89%. Barnet and Enfield backlog of waits over 7 weeks is reporting in single numbers.

The improvement in Enfield will be evident in April reporting.
TARGET: 5%

The SPC chart for emergency re-admissions indicates a period of special cause variation (concern) against the 2.3% mean but continues to remain below the 5% target.

Emergency re-admissions in the month was above target at 7.3% representing 8 breaches. Within the services Enfield and Haringey remained with target, whilst Barnet reported 7.3%. There were 6 breaches in Barnet identified as patients being suicidal, relapse, 2 transferred to other hospitals, 1 transferred to private and another patient unsafe in the community.

The National benchmarking shows that BEH has less emergency re-admission. The national average is 9.1%.

The SPC chart shows the number of patient admissions to out of area placement - mean 40 a month.

The SPC chart below shows the out of area placements occupied bed days by BEH CCGs. The Trust has seen an increase in OAP and occupied bed days since May 2018.
Delayed Transfers of Care (DTOC) - Adults & Older Adults

TARGET: 2.5%

The SPC chart indicates that there is a special cause variation (improvement) since January 18 but remains above the target of 2.5%.

Improvement for the combined number of Adults and Older Adults DTOCs reported for the month. A total of 16 DTOCs were reported compared to 23 last month. The average number of OBDs pertaining to DTOCs increased in the month by approximately 5 bed days as patients spent a longer time on the wards. Effective management is aiming to reduce numbers and the time spent on the wards. At the end of the month responsibilities for DTOCs were assigned as NHS 9 LA 4 and Joint 3.

Overall improvement in performance attributable to fall in the total number of Adult DTOCs. A total of 10 adult DTOCs was reported for the month compared to 17 last month. The average number of bed days attributable to DTOCs remained relatively the same as the previous month. Within the services the number of DTOC fell by 4 in Barnet, fell by 3 in Haringey with no change in Enfield. Month end performances were reported as Barnet achieving 8%, Enfield and Haringey both achieved 2% within the 2.5% target.

Performance dropped by 5.3%. Although the number of 6 Older Adult DTOCs remained the same as the previous month, the average number of bed days increased by approximately 13 days in the month as patients spent a longer time on the wards. Month end performance were reported as Barnet 14%, Enfield on target at 1% and Haringey 15%. Number of DTOCs 2 in Barnet, 1 in Enfield and 3 in Haringey.
**WELL LED**

**Workforce - Key Performance Indicators**

**TARGET: 90%**

The SPC chart indicates that there is special cause variation (concern) back in October. The Trust remains below target in this area.

A further improvement in compliance this month. The L&D team's improvement plan has been implemented. Outreach, e-learning clinics, self service booking facility and peer reviews all continue.

**TARGET: 3.5%**

The SPC chart indicates that there is special cause variation (concern). The trust remains above target in this areas.

Sickness absence has remained at 4.2% for March 2019. Long term sickness has increased to 2.0% (February 1.7%), Short term sickness has had a further decrease of 0.2% within the reporting month, March 2019 2.2% (February 2.4%). It is hoped that the new attendance policy, with its focus on facilitating return to work, will have a positive impact on the level of sickness absence.

**TARGET: 15%**

The SPC chart indicates that there is special cause variation (improvement), the chart shows in the last three months below mean 13.8%.

Total staff turnover has increased slightly in March, however remains within target of 15%. The Unplanned Turnover has remained at 10.9% and remains within the Trust Target. We have set an ambitious target to reduce the turnover rate to 11% by September 2019. The retention programme is well supported with good engagement from boroughs. NHSI undertook a review on 12 December, reported good progress and were particularly pleased with our focus on engaging staff in the process and delivery of projects. The launch of Vivup (a portal providing a range of non-pay benefits) has been well received.
TARGET: 10%

The SPC chart for total vacancy rate within the 10% target. Vacancies have decreased by 0.7% and has met the Trust target. Bespoke activities are underway in vacancy hotspots, with consideration of skill mix reviews to fill gaps that remain hard to fill.

TARGET: 10%

The SPC chart for % medical vacancy rate remains within the Trust target of 10%. There are challenges in particular areas which are being addressed by the boroughs and medical HR.

TARGET: 10%

The SPC chart for % nursing vacancy rate shows above target of 10% and above the lower process limit 13%. The current month is reporting at 14.2%, a marginal increase to vacancies within nursing - 0.1% increase within the reporting month. There are some areas of hotspots, both Nursing and Workforce are supporting those areas to facilitate filling those vacancies.

Special Cause Variation Improvement (7 or more consecutive data points better than the mean, or a single point outside the control limit)

Special Cause Variation Concern (7 or more consecutive data points worse than the mean, or a single data point outside the control limit)

Common Cause Variation
**TARGET: 10%**

The SPC chart shows the Trust is continuing to performing below the 10% target.

There has been a slight decrease in the Bank expenditure in March 2019 reporting at 10%. The main cause for the recent decrease is due to a reclassification of constant watch costs in the prisons from pay to non-pay. It remains a challenge and so the business partnering team continue to work with managers to convert agency to bank or permanent and to manage vacancies. Proactively, Workforce team is working with borough managers to address hotspots.

**TARGET: 8%**

The SPC chart shows the Trust is continuing to perform below the 8% threshold. The last three months show an increase above the mean 6.3%. There has been a slight decrease in the Agency expenditure in March 2019. The main cause for the recent decrease is due to a reclassification of constant watch costs in the prisons from pay to non-pay. It remains a challenge and so the business partnering team continue to work with managers to convert agency to bank or permanent and to manage vacancies proactively. The Workforce team is working with borough managers to address hotspots.

**TARGET: 77 days**

The SPC chart indicates that there has been a period of special cause variation (concern) since July 2018. The time to hire figure has seen an increase within the reporting month at 90 days above the Trust target of 77 days.

The recruitment team remain focussed on streamlining the process to ensure effective recruitment, selection and on boarding processes.
The figure is largely stable in that slightly less than 2/3rds of staff who leave the Trust would recommend it as a "great place to work". Exit interviews are monitored and where trends/themes can be identified, these are fed into the retention working group for consideration. The Workforce team is considering options to increase the level of exit interview completion.

Target: 50%

The overall score for both indicators under staff FFT remains above target. The weighted Qtr 3 score as measured in the national staff survey have now been added as well as the Qtr 4 scores. The trend is broadly positive again. The scores for both categories have increased with a significant increase percentage for recommendation as a place to work.

The SPC charts below - Patient FFT Mental Health overall score and Enfield Community Health overall score are reporting above Trust target.
Quality - Key Performance Indicators

TARGET: 0

The chart shows the number of cases reported as grade 3 or 4 pressure ulcers. One was reported in March, in prior month the number varied.

1 reported incident in the reporting month in Forest District Nursing Team.

### TARGET: 0

The above table shows that there have been no reported cases of:

- Inappropriate use of inpatient beds
- Never events
- Falls resulting in severe injury or death (with the exception of 1 in April).

- Special Cause Variation Improvement (7 or more consecutive data points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (7 or more consecutive data points worse than the mean, or a single data point outside the control limit)
- Common Cause Variation
**Quality - Key Performance Indicators - Patient Satisfaction**

**TARGET: 0**

The SPC chart shows the level of variation in the process is of special cause variation (concern) since May 18 and continued to increase month on month.

In the reporting month there were 8 patients kept in the S136 suite after the time had expired awaiting bed availability. Three of the patients were bought to the S136 from A&E with no legal powers under the MHA waiting for an inpatient bed.
Enfield Community Health

**Podiatry % of non-urgent referrals assessed within 13 weeks**

The SPC chart for Podiatry of non-urgent referrals assessed within 13 weeks indicates a level of variation of special cause (improvement). The reporting month is showing 100% compliance, the contributory factor has been fully established service.

**TARGET: 90%**

There are insufficient data points to prepare an SPC chart for Podiatry and District Nursing.

The Enfield Health KPIs on District Nursing, Podiary and New Birth visit continue to exceed target month on month.

**TARGET: 95%**

There are insufficient data points to prepare an SPC chart for Podiatry and District Nursing.

The Enfield Health KPIs on District Nursing, Podiatry and New Birth visit continue to exceed target month on month.

---

**Common Cause Variation**

- Special Cause Variation Improvement (7 or more consecutive data points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (7 or more consecutive data points worse than the mean, or a single data point outside the control limit)
<table>
<thead>
<tr>
<th><strong>Title:</strong></th>
<th>Finance Report as at Month 12 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report to:</strong></td>
<td>Trust Board</td>
</tr>
<tr>
<td><strong>Date:</strong></td>
<td>23 May 2019</td>
</tr>
<tr>
<td><strong>Security Classification:</strong></td>
<td>Public Board Meeting</td>
</tr>
</tbody>
</table>

**Purpose of Report:**
To update the Trust Board on the Trust's financial position.

**Recommendations:**
The Trust Board is asked to note:
- I&E deficit £0.2m at year-end, which is £2.9m better than plan (£3.1m better than NHSI Plan profile);
- Cost Improvement Plan (CIP) delivery ended the year £1.2m behind plan;
- Cash balance is £55.5m against a plan of £53.3m. Capital expenditure is £15.5m against a plan of £18.4m;
- NHSI Single Oversight rating is currently 3 and is forecast to stay as a 3 for the rest of the year.

**Report Sponsor:**
David Griffiths, Chief Finance and Investment Officer

**Report Author:**
Nina van Markwijk
Deputy Director of Finance
0208 7023712
Nina.van-markwijk@nhs.net

**Report History:**
Monthly report to the Trust Board to update on the current financial position of the Trust

**Budgetary, Financial / Resource Implications:**
These are covered in the report.

**Equality and Diversity Implications:**
None

**Links to the Trust’s Objectives, Board Assurance Framework and/or Corporate Risk Register**
This report supports the Trust’s objective to ‘meet our financial and other targets’.

**List of Appendices:**
Appendix A – Performance by Service Line
## Financial Performance Executive Summary

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Status</th>
<th>Position</th>
<th>Trend</th>
<th>Variation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance against NHSI Control Total</td>
<td>Net income and expenditure</td>
<td></td>
<td><strong>Net surplus/(deficit) in month:</strong> Plan £0.1m, actual £2.1m, variance £2.0m favourable</td>
<td><img src="image-1.png" alt="Cumulative Financial Position against Plan" /></td>
<td>Income: Favourable to plan £6.7m - additional services commissioned from the CCGs, NMOC income from NHSE, and additional Incentive PSF £2.5m. Pay: Favourable to plan £1.5m - vacancies. Non Pay: Adverse to plan by £5.3m –bed placements and CIP slippage, partially offset by release of provision and depreciation charges behind plan.</td>
</tr>
<tr>
<td>Cost Improvement Programme (CIP)</td>
<td>Savings against the CIP plan</td>
<td></td>
<td><strong>CIP in month:</strong> Plan £0.8m, actual £0.6m, variance (£0.2)m adverse.</td>
<td><img src="image-2.png" alt="Cumulative CIP Performance" /></td>
<td>Actual delivery is adverse to plan due to several schemes slipping into next financial year (inc. Capetown), several schemes no longer planned to deliver, and the IT savings lower than anticipated.</td>
</tr>
<tr>
<td>Capital expenditure</td>
<td>Year to date cumulative expenditure in non-current assets</td>
<td></td>
<td><strong>CAPEX in month:</strong> Plan £1.8m, actual £7.7m, variance £5.9m adverse</td>
<td><img src="image-3.png" alt="Capital Expenditure 2018-19" /></td>
<td>Capital expenditure on projects has been behind schedule throughout the year. This slippage was reduced in March 2019 but overall it was £2.9m behind plan at the end of the year.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>CAPEX YTD:</strong> Plan £18.4m, actual £15.5m, variance £2.9m favourable</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Cash

- Cash held with the Government Banking Service: Green

Cash flow in month: Plan £1.5m outflow, actual £2.4m inflow, variance £3.9m favourable.

Cash balance: Plan £53.3m, actual £55.5m, variance £2.2m favourable.

Cash balance is £2.2m higher than planned mainly due £1.4m of PDC being received in March but not paid on to Royal Free until after year end together with delayed payments to creditors over the year end period.

NHSI Single Oversight Framework

- NHSI Use of Resources rating: Amber

The Trust’s risk rating for 2018/19 is a 3. The Trust has generally had a risk rating of 3 except at the end of 2017/18 when the Trust had a risk rating of 1 thanks to the proceeds of the partial sale of the St Ann’s site.

<table>
<thead>
<tr>
<th>Financial Criteria</th>
<th>Metric</th>
<th>Year to Date</th>
<th>Full Year Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Actual</td>
<td>Rating</td>
</tr>
<tr>
<td>Continuity of Services</td>
<td>Capital service cover rating</td>
<td>0.6</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Liquidity rating</td>
<td>64.0</td>
<td>1</td>
</tr>
<tr>
<td>Financial Efficiency</td>
<td>I&amp;E margin rating</td>
<td>-0.1%</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Distance from financial plan</td>
<td>1.5%</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Agency rating</td>
<td>16.8%</td>
<td>2</td>
</tr>
<tr>
<td>Weighted Risk Rating</td>
<td></td>
<td>3</td>
<td>●</td>
</tr>
</tbody>
</table>
1. **Introduction and Background**

1.1 This report presents the financial position of the Trust as at the end of March 2019 (month 12 of the 2018/19 financial year).

2. **Financial Performance Overview**

2.1 **Performance against the NHSI Control Total**

2.1.1 Financial performance at the end of month 12 is a deficit of £185k against a planned deficit of £3,134k. Performance is reported against the Trust’s re-profiled budget with adjustments which is now different to the plan submitted to NHSI in April 2018. Financial performance at the end of month 12 against the NHSI plan of £3,346k means that the deficit is £3,161k favourable to NHSI plan.

2.1.2 The table below shows the values for planned and actual performance against the budgeted deficit of £3.3m submitted to NHS Improvement in April, with £4.1m of Provider Sustainability Funding (PSF) included in the final position.

<table>
<thead>
<tr>
<th>Annual Budget £000’s</th>
<th>Monthly 12</th>
<th>YTD Monthly 12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget £000’s</td>
<td>Actual £000’s</td>
</tr>
<tr>
<td>Patient Care Income</td>
<td>209,774</td>
<td>17,808</td>
</tr>
<tr>
<td>Non Patient Care Income</td>
<td>8,376</td>
<td>1,130</td>
</tr>
<tr>
<td>Pay</td>
<td>(164,729)</td>
<td>(14,033)</td>
</tr>
<tr>
<td>Non Pay</td>
<td>(44,266)</td>
<td>(3,828)</td>
</tr>
<tr>
<td>EBITDA</td>
<td>9,155</td>
<td>1,078</td>
</tr>
<tr>
<td></td>
<td>-4%</td>
<td>-6%</td>
</tr>
<tr>
<td>Profit / (loss) on disposal of assets</td>
<td>-</td>
<td>(51)</td>
</tr>
<tr>
<td>Fixed Asset Impairments</td>
<td>-</td>
<td>(132)</td>
</tr>
<tr>
<td>Depreciation and Amortisation</td>
<td>(6,597)</td>
<td>(550)</td>
</tr>
<tr>
<td>PDC Dividend</td>
<td>(5,441)</td>
<td>(453)</td>
</tr>
<tr>
<td>Interest payable</td>
<td>(351)</td>
<td>(29)</td>
</tr>
<tr>
<td>Interest Receivable</td>
<td>100</td>
<td>8</td>
</tr>
<tr>
<td>Surplus / Deficit</td>
<td>(3,134)</td>
<td>53</td>
</tr>
<tr>
<td>Fixed Asset Impairments removed</td>
<td>-</td>
<td>132</td>
</tr>
<tr>
<td>Surplus / Deficit excluding impairments</td>
<td>(3,134)</td>
<td>53</td>
</tr>
</tbody>
</table>

2.1.3 The Trust achieved a position £3.1m better than the control total set by NHSI. The Trust benefitted from an additional £2.5m incentive PSF allocated from NHSI at year-end. The settling of prior year OSV invoices and an improvement in aged debt has helped improve the position this year.

2.1.4 The actual surplus in month is better than plan by £2.0m due to the PSF incentive funding received.
2.1.5 Income is ahead of plan in month (£5.8m) due to the billing of 100% CQUIN at the year-end (an offsetting provision has been made for doubtful debt assuming 71% achievement is agreed), £2.5m Incentive PSF received, additional NMOC funding above plan and continued strong OSV performance. Year to date income is £6.7m ahead of plan. Additional income as mentioned above and including Enfield CAMHS Transformation income more than offsets the OSV credit notes issued to Enfield CCG in September to resolve the final OSV invoices for 2016/17 and 2017/18 (£790k).

2.1.6 Total pay expenditure of £14m in month is £0.2m worse than plan. The adverse position is driven by continuing high 1:1 usage in Thames and Trent and the Older Peoples wards; and a provision made at year-end for outstanding holiday pay. Vacancies across the Trust continue to partially offset the overspend on Healthcare Assistants (HCAs). Agency expenditure of £0.9m in March is an improvement of £0.1m from February. Overall, agency usage remains high though, finishing the year end £1.3m above the agency cap of £8.2m. An agency review group is in place chaired by the Executive Director of Workforce allocating actions to reduce expenditure.

2.1.7 Non pay expenditure is overspent by £3.5m in month. NMOC costs in month are driving £1.6m overspend. Expenditure on private beds has further deteriorated the position. In month 12 costs for the Trustwide restructure have been included and a provision for CQUIN underachievement against the 100% billed. Offsetting these costs there has been an improvement in the aged debt position.

2.1.8 An average of 16 private beds per night were used during March, compared to 15 in February. The Trust's bed position deteriorated significantly in the last few days of March, increasing to 27 private beds. This continued into early April, highlighting the volatility of the Trust's bed position, as presented below. At the year end the private bed cost to the Trust was £4.4m, which is partly offset by £1.9m of reserves. The continued use of private beds is the most significant expenditure risk to the Trust.
2.2  Cost Improvement Programme

2.2.1  CIP performance underachieved in month, and is £1.2m behind plan at year-end.

2.2.2  The trust’s savings target was £8.2m, and the Trust had £8.7m of identified schemes.

2.2.3  £7.5m of CIPs has been achieved this year. £2.0m of identified CIP is non-recurrent, £1.4m of which was planned.

2.2.4  Enfield performance behind plan (£684k) is largely driven by slippage on several key schemes – Capetown, Bay Tree and the extra rehab bed. Several schemes were also unable to deliver including Continence procurement savings due to changing volumes required.

2.2.5  Trustwide performance behind plan (£454k) is due to a reduction of the planned savings from the I.T. re-procurement.

2.3  Performance against actions to achieve the Forecast Outturn

2.3.1  The new actions implemented by the Chief Operating Officer from 31st January to tackle the bed capacity crisis have continued and were effective as reflected in the reduced average private bed usage in February/March. However there was a surge in demand for beds at the end of March, leading to a major incident being declared on the Trust’s bed capacity. A review is now underway focusing on the care provided in the community and the requests for beds being received. The reduced bed usage for the majority of March ensured private bed costs were kept down, helping to achieve the Control Total.

2.3.2  CIP delivery for the year-end was in line with the forecast position. However as detailed above, the CIP schemes delivered were £1.2m behind plan. Enfield and Trustwide schemes did not reach the target, resulting in additional risk for the new financial year. See section 2.4.

2.3.3  Continued focus on run rate. Barnet, Enfield and Haringey forecast overspends against their plan – see Appendix A for final performance by service line. Barnet and Haringey overspends were primarily driven by out of area placements, hence actions noted above and the continued priority. Haringey’s recovery plan to reduce their run rate also focused on agency spend. This focus will continue in the new financial year. Enfield’s underperformance is largely driven by the gap in achievement of CIPs. The service continue to meet weekly to maintain the focus on securing further CIP delivery.

2.3.4  Overseas visitors income. The residual £0.7m OSV invoices from 2016/17 and 2017/18 were settled with the CCG and a further £0.7m bad debt provision was released into the position at the-end, ensuring the Trust met the Control Total. The OSV manager recruited in July 2018 has ensured a high level of activity invoiced each month in the second half of 2018/19 (average over £300k/mth) with the profile and focus on OSVs being raised.
2.3.5 Focus on agency expenditure via the Agency Review Group. Agency expenditure remained high at the end of the financial year - £1.3m above cap at year-end. The commissioning of new services where extra posts have been created has put added pressure on the staffing pool. The focus on reducing agency spend continues. Services are looking to increase staff available to work on the bank, and working with the recruitment team for rolling advertisements and generating bespoke adverts for hard to recruit specialisms.

2.3.6 The Edgware hospital premises costs for 2016/17 generated a benefit in the year-end position and a rates rebate was received (£250k). The final position is yet to be formally agreed with NHS Property Services but significant steps forward have been made in agreeing a reduced SLA. However this is a non-recurrent benefit for 2018/19. The accounting treatment for PDC calculations did not materialise as a benefit to the accounts, however PDC charges were lower than forecast (£100k) due to the revaluation exercise completed in March.

2.3.7 Improvement in the Trust’s CQUIN position. The forecast out-turn assumed 62% CQUIN achievement. Based on the latest performance measures, the Trust is expecting 71% achievement and this is included in the year-end position.

2.4 Key Areas of Risk

2.4.1 Whilst the Trust was able to meet the Control Total in 2018/19, a number of key risks continue into the new financial year which will impact the ability of the Trust to perform financially and meet the new control total set for 2019/20 – a breakeven position.

2.4.2 Key risks are considered below:

- Private bed usage has averaged 21 beds per night this year, and the volatility remains – see section 2.1.8 and 2.3.1. The Trust is due to open a new ward to increase our bed capacity in October 2019 to reduce the need to source beds externally in the private sector. However the demand for beds will continue to need to be managed, with the actions mentioned above.

- CIP achievement. The Trust has carried forward non-recurrent and unmet CIP from 2018/19 and has a £6.1m CIP target for 2019/20. Currently £6.3m of schemes have been identified, however £4.2m (66%) is red/amber rated. Continued focus is required on CIP delivery where savings are forecast to start delivering later than planned or are yet to be confirmed (red/amber rated). For some schemes this relates to the settling of contractual disputes around overheads, which is a focus for the Contracts team.

- Acuity of patients driving unbudgeted use of 1:1’s across all wards remains high and will need to be controlled in the new financial year.

- CQUIN delivery – achievement of the Trust’s Control Total assumes 100% delivery of CQUIN. The total funding attached to CQUIN for 2019/20 has reduced to 1.25% of the contract values, which equates to £1.7m for the CCG contracts. Therefore, performance at 71% (the same as for 2018/19) would give a reduction in income of c£0.5m.

- Cost and volume contracts – risk remains on contracts that are not in the block where income is directly linked to performance. For example the Beacon Centre and Eating Disorders. Performance at 2018/19 activity levels would reduce income by c£0.5m, however activity increased during the second half of the financial year and the service is confident this can be maintained.
2.5 Balance Sheet

<table>
<thead>
<tr>
<th></th>
<th>YTD Actual</th>
<th>YTD Variance</th>
<th>Year end forecast</th>
<th>Forecast variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Non-Current Assets</strong></td>
<td>180,041</td>
<td>(3,760)</td>
<td>183,186</td>
<td>(1,791)</td>
</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inventories</td>
<td>9</td>
<td>(82)</td>
<td>91</td>
<td>0</td>
</tr>
<tr>
<td>Receivables</td>
<td>27,433</td>
<td>14,069</td>
<td>18,082</td>
<td>5,718</td>
</tr>
<tr>
<td>Cash at Bank &amp; in Hand</td>
<td>55,536</td>
<td>621</td>
<td>54,403</td>
<td>1,117</td>
</tr>
<tr>
<td>Non-Current Asset held for sale</td>
<td>755</td>
<td>(965)</td>
<td>755</td>
<td>(965)</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td>83,733</td>
<td>13,643</td>
<td>73,331</td>
<td>5,870</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>(45,394)</td>
<td>(15,154)</td>
<td>(34,824)</td>
<td>(5,581)</td>
</tr>
<tr>
<td><strong>Non-Current Assets/Liabilities</strong></td>
<td>218,380</td>
<td>(5,071)</td>
<td>221,693</td>
<td>(1,502)</td>
</tr>
<tr>
<td><strong>Total Non-Current Liabilities</strong></td>
<td>(8,366)</td>
<td>254</td>
<td>(8,282)</td>
<td>84</td>
</tr>
<tr>
<td><strong>Total Assets Employed</strong></td>
<td>210,014</td>
<td>(4,817)</td>
<td>213,411</td>
<td>(1,418)</td>
</tr>
</tbody>
</table>

**Taxpayers and Others Equity**

<table>
<thead>
<tr>
<th></th>
<th>YTD Actual</th>
<th>YTD Variance</th>
<th>Year end forecast</th>
<th>Forecast variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Dividend Capital</td>
<td>149,438</td>
<td>(356)</td>
<td>149,438</td>
<td>(356)</td>
</tr>
<tr>
<td>Revaluation Reserve</td>
<td>70,446</td>
<td>(1,954)</td>
<td>71,699</td>
<td>(701)</td>
</tr>
<tr>
<td>Retained Earnings</td>
<td>(9,870)</td>
<td>(2,508)</td>
<td>(7,372)</td>
<td>(361)</td>
</tr>
<tr>
<td><strong>Total Taxpayers and Others Equity</strong></td>
<td>210,014</td>
<td>(4,818)</td>
<td>213,411</td>
<td>(1,418)</td>
</tr>
</tbody>
</table>

2.6 Non-Current Assets and Capital

2.6.1 £15.5m has been spent on capital in 2018/19, which is £2.9m behind plan. The underspend is primarily due to £1.4m of slippage on the St Ann’s redevelopment due to delays by the local highway authority in agreeing necessary road closures to allow the new electrical infrastructure to be installed. The balance primarily reflects a delay in the planned refurbishment of Avon Ward due to the ward not being vacated to the originally planned timetable and slippage on several smaller Estates projects.

2.6.2 The mothballing of 2 surplus properties has impaired non-current assets by £1.1m and the annual year end revaluation of land & buildings by external valuers decreased capital values by £6.5m.

2.6.3 Non-current assets at 31 March 2019 includes £4.0m of prepayments arising from the transition to Atos, these prepayments being released evenly over the remaining life of the Atos contract. Previously this prepayment shave all been reported as current assets.

2.6.4 The main item of capital expenditure so far this year has been preparatory work costing £3.2m for the new building at St Ann’s.

2.7 Cash

2.7.1 The cash balance at the end of March 2019 was £55.5m, £2.2m better than plan, mainly due to £1.4m of PDC being received in March but not paid on to Royal Free until after year end together with delayed payments to creditors over the year end period.
2.7.2 Construction of the new building at St Ann’s and the redevelopment programme has now begun, incorporating both new build and refurbishments will take 3 years to complete. The cash balance will gradually reduce over this period as payments are made in instalments to the companies involved in the project.

2.8 Single Oversight Rating

<table>
<thead>
<tr>
<th>Financial Criteria</th>
<th>Metric</th>
<th>NHSI Risk Ratings</th>
<th>Year to Date</th>
<th>Full Year Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Actual</td>
<td>Score</td>
</tr>
<tr>
<td>Continuity of Services</td>
<td>Capital service cover rating</td>
<td></td>
<td>0.6</td>
<td>0.6</td>
</tr>
<tr>
<td></td>
<td>Liquidity rating</td>
<td></td>
<td>64.0</td>
<td>64.0</td>
</tr>
<tr>
<td>Financial Efficiency</td>
<td>I&amp;E margin rating</td>
<td></td>
<td>-0.1%</td>
<td>-0.1%</td>
</tr>
<tr>
<td></td>
<td>Distance from financial plan</td>
<td></td>
<td>1.5%</td>
<td>1.5%</td>
</tr>
<tr>
<td></td>
<td>Agency rating</td>
<td></td>
<td>16.8%</td>
<td>16.8%</td>
</tr>
<tr>
<td>Weighted Risk Rating</td>
<td></td>
<td></td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

2.8.1 The Trust scored 3 against the NHS Improvement Single Oversight Risk Assessment Framework for 2018.

3. Conclusion

3.1 The full year position at month 12 has benefitted from the release of part of the bad debt provision for overseas visitors, and a general improvement in aged debt. Given the Trust was able to deliver a position better than the Control Total, additional PSF funding was received and has further improved the deficit reported.
## Performance by Service Line

<table>
<thead>
<tr>
<th>Service Line</th>
<th>Budget YTD</th>
<th>Actual YTD</th>
<th>Variance YTD</th>
<th>Reasons for Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Barnet</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>(8,246)</td>
<td>(9,024)</td>
<td>777</td>
<td>Contract variations for CAMHs and ADHD income higher than budgeted</td>
</tr>
<tr>
<td>Pay</td>
<td>28,497</td>
<td>29,024</td>
<td>(527)</td>
<td>Agency usage on inpatient wards plus staffing over and above establishment for 1-1 observations</td>
</tr>
<tr>
<td>Non-Pay</td>
<td>2,422</td>
<td>4,990</td>
<td>(2,568)</td>
<td>£2.6m relates to private bed usage.</td>
</tr>
<tr>
<td>Total</td>
<td>22,673</td>
<td>24,990</td>
<td>(2,317)</td>
<td></td>
</tr>
<tr>
<td><strong>Enfield</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>(34,547)</td>
<td>(35,724)</td>
<td>1,177</td>
<td>Additional funding received for various services including CAMHS, Primary Care Link Workers, IAPT, CHAT</td>
</tr>
<tr>
<td>Pay</td>
<td>55,277</td>
<td>55,673</td>
<td>(396)</td>
<td>£0.25m overspend relates to HV reduction in income. 1-1 observations on MHSOP wards driving £1.0m overspend, offset by vacancies across the service.</td>
</tr>
<tr>
<td>Non-Pay</td>
<td>3,266</td>
<td>4,556</td>
<td>(1,290)</td>
<td>Mainly unachieved CIP</td>
</tr>
<tr>
<td>Total</td>
<td>23,996</td>
<td>24,505</td>
<td>(509)</td>
<td></td>
</tr>
<tr>
<td><strong>Haringey</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>(1,743)</td>
<td>(2,010)</td>
<td>267</td>
<td>Unbudgeted winter pressures funding and new Trailblazer income</td>
</tr>
<tr>
<td>Pay</td>
<td>20,000</td>
<td>19,614</td>
<td>386</td>
<td>Vacancies</td>
</tr>
<tr>
<td>Non-Pay</td>
<td>1,738</td>
<td>3,471</td>
<td>(1,733)</td>
<td>£1.5m relates to private bed usage and £0.2m drugs over spend due to VAT being charged on deliveries formerly made to Canning Crescent.</td>
</tr>
<tr>
<td>Total</td>
<td>19,995</td>
<td>21,076</td>
<td>(1,080)</td>
<td></td>
</tr>
<tr>
<td><strong>Specialist Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>(58,321)</td>
<td>(60,671)</td>
<td>2,350</td>
<td>£1.8m New Care Model income higher than planned (offset by expenditure). Remainder is EPoC and additional income for Beacon beds.</td>
</tr>
<tr>
<td>Pay</td>
<td>39,826</td>
<td>39,121</td>
<td>706</td>
<td>High level of vacancies</td>
</tr>
<tr>
<td>Non-Pay</td>
<td>7,785</td>
<td>10,396</td>
<td>(2,611)</td>
<td>New Care Model expenditure £1.4m higher than planned. Remainder is social workers recharges above plan, n/r expenditure on Beacon Centre (offset by income) and n/r CIP</td>
</tr>
<tr>
<td>Total</td>
<td>(10,710)</td>
<td>(11,154)</td>
<td>444</td>
<td></td>
</tr>
<tr>
<td><strong>GRAND TOTAL</strong></td>
<td>55,954</td>
<td>59,416</td>
<td>(3,462)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Line</th>
<th>Budget YTD</th>
<th>Actual YTD</th>
<th>Variance YTD</th>
<th>Reasons for Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corporate</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>(112,846)</td>
<td>(115,120)</td>
<td>2,273</td>
<td>Additional incentive PSF received - £2.5m</td>
</tr>
<tr>
<td>Pay</td>
<td>18,074</td>
<td>16,799</td>
<td>1,275</td>
<td>Release of pay reserve for NMET students and under spent across pay budgets</td>
</tr>
<tr>
<td>Non-Pay</td>
<td>16,786</td>
<td>15,212</td>
<td>1,575</td>
<td>Release of non pay reserves £1.9m - offsets bed expenditure in boroughs</td>
</tr>
<tr>
<td>Non-Operating Expenditure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12,289</td>
<td>11,318</td>
<td>971</td>
<td>Under spend against PDC dividend due to asset revaluation. Depreciation charges lower than budgeted due to slippage in capital programme and more expenditure on assets of longer useful life.</td>
</tr>
<tr>
<td>Total</td>
<td>(65,697)</td>
<td>(71,791)</td>
<td>6,094</td>
<td></td>
</tr>
<tr>
<td><strong>Estates</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>(2,447)</td>
<td>(2,316)</td>
<td>(131)</td>
<td>Lower than budgeted income from SLAs with other Trusts - reduction in tenants space occupation.</td>
</tr>
<tr>
<td>Pay</td>
<td>3,055</td>
<td>2,971</td>
<td>84</td>
<td>Credit note for Edgware SLA and release of provisions</td>
</tr>
<tr>
<td>Non-Pay</td>
<td>12,269</td>
<td>11,905</td>
<td>364</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>12,877</td>
<td>12,560</td>
<td>317</td>
<td></td>
</tr>
<tr>
<td><strong>GRAND TOTAL</strong></td>
<td>(52,820)</td>
<td>(59,231)</td>
<td>6,411</td>
<td></td>
</tr>
</tbody>
</table>
Title: Workforce Update
Report to: Trust Board
Date: 23 May 2019
Security Classification: Public Board meeting

Purpose of Report:
This report aims to provide the Trust Board with insight into current performance in relation to our workforce indicators.

Attached is the March 2019 dashboard providing performance over time across our key performance indicators at Trust level. The accompanying report highlights areas of good performance and those areas which face challenges.

Recommendations:
The Trust Board is invited to note the report.

Report Sponsor: Jackie Stephen, Director of Workforce & OD

Comments/views of the Report Sponsor: This is the proposed format for regular updates to the Trust Board

Report Author: Jackie Stephen, Director of Workforce & OD

Report History: First report in this format

Budgetary, Financial/Resource Implications: None identified

Equality and Diversity Implications: None identified

List of Appendices: Workforce dashboard for March 2019
1. Introduction

Workforce data is reported to a range of Trust meetings including Deep Dives and Integrated Performance Meetings and will be presented to the Trust Performance Management meeting which is being introduced at the end of May.

The attached dashboard (Appendix 1) provides Trust-level data over time for a number of key staff performance indicators.

This report highlights areas of improvement as well as challenges and risks, and includes activities underway to support improvement.

2. Summary

Overall vacancies fell in March, achieving our target of 10%. This is offset, however, by an increase of 0.1% to 14.2% for nursing vacancies.

Medical vacancies fell again in March, maintaining a vacancy rate well below our Trust target of 10%.

Time to hire remains erratic and reported an increase of two weeks to 12.8 weeks in March.

Temporary staffing expenditure continues to rise. This is partly due to long term vacancies but also extended time to hire, particularly for prison-based staff who are subject to additional checks.

Whilst agency spend fell in March, the total expenditure for 2018/19 exceeded £9m so concerted effort is required to tackle use of temporary staff.

Turnover has risen to 13.8%, above our target of 11%.

Sickness absence has remained at 4.2% for two months.

Mandatory training remains at 84% against a target of 90%. At the time of writing, the compliance for four topics has exceeded the target. The main areas of concern are life support training and other core skills such as information governance.

3. Issues

3.1 Vacancies

Whilst overall vacancies have reduced to achieve our target of 10%, there are a number of areas that remain challenging to recruit to. These include:

Magnolia Unit – there has been some success in relation to attracting soon-to-be-qualified nurses to the unit and they will join the Trust in September. In the meantime, the recruitment team is working closely with unit managers to identify more innovative recruitment strategies.

Devon PICU – the Avon ward has recently transferred to Enfield so the Enfield management team have inherited staffing challenges (the unit has traditionally used high levels of agency).
Beacon Centre – this team is still carrying a number of vacancies. The unit is the first to pilot our people-focused workforce planning approach to help identify potential new roles that could be introduced into the unit.

Eating Disorders – this remains an area that struggles to recruit permanent staff. A recent open day did not have a positive outcome so local management and the recruitment team are looking at alternative ways to promote the unit. It is also planned to pilot the workforce planning approach in this area so that new roles may be considered to close the vacancy gap.

The recruitment team has reintroduced regular recruitment meetings with the divisions to support generation of ideas for promoting the Trust as a great place to work and improving the recruitment and selection process.

### 3.2 Time to hire

As mentioned above, the time to hire has varied across the past year, largely because of prison checks for our staff based in prisons, over which we have no control. This also has a direct impact on agency spend by those teams and vacancy levels, as staff are in the recruitment process for longer than for other areas in the Trust.

### 3.3 Temporary and agency expenditure

This area of expenditure is still a concern. The new temporary staffing manager (interim) is interrogating usage and, as a priority, seeking to expand the Trust bank in order to address the high level of agency spend.

The e-rostering project is expected to impact this area of expenditure by improving rostering of staff and therefore reducing reliance on bank and agency staff.

### 3.4 Staff turnover

Whilst staff turnover is steady, the retention project is intended to support improvement in this area. Priority areas are flexible working, learning and development and staff wellbeing which are all key factors in retaining staff.

Areas of concern include District Nursing (at 13.5%) since other KPIs for this team are also unsatisfactory, for example, high sickness absence (6%), high level of vacancies (over 14 WTE) and low mandatory training compliance (74%). Discussions are underway to support this large team to address some of these issues.

### 3.5 Sickness absence

The sickness absence rate has only met the Trust target once in the last 12 months (in June 2018). This is despite the improvement in application of the attendance policy and regular sickness boards. Incidences of long term sickness absence affect the rates within teams. Line managers and the HR business partnering team are prioritising these absences, in collaboration with Occupational Health.

### 3.6 Mandatory training

Mandatory training compliance has been monitored closely and has seen a slow, but steady improvement in recent weeks. The Estates and Facilities team, for example, had been an
outlier with very low compliance rates but has improved following close scrutiny and provision of bespoke training.

District nursing, with over 100 staff, remains a challenged team in respect of training compliance.

4. Areas of focus

In reviewing the team level data, it is clear that a number of areas/teams are challenged, as outlined below. We are seeking assurance from the relevant managers that they have plans in place to make improvements in performance and providing them with targeted support as required. KPIs that are highlighted below are worse than the average for the Trust and so merit further attention.

<table>
<thead>
<tr>
<th>Service Line</th>
<th>Department</th>
<th>Budget (fte)</th>
<th>Staff in Post (fte)</th>
<th>Agency usage (fte)</th>
<th>Bank usage (fte)</th>
<th>Vacancies (fte)</th>
<th>Vacancy %</th>
<th>Turnover %</th>
<th>Sickness Absence %</th>
<th>Mandatory Training %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet</td>
<td>BAW70 - Edgware PICU Avon Ward</td>
<td>41.90</td>
<td>32.71</td>
<td>6.85</td>
<td>21.39</td>
<td>9.19</td>
<td>21.9%</td>
<td>12.3%</td>
<td>6.1%</td>
<td>83.6%</td>
</tr>
<tr>
<td>Enfield</td>
<td>P12DT - Magnolia Unit</td>
<td>56.84</td>
<td>38.21</td>
<td>4.15</td>
<td>5.66</td>
<td>18.63</td>
<td>32.8%</td>
<td>16.7%</td>
<td>4.4%</td>
<td>80.4%</td>
</tr>
<tr>
<td>Enfield</td>
<td>P1CND - District Nursing</td>
<td>114.18</td>
<td>99.98</td>
<td>4.56</td>
<td>10.38</td>
<td>14.20</td>
<td>12.4%</td>
<td>13.5%</td>
<td>6.0%</td>
<td>74.4%</td>
</tr>
<tr>
<td>Barnet</td>
<td>T3B22 - Home Treatment Team – Barnet</td>
<td>24.09</td>
<td>18.58</td>
<td>1.99</td>
<td>5.46</td>
<td>5.52</td>
<td>22.9%</td>
<td>11.6%</td>
<td>6.9%</td>
<td>73.2%</td>
</tr>
<tr>
<td>Barnet</td>
<td>BAW10 - Thames Acute Inpatients (formerly Ken Porter)</td>
<td>29.61</td>
<td>23.65</td>
<td>0.84</td>
<td>17.15</td>
<td>5.96</td>
<td>20.1%</td>
<td>17.9%</td>
<td>9.3%</td>
<td>83.2%</td>
</tr>
<tr>
<td>Specialist Services</td>
<td>FFW82 - Derwent Ward</td>
<td>25.00</td>
<td>21.94</td>
<td>0.00</td>
<td>8.09</td>
<td>3.06</td>
<td>12.2%</td>
<td>13.2%</td>
<td>5.8%</td>
<td>80.5%</td>
</tr>
<tr>
<td>Specialist Services</td>
<td>FFW84 - Tamarind Ward</td>
<td>25.50</td>
<td>22.37</td>
<td>0.00</td>
<td>10.58</td>
<td>3.13</td>
<td>12.3%</td>
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Title: Draft Quality Account 2018/19

Report to: Trust Board

Date: 23 May 2019

Security Classification: Public Board Meeting

Report Author: Shila Mumin, Head of Effectiveness

Report Sponsor: Amanda Pithouse, Executive Director of Nursing, Quality & Governance

Comments / views of the Report Sponsor:

Overview of the report:

The Quality Account is an annual report that all Trusts must produce and publish on NHS Choices by 30th June.

The Quality Account provides a detailed overview and examples of the work we have undertaken across our services during 2018/19 to improve the quality of care and services for our local communities and to improve staff wellbeing. The attached draft Quality Account 2018/19 is work in progress. Highlighted sections indicate that further or updated information is pending. A timeline for completion of the Quality Account is attached for reference.

Our Quality Account 2018/19 documents the Trust’s progress against the quality priorities that were agreed for 2018/19 and outlines our quality priorities for 2019/20 which are based on service user and stakeholder feedback and our own identified areas for focus which are in line with the Brilliant Basics work streams.

The Quality Account reports on our performance against a set of nationally mandated indicators, a requirement for all Trusts to demonstrate. Additionally, as part of the external audit limited assurance process, testing will be undertaken by Grant Thornton LLP on two specific indicators which will be reported in the Quality Account:

- The percentage of patients on Care Programme Approach (CPA) who were followed up within 7 days of discharge from psychiatric inpatient care.
- The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment (CRHT) Team acted as a gatekeeper.

It is a requirement that the Quality Account is subject to independent assurance. This will be undertaken by Grant Thornton UK LLP in accordance with the ‘NHS Quality Accounts Auditor Guidance 2014-15’. A Limited Assurance report will be provided for inclusion in the final Quality Account.

As stipulated in the national NHS Quality Account guidance, key stakeholders such as the CCGs,
Health Watch and Joint Overview and Scrutiny Committee must be given the opportunity to review and comment on the report ahead of providing statements for inclusion in the final report. All feedback has been considered and appropriate amendments have been made to the report.

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Trust Board Page 104
Quality Account 2018 - 2019
Contents

PART 1
• Statement from the Chief Executive ......................... 3
• Statement from Executive Director of Nursing, Quality and Governance ........................................ 4
• What is a Quality Account ........................................... 5
• About Barnet, Enfield & Haringey Mental Health NHS Trust (BEH) .................................................. 6
• Brilliant Basics ...................................................... 7

PART 2
• Statement of Assurance from the Board, 2018/19 ........ 11
• Review of Quality Performance 2018/19 .................... 11
• Enablement Programme ......................................... 16
• Quality Improvement Programme ............................ 19
• Quality Priorities - Looking Back 2018/19 ............... 22
• Clinical Audit and Quality Assurance Programme ....... 28
• Participation in Clinical Research .............................. 39
• Commissioning for Quality & Innovations (CQUINs) .. 40
• Participation in Accreditation Schemes ....................... 41
• Information Governance Toolkit Compliance ............. 42
• Data Quality & National Mandated Indicators ............ 43
• Patient Experience ................................................. 45
• Patient Safety (including incidents and learning) ......... 49
• Learning from Deaths .............................................. 56
• Safeguarding ....................................................... 59
• Infection Prevention and Control ............................... 61
• Staff Experience .................................................... 65

PART 3
• Quality Priorities, 2019/20 ........................................ 69

PART 4
• Borough Quality Improvements and Initiatives 2018/19 .. 72

PART 5
• Statements from Commissioners, Joint Health Overview and Scrutiny Committee, Healthwatch, Auditor ....... 84

Glossary .............................................................. 90
How to Provide Feedback ................................. 91
Part 1

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

I am pleased to present our Quality Account which describes in detail how we are continuously improving the quality of our services.

Over the past year, we have strengthened our relations with our service users through our dedicated Enablement programme and our Patient Engagement Strategy. Our service users shared with us via forums and the service user survey, their views on our services and where we were doing well and where we could improve.

Staff across the Trust have worked very hard to make and embed improvements throughout our services for the benefit of our service users and staff. We have worked with staff to involve them in quality improvement to make measurable differences that can be sustained.

Our 3rd Patient Safety Conference was another huge success. It was great to see so many of our staff there, wanting to hear and learn about the great projects and initiatives our staff have been involved in and the excellent outcomes achieved for our staff and service users.

In late 2018/19, we introduced the Brilliant Basics work streams which is about getting the basics right across the Trust, every time. We will be able to report on these during the coming year and demonstrate progress. Our Quality Priorities for the year ahead will support the implementation of these fundamentals.

I hope you find our Quality Account interesting and informative. Your feedback would be welcomed.

Amanda Pithouse
Executive Director of Nursing, Quality and Governance, Barnet, Enfield and Haringey Mental Health NHS Trust
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 £212 million.

In 2018/19, our 3300 plus staff helped care for more than 147,500 people - approximately 2800 patients on our wards and over 146,400 service users in the community. 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 support healthy lives and healthy communities through the provision of excellent integrated mental and community healthcare to 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 trends in patient experience and complaints; we monitor the standards of our inpatient wards through a programme of audits and unannounced ward visits and we 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 in which the Trust received a Requires Improvement rating, 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 Mental Health Act 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

Geoff 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 team 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.

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 whose 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.
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


**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

**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 representatives 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 how these are being managed and mitigated, and serious patient safety incidents that have occurred and investigations being undertaken.

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 shared knowledge and understanding in relation to 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.
• **Mindfulness - supporting the wellbeing of our staff**

We have worked with Headspace to offer our staff free access to their mindfulness app on staff 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.

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<td>Haringey Early Intervention in Psychosis</td>
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<td>Nursing and Governance Directorate</td>
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<td>Beacon Centre Secret Garden</td>
<td>Specialist Services – CAMHS Inpatient</td>
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<td>4</td>
<td>Live, Love, Grow – harvesting our own produce to learn to love food</td>
<td>Specialist Services, Eating Disorders Service</td>
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<td>5</td>
<td>Inside Out – Making CHOICES that count</td>
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<td>6</td>
<td>Tovertafel – The Magic Table</td>
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<td>Safer Discharge &amp; Carers Awareness Project</td>
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<td>Early Intervention Service Gardening Project</td>
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<td>10</td>
<td>Use of Neuromuscular electrical stimulation as an adjunct to therapy programmes for patients following a stroke and with other neurological conditions.</td>
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<td>11</td>
<td>Grounding Kits for PTSD Clients</td>
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"Tissue Viability team, July 2018

We are always seen promptly and treated very courteously with dignity and respect. Staff are very professional and caring."
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 ongoing 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 PeerWorkers 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 its 14 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.

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*Haringey Memory Service, August 2018*

*Friendly staff at reception- offered refreshments, short wait, the doctor was kind and helpful*
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 – coordinated 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.
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.

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.

“Enfield ICT West Team, December 2018

“You Listen, You Care” - What more could we want."
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).

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 Wellbeing clinic, Ken Porter ward and Early Intervention 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 incoming 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.

<table>
<thead>
<tr>
<th>Physical Health</th>
<th>Q1 (%)</th>
<th>Q2 (%)</th>
<th>Q3 (%)</th>
<th>Q4 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health Assessment (MH)</td>
<td>82.08</td>
<td>87.77</td>
<td>85.12</td>
<td>67.91</td>
</tr>
<tr>
<td>Physical Health Intervention (MH)</td>
<td>74.27</td>
<td>78.44</td>
<td>79.07</td>
<td>60.80</td>
</tr>
<tr>
<td>Alcohol/substance misuse (MH &amp; ECS)</td>
<td>81.89</td>
<td>87</td>
<td>81.33</td>
<td>87.42</td>
</tr>
<tr>
<td>Smoking(MH &amp; ECS)</td>
<td>94</td>
<td>91</td>
<td>89.63</td>
<td>89.83</td>
</tr>
<tr>
<td>Physical Health (Specialist)</td>
<td>98.11</td>
<td>95.84</td>
<td>98.77</td>
<td>99.57</td>
</tr>
<tr>
<td>Physical Health (Magnolia)</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>
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

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%).

<table>
<thead>
<tr>
<th>Risk</th>
<th>Q1 (%)</th>
<th>Q2 (%)</th>
<th>Q3 (%)</th>
<th>Q4 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of Responses</td>
<td>396</td>
<td>396</td>
<td>456</td>
<td>411</td>
</tr>
</tbody>
</table>

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
North London Forensic Services

<table>
<thead>
<tr>
<th>Question Text</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is the risk assessment up to date (within 7 days of admission or since most recent review)</td>
<td>99</td>
<td>99</td>
<td>95</td>
<td>95</td>
<td>95</td>
</tr>
<tr>
<td>2. If there has been a recent risk incident, has the risk summary been updated following the incident?</td>
<td>100</td>
<td>97</td>
<td>96</td>
<td>99</td>
<td>95</td>
</tr>
<tr>
<td>3. Does the risk assessment clearly identify all clinical restrictions in place? (please note that this does not apply to general restrictions on the ward which are in community living guidelines)</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>4. Is there a Dual Diagnosis Risk Summary?</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>5. Does the risk chronology include all historical risk details relating to substance use, including particular risk?</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>6. Do the restrictions identified in the risk assessment all relate to those in the care plan? Are the restrictions identified 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.</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>7. Do the last four face to face contacts in the progress notes (or last ward round review) include a comment on risk?</td>
<td>97</td>
<td>96</td>
<td>99</td>
<td>100</td>
<td>97</td>
</tr>
<tr>
<td>8. Has an updated RIO risk assessment and CPA form been sent to hostel/support worker?</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>9. If there is identification of risk on the progress note or progress note, is the risk added on the Risk History (to tick the Add to Risk History check box)?</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Communication with GP or partner agencies</th>
<th>Q1 (%)</th>
<th>Q2 (%)</th>
<th>Q3 (%)</th>
<th>Q4 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication with GP or partner agencies</td>
<td>93.3</td>
<td>92.38</td>
<td>93.06</td>
<td>91.82</td>
</tr>
<tr>
<td>Total Number of Responses</td>
<td>585</td>
<td>580</td>
<td>595</td>
<td>578</td>
</tr>
</tbody>
</table>

However, there are a number of indicators below the benchmark. The relevant teams have been working to address the gaps.
Primary care communication: Enfield Health (community teams)

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.

<table>
<thead>
<tr>
<th>Audit Type</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Audit</td>
<td>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.</td>
</tr>
<tr>
<td>Priority Audits</td>
<td>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.</td>
</tr>
<tr>
<td>Local Service/Team Audit</td>
<td>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.</td>
</tr>
</tbody>
</table>
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 Health 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 2 national confidential enquiries that covered relevant 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 in 100% 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.

<table>
<thead>
<tr>
<th>National Audit</th>
<th>Number of submissions to audit</th>
<th>% eligible submitted</th>
<th>cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>POMH-UK Audits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Topic 16a - Rapid Tranquilisation in</td>
<td>24</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>the context of pharmacological</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>management of acutely disturbed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>behaviour</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Topic 16a - The use of lithium</td>
<td>14</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Assessment of the side effects of</td>
<td>77</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>depot antipsychotics POMH-UK – Topic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6d</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>POMH-UK – Monitoring of patients</td>
<td>126</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>prescribed lithium</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National audits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sentinel Stroke National Audit</td>
<td>Enfield Community Stroke</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>programme (BSNAP)</td>
<td>Rehab Team April-June 2018:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Insufficient records for</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enfield &amp; SD Team April-June</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2018: 33 records</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>July-December 2018: 20 records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Clinical Audit of Ankylosing</td>
<td>80</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Spondylitis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Clinical Audit of Neurosis</td>
<td>150</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>medical conditions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Clinical Audit of Psychiatry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and Depression (NOAD)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCOAD Psychological Therapies</td>
<td>90</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Spotlight Audit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Audit of Intermediate Care</td>
<td>2 (organisational and service user submissions)</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>(NAIC)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls and Frailty Fracture Audit</td>
<td>0 cases identified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Confidential Enquiries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Confidential Enquiry into</td>
<td>14/16</td>
<td>87% of NCTISH</td>
<td></td>
</tr>
<tr>
<td>Suicide and Homicide</td>
<td></td>
<td>questionnaires</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>returned</td>
<td></td>
</tr>
<tr>
<td>Maternal, newborn and infant clinical</td>
<td>0 cases identified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>outcome review programme</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 coordination, 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.

<table>
<thead>
<tr>
<th>Quality Assurance Audit (QA)</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Score %</td>
<td>Number of returns</td>
</tr>
<tr>
<td>QA Specialist Services</td>
<td>97</td>
<td>2031</td>
</tr>
<tr>
<td>QA ESC Services</td>
<td>96</td>
<td>1980</td>
</tr>
<tr>
<td>QA Mental Health Services</td>
<td>94</td>
<td>4175</td>
</tr>
<tr>
<td>(Barnet, Enfield &amp; Haringey Boroughs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>QA Prison Services</td>
<td>91</td>
<td>208</td>
</tr>
<tr>
<td>Total QA returns</td>
<td>95</td>
<td>8397</td>
</tr>
</tbody>
</table>

All teams achieved above the benchmark compliance target of 90% in the Quality Assurance Audit overall.
Breakdown by overall competency scores:

<table>
<thead>
<tr>
<th>Competency</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>84%</td>
</tr>
<tr>
<td>Capacity and Consent</td>
<td>93%</td>
</tr>
<tr>
<td>Care &amp; Treatment</td>
<td>95%</td>
</tr>
<tr>
<td>Care plan</td>
<td>99%</td>
</tr>
<tr>
<td>Carers</td>
<td>96%</td>
</tr>
<tr>
<td>Communication with GP or partner agencies</td>
<td>93%</td>
</tr>
<tr>
<td>Health Records</td>
<td>97%</td>
</tr>
<tr>
<td>Information</td>
<td>98%</td>
</tr>
<tr>
<td>Involvement</td>
<td>96%</td>
</tr>
<tr>
<td>Physical Health</td>
<td>97%</td>
</tr>
<tr>
<td>- Physical Health Assessment</td>
<td>86%</td>
</tr>
<tr>
<td>- Physical Health Intervention</td>
<td>78%</td>
</tr>
<tr>
<td>Risk</td>
<td>97%</td>
</tr>
<tr>
<td>Smoking</td>
<td>91%</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Inspection</td>
<td>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.</td>
</tr>
<tr>
<td>Patient Records Inspection</td>
<td>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.)</td>
</tr>
<tr>
<td>Service User Interview</td>
<td>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).</td>
</tr>
<tr>
<td>Staff Interview</td>
<td>This element requires reviewers to speak to three staff members and assess their knowledge in relation to key trust policy and procedures.</td>
</tr>
</tbody>
</table>
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 all 13 of the Peer Service Reviews in 2018/19. Improvements were made in 12/13 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.

---

<table>
<thead>
<tr>
<th>Care Quality Commission (CQC) Regulatory Outcome - Peer Service Review Topic</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score (%)</td>
<td>Returns</td>
<td>Participating Teams</td>
</tr>
<tr>
<td>CQC Reg 11 - Need for Consent</td>
<td>94</td>
<td>526</td>
</tr>
<tr>
<td>CQC Reg 12 - Safe Care and Treatment</td>
<td>96</td>
<td>708</td>
</tr>
<tr>
<td>CQC Reg 16 - Acting on Complaints and Reg 17 - Good Governance</td>
<td>97</td>
<td>405</td>
</tr>
<tr>
<td>CQC Reg 10 - Dignity and Respect</td>
<td>95</td>
<td>556</td>
</tr>
<tr>
<td>CQC Reg 14 - Meeting Nutritional and Hydration Needs</td>
<td>93</td>
<td>266</td>
</tr>
<tr>
<td>CQC Reg 13 - Safeguarding</td>
<td>97</td>
<td>592</td>
</tr>
<tr>
<td>CQC Reg 9 - Person Centred Care</td>
<td>96</td>
<td>845</td>
</tr>
<tr>
<td>Outcome Reg 13 - Management of Medicine</td>
<td>95</td>
<td>371</td>
</tr>
<tr>
<td>CQC Reg 18 - Staffing</td>
<td>95</td>
<td>729</td>
</tr>
<tr>
<td>CQC Reg 15 - Premises and Equipment</td>
<td>92</td>
<td>542</td>
</tr>
<tr>
<td>Seclusion Peer Review</td>
<td>89</td>
<td>33</td>
</tr>
<tr>
<td>Restraint Peer Review</td>
<td>82</td>
<td>58</td>
</tr>
<tr>
<td>Forced Care</td>
<td>94</td>
<td>14</td>
</tr>
</tbody>
</table>
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.
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 £3 billion 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.
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.

<table>
<thead>
<tr>
<th>Programme</th>
<th>Participating services in the Trust</th>
<th>Accreditation Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECTAS: Electroconvulsive Therapy Accreditation Service</td>
<td>Chase Farm ECT Clinic</td>
<td>Accredited</td>
</tr>
<tr>
<td>MSNAP: Memory Services National Accreditation Programme</td>
<td>Barnet Memory Assessment Service</td>
<td>Accredited</td>
</tr>
<tr>
<td></td>
<td>Enfield Memory Service</td>
<td>Accredited</td>
</tr>
<tr>
<td></td>
<td>Haringey Memory Service</td>
<td>Accredited</td>
</tr>
<tr>
<td>PLAN: Psychiatric Liaison Accreditation Network</td>
<td>Mental Health Liaison Service (Barnet Hospital)</td>
<td>Accredited</td>
</tr>
<tr>
<td></td>
<td>North Middlesex Mental Health Liaison Service (North Middlesex Hospital)</td>
<td>Accredited</td>
</tr>
<tr>
<td>QED: Quality Network for Eating Disorders</td>
<td>Phoenix Wing, St Ann’s Hospital</td>
<td>Accredited</td>
</tr>
</tbody>
</table>
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 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.

<table>
<thead>
<tr>
<th>Completion of valid patient care data set</th>
<th>NHS Number (%)</th>
<th>National Result (%)</th>
<th>GP Code (%)</th>
<th>National Result (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>99.9%</td>
<td>98.6%</td>
<td>100%</td>
<td>99.9%</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Average Results</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>BEH Result</td>
<td>99.1%</td>
<td>99.4%</td>
<td>99.5%</td>
<td>99.0%</td>
</tr>
<tr>
<td>National Results</td>
<td>97.2%</td>
<td>97.2%</td>
<td>97.2%</td>
<td>95.7%</td>
</tr>
</tbody>
</table>
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 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.

<table>
<thead>
<tr>
<th>Q1 15/16</th>
<th>Q2 15/16</th>
<th>Q3 15/16</th>
<th>Q4 15/16</th>
<th>Q1 16/17</th>
<th>Q2 16/17</th>
<th>Q3 16/17</th>
<th>Q4 16/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr</td>
<td>May</td>
<td>Jun</td>
<td>Jul</td>
<td>Aug</td>
<td>Sep</td>
<td>Oct</td>
<td>Nov</td>
</tr>
<tr>
<td>% Emergency Re-admissions</td>
<td>4.2%</td>
<td>2.2%</td>
<td>3.1%</td>
<td>6.5%</td>
<td>4.9%</td>
<td>5.6%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Target %</td>
<td>5.0%</td>
<td>5.0%</td>
<td>5.0%</td>
<td>5.0%</td>
<td>5.0%</td>
<td>5.0%</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

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 (FFT) 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.

<table>
<thead>
<tr>
<th>FFT score</th>
<th>Would Recommend</th>
<th>Would not recommend</th>
<th>Total responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust overall</td>
<td>90.21%</td>
<td>2.20%</td>
<td>10773</td>
</tr>
<tr>
<td>FFT Mental Health Services</td>
<td>88.01%</td>
<td>2.66%</td>
<td>8248</td>
</tr>
<tr>
<td>FFT Enfield Community Services</td>
<td>97.39%</td>
<td>0.71%</td>
<td>2525</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Question</th>
<th>Best</th>
<th>Worst</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do staff clearly explain the purpose and side effects of medication in a way that you can understand?</td>
<td>100.00</td>
<td></td>
</tr>
<tr>
<td>Do staff encourage you to participate with your community by informing you about local groups, events and other organisations?</td>
<td></td>
<td>54.21</td>
</tr>
</tbody>
</table>

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 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.

<table>
<thead>
<tr>
<th>Feedback Type</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliments</td>
<td>497</td>
</tr>
<tr>
<td>Issues and Concerns</td>
<td>313</td>
</tr>
<tr>
<td>Informal Complaints</td>
<td>189</td>
</tr>
<tr>
<td>Formal complaints</td>
<td>77</td>
</tr>
<tr>
<td>Members Enquiries</td>
<td>65</td>
</tr>
<tr>
<td>PHSO Enquiries</td>
<td>3</td>
</tr>
</tbody>
</table>

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
- Triangulation of incident, complaints and safeguarding data and intelligence.
- Physical health management and use of NEWS
- Reducing violence & aggression
- Reducing restrictive interventions
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 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.

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.

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

- The Trust Boroughs and Specialist Services each have a Serious Incident Review Group (SIRG) that has oversight 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 reports on Serious Incidents, triangulated with complaints and highlighting themes and trends where possible.

- 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 Commissioners to successfully reduce the number of overdue serious incident investigations.

- 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.

- 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)

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

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

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 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. The following themes were identified:

- Communication and information sharing with family members and carers, both as part of routine communication and post incident, and with key partners such as GPs and other external providers were not considered and actioned in a timely manner.
- Crisis and contingency plans should be developed by inpatient services in conjunction with the patient, and that the patient and any involved family members should have a copy.
- Whilst risk documentation had improved, there were still occurrences where the Risk Summaries did not contain up to date relevant information that took into consideration the full clinical risk and risk history, nor updated systematically with a grading and a rationale that would inform the continuity of the service user’s care moving forward.

To enhance the learning and assess appropriateness of action taken, we introduced 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 89%. At the time of writing 37 SI reports have been submitted to the Commissioning Support Unit for review. In 4/37 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 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 decrease in the number of incidents reported in Quarter 4, (January to March 2019) may be due to the Trust’s move to a new risk management system in January 2019 and a period of adjustment required by staff in using the new system. Staff have received training and on-going support to ensure incident reporting is continued and learnt from.

The number of patient safety incidents reported to the National Reporting and Learning System (NRLS) for the period April to September 2018 increased by 6.5% when compared to the previous six month period and by almost 12% when compared to the same period in 2017. The number of incidents per 1,000 bed days for the period April to September 2018 was 43.89; the Trust is ranked the second highest out of seven London Mental Health Trusts. (NRLS data for Oct 18 - Mar 19 is not yet available).
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:

<table>
<thead>
<tr>
<th>2018/19</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of deaths reported</td>
<td>137</td>
<td>101</td>
<td>116</td>
<td>141</td>
</tr>
</tbody>
</table>

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.

![Trust Hand Hygiene Audit Scores 2018-2019](image)
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.

Hygiene Assurance monthly Trust compliance scores:

![Hygiene Assurance Trust Scores 2018-2019](image)

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.

![Trustwide Inpatient Cleanliness Scores 2018-2019](image)
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.

Five assessments were carried out in collaboration between Trust staff and local people known as Patient Assessors recruited from Healthwatch, Barnet Voice, Haringey User Network, and Enfield Mental Health Users. The Trust ran twelve training sessions for the assessors to carry out the PLACE assessments.

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](image)

Percentage Trust compliance scores in each domain against the national average:

<table>
<thead>
<tr>
<th>Domain</th>
<th>BEH-MHT</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleanliness</td>
<td>99.56%</td>
<td>98.50%</td>
</tr>
<tr>
<td>Ward Food</td>
<td>95.65%</td>
<td>90.20%</td>
</tr>
<tr>
<td>Privacy, Dignity and Wellbeing</td>
<td>89.67%</td>
<td>84.20%</td>
</tr>
<tr>
<td>Condition, Appearance and Maintenance</td>
<td>96.32%</td>
<td>94.30%</td>
</tr>
<tr>
<td>Dementia</td>
<td>87.42%</td>
<td>78.90%</td>
</tr>
<tr>
<td>Disability</td>
<td>87.02%</td>
<td>84.20%</td>
</tr>
</tbody>
</table>
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 bullying 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.
The survey highlighted some good areas of staff experience but it is evident that our staff's experience of our Trust should be better and we are determined to improve.

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 with mandatory training at the end of March 2019 was slightly below our target of 90%, at 83% for the core topics. To improve this we have focused on areas that are below target 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 mandatory training that they have already completed with another NHS employer.

The figures below demonstrate that we have done well in relation to some topics, including equality and diversity and safeguarding children level 2. 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.
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.
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.

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.

- Timely access to beds
- Risk assessments and care plans (embedding a sound culture across all teams)
- Reducing restrictive practices
- Learning & improving from Patient & Carer feedback and staff feedback

1) Timely access to beds

We will:
- Reduce the number of service users being admitted to inpatient beds outside of the Trust due to there being no bed available.
- Reduce bed occupancy rates so that beds are always available.
- Reduce the number of service users who are admitted to our beds outside of their home locality.
- Monitor the feedback we receive from inpatients about their experience of being cared for on our wards.
- Ensure risk assessments are utilised appropriately to inform bed management decisions.
2) Risk assessments and care plans

We will:
• Revise the Trust’s risk documentation on RiO and implement Trust wide.
• Improve the quality and timeliness of risk documentation
• Ensure risk assessments are appropriately used to inform all decisions regarding the patient
• Ensure risk documentation is audited appropriately through the monthly Quality Assurance audit. Monthly audit to include a standard set of 4 risk assessment questions monthly
• Revise training on CPA and clinical risk assessment, to include training on the new risk documentation
• Improve the quality of patient care plans by increasing collaboration and shared decision making with the patient, carer and appropriate clinical team
• Ensure care plans demonstrate:
  o Risk assessment.
  o Person centred holistic assessment.
  o Service user voice
  o Regular Review

3) Reducing restrictive practices

We will:
• Reduce prone restraints by 30%
• Introduce and implement staff training and education in relation to administering rapid tranquillisation
• Improve the environment of areas for seclusion and restraint which will contribute to the reduction of prone restraints.

4) Learning & improving from Patient & Carer feedback

We will:
• Work with the complaints Ombudsman to improve the quality of complaints responses. BEH is the only Trust to have been selected by the Ombudsman to participate in this process
• Increase responses to the patient survey

5) Reducing locally acquired pressure ulcers within adult community health (Enfield Adult Community teams)

6) Reducing medication incidents (Enfield Community Health)
Part 4

Highlights from BEH Boroughs and Specialist Services management teams on quality improvements, initiatives and achievements, 2018/19

Barnet

Our services in Barnet have made very good progress in 2018-19 demonstrating excellence in the areas of innovation and engagement.

The Directorate’s performance has been strong with all efficiency targets reached through growth and through positive service development. The leadership approach in Barnet is very much one that seeks to emulate the BEH MHT values and see these lived through active engagement with teams, stakeholders and partners – promoting a context of trust and respect across boundaries and between existing providers - seeking to lead on the creation of new opportunities via partnership. In addition significant effort has been invested in engaging with our colleagues delivering sessions on the theme of diversity, bullying and harassment with the leadership team promoting the use Head-space within Barnet and leading on the drive with Executive colleagues to make this available to all Trust employees.

Barnet Child and Adolescent Mental Health Services (CAMHS)

Significant progress has been made by our CAMHS service in Barnet – we are working very closely with commissioner colleagues and leaders from across the CAMHS provider scene and key representatives within the Barnet Transformation Board.

Our nationally bench-marked data demonstrates that we are a highly productive service and support a very high volume of young people and their families to navigate and realise benefit from the local mental health resources. We are anticipating the successful implementation of a re-design within the service which will see the implementation of a co-produced model of care.

BEH MHT CAMHS team member have been centrally involved in the re-design process and there is a real sense of optimism present associated with the pending changes. The model is built upon ‘Thrive’ principles and offers a stepped care approach to people that will be both individualised and standardised, The model aims to provide rapid and accessible early help and also highly specialist assessments and treatments – targeting the reduction of waiting times and the provision of highest quality and evidence based assessments and treatments.

Excellent progress has also been made with effective management of transitions between the CAMHS and Adult services. This year has also seen the inception of a CAMHS Assertive Outreach provision – designed to support young people in times of crisis – aiming to prevent admission, provide care closer to home and in community settings and to reduce inpatient stays. Whilst this is a very limited resource at the moment, we are very pleased to be delivering this service and hope that, as the evidence of its success is established, further investment and growth may be realised.
Let’s Talk Barnet has consistently over-performed on its monthly access target as well as exceeding the recovery rate target of 50% every month since April 2018. This is a partnership offer with some of the IAPT activity procured by us and delivered through a partnership, the Multi-lingual Wellbeing Service (MWS).

Following the adult pathway redesign we now have much closer links with secondary care services and the borough Crisis Resolution Home Treatment Team. Our current focus in both services is on securing additional investment in order to reduce waits and meet the increasing access targets for 2018/19, as well as further developing our offer for people with long term conditions. In Barnet we are in discussion with the commissioning teams to develop a more integrated service within primary care for people with diabetes, and are working hard to expand the range of groups and workshops we offer to people with a diagnosed long term condition.

Some quotes from our patient experience questionnaires:

‘I simply cannot thank the therapist and service enough for these sessions. It has allowed me to open up when I’ve been unable to speak to anyone else. I realise attending these sessions is the beginning of my journey to getting help, thank you’

‘When I first came I was sceptical about the service, but after a few sessions, I knew the service was there to help me, and I think I achieved what I came for.’

‘It was the type of help I was looking for I felt safe and comfortable, and it helped me at a desperate time of need. Thank you’

‘Grief doesn’t go away it just changes shape. I have changed the shape of mine.’

‘I have been hugely benefitted by the sessions, the therapist is knowledgeable and understanding and always managed to make me feel comfortable to talk. I did not believe I would be so hugely benefitted by CBT and I am impressed. I hope I keep doing progress and keep the learnings of the sessions with me’

‘The service I received was above and beyond what I expected. I am much happier and confident moving forward and feel well equipped to do so.’
Barnet Liaison

Our Liaison services have introduced some excellent innovations this year and we are very much hoping that commissioner support to continue the schemes will be realised.

Our service in North Middlesex A&E has developed two outstanding schemes – one targeting the provision of rapid assessment and expert guidance for people experiencing signs of dementia in the Medical wards and the other is the development of a very exciting scheme seeing the employment of experts by experience – in roles as Peer Support Workers who work as part of our Liaison team to support service users and their families in the department easing the assessment process and providing truly empathic and engaged support. In addition we are seeing other very positive de-stigmatisation effects and are very much looking forwards to the evaluation of this service and its impacts on the quality of our provision.

Performance in A&E in Barnet has remained very good throughout the year and we are seeking further discussion and negotiation with our commissioners regarding the resources for 2019-20 to support more quicker assessment and mobilisation in North Mid – being mindful that the area has historically been significantly busier than Barnet A&E.

Barnet Acute Services

The context in Barnet remains challenging for our acute services with increasing demand evident for home treatment and inpatient care. We have continued to implement the Trust’s Enablement strategy and are very pleased to have been able to recruit a peer support worker to our Crisis Resolution and Home Treatment team. We have continued to develop and embed Quality Improvement (QI) methodology in our area – focusing on schemes to improve staffs’ working lives and patient safety. This year we were very pleased to see that staff received recognition for their QI work on Thames ward at the Trust’s Annual Staff Awards.

In 2019 we will be developing a further adult acute inpatient facility in Barnet to improve the availability of local beds for people needing this level of support.

We have started the challenging process of preparing for College of Psychiatrists accreditation for our Home Treatment Team. Our determination to meet these standards is testament to our commitment to evidence the quality of care and treatment that people have the right to receive from our services in their times of most significant need. We will continue to recruit people to work in our services who reflect our Trust values and have welcomed many new colleagues to our team this year.
Barnet Physical Health Care progression

The service has made good progress with the introduction of a substantive physical health-care lead in the Directorate.

Momentum has been created and we are seeing significant and tangible improvements in our physical healthcare of people with Severe Mental Illnesses on Care Programme Approach (CPA) across our community teams, our Wellbeing clinic and inpatient pathways. A co-operative and systematic approach has been adopted with excellent contributions from our link-working team to support sharing of information between primary care practices and our secondary care services.

We have not yet achieved all that we want to in this area and will be further enhancing the approach through 2019-20 – building more physical healthcare screening capability in our teams and continuing to enhance our monitoring systems.

Our acute service was very fortunate to receive a donation from the Hampstead Garden Suburb Free Church to spend on exercise equipment for our inpatient services. The equipment has now been procured and installed and is available for use at the Dennis Scott Unit.

Barnet Older People Services

Our older people service has been successful once more in achieving Memory Service National Accreditation Programme (MSNAP) accreditation. This is demonstrative of the service’s ability to work to the highest standards in terms of providing quick and evidence based assessment and treatment for people with declining cognitive functioning. The multi-disciplinary team approach is robust and includes psychiatric diagnosis, Cognitive Stimulation Therapy and psychological assessment and treatment.

Our older people service will be seeking to work closely with commissioner colleagues and the emerging CHIN (Care Closer to Home Intergrade Network) structures in primary care to further enhance and develop the offer for the growing Barnet population of older people with complex needs associated with Dementia and functional illnesses.

Barnet Younger Adult Services

A further year of embedding the Link Working service in the Adult pathways has now led us to a position where we have secured recurrent support from our CCG to continue to run this excellent service which acts as a responsive expert point of entry to our services in Barnet and facilitates navigation of the mental health services across the Barnet provider scene.

Good success has been achieved in joining with CAMHS to monitor and plan transitions for young people as they approach the boundary of reaching 18. There has been excellent joined up planning and connectivity in this area with the CAMHS and Adult leads showing great leadership. Further work needs to be done in this area across other provider boundaries for 2019-20.

Another highlight this year has been that the Early Intervention Service was successful in its bid to secure funding for a gardening project in the garden of our outpatient clinic – The Redhill clinic in Edgware.

Our Personality Disorder team has provided Structured Clinical Management sessions for colleagues from across the adult services and beyond – this is an evidence based support
approach to enable practitioners to work with a set methodology with people who are experiencing complex needs associated with significant psychological distress. The training was very well received and will be rolled out further to continue to enhance our work-force’s capabilities.

Enfield

Adult Mental Health

Year in Review Highlights

- The embedding of new care pathways and delivering well against our bed target while maintaining high levels of compliance with respect to Key Performance Indicators.
- Working collaboratively with the Enfield Carers Association on a new project to ensure safer discharge planning with patients & carers.
- The introduction of the Enfield Primary Care Link Worker scheme which has been rolled out to 20 General Practices in Enfield.
- The introduction of the IPS (Independent Placement Support) scheme which supports service users to secure employment.
- The opening of a new 13 Bedded Complex Rehabilitation service on the Chase Farm site which is enabling us to treat service users closer to home.

Looking Ahead

- Delivering the transformation programme associated with the requirements of a mobile workforce.
- The relocation of the Psychiatric Intensive Care Service to the Chase Farm site.

Mental Health Services for Older People

Year in Review

Further improvements in inpatient length of stay and bed use: best nationally

- The 2017/18 National Benchmarking report ranks BEH MHSOP inpatient services as the best in the country in relation to OBDs per capita and a very low length of stay. This is the successful accumulation of several years of close working between inpatient services and community services in Barnet, Enfield and Haringey. Further improvements have been made this year and DToC numbers are at an all-time low. This is a major success as services avoid unnecessary admissions, effectively treat patients and facilitate discharge.

- Successful Dragons den bid - Significant improvements have been made to our dementia care environment on Silver Birches Ward.

Looking Ahead

- Strengthen physical healthcare on our mental health services older people’s inpatient wards.

Adults Community Health Services

Year in Review

- Care Home Assessment Team (CHAT) – reducing discharge delays within acute hospitals
  - There has been further expansion this year to include the ‘Trusted Assessor’ function for acute hospitals. The CHAT team assess patients who are ready for discharge from an acute setting back to a care home. The care home accept these assessments without the need for care home staff to attend the acute hospital, reducing delays.
Response & Pain Management Pathways
• During the last 12 months the borough has worked closely with commissioners and other stakeholders to develop proposals for an expanded Rapid Response function and to address a specific service gap – community pain management services. These proposals have now been agreed by Enfield CCG.

Looking Ahead
• Transition of Cape Town Ward from the acute trust to BEH & development of rehabilitation transformation plan.
• Development of Integrated teams, Rapid Response and Pain Management.
• Review of Long-term Conditions services: strengthen pathways and improve resilience.

Child & Adolescent Mental Health

Year in Review
• Enfield CAMHS Admin Team winner of the BEHMHT Diamond “Team of the year”.
• Haelo quality improvement initiative reduced the number of service users who did not attend first appointments by 75%.
• Access team launched significantly reducing waits for clinical contact and improving referral to treatment.
• BEH CAMHs identified as one of the top 10 most productive teams nationally – as reflected in NHS Benchmarking report.
• 100% increase in resource to SCAN (Service for Children and Adolescents with Neuro-developmental disorders) team including nursing and strengthening team leadership to support mental health provision to children and young people with significant learning difficulties.

Looking Ahead
• The creation of a Children’s Hub at Baytree House bringing together Universal and CAMHs services and improving the experience of service users that need access to both 0-19 universal services and psychological and specialist mental health services.
• Further work to embed user engagement and co-production.
• Strengthening the implementation of ICAN across services (CAMHs outcome measures).
• Sustaining the ITHRIVE conceptual framework, successful site for training programme of Children’s Wellbeing Practitioners (CWP’s).
• Piloting a new crisis liaison nurse role to provide and coordinate urgent CAMHS risk assessments to Enfield children and young people presenting to local acute hospitals and to improve liaison between CAMHS and hospital paediatric teams.
• Embedding the learning from the analysis and evaluation of the CAMHs Transition CQUIN.

Children and Young Persons (CYP) Community Services

Year in Review
• School Aged Immunisation Team: identified as most improved in London for uptake. The Team worked proactively to increase uptake of all immunisations for 4-10 year olds including HPV vaccine for 12 year old girls. NHSE rolling out HPV for 12 year old boys from September 2019.
• Data for Universal Children’s services is showing a steady improvement in quality. Reported to Public Health England following more robust data extraction and utilisation of RiO.
• School Nursing moved to corporate model of delivery, streamlining processes and generating some traded bespoke services with Academy schools.
• Dietetics BEAR NECESSITIES’, OAKTREE SCHOOL: 6 week programme focused on weight management for children and young people aged 9-19 years and their families. Cohort 1: At 6 weeks, 75% of participants had lost or maintained weight. Offer delivered with support from
school nursing and Improving Access to Psychological Therapies (IAPT).

- School age offer in mainstream – Assessment of Needs and Interventions for all CYP with an Education / Health Care Plan. Assessment and Intervention for CYP with Primary Health Needs. Training for schools at no charge.
- Traded offer: Voice of The Child Project with Our Voice – a language toolkit to support non-verbal communication and engagement in decision making of Children and Young People.

Looking Ahead
- The creation of a Children’s Hub at Baytree house.
- Launch of the consultation and implementation of the Remodelled care group for CYP with Additional Needs and Disabilities.
- Early Years Positive Beginnings: Parent mediated intervention for toddlers with social communication disorders – 73 families of children 2-3 years will be offered the program in 2019.
- Dietetics BEAR NECESSITIES’ Planned for Spring 2019. Future plans to roll out to another local school.

Enfield Learning Disability (LD) Service

Year in Review
- One of the highest numbers in London of people with LD supported to live in community settings / accommodation.
- The development of a Positive Behavioural Support pathway to improve quality of life and reduce challenging behaviours.
- Very low numbers of admission to LD Assessment & Treatment units and reduction in length of stays in line with the Transforming Care Agenda.

Increasing Access to Psychological Therapies (IAPT)

Year in Review
- The Enfield IAPT service has consistently met the monthly access target and has achieved an average recovery rate through the year in excess of the 50% target. The service has consolidated its perinatal offer and continues to offer a wide range of therapeutic interventions including two digital options for those requiring out of hours support.

Looking Ahead
- Integration and co-location within primary care.
- Further developing offer for people with long term conditions through collaboration with the North Middlesex Hospital in the development of an integrated care pathway for service users with chronic pain.
What has gone well:

- **Primary care link worker project**
- **Service relocation**
  - Locality teams and adult community pathways embedded at St Ann’s hospital site
  - CAMHS relocated from Burgoyne Road to St Ann’s site
  - St Ann’s re build underway

- **Quality improvement collaboratives**
  - Community teams - improved staff satisfaction
  - Out of area placements
  - Recruitment

What has been challenging:

- **Risks**
  - CRHTT crisis response
  - Staff recruitment and retention
  - Fit for purpose inpatient environment
  - Interface with London Borough of Haringey
  - Increasing demand
    - Caseloads for community teams
    - Pressure on acute care beds
    - Waiting times for psychological Therapies

- **Main concerns**
  - communication of diagnosis and/or discharge plans in community services
  - liaison with primary care for follow up of care.

**Child & Adolescent Mental Health Services**

Multi phased service move from Burgoyne road to St Ann’s site and the refurbishment of Mulberry House and H block at St Ann’s. Requiring frequent planning and close work with contractors to keep the service operational during the last half of November up until early January. Work was successfully finished on time and also disruption to patients was kept to a minimum.

Haringey was chosen to be one of 20 first wave national pilot sites for the CAMHS Trailblazer initiative in December 2018. This was an NHS England funded pilot to bring mental health support to schools. We have recruited into key posts and have had staff going into schools from end of March 2019. This bid also funded the four week waiting time initiative and we have put together the new triage and access team which has already impacted on waiting lists. We were able to start this initiative ahead of schedule.

Transforming Care and Partnership Support (TCaPs) is the project to help Young People with learning disabilities and/or Autistic Spectrum Disorder to not go into crisis and stay in the family home. Haringey has become a key component of the project and is hosting three workers who start going into homes in early April.

The North Central London crisis team is funded by Whittington Health but with significant input from BEH CAMHS, led to a roll out in April. This will provide out of hours cover in the borough.
Sustainability and transformation partnerships (STP)
Psychiatric liaison project: this is on-going but has the aim of having young people spend less time in paediatric beds with co-morbid mental health difficulties and facilitating an integrated care package in the community.

Areas for improvement for our CAMHS service are waiting times and the need for more engagement and integration with community services.

**Older People's Community Mental Health Team (OPCMHT)** - a service rated Outstanding by the CQC in 2017.

CMHT has expanded the Wellbeing Clinic since January 2019 to include service users on Depot injections who do not meet the threshold for Care Coordination. Prior to this, the CMHT Wellbeing Clinic would only manage physical health for service users on anti-psychotic medications.

Another service improvement initiative the CMHT has undertaken includes Caseload Reviews with care-coordinators and CMHT Doctors to review care plans and patient’s journeys. The driver for this was an identified need for closer collaborative working by the MDT.

**Psychology Service for Older People** has trialled a Tree of Life group for older people with a diagnosis of dementia, with the aim of providing a group experience where service users can move beyond ‘problem-focused’ stories about themselves and their situations to draw out strengths and resources to support them in the later stages of their lives.

Service user feedback has been very positive. We have a well-established Mindfulness-Based Cognitive Therapy (MBCT) group for older people with longstanding anxiety/depression but have been looking at how we can make mindfulness more accessible to service users who are not able to meet the cognitive demands of the MBCT group.

In early 2019, we trialled an introductory level skills group with a view to engaging service users with a greater range of needs/abilities. Early results and feedback have been very positive.

**Haringey Memory Service** has recently undergone its 4th cycle of accreditation with the Memory Service National Accreditation Programme (MSNAP) by the Royal College of Psychiatrists. This accreditation process ensures that the Memory Service is adhering to the standards prescribed in terms of the delivery of quality care, patient and carer outcomes and provision of a dementia-friendly environment. The team has been innovative and applying the QI methodology to service improvement whereby the process is owned by the whole team. As such the team has managed to improve on waiting times and patient experience; this was echoed in the MSNAP Peer Review.

The following is a comment from a Peer Reviewer:
“Thank you to you and the team yesterday for making us so welcome and looking after us. It was a very positive experience and the peer review was a pleasure to complete”

The Memory Service received a donation of almost £7000 for an equipment called a Tovertafel; developed for people in the moderate to severe stages of dementia. The interactive games break through apathy by stimulating both physical and cognitive
activity and encouraging social interaction. This donation was made by a service user’s carer in their appreciation of the service that their loved one had received whilst in the care of the Memory Service.

Specialist Services – North London Forensic Service highlights

Secure Care
- Covering 5 North Central London boroughs
- 210 beds (99% occupancy) and 5 Outreach teams
- The only NHS secure service in country with two CQC Outstanding ratings
- 7 prisons with mental health input from our services - HMYOI Feltham, HMP Brixton, HMP Pentonville, HMP Wormwood Scrubs, HMP Springhill, HMP Aylesbury, HMP Grendon
- All received great reports from HMIP, CQC and Quality Network. HMP Brixton was the highest achiever of quality standards in the country. HMYOI Feltham is the only prison accredited by the Autistic Society.

Quality improvement initiatives
- CHOICES – values based co-produced model that support users to develop skills to make better CHOICES
- Reduce violence and aggression
- Reduce restrictive practice
- Increase co-production
  = improved care pathway, reduced length of stay/recalls

Initiatives in practice
- Recovery college - Over 60 co-produced courses
- Care Zoning
- Sensory Modulation – there are sensory rooms on 9 inpatient wards. It was started on the learning disability ward. The QI project saw a reduction in verbal aggression.

• Positive Behaviour Support
• Mobile phones
• Self-catering
• Ward Round Summaries
Ward to Board engagement. Examples include:

- Ward Community/Business meetings
- User Forum
- Elected ward reps
- Open Dialogue
- Experts By Experience
- Co-production
- Management Forums
- Recovery College

Involvement of Families, Friends and Carers

- Monthly Friends and Families meetings
  - MDT supported group
  - 140+ invites per month
  - Psycho-educational, service and pathway information
  - Peer support
- Family Intervention Service
  - Specialist MDT group offering short and longer term sessions to families and service user (where appropriate)
  - Referred intervention for psycho education work, family support, signposting
  - Confidential
- MDT liaison – named social worker
- Inpatient management meeting representation

Beacon Centre

Achievements

- QNIC Accreditation review (Awaiting Decision)
- CQC – rated Good
- Successful Dragons Den Bid for Sensory Garden
- Successful recruitment into all RMN post
- Assertive outreach and Discharge Nurses
- Appointment of two activity co-ordinators
- Weekly ward programme that includes evening groups
- The development of community links/partners in the local area and across London.

Beacon Quality Improvement Initiatives

- Evening and night groups introduced onto the ward by OT staff
- 95% reduction in self-harm after going staple free and activity at night
- Creation of assertive Outreach team with experienced community nurses which will reduce in-patient length of stay.

Beacon engagement with service users and staff

- Ward Community/Business meetings
- Ward reps
- 7 day time table – with a range of optional weekend activities.
- Occupational therapy groups out of hours and weekends
• Key changes music making sessions
• Kick boxing sessions
• Young Peoples Forum
• Expanded to include bi-weekly community meetings including all staff on the ward at the time.
• Experts By Experience
• Young people on Interview Panels
• Young People as part of policy review group
• Developing training content for staff

EATING DISORDERS SERVICE

Continuous Quality Improvement

Phoenix Ward – Patient Engagement
• Patient Rep attends ward based group planning meetings and changes are made to the group timetable based on patient feedback
• Patient led groups on the ward
• Patient led social events on the ward, including fundraisers for BEAT over 2018 that raised £1000
• Prompt action of issues raised in weekly Community Meeting
• Significant improvements in Patient Experience scores over last 6 months (90% or above)

High Levels of Engagement with Carers – Phoenix Ward
• Carer feedback to the service led to the development of:
  • Monthly Welcome Groups facilitated by ward/MDT staff for the families of recently admitted patients to share information about the ward routines and treatment provided on the ward
• Carers’ Skills Training Groups – series of 5 monthly groups to provide advice and support for families of patients with anorexia
• Fortnightly Carers’ Support Group – well attended and provides information on various topics as requested by the carers

Eating Disorders Community Services

• Peer Support Group – Weekly evening group in the community facilitated by two Peer Support Group workers with lived experience of an eating disorder. Very good feedback from service users about the group.
• Improvements in the quality of psychological treatment provided and the service now offers patients a choice of the three NICE guidelines approved treatments for eating disorders

Eating Disorders Day Programme

• As a result of service user feedback, in 2018 the Day Programme started providing a more flexible programme, offering both full-time and part-time options. The greater accessibility of the Day Programme has been a well-received initiative.
• Service users continuously provide feedback about the therapeutic programme on offer in the Day Programme, which leads to changes in the groups provided.
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

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

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

Communications Department
Barnet, Enfield & Haringey Mental Health NHS Trust
Trust Headquarters, Orchard House St Ann’s Hospital
London N15 3TH
beh-tr.communications@nhs.net
Title: Board Assurance Framework (BAF)

Report to: Trust Board

Date: 23 May 2019

Security Classification: Public Board Meeting

Purpose of Report:

The Trust Board approved the new Trust Strategy and corporate objectives for 2019/20 at its previous meeting on 25 March. A process for refreshing the BAF with input from the Executive Leadership Team and the Board has been agreed before the revised BAF is brought to the July Trust Board meeting.

In the meantime, the 2018/19 risks have been reviewed and aligned to the new corporate objectives for 2019/20 and are presented at the Appendix.

Recommendations:

The Trust Board is asked to note the report.

Sponsor: Jinjer Kandola, Chief Executive

Comments / Views of the Report Sponsor:
The BAF sets out details of the identified risks to meeting the Trust's organisational objectives and the progress being taken to mitigate these.

Report Author: Name: Andrew Wright
Title: Director of Strategic Development
Tel Number: 020 8702 3035
E-mail: andrew.wright14@nhs.net

Report History: Regular Report

Budgetary, Financial / Resource Implications:
The BAF contains risks which have a combination of resource and budgetary implications. All risks are mitigated and subject to regular review.

Equality and Diversity Implications:
None.

Links to the Trust's Objectives, Board Assurance Framework and / or Corporate Risk Register:
This report presents the BAF outlining the key risks to achieving the Trust's organisational objectives.

List of Appendices:
- BAF
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Board Assurance Framework – Regulatory Standards

Objective: 1. Delivering our core services effectively (brilliant basics)

Board Lead: Amanda Pithouse  Date of review: May 2019

Lead Committee: Quality and Safety  Date of next review: July 2019

Risk ID: 2  Risk: Regulatory Standards - If services consistently do not meet regulatory core standards in respect of essential standards for quality and safety, this will impact on the quality of care given to patients and may result in regulatory action.

Relevant CQC Domain(s): Caring / Effective / Responsive / Safe / Well-led

Relevant H&SC Act 2008 Regulations: 4, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18

Relevant CQC Regulations 2009: 16, 17, 18,

Risk Rating: (Likelihood x impact):

Initial Risk Score: 3 x 4 = 12

Current Risk Score: 3 x 4 = 12

Tolerable Risk: 3 x 3 = 9

Direction of travel:

Rationale for current score:

Following the outcome of the CQC inspection in 2017, the Trust produced a Quality Improvement Plan (QIP) which is developed with and regularly reviewed by CQC colleagues and Commissioners. The Quality Improvement Plan has reached the stage where the remaining actions are now included in regular performance monitoring, to ensure they are fully embedded across the organisation and support the Trust’s overall corporate priorities. In order to support this, the Trust has moved to a themed based quality improvement programme, embedding key themes into everyday activity. Triangulating the key themes from serious incident investigations, quality reviews, CQC inspections and patient feedback, the Trust has agreed Ten Quality Priority areas for 2019/20, which are regularly monitored at service and Board level.

Controls: (What are we currently doing about the risk?)

1. The Trust’s Quality Strategy 2016 – 2019 aims to address quality issues for patients
   • Quality metrics reported to every meeting of the Quality and Safety Committee and Trust Board via the Trust Quality and Performance Report and the Clinical, Quality and Safety Report (I).
   • Patient feedback via complaints & claims, as reported in the KPIs reported to every Trust Board meeting (I).
   • Safety Thermometer data submitted and reviewed quarterly (I).
   • Safe Staffing Report to every meeting of the Trust Board (I).
   • Appraisal / revalidation in place across all Trust teams (I).

2. Quality Account, which details the quality priorities for the Trust:
   • Six monthly update reports to the Quality and Safety Committee (I) and Clinical Quality Review Group (E) meetings.
   • Quality metrics reported to every meeting of the Quality and Safety Committee and Trust Board via the Trust Quality and Performance Report (I).
   • Annual External Audit review of the Quality Account

Assurances: (How do we know if the things we are doing are having an impact?)
(Key: I = Internal / E = External)

- Number of Never Events
- Formal Complaints received
- Overall Patient Satisfaction
- Overall Carer Satisfaction
- Nursing Vacancy Rate
- Staff Turnover (total)
- Proportion of staff compliant with individual mandatory training requirements

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Never Events</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Formal Complaints received</td>
<td>9</td>
<td>6</td>
<td>6*</td>
<td></td>
</tr>
<tr>
<td>Overall Patient Satisfaction</td>
<td>90.4%</td>
<td>90.3%</td>
<td>89.9%</td>
<td>80%</td>
</tr>
<tr>
<td>Overall Carer Satisfaction</td>
<td>87.6%</td>
<td>88.9%</td>
<td>88.5%</td>
<td>80%</td>
</tr>
<tr>
<td>Nursing Vacancy Rate</td>
<td>13.3%</td>
<td>13.7%</td>
<td>14.1%</td>
<td>10%</td>
</tr>
<tr>
<td>Staff Turnover (total)</td>
<td>11.87%</td>
<td>11.84%</td>
<td>12.66%</td>
<td>15%</td>
</tr>
<tr>
<td>Proportion of staff compliant with individual mandatory training requirements</td>
<td>79.0%</td>
<td>81.2%</td>
<td>83.8%</td>
<td>90%</td>
</tr>
</tbody>
</table>
   - Annual reports are produced for Safeguarding, Infection Control and Health and Safety which are reviewed by the Quality and Safety Committee and ratified by the Trust Board each financial year. (I)

4. Skill Mix Review.
   - Trust receives Safe Staffing report at each Trust Board meeting (I).
   - SafeCare module implemented which will allow for real time acuity / dependency data.

5. CQUIN and Contract monitoring process.
   - CQUIN delivery monitored through meetings of the Integrated Performance Meeting

6. Quality impact review process of all CIP plans.
   - All CIPs have a Quality Impact Assessment in place and key milestones tracked through to delivery and monitored via the Integrated Performance Meeting (I).
   - There is a QIA monitoring group in place to review and monitor the process with reports to the Quality and Safety Committee. (I)

7. Serious Incident Groups at Team / Borough Level
   - All Serious Incidents scrutinised and action plans in place to address learning (I). Trust Serious Incident Review Group (I)
   - There is also independent scrutiny which is overseen by Commissioners.

8. Borough Level Clinical Governance meetings.
   - All key clinical governance indicators reviewed and actions agreed to address any variations (I).

   - The Trust has two Independent Freedom to Speak Up Guardians in place with regular reporting to the Trust Board.

    - The Patient Experience Committee (PEC) reports regularly to the Quality and Safety Committee. (I).
    - There is an Engagement and Involvement Strategy 2016-2019 in place with Borough level action plans in place to deliver strategy (I).
    - Friends and Family Test and 'You said, we did' identifies actions taken (I).
    - Patient Experience & Complaints Annual Report is ratified annually by the Trust Board.

11. Internal Peer Assessment Programme which mirrors CQC inspections.
    - Quality assurance monitoring in place via key performance discussions and Deep Dive meetings (I).

<table>
<thead>
<tr>
<th>Gaps in controls and assurances: (What additional controls and assurances should we seek?)</th>
<th>Mitigating actions: (What more should we do?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Skill Mix Review to be undertaken</td>
<td>1. Skill Mix Review to be presented to Trust Board on 23 May</td>
</tr>
</tbody>
</table>

Additional Comments:
# Board Assurance Framework – Managing Services within Resources

**Objective:**
1. Delivering our core services effectively (brilliant basics)

**Board Lead:** Stanley Riseborough  
**Date of review:** May 2019

**Lead Committee:** Finance and Investment  
**Date of next review:** July 2019

**Risk ID:** 3
**Risk:** Managing Services within Resources – If the Trust does not have sufficient resources to manage the demands on its service then there is a risk that patients will not get an appropriate service and/or the Trust will not achieve its financial control total

**CQC Domain:** Caring / Effective / Responsive / Safe / Well-led

**Relevant H&SC Act 2008 Regulations:** -

**Relevant CQC Regulations 2009:** -

**Risk Rating:**  
( Likelihood x impact):

<table>
<thead>
<tr>
<th>Initial Risk Score</th>
<th>Current Risk Score</th>
<th>Tolerable Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 x 4 = 12</td>
<td>3 x 4 = 12</td>
<td>3 x 3 = 9</td>
</tr>
</tbody>
</table>

**Direction of travel:**

- Financial Performance is measured against the Trust’s Control Total set by NHS Improvement

## Rationale for current score:
The main risks relate to adult mental health bed occupancy and long waits for psychological therapies where demand is increasing.

## Controls: (What are we currently doing about the risk?)

**Assurances:** (How do we know if the things we are doing are having an impact?)  
(Key: I = Internal / E = External)

1. Additional investment in improved admissions, discharge and bed management.
   - Significantly strengthened bed management processes and protocols, led directly by COO
   - CEO led Improvement and Delivery Board oversee these (I).
   - Progress reviewed at Finance and Investment Committee (I).

2. Repatriation of 10 beds from East London Foundation Trust to Barnet in September 2019
   - Capital Plan in place. Project Group established to manage repatriation. Progress reviewed at Finance and Investment Committee (I).

3. Series of actions underway aiming to address long waits within resource limits.
   - CCG commissioners have confirmed additional resources to help address issues in Barnet, which is the area with the most significant issues.

## Gaps in controls and assurances: (What additional controls and assurances should we seek?)

**Mitigating actions:** (What more should we do?)

1. Clinical activity reporting is being improved so that it is linked to overall Trust Performance reporting.
   - This is currently in development and due to be in place by April 2019. A report on the improved approach to Board reporting is being presented to the Board at the 25 March 2019 meeting.
**Board Assurance Framework – Recruit and Retain Staff**

<table>
<thead>
<tr>
<th>Objective:</th>
<th>2. Developing the organisation’s culture and people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board Lead:</td>
<td>Jackie Stephen</td>
</tr>
<tr>
<td>Date of review:</td>
<td>May 2019</td>
</tr>
</tbody>
</table>

**Lead Committee**
People and Culture Committee (under establishment)

**Date of next review:** July 2019

**Risk ID:** 4

**Risk:** Recruit and Retain Staff - If the Trust is unable to recruit and retain sufficient levels of staff or staff with appropriate skills and capability to meet the needs of changing services, this will result in a continued dependency on the need for temporary staffing which impacts on the quality of care delivered and financial sustainability of the Trust.

**Risk ID:** 4

**Risk Rating:** (Likelihood x Impact):

| Initial Risk Score: | 4 x 4 = 16 |
| Current Risk Score: | 4 x 4 = 16 |
| Tolerable Risk: | 3 x 4 = 12 |

**CQC Domain:** Effective / Safe / Well-led

**Relevant H&SC Act 2008 Regulations:** 18

**Relevant CQC Regulations 2009:** 13

**Relevant Key Performance Indicators:**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency as a % of Employee expenditure</td>
<td>5.4%</td>
<td>5.6%</td>
<td>6.4%</td>
<td>8%</td>
</tr>
<tr>
<td>Bank as a % of Employee expenditure</td>
<td>9.1%</td>
<td>9.6%</td>
<td>9.9%</td>
<td>10%</td>
</tr>
<tr>
<td>Total vacancy rate (% established posts without staff members in place)</td>
<td>11.0%</td>
<td>11.2%</td>
<td>10.7%</td>
<td>10%</td>
</tr>
<tr>
<td>Nursing Vacancy Rate</td>
<td>12.2%</td>
<td>13.3%</td>
<td>13.7%</td>
<td>10%</td>
</tr>
<tr>
<td>Medical Vacancy Rate</td>
<td>6.8%</td>
<td>6.7%</td>
<td>7.0%</td>
<td>10%</td>
</tr>
<tr>
<td>Staff Turnover (Total)</td>
<td>14.3%</td>
<td>14.1%</td>
<td>13.3%</td>
<td>15%</td>
</tr>
</tbody>
</table>

**Rationale for current score:**

New Trust Workforce Strategy presented to the Trust Board for approval on 25 March 2019. This outlines actions to support staff recruitment, including those hotspots that are difficult to recruit to. For such areas, bespoke recruitment campaigns are underway in collaboration with recruiting managers.

**Controls:** (What are we currently doing about the risk?)

**Recruitment**
1. Continuing to monitor relevant data e.g. vacancy rates, time to hire, turnover.
2. Training for first-line managers to improve their knowledge of workforce policies (including recruitment, disciplinary etc) has been launched and is expected to improve their skill in dealing with employee matters.
3. Continuing to hold a weekly Vacancy Control Panel, led by Executive Directors, to review all recruitment and non-urgent temporary staffing requests and ensuring that managers are considering all feasible options for filling vacancies.
4. There has been an increased level of engagement with universities to recruit newly qualified nurses and mental health workers and the launch of rotation programmes for newly qualified nurses.

**Staff Retention**
5. Electronic exit interview monitoring and feedback is shared with boroughs for change and remedial action.
6. Standardised pay rates for bank work so that bank work is more competitive.
7. Progressing the NHSI-supported retention programme, focussing on flexible working, learning and development and wellbeing which are recognised as important levers for improving retention.
8. Monthly agency monitoring meetings, requiring manager to share plans for ending assignments whilst maintaining

**Assurances:** (How do we know if the things we are doing are having an impact?)
(Key: I = Internal / E = External)

Workforce KPIs as above: vacancy rate, time to hire, agency spend, mandatory training compliance, turnover rate
safe staffing. A review of the monitoring meetings is underway as we are keen to accelerate a reduction in agency spend.

<table>
<thead>
<tr>
<th>Gaps in controls and assurances: (What additional controls and assurances should we seek?)</th>
<th>Mitigating actions: (What more should we do?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visibility of team-level workforce metrics.</td>
<td>Team-level metrics shared at IPMs and with executives to facilitate identifying hotspots and targeting those areas to support recruitment and retention.</td>
</tr>
</tbody>
</table>

**Additional Comments:**

- Staff Survey 2018 results are being presented to the Trust Board on 25 March 2019.
Board Assurance Framework – Development of the Trust’s Culture

**Objective:**
2. Developing the organisation’s culture and people.

**Board Lead:** Jackie Stephen  
**Date of review:** May 2019

**Lead Committee:** People and Culture Committee (under establishment)  
**Date of next review:** July 2019

**Risk ID:** 5  
**Risk:** Development of the Trust’s Culture - If the Trust fails to develop an open, people-focused and values-based organisational culture this will result in concerns not being effectively reported, failure to adopt best practice, inability to attract / retain staff and deliver change programmes including Quality Improvement and Enablement.

**CQC Domain:** Well-led  
**Relevant H&SC Act 2008 Regulations:** 18  
**Relevant CQC Regulations 2009:** -

**Risk Rating:**  
(Likelihood x impact)  
Initial Risk Score: $4 \times 5 = 20$  
Current Risk Score: $3 \times 4 = 12$  
Tolerable Risk: $3 \times 3 = 9$

**Direction of travel:**

The Staff Survey 2018 results were presented to the Trust Board on 25 March 2019, alongside proposals to address the themes from the Staff Survey, including staff engagement, which the Board will review regularly.

The Trust is developing a new Organisational Development Strategy which will be presented to the Trust Board in July 2019. This will set out a comprehensive OD programme to develop the culture of the Trust, which the Board will review regularly.

**Controls:** (What are we currently doing about the risk?)  
**Assurances:** (How do we know if the things we are doing are having an impact?)

(Key: I = Internal / E = External)
1. Identifying actions to contribute to improving staff engagement and staff survey results.
2. Undertaking a series of roadshows to share early thinking around Trust strategy and seeking staff feedback.
3. Undertaking informal and planned visits to services to discuss working environment with staff.
4. Ongoing training sessions to support staff to deal effectively with bullying and harassment.
5. Raising Concerns Policy and Procedure (Whistleblowing) and Freedom to Speak Up Champions provide point of contact to raise concerns.
6. Refreshing our wellbeing and equalities forums to increase staff engagement.
7. Developing staff networks which give opportunities for shared learning, input to policy and practice.
8. Equality and Diversity Group chaired by CEO.

<table>
<thead>
<tr>
<th>Gaps in controls and assurances: (What additional controls and assurances should we seek?)</th>
<th>Mitigating actions: (What more should we do?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited sources of staff feedback to help assess whether interventions have had a positive impact.</td>
<td>Sourcing portal to conduct pulse surveys of staff on a regular basis, to build an on-going and up-to-date picture on the impact of interventions.</td>
</tr>
</tbody>
</table>

Additional Comments:
None
# Board Assurance Framework – Staff Engagement

**Objective:**
2. Developing the organisation’s culture and people.

**Board Lead:** Jackie Stephen  
**Date of review:** May 2019

**Lead Committee:** People and Culture Committee (under establishment)  
**Date of next review:** July 2019

**Risk ID:** 6  
**Risk:** Staff Engagement - If the Trust fails to engage effectively with staff through robust communication, appraisals and the development of personal development plans, this will affect their ability to deliver excellent care and maintain professional standards.

**CQC Domain:** Well-led  
**CQC Outcomes:** 14 - Supporting workers

**Risk Rating:**  
(Likelihood x impact):  
- Initial Risk Score: $4 \times 5 = 20$  
- Current Risk Score: $3 \times 4 = 12$  
- Tolerable Risk: $3 \times 3 = 9$

**Direction of travel:**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>18/19 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of staff who have completed mandatory training</td>
<td>81.0%</td>
<td>81.3%</td>
<td>82%</td>
<td>90%</td>
</tr>
<tr>
<td>% of staff who have received an appraisal</td>
<td>-</td>
<td>-</td>
<td>78%</td>
<td>90%</td>
</tr>
</tbody>
</table>

## Rationale for current score:
The risk score remains the same as compliance with mandatory training and completion of appraisals remain below the Trust's target.

Mandatory training continues to be discussed at a range of meetings – weekly ELT, Deep Dives, IPMs, meetings with subject matter experts and safety huddles. The Learning and Development team continue to provide outreach and e-learning clinics, as well as producing a training bulletin to remind staff of ways to achieve and maintain compliance. Work continues with colleagues in NCL STP to streamline mandatory training and improve portability.

The new Trust Workforce Strategy was presented to the Trust Board for approval on 25 March 2019. This sets out a range of actions underway to improve staff engagement, building on the wide range of activities and engagement forums/approaches already in place, such as Executive Team Staff Roadshows, CEO lunches, Board member visits to services etc.

The Staff Survey 2018 results were presented to the Trust Board on 25 March 2019, together with proposals to address the themes that have emerged from the survey, including staff engagement.

**Controls:** (What are we currently doing about the risk?)

1. Workforce Development and Study Leave Policy, including arrangements for appraisals
2. Training Panel processes for the agreement of professional development programmes.
3. Recording appraisals on Electronic Staff Record
4. Booking and recording course attendance on Electronic Staff Record
5. Regular updates on training opportunities through Trust communication channels
6. Outreach sessions provided by the L&D team to address training

**Assurances:** (How do we know if the things we are doing are having an impact?)

- Workforce KPIs, including compliance with mandatory training, appraisals (I).
- Workforce Information Reporting Engine Database (WIRED) IT system which shows levels of compliance from Trust-wide to individual level – the data illustrated on WIRED is driven by our ESR records and is available for all staff to view.(I)
- Annual training needs analysis and delivery against it.
7. E-learning clinics provided at three main sites to support staff to complete mandatory training.
8. Providing support and training to managers to improve appraisal quality

<table>
<thead>
<tr>
<th>Gaps in controls and assurances: (What additional controls and assurances should we seek?)</th>
<th>Mitigating actions: (What more should we do?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

**Additional Comments:**

None
Objective: 3. Strengthening governance systems and processes.

Board Assurance Framework – Financial Management

Risk ID: 7  Risk: Financial Management – If the Trust fails to have appropriate mechanisms in place to ensure delivery of Cost Improvement Programmes, the management of budgets and improvements in productivity then the Trust will not deliver its financial plan, and may face further regulatory action.

Risk Rating: (Likelihood x impact): 4 x 4 = 16

Initial Risk Score: 4 x 4 = 16

Current Risk Score: 4 x 3 = 12

Tolerable Risk: 3 x 3 = 9

Direction of travel:

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Barnet</td>
<td>824</td>
<td>15</td>
<td>839</td>
<td>521</td>
<td>363</td>
<td>-45</td>
<td></td>
</tr>
<tr>
<td>Corporate</td>
<td>1,065</td>
<td></td>
<td>1,065</td>
<td>441</td>
<td>388</td>
<td>237</td>
<td></td>
</tr>
<tr>
<td>Enfield</td>
<td>1,497</td>
<td>695</td>
<td>2,192</td>
<td>1,201</td>
<td>397</td>
<td>377</td>
<td></td>
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<tr>
<td>Estates</td>
<td>544</td>
<td>333</td>
<td>877</td>
<td>401</td>
<td>230</td>
<td>247</td>
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<tr>
<td>Haringey</td>
<td>608</td>
<td>246</td>
<td>854</td>
<td>702</td>
<td>135</td>
<td>-117</td>
<td></td>
</tr>
<tr>
<td>Specialist</td>
<td>1,114</td>
<td>11</td>
<td>1,125</td>
<td>308</td>
<td>477</td>
<td>340</td>
<td></td>
</tr>
<tr>
<td>Trustwide</td>
<td>469</td>
<td>30</td>
<td>499</td>
<td>469</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>6,121</td>
<td>1,330</td>
<td>7,451</td>
<td>352</td>
<td>3,573</td>
<td>2,460</td>
<td>1,067</td>
</tr>
</tbody>
</table>

Rationale for current score:
The risk rating has been increased to reflect the fact that the Trust’s financial plan includes a CIP requirement of £7.5m, of which £1.1m is unidentified as at M1, and £3.9m is assessed at Red/Amber.

Controls: (What are we currently doing about the risk?)
1. Programme Management Office oversight of the Cost Improvement Programme with dedicated Project Managers ensuring that CIPs are planned and delivered in accordance with set milestones.
2. Workshops continue to be held with Service Lines that still have a gap to their CIP target.

Assurances: (How do we know if the things we are doing are having an impact?)
• Financial Performance Report considered at all meetings of the Trust Board and Finance and Investment Committee (I).
• Current financial position and actions taken to deliver cost control and CIP savings discussed monthly at Trust Performance Monitoring Group (I).
• CIPs are a standing item at each Service Line Senior Management Team meeting (me).
• A detailed review of the Trust’s CIP control environment was undertaken by Internal Audit in Q1 2019 and Reasonable Assurance was reported to the Audit Committee on 11 March 2019 (E).
4. Monthly Integrated Performance Meetings to review Service Line performance, risks and opportunities, including CIP delivery.
5. Divisions with 2019/20 CIP gaps required to identify, from M1, non-recurrent savings, to address CIP gaps
7. Service Line Recovery Plans to identify CIPs where a gap remains to target.

<table>
<thead>
<tr>
<th>Gaps in controls and assurances: (What additional controls and assurances should we seek?)</th>
<th>Mitigating actions: (What more should we do?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No significant gaps in controls and assurances identified, as evidenced by extant Internal Audit reports and the Statement of Internal Control.</td>
<td></td>
</tr>
</tbody>
</table>

Additional Comments:
### Board Assurance Framework – Medium / Long Term Financial Sustainability

**Objective:**

**Board Lead:** David Griffiths  
**Date of review:** May 2019

**Lead Committee:** Finance and Investment  
**Date of next review:** July 2019

**Risk:** Medium / Long Term Financial Sustainability - If the Trust is unable to achieve and maintain financial sustainability, this will lead to widespread loss of public and stakeholder confidence with potential for regulatory action such as financial special measures.

**CQC Domain:** Well-led

**Relevant H&SC Act 2008 Regulations:** -

**Relevant CQC Regulations 2009:** 13

**Risk ID:** 8

**Initial Risk Score:** $3 \times 4 = 12$

**Current Risk Score:** $3 \times 4 = 12$

**Tolerable Risk:** $3 \times 4 = 12$

**Risk Rating:** (Likelihood x impact): $3 \times 4 = 12$

**Direction of travel:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Jul 18</th>
<th>Sep 18</th>
<th>Nov 18</th>
<th>Jan 19</th>
<th>Mar 19</th>
<th>May 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Risk Score</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Current Risk Score</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Tolerable Risk</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

**Rationale for current score:**

The unchanged Risk Score reflects the fact that whilst the Trust is planning for a break-even position in 2019/20, this assumes receipt of £5.5m of non-recurrent Provider Sustainability Fund and Financial Recovery Fund income from NHS Improvement. This is a more challenging position than the Medium Term Financial Plan presented to F&I in July 2018 showed a breakeven position for 2019/20 onwards, however this was dependent on the delivery of a number of assumptions regarding additional funding from the CCGs, NHSE and local authorities, along with the achievement of some challenging CIP targets. The North Central London STP footprint remains one of the most challenging in England, which will have a major influence on the Trust’s financial position.

**Controls:** (What are we currently doing about the risk?)
1. Standing Financial Instructions (SFI) providing framework of financial controls.
2. Reservation of Powers to the Board and Delegation of Powers.
3. Full suite of financial policies and procedures, in line with best NHS practice.
4. Controls for approving bank and agency staff usage to reduce costs associated with the use of temporary staffing.
5. Agency Review Group targeting highest spending areas with action plans to reduce.
6. Efficiency plan in place to achieve c. £7.5m of savings, overseen by a Programme Management Office.
9. New Trust Performance Monitoring Group established wef May 2019 to undertake an

**Assurances:** (How do we know if the things we are doing are having an impact?)
1. SFI and Reservation of Powers considered annually by the Audit Committee and approved by the Trust Board. Last review in November 2018. (I)
2. Financial Performance Report considered at all meetings of the Trust Board and Finance and Investment Committee (I).
3. Current financial position and actions taken to deliver cost control and CIP savings discussed monthly at Trust Performance Monitoring Group.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>17/18 outturn</th>
<th>18/19 outturn</th>
<th>Apr 19</th>
<th>YTD</th>
<th>19/20 Forecast £000's</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget – surplus / (deficit)</td>
<td>(4,616)</td>
<td>(3,346)</td>
<td>(700)</td>
<td>(700)</td>
<td>0</td>
</tr>
<tr>
<td>Actual performance – surplus / (deficit)</td>
<td>32,710</td>
<td>(182)</td>
<td>(754)</td>
<td>(754)</td>
<td>0</td>
</tr>
<tr>
<td>Variance to budget – Favourable / (adverse)</td>
<td>37,326</td>
<td>3,164</td>
<td>(54)</td>
<td>(54)</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Score</th>
<th>Tolerable Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 x 4 = 12</td>
<td>3 x 4 = 12</td>
</tr>
</tbody>
</table>

**Relevant Key Performance Indicators:** (taken from the Financial Performance Report)
integrated review of financial, CIP, quality, workforce and operational performance indicators for each Division

<table>
<thead>
<tr>
<th>Gaps in controls and assurances: (What additional controls and assurances should we seek?)</th>
<th>Mitigating actions: (What more should we do?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No significant gaps in controls and assurances identified, as evidenced by extant Internal Audit reports and the Statement of Internal Control. However, the Trust’s Medium Term Financial Plan needs updating to inform the refresh of the NCL Strategic Financial Plan and to address, over a period to be agreed with NHSI/E and commissioners, the Trust’s underlying recurrent deficit of £5.5m.</td>
<td>Action</td>
</tr>
<tr>
<td></td>
<td>Update Medium Term Financial Plan</td>
</tr>
<tr>
<td></td>
<td>Develop Financial Strategy to support new Strategic Aims</td>
</tr>
</tbody>
</table>

**Additional Comments:**

The Trust will be developing a new Medium Term Financial Plan, taking into account the outcome of the NHS Long-Term Plan and revised financial framework for providers during 2019/20. This will also take into account the output of the new Trust Strategy currently in development.
## Objective:
4. Strengthening leadership

## Board Lead:
Jinjer Kandola (Andrew Wright)

## Date of review:
May 2019

## Lead Committee:
Trust Board

## Date of next review:
July 2019

<table>
<thead>
<tr>
<th>Risk ID</th>
<th>Risk</th>
<th>Description</th>
<th>CQC Domain</th>
<th>Relevant H&amp;SC Act 2008 Regulations</th>
<th>Relevant CQC Regulations 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Local Health Economy – If the Trust fails to engage in the local health economy in the North Central London sector and beyond, this will lead to failure to deliver health improvements or capitalise on opportunities, undermining transformation and sustainability.</td>
<td>Well-led</td>
<td>17</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

#### Risk Rating:

<table>
<thead>
<tr>
<th>Initial Risk Score</th>
<th>Current Risk Score</th>
<th>Tolerable Risk</th>
<th>Direction of travel</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3 \times 3 = 9$</td>
<td>$3 \times 3 = 9$</td>
<td>$3 \times 3 = 9$</td>
<td>▶️</td>
</tr>
</tbody>
</table>

#### Rationale for current score:

The Trust is represented at CEO / Director level at the key North Central London forums and on the Mental Health, Workforce and Estates workstreams of the North London Partners STP.

Directors are also engaged in the relevant national, London and NCL professional networks. Relevant information is fed back to the Trust Board at Board meetings, Board Workshops and Board Committees.

Current restructure of clinical divisions will strengthen leadership of services at Borough level, to ensure effective engagement in local health and care systems and the developing Integrated Care Partnerships.

### Controls: (What are we currently doing about the risk?)

1. Ensuring appropriate Trust representation at key forums and workstreams in NCL and beyond.
2. Effectively influencing wider health economy and ensuring that Trust priorities are taken into account.
3. Trust Board is made aware of wider issues in the local health economy.
4. Regular 1:1s between COO and Enfield Director of Commissioning.
5. Borough based forums attended by Clinical Directors
6. CEO engaged with NCL level meetings
7. BEH regular contributor to STP development
8. Exec-to-exec team meetings with all three local CCGs were held in January/February 2019 – summary presented to Trust Board at 25 March 2019 meeting

### Assurances: (How do we know if the things we are doing are having an impact?)

- Regular reviews of effectiveness via the Executive Leadership Team (I).
- Ability to deliver Trust priorities and capitalise on opportunities (I).
- Board understanding of wider issues (I).
<table>
<thead>
<tr>
<th>Gaps in controls and assurances: (What additional controls and assurances should we seek?)</th>
<th>Mitigating actions: (What more should we do?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None identified.</td>
<td></td>
</tr>
</tbody>
</table>

**Additional Comments:**

The Trust is effectively engaged in the wider local health economy and able to influence partners, formally and informally. However, this needs to be kept under review, with effective feedback to Board members on issues and opportunities.
Objective: 1. Delivering our core services effectively (brilliant basics)

Board Lead: David Griffiths / Stanley Riseborough (John Mills / Andrew Wright)

Date of review: May 2019

Lead Committee: Finance and Investment Committee

Date of next review: July 2019

Risk ID: 10

Risk: Estate Management - Failure to modernise the Trust’s estate may result in a failure to realise the potential estate cost reductions and detrimentally impact on the quality and safety of services, poor patient outcomes and affect the patient experience.

CQC Domain: Safe / Well-led

Relevant H&SC Act 2008 Regulations: 15

Relevant CQC Regulations 2009: -

Risk Rating: (Likelihood x impact):

Initial Risk Score: 4 x 4 = 16

Current Risk Score: 3 x 4 = 9

Tolerable Risk: 3 x 3 = 9

Direction of travel: 

PLACE scores improved slightly.

Rationale for current score:

- The Trust’s Full Business Case (FBC) for the redevelopment of St Ann’s Hospital has been approved by NHS Improvement and construction has commenced on the new inpatient unit, therefore the Risk Score reduced in January 2019.
- Work continues to take place to improve the environment for service users of wards at St Ann’s in the interim, and the implementation of the Trust Wide prioritised ligature mitigation plan.
- Planned maintenance work continues to take place in line with the Estates Strategy and maintenance programmes.

Controls: (What are we currently doing about the risk?)

1. Estates Strategy, which sets out how the Trust will achieve the desired facilities that best accommodate the services provided in the most cost effective way.

2. Adherence to the Estates and Facilities work programme.


Assurances: (How do we know if the things we are doing are having an impact?)

(Key: I = Internal / E = External)

1. HealthWatch Enfield’s Patient Led Assessments of the Care Environment (PLACE) - Summary report of 2018 inspection. Annual PLACE Survey reported to the Trust Board on 24.09.18 as part of the Clinical, Quality and Safety Report (E).
- Asbestos Register and Management Action plan reported to the Health and Safety Committee (I).
- Compliance with the Legionella Water Management Policy, reported to the Health and Safety Committee (I).
- Estates and Facilities KPIs (I).
- Services provided at Baytree House relocated to Somerset Villa. Baytree House being converted to new centre for Children’s services in Enfield

2. Estates and Facilities KPIs (I).
4. Implementation of the re-development of the St Ann’s Hospital site to provide new mental health inpatient facilities.

- Approval for the FBC was given by NHSI in September 2018. Construction of the new mental health inpatient facilities commenced in January 2019, with completion by late summer 2020. Project remains on track. Contractor for Phase 2 of the redevelopment approved by Trust Board and initial mobilisation underway.

5. Ligature Mitigation Work Plan.
The previous five year programme (2015 – 2020) for mitigating ligature risks has been reviewed and refreshed to cover the period 2019 – 2024 and has been approved by Quality and Safety Committee. £1.2m spend is planned 2019/20

- Summary of Highest, Medium and Low Risk areas following Review of In-Patient Ligature Risk Assessments considered by the Quality and Safety Committee regularly(I).
- Regular reports to the Trust Board(I)

<table>
<thead>
<tr>
<th>Gaps in controls and assurances: (What additional controls and assurances should we seek?)</th>
<th>Mitigating actions: (What more should we do?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Trust’s Estates Strategy needs further review following development of Trust’s new Strategic Aims, and to consider options for improvements to other Trust inpatient units (apart from St Ann’s).</td>
<td><strong>Action</strong></td>
</tr>
<tr>
<td>Develop Strategic Outline Case for rest of Trust Estates</td>
<td>Director of Strategic Development</td>
</tr>
</tbody>
</table>

**Additional Comments:**
### Board Assurance Framework – Performance Information

<table>
<thead>
<tr>
<th>Objective:</th>
<th>3. Strengthening governance systems and processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board Lead:</td>
<td>Stanley Riseborough (CIPO)</td>
</tr>
<tr>
<td>Date of review:</td>
<td>May 2019</td>
</tr>
<tr>
<td>Lead Committee:</td>
<td></td>
</tr>
<tr>
<td>Date of next review:</td>
<td>July 2019</td>
</tr>
</tbody>
</table>

#### Risk ID: 12

**Risk:** Performance Information  - If the Trust fails to ensure reliable, accurate, timely or complete clinical or management information this may impair decision-making, the optimal use of resources to deliver safe patient care efficiently, and the Trust's ability to evidence this to commissioners in line with contractual requirements.

**CQC Domain:** Well-led

**Relevant H&SC Act 2008 Regulations:** 17

**Relevant CQC Regulations 2009:** -

**Risk Rating:**

(Likelihood x severity):

<table>
<thead>
<tr>
<th>Initial Risk Score:</th>
<th>4 x 5 = 20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Risk Score:</td>
<td>3 x 4 = 9</td>
</tr>
<tr>
<td>Tolerable Risk:</td>
<td>3 x 4 = 12</td>
</tr>
</tbody>
</table>

**Top Relevant Key Performance Indicators:** (taken from the Performance and Quality Dashboard Report)

- Year to date activity recording

**Rationale for current score:**

The Risk Score has fallen as the likelihood of information being incomplete has reduced through the new controls which continue to prove effective via the assurances described below.

**Controls:** (What are we currently doing about the risk?)

1. The Integrated Performance and Quality & Safety Dashboard Report and the Trust Risk Register are considered by the Quality and Safety Committee and Trust Board at each meeting.
2. Integrated Performance and Quality Dashboard Report which presents performance information across a number of KPIs.
3. Validity and completeness of information is being monitored as part of Borough level performance reporting.
4. Further controls include scrutiny at the new Performance Improvement Committee and the Integrated Performance Meetings.
5. Productivity information is being produced weekly. Some evidence that IT is impacting negatively on recording is being addressed through Open Rio functionality and a 12-month project to improve information reporting.
6. Any apparent under recording is now cross referenced with ESR staffing data and discrepancies are queried within the month, prior to reporting. The unoutcomed appointments and activity levels are sent weekly to the teams by patient and staff level in order to ensure updates are reflected on RiO within timescale provided.

**Assurances:** (How do we know if the things we are doing are having an impact?)

- Activity recording is now more in line with expectations, based on the team-level delivery plans and analyses.
- Trust Quality and Performance Report presented to every meeting of the Quality and Safety Committee and Trust Board (I).
- Bi-Monthly Data Quality Improvement Meetings (I).
- Data Quality (validity) is part of contracts with commissioners and is scrutinised by the CCGs via the NELCSU (E).
- Integrated Performance Meeting with each Borough and Specialist Team (I).
- Activity is being monitored in staff supervision and weekly basis by Team Managers to ensure accurate recording of activity in timely manner.
<table>
<thead>
<tr>
<th><strong>Gaps in controls and assurances</strong>: (What additional controls and assurances should we seek?)</th>
<th><strong>Mitigating actions</strong>: (What more should we do?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The replicability of performance information (i.e. the ability to reproduce the same, validated information from a source that integrates all of our key systems) is impacted by the absence of a static reporting data warehouse.</td>
<td>Improvements in clinical activity reporting are in development and phase one of the improvements are due to be in place by April 2019. A report on the proposed approach to improving performance reporting to the Board, including clinical activity, is being presented to the Board at the 25 March 2019 meeting for review and approval. Further changes to the way the Trust sees reports will be implemented through 19/20, including the implementation hierarchical reporting systems that ensures all Board KPI's are reflected in the reporting of subsidiary committees to focus on the best possible Patient experience, quality, safety and efficiency across the Trust.</td>
</tr>
<tr>
<td>Title:</td>
<td>Summary Report on Corporate Risk Register</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Report to:</td>
<td>Trust Board</td>
</tr>
<tr>
<td>Date:</td>
<td>23 May 2019</td>
</tr>
<tr>
<td>Security Classification:</td>
<td>Public Board Meeting</td>
</tr>
</tbody>
</table>
| Report Author: | Name: Rosina Kashif  
Title: Ulysses Manager |
| Report Sponsor: | Amanda Pithouse, Director of Nursing |
| Comments / views of the Report Sponsor: | The aim of this report is provide a summary update of the status of the corporate risk register. |

**Overview of the report:**

This report brings to the attention of the Quality and Safety Committee all clinical, financial, governance and operational risks. The Corporate Risk Register has been aligned to Borough level risks.

This report was correct as at 24th April 2019.

**Key issues to bring to the attention of members:**

The management of risk and the use of the Register has been the focus of attention by Patient Safety Team.

**Key supporting documents:**

Corporate Risk Register.

**Decisions / actions required:**

The Trust Board is asked to:

1. Consider the Corporate Risk Register and whether there is adequate mitigation of all corporate risks and aligned organisational objectives.

2. Consider organisational risks that are currently not appearing on the Corporate risk register but should be included.

3. Advise if further amendments are required to the Corporate Risk Register template.

**Likely onward reporting:**

Trust Board

**Report History:**

Regular Report
<table>
<thead>
<tr>
<th><strong>Implications of the decision / actions:</strong></th>
<th>The Corporate Risk Register contains risks which have a combination of resource and budgetary implications. All risks are mitigated and subject to regular review.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Links to the Trust’s Objectives, Board Assurance Framework and / or Corporate Risk Register</strong></td>
<td>Corporate risks are linked to the Trust’s Objectives and should align with the Board Assurance Framework.</td>
</tr>
</tbody>
</table>

**List of Appendices:**
- Corporate Risk Register
1.0 Introduction

1.1 This report provides an update on risks monitored at Board level. The report outlines progress in improving the robustness of the Trust’s risk management arrangements with a review of the Risk Register.

1.2 The Trust has identified a range of significant risks that are currently being mitigated, whose impact could have a direct bearing on the achievement of Trust Plans and priorities and requirements within the NHSI Accountability Framework or CQC registration.

2.0 Risk Management

2.1 Deloitte has been commissioned to carry out a significant piece of work to help develop and manage our risk registers. This will include a programme to review and cleanse the risk register and ensure all risks are appropriately scored, closed if no longer live and are accompanied by actions.

2.2 Our new risk management process requires 2 months of data to function correctly; therefore this month data does not include risk movement or risks removed in the last month. For this month, only risks that have been removed from the corporate risk register have been listed separately.

2.3 Actions are being introduced as part of the new process which managers have yet to complete. Therefore the action column in most cases will be blank until this field is populated within Ulysses.

3.0 Risk Analysis

3.1 The graphs below show detailed analysis of risk scores and open risks by borough and service line.

![Risk Register Analysis](image-url)
3.2 The graphs below show all risks that are overdue for review by borough and by number of months overdue.
3.3 The graph below shows open risks trend analysis.

4.0 Risks closed since last report

9 risks have been removed from the corporate risk register since the last report.

- **Risk 1283** – (Magnolia Unit) – Risk of staff shortages due to high numbers of vacancies which will lead to failure to recognise a deteriorating patient. Risk reduced due to staff recruitment (Score 12).

- **Risk 1542** (Salt School Age) – Poor connectivity to access electronic records for staff based on non-nhs sites. Risk reduced due to the implementation of WIFI on some sites (Score 12).

- **Risk 3249** (Senior Management Team Haringey Community Services) – Lack of continuity of clinical care due to teams being unable to recruit and retain Band 6 Care Co-ordinators. Risk reduced due to the review of local recruitment strategy with Finance and HR recruitment. (Score 12).

- **Risk 3295** (Health Visiting Teams) – Due to reduced funding and continued contract negotiations with LBE, risk that Trust will continue to provide Universal Children’s services at a cost pressure and excess staff will be at risk (Score 9).

- **Risk 3561** (Information Governance) – Risk to the organisation of not meeting National standards requiring 95% of the organisation have completed IG training in the last 12 months, leading to the Trust not attaining the required IG Toolkit standards. Risk reduced due to reminders sent to managers to become compliant (Score 12).

- **Risk 3708** (Corporate Affairs) – Trust will not respond adequately to a Major Incident because there is no current Major Incident Plan and this could lead to adverse patient outcomes, harm to staff and/or patients and damage to Trust reputation. Risk closed due to Major Incident plan now in place.

- **Risk 3715** (Ken Porter) – Lack of access to specialist community services (including those that a nursing home facility would have). Risk reduced due to recruitment of Adult trained RN’s (Score 12).
Risk 3757 (IM&T) – New site building works damages the cables and can result in network loss across the lines the cables convey. This could be within St Ann’s and peripheral sites outside of St Ann’s. Risk reduced due to engaging the correct engineers to deal with this problem (Score 9).

Risk 3776 (Haringey North East Locality) – Delay in patient care delivery due to the team being down by 3.6 WTE Care Coordinators. (1WTE deleted from Budget Code still outstanding to be re-instated to be able to recruit into post and currently affecting capacity to allocate Care Coordinators). Risk closed NELT now fully covered with Agency Band 6 Care Co-ordinators with 3 new substantive Care Co-ordinators due to start.

5.0 New risks

Risk 3805 (District Nursing – Bowes Road) – Shortage of staff in District Nursing teams due to vacancies and difficult recruitment (Score 16).

Risk 3822 (Senior Management Team Haringey Community Services) – Delays with London Borough of Haringey Approved Mental Health Professional (AMPH) Service undertaking Mental Health Act Assessments in the community leading to risk of mentally unwell clients being an increased risk to themselves and others (Score 16).

Implications

6.0 Budgetary / Financial Implications

6.1 Budgetary and/or Financial Implications are highlighted within each risk.

7.0 Risk Management

7.1 This report sets out details of all clinical, financial, governance and operational risks identified as part of a regular review process.

8. Equality and Diversity Implications

8.1 None.

9. Consultation

9.1 Clinical Directors, Assistant Directors and Service Managers have been consulted in the preparation of this report.

End.
The Trust has a high number of policies that are overdue for renewal. Where policies are not regularly reviewed there is a risk that they are not compliant with national standards and the incorrect care could therefore be provided.

Capital bid request made to have fence built to limit access the patient garden

Trust wide update on ligature risks underway. Operational mitigations in place in identified risk areas. Proposal reviewed by Q&S Committee in September.

Completely redesign end to end. Report to be presented to the board in the next quarter.

ID  Date of entry  Division  Directorate  Risk title  Risk description  Risk group  Controls  Borough lead  Risk lead (Owner)  Initial risk rating  Action plan lead (Owner)  Action number  Action description  Action completion deadline  Current risk rating  Next review date  Residual risk score
3788  12/01/2019  Enfield Borough  CYP & CAMHS  One of the consultants is leaving the service in March 2019, leaving the service depilated and without sufficient Franciatric cover. Impact: Could result in delays in OP appointments, impact on ability to complete risk assessments in time, could also result in patient harm if not seen within timescales. This could also add extra pressure on the current staffing.  Enfield CAMHS  Tristian McGeorge  Tristian McGeorge  4  Recruit locum consultant  31/05/2019  4  04/05/2019  4

1805  20/01/2019  Enfield Borough  AOP & Older People Mental Health  There is a risk to patient safety because of ligature points leading to serious harm or death.  Adult Community recruitment  Tristian McGeorge  Nilumbok Abeyewickreme  3  Ongoing recruitment  16/04/2019  4  10/04/2019  16

1822  29/01/2019  Haringey Borough  Senior Management Team  Haringey  Delays with London Borough of Haringey Approved Mental Health Professional Senior Manager's timescale for appointment. This has affected the local service's ability to appoint a new Senior Manager. Performance is monitored on a daily basis.  London Borough of Haringey Approved Mental Health Professional (AMHP) Service  Steven Livingstone  4  Working with the police to improve response to AMHP referrals and local authority to increase number of AMHPs.  01/08/2019  4  28/04/2019  4

1675  15/06/2018  Enfield Borough  Adults Mental Health  Delays with London Borough of Haringey Approved Mental Health Professional Senior Manager's timescale for appointment. This has affected the local service's ability to appoint a new Senior Manager. Performance is monitored on a daily basis.  Enfield Adult MHN  Tristian McGeorge  Sean Edwards  4  1  Tristian McGeorge  30/06/2019  4  10/05/2019  4

3798  06/03/2019  Corporate Business  Corporate  The Trust has a high number of policies that are overdue for not re-appointing for new consultants. Performance is monitored on a daily basis.  Corporate Affairs  Claire Scott  Claire Scott  4  3  Claire Scott  30/06/2019  4  16/05/2019  2

3641  02/03/2019  Corporate Business  Information Management And Tec  There is a risk to patient safety because of ligature points leading to serious harm or death.  Network  Bob Silverman  Bob Silverman  3  1  Bob Silverman  29/03/2019  6  20/03/2019  6

1644  09/05/2019  Corporate Business  Workforce Directorate  There is a risk to patient safety because of ligature points leading to serious harm or death.  Workforce Directorate  Jacqueline Stephen  Jacqueline Stephen  3  2  Jacqueline Stephen  30/09/2019  5  11/04/2019  5

1321  08/03/2019  Haringey Borough  Haringey Acute Care Services  There is a risk to in-patients being supplied with illicit drugs through the bedroom windows as a result of ligature points leading to serious harm or death.  Staff Observation and Managers via Staff Intranet  Lazarus Ndhlovu  4  5  Lazarus Ndhlovu  30/04/2019  3  08/05/2019  3

1562  01/03/2015  Corporate Business  Corporate  There is a risk to patient safety because of ligature points leading to serious harm or death.  Trust-wide update  Stanley Reid  Stanley Reid  4  1  Stanley Reid  30/01/2020  4  03/05/2019  5

1385  12/04/2016  Corporate Business  Corporate  There is a risk to patient safety because of ligature points leading to serious harm or death.  Corporate Affairs  Stanley Reid  Stanley Reid  4  Stanley Reid  30/01/2020  4  03/05/2019  6
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<table>
<thead>
<tr>
<th>Title:</th>
<th>Equality and Diversity Report for 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report to:</td>
<td>Trust Board</td>
</tr>
<tr>
<td>Date:</td>
<td>23 May 2019</td>
</tr>
<tr>
<td>Security Classification:</td>
<td>Public Board Meeting</td>
</tr>
<tr>
<td>Purpose of Report:</td>
<td>The attached report is an annual report on our equality, diversity and inclusion activities in 2018. It includes our performance in relation to the requirements of the Equality Act 2010, the Workforce Race Equality Standard and the Gender Pay Gap and aims to reinforce our commitment to improving the experience for our staff as well as the people who use our services.</td>
</tr>
<tr>
<td>Recommendations:</td>
<td>The Trust Board is asked to review the report and approve its publication on our Trust website.</td>
</tr>
<tr>
<td>Report Sponsor:</td>
<td>Jackie Stephen, Executive Director of Workforce and OD</td>
</tr>
<tr>
<td>Comments / views of the Report Sponsor:</td>
<td>This report provides an overview of the Trust’s performance in relation to our statutory equality requirements in the past year.</td>
</tr>
<tr>
<td>Report Author:</td>
<td>Name: Jide Odusina</td>
</tr>
<tr>
<td></td>
<td>Title: Head of Equalities and Engagement</td>
</tr>
<tr>
<td></td>
<td>Tel Number: 020 8702 5464</td>
</tr>
<tr>
<td></td>
<td>E-mail: <a href="mailto:jide.odusina@beh-mht.nhs.uk">jide.odusina@beh-mht.nhs.uk</a></td>
</tr>
<tr>
<td>Report History:</td>
<td>A report on our equality and diversity activities is presented to the Trust Board on an annual basis, following which the report is published on our website.</td>
</tr>
<tr>
<td>Budgetary, Financial / Resource Implications:</td>
<td>There are budgetary requirements to implement the Trust’s equality objectives and these are contained within the current Workforce budget.</td>
</tr>
<tr>
<td>Equality and Diversity Implications:</td>
<td>The report specifically outlines the Trust’s progress against its equality and diversity objectives.</td>
</tr>
<tr>
<td>Links to the Trust’s Objectives, Board Assurance Framework and/or Corporate Risk Register</td>
<td>The report supports delivery of the Trust’s vision and strategic aims.</td>
</tr>
<tr>
<td>List of Appendices:</td>
<td>• Appendix 1 - Equality and Diversity Report for 2018</td>
</tr>
</tbody>
</table>
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Equality and Diversity Report for 2018
Introduction

This report is aimed at the wider public and our stakeholders. We want our Trust not only to deliver excellent care and an innovative provider, but to work closely with the communities we serve and to reflect those communities at all levels in our workforce.

This report provides an overview of our activities in 2018 in relation to equality, diversity and inclusion. The Trust has been able to meet its statutory obligations and in some ways innovate, but our ambitions are more than this, as are the expectations of our stakeholders, so we are keen to signal a step change in our approach to equality, diversity and inclusion.

This report sets out the Trust’s work in meeting its regulatory obligations in four areas in 2018:

1. **Equality Act 2010**, in having due regard to the need to:
   - eliminate unlawful discrimination, harassment and victimisation and any other conduct prohibited by the Act
   - advance equality of opportunity between people who share a protected characteristic and people who do not share it
   - foster good relations between people who share a protected characteristic and people who do not share it

2. The standard NHS provider contract which requires us to operate the NHS-wide **Equality Delivery System (EDS)** to evaluate our general performance in delivering equal opportunities

3. The **Workforce Race Equality Standard**, in relation to race equality within our workforce

4. **Gender Pay gap report**

Summary

We have started the process of adding urgency and vigour to our equalities, diversity and inclusion activities. Some of the changes are procedural e.g. the creation of a formal equalities, diversity and human rights committee made up of senior staff from across the whole Trust and chaired by our Chief Executive. Others include the recent distribution of new rainbow lanyards during LGBT+ history month so staff from all backgrounds can show their support. Proposed and supported by the Trust’s Chair, Mark Lam, over 300 staff have supported this initiative so far.

A women’s equality group was launched on International Women’s Day, 08 March 2019, which included powerful stories from women in a range of roles across the Trust.

Preparations are underway for the launch of the workforce disabilities equality standard which will help us identify where we can better support colleagues who have a disability.
Our ambitions for 2019/10 include:

- Mainstreaming equality, diversity and inclusion into how we design and deliver our services
- Paying heed to equality, diversity and inclusion in the way we procure services
- Demonstrating senior management support through greater engagement with the communities we serve and our staff networks
- Identifying senior clinical leads for the equality, diversity and inclusion agenda to support evidence-gathering and improvements in the delivery of our services
- Implementing fully our action plans, as outlined in this report

About Barnet, Enfield and Haringey Mental Health Trust

Our Trust is a large provider of integrated mental health and community health services in north London. The Trust currently employs over 3,000 staff with an annual income of £212 million. We serve a population of just over a million people.

We provide mental health services to people living in the London boroughs of Barnet, Enfield and Haringey, and a range of more specialist mental health services to our core catchment area and beyond. We also provide a full range of child and adult community health services in Enfield and are increasingly integrating these with our mental health services to provide a range of holistic services.

Our values

The Trust’s values are:

- Compassion
- Respect
- Being Positive
- Working together

Our objectives for 2018/19 were:

- Happy staff
- Value for money services
- Excellent care

Within our part of London and England in general, there are well documented and understood health and employment inequalities, the causes of which lie outside the scope of the Trust to affect significantly. We focus on the areas of:

- Improving our patients’ health outcomes, reducing health inequalities
- Improving access to and the experience of our services for all groups of service users
- Creating a workforce which reflects the diversities of the communities we serve, feels supported and engaged in delivering excellent care to all
- Fostering inclusive leadership at all levels so that our policies, practices and priorities take into account the diversity of local interests
These areas are aligned with the four goals of the NHS Equality Delivery System, the performance management framework for delivering equal opportunities in the NHS.

**Review of our overall equalities activities in 201, by protected characteristics**

This is a summary review of key initiatives addressing issues linked to specific protected characteristics and groups.

**Age:**

Our Care Home Assessment Team, part of Enfield Health, is a nurse-led community service which provides rapid response visits or telephone advice at times of crisis, and works with residents, families and care home staff to make end of life care plans and stabilise long term conditions. As well as the benefits to the service users and their families, the project aims to prevent hospital admissions and associated risks for older people in care homes.

We are innovating in our Children’s Mental Health Services (CAMHS) - in Haringey we offer the CHOICES service to support children and young people who are facing issues that can impact them emotionally. This may include bullying, anxiety or family problems.

Our Project Future award-winning partnership with the community continues to work with a community of young men, aged 16 to 25 years, who are often labelled as "socially excluded", "offenders" and "gang members". The project works in partnership with Haringey Council, Mind in Haringey, NHSE and Metropolitan Police.

The project is underpinned by evidence-based psychological approaches and was originally founded on the Integrate model. Dr Suchi Bhandari, Consultant Clinical Psychologist and Trust Lead for Psychological Therapies who has launched and developed the service with partners, says:

“We help young people affiliated with gangs to turn their lives around. In the last four years, we have worked meaningfully and psychologically with nearly 300 young people who have worked hard to engage and make a positive difference in their lives. I am proud that with a brilliant team and our key partners we make a difference to our young people’s lives and hope the project receives the recognition it so deserves”.

**Disability:**

The Trust has expanded its very successful peer workers (Expert by Experience) programme. There are now 28 employed by the Trust. The programme brings people with lived experience of mental illness into the workforce to support recovery and enablement. The first cohort of eight was recruited and deployed and, following an independent review by Middlesex University, we have expanded the programme.

The Trust has renewed its commitment to the disability confident employer programme. This is a developmental programme which replaced the “two ticks” disability positive programme. The Trust has attained the second level of accreditation but aspires to attain the third (and highest) level, disability confident leader. This requires us to proactively promote employment and career development opportunities for people with disabilities and be an exemplar to other employers.
**Ethnicity:**

The Trust’s race equality staff network, Better Together Network (BTN), has continued to develop and provide opportunities for partnership working to improve race equality in services and employment. The network has organised two career development days in partnership with the Trust to help more staff from a BME background to develop the confidence and skills to apply for more senior posts.

The career development workstream also encompasses a listening lunches programme where guest speakers talk about their career journey and the lessons for others. The 2018-19 programme included one of our non-executive directors and senior managers in the Trust.

**Sex (male or female):**

The Trust published its first Gender Pay Gap report in March 2018. It showed a mean gap of 9% and a media gap of just 5%; these were the second lowest amongst London mental health Trusts. The two main contributors to the gap were the consultants’ clinical excellence awards (CEA), bonus payments which favour longer-serving consultants who tend to be male and, to some extent, the slight over-representation of men in higher paid roles and their slight under-representation in lower paid roles. In response, support is being made available to female colleagues with their CEA applications.

**Sexual Orientation:**

The Trust continues to be a member of the Stonewall Diversity Champions programme which has contributed to the introduction and growth of a staff-led LGBT+ equality group.

The Trust has met the requirements of the NHS sexual orientation information monitoring standard. The layout of our main patient information system has been updated to make it compliant with the national minimum data set and for staff to be able to input the data in one place.

**The Equality Delivery System (EDS)**

The EDS is a developmental performance framework which asks service users, carers, staff and their representatives to grade the work of the organisation based on the evidence it provides.

Since 2011 when the Trust became subject to the Public Sector Equality Duty under the Equality Act 2010, it has used the NHS-wide Equality Delivery System (EDS) as its framework for managing its performance.

In 2013, NHS England launched the EDS2 which uses a simplified grading system and is focussed more on outcomes. All NHS service providers are now required to use the EDS under the provisions of the standard contract.

The EDS is a RAG+ (red, amber, green plus purple) grading system, where stakeholders grade the Trust based on how well they perceive the Trust to have performed against four EDS goals:

- Better outcomes for all
- Improved patient access and experience
- Empowered, engaged and well supported staff
- Inclusive leadership
The grades are as follows:

- Excelling Purple
- Achieving Green
- Developing Amber
- Undeveloped Red

**The Trust’s progress**

The Trust’s grades in the last EDS round were disappointing; the current round of events is underway. The Haringey community stakeholder event has been held and the grades are reflected in the table below; these are provisional as staff and other stakeholders’ grades will be added. The previous grade is in brackets. It is pleasing to note that stakeholders have recognized improvement since the last review in a number of areas including access to services and flexible working options for staff.

<table>
<thead>
<tr>
<th>Goal</th>
<th>No</th>
<th>Description of outcome</th>
<th>Grading (updated Haringey grading in brackets)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better health outcomes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.1</td>
<td>We commission, procure, design and deliver services to meet the health needs of local communities</td>
<td>Undeveloped (Undeveloped)</td>
</tr>
<tr>
<td></td>
<td>1.2</td>
<td>We assess and meet Individual people’s health needs in appropriate and effective ways</td>
<td>Undeveloped (Developing)</td>
</tr>
<tr>
<td></td>
<td>1.3</td>
<td>Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed</td>
<td>Undeveloped (Undeveloped)</td>
</tr>
<tr>
<td></td>
<td>1.4</td>
<td>We prioritise the safety of people using our services and they are kept free from mistakes, mistreatment and abuse</td>
<td>Undeveloped (Undeveloped)</td>
</tr>
<tr>
<td></td>
<td>1.5</td>
<td>Early intervention, health screening and other health promotion services reach and benefit all local communities</td>
<td>Undeveloped (Developing)</td>
</tr>
<tr>
<td>Improved patient access and experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.1</td>
<td>People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds</td>
<td>Developing (Achieving)</td>
</tr>
<tr>
<td></td>
<td>2.2</td>
<td>People are informed and supported to be as involved as they wish to be in decisions about their care</td>
<td>Undeveloped (Developing)</td>
</tr>
<tr>
<td></td>
<td>2.3</td>
<td>People report positive experiences of the NHS services we provide</td>
<td>Undeveloped (Developing)</td>
</tr>
<tr>
<td></td>
<td>2.4</td>
<td>People’s complaints about services are handled respectfully and efficiently</td>
<td>Undeveloped (Undeveloped)</td>
</tr>
<tr>
<td>A representative and supported workforce</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.1</td>
<td>Our fair NHS recruitment and selection processes lead to a more representative workforce at all levels</td>
<td>Developing (Achieving)</td>
</tr>
<tr>
<td></td>
<td>3.2</td>
<td>Our Trust is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations</td>
<td>Developing (Achieving)</td>
</tr>
<tr>
<td>Goal</td>
<td>No</td>
<td>Description of outcome</td>
<td>Grading (updated Haringey grading in brackets)</td>
</tr>
<tr>
<td>------</td>
<td>----</td>
<td>-------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>3.3</td>
<td></td>
<td>Training and development opportunities are taken up and positively evaluated by all staff</td>
<td>Developing (Achieving)</td>
</tr>
<tr>
<td>3.4</td>
<td></td>
<td>When at work, staff are free from abuse, harassment, bullying and violence from any source</td>
<td>Undeveloped (Undeveloped)</td>
</tr>
<tr>
<td>3.5</td>
<td></td>
<td>Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives</td>
<td>Developing (Achieving)</td>
</tr>
<tr>
<td>3.6</td>
<td></td>
<td>Staff report positive experiences of their membership of the workforce</td>
<td>Developing (Achieving)</td>
</tr>
</tbody>
</table>

**Inclusive leadership**

| 4.1  |    | Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations | Developing (Undeveloped) |
| 4.2  |    | Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed | Undeveloped (Developing) |
| 4.3  |    | Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination | Developing (Developing) |

**EDS Goal One: Better health outcomes for all the people we care for**

The RAG rating given by a range of stakeholders including service users was “undeveloped”.

**Action to improve the grade**

- We will collect more data, systematically review it and use it to inform service developments:
  - Following a decision at the inaugural meeting of the equality, diversity and human rights committee chaired by the Chief Executive, from April 2019 there will be quarterly reports on a dashboard of key service user outcomes and staff experience. These will be used to assess the effectiveness of Trust work and to develop initiatives for the future.

**EDS Goal two: Improved patient access and experience**

The RAG rating given by a range of stakeholders including service users was “undeveloped”.

A comment from the Haringey grading event was typical of the sentiment about the quantity and quality of information:

“The Patient Friends and Family Test [with] equalities questionnaire should be asked more than once to get stage evaluations of what is happening”.

**Action to improve the grade**
We will launch a standardised dataset for collecting equalities information from service users in June 2019. All settings will be expected to implement it and improve the disclosure rate of race, sexual orientation, religion/belief, disabilities etc. This will be backed by an information campaign to reassure service users that their information will be safe and used to make improvements and encourage staff to ask at appropriate times.

**EDS GOALS Three and Four: Empowered, engaged and well supported staff with inclusive leadership**

The last two EDS goals relate to equality and improved diversity of the workforce. The stakeholders rated the Trust as ‘developing’ and ‘undeveloped’ which is disappointing given the Trust has previously been graded ‘achieving’ in both. The grading reflects concerns about the anecdotal evidence of problems with equalities for staff, and is also reflected in the most recent staff survey results.

The staff group most concerned about their treatment within the Trust are black and minority ethnic staff. This is a NHS-wide phenomenon and the reason why the Workforce Race Equality Standard was introduced for all NHS provider organisations in 2015.

In summary, there has been some improvement in relation to our EDS grading from stakeholders in Haringey, but it is disappointing to note that, in most cases, the grading remains either undeveloped or developing. An action plan is provided in Appendix 1.

The Trust is committed to improving its results in the short term and establishing a positive trend to reach excelling grades in all areas. There are three parts to this strategy:

- Collect patient demographic data and use it to produce outcome data by key demographic groups so it is easy to compare patient access and experience performance
- Systematically and formally review the access and experience information so that services and their stakeholders can see whether all groups of patients are receiving equitable treatment
- Where there is evidence of differences in outcomes between groups that cannot be explained, the Trust will revise any process or procedure which is the source of any systemic bias

In this way we will address one of the fundamental criticisms from our community stakeholders, the lack of evidence that we actively consider and address health inequalities and then act on any evidence in the way we develop services.

In addition, we will work to create an ongoing dialogue with groups so they have a deeper understanding of local health challenges and can influence our responses to them. Finally, we will align our leadership development interventions, governance and performance management process with the need to collect, consider and act on service equality information.
Progress on the NHS Workforce Race Equality Standard (WRES)

The Trust has made good progress in addressing the challenges it faces in relation to some of the standard indicators of the NHS-wide matrix for all provider bodies. The tables below provide details of the Trust’s performance against each WRES indicator since 2015.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. In 2015 the indicator was expressed as the difference between the percentages of BME staff in Bands 8-9, VSM compared with the percentage of BME staff in the overall workforce. This is still a useful indicator</td>
<td>The difference was: <strong>30</strong> 50% (% BME staff in workforce): 20% (% BME staff in band 8 and above)</td>
<td>The difference was: <strong>24</strong> 48% (% BME staff in workforce): 24% (% BME staff in band 8 and above)</td>
<td>The difference was: <strong>21</strong> 48% (% BME staff in workforce): 27% (% BME staff in band 8 and above)</td>
<td>The difference was: <strong>27</strong> 55% (BME staff in the Workforce):28% (% BME staff in band 8 and above)</td>
</tr>
<tr>
<td>2. Compare the data for White and BME staff: the relative likelihood of staff being appointed from shortlisting across all posts</td>
<td>1.21</td>
<td>1.20</td>
<td>1.44</td>
<td>1.39</td>
</tr>
<tr>
<td>3. Compare the data for White and BME staff: relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. (This indicator is based on data from the most recent two-year rolling average)</td>
<td>3.41</td>
<td>6.18</td>
<td>2.02</td>
<td>5.10</td>
</tr>
<tr>
<td>4. Compare the data for White and BME staff: relative likelihood of staff accessing non-mandatory training and CPD</td>
<td>1.11</td>
<td>0.91</td>
<td>0.91</td>
<td>0.94</td>
</tr>
</tbody>
</table>

For each of the following indicators, the standard compares the metrics for each staff survey question response from White and BME staff.

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
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</thead>
<tbody>
<tr>
<td><strong>White</strong></td>
<td></td>
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<tr>
<td><strong>BME</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>White</strong></td>
<td></td>
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<tr>
<td><strong>BME</strong></td>
<td></td>
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</tbody>
</table>
Six of the nine indicators have improved in 2018/19, whilst three have deteriorated.

Indicator 1 is worse because the growth in the number of BME staff in senior pay bands did not grow as fast as the number of BME staff in the workforce.

Indicator 3 is the subject of an accelerated roll out of training and development for line managers and will be the subject of close scrutiny through 2019-20.

Work to convince BME staff that the Trust is fair in career progression and promotion is a major part of the Trust’s work plan, in partnership with the Trust’s race equality network, Better Together. Appendix 2 outlines actions for improvement against the WRES standards.

**Gender Pay Gap Report**

As an employer with over 250 employees, the Trust is required to publish statutory calculations every year, showing how large the pay gap is between male and female employees.

The results must be published on the employer's website and a government website.

The gender pay gap is different to equal pay - equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman. Agenda for Change should eliminate gaps of this type.
The gender pay gap shows the difference in the average pay between all men and women in a workforce, indicating the distribution of men and women across the pay scales and in full or part-time working arrangements as well as the impact of any ‘bonus’ schemes.

The Trust has a gender pay gap which was the second lowest of comparable Trusts in 2018.

The results for 2018 are shown below, set against those of 2017.

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th></th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lower</td>
<td>Lower</td>
<td>Lower</td>
</tr>
<tr>
<td></td>
<td>Mean</td>
<td>Median</td>
<td>Mean</td>
</tr>
<tr>
<td></td>
<td>9%</td>
<td>5%</td>
<td>9%</td>
</tr>
</tbody>
</table>

The number of men and women who are in each quarter of the Trust’s payroll:

**Top quartile**
- Men: 27%
- Women: 73%

**Upper middle quartile**
- Men: 29%
- Women: 71%

**Lower middle quartile**
- Men: 32%
- Women: 68%

**Lower quartile**
- Men: 34%
- Women: 66%

Women’s bonus pay in 2017
- Lower (mean): 26%
- Lower (median): 25%

Recipients of bonus pay
- Medical CEA 2017
  - Consultants: 50%
  - Applied: 10%
  - % applied: 20%
  - Awarded: 7%
  - % awarded: 70%

- Medical CEA 2018
  - Consultants: 43%
  - Applied: 13%
  - % applied: 30%
  - Awarded: 10%
  - % awarded: 77%

The only Trust staff who receive bonus pay are consultant psychiatrists. These senior doctors are eligible for the NHS-wide Clinical Excellence Awards. Women’s mean bonus pay is 26% lower.
than the male mean. This is despite 30% of women consultants applying for CEA compared to 23% of men and 77% being successful, compared to 70% of their male colleagues.

The CEAs have a cumulative element which favours staff who have applied and been successful over a period of years.

The medical director is acting to provide additional support to women consultants and to encourage more to apply and be successful. Under the current arrangements, it would take time for women consultants to accumulate similar levels of CEAs as their male peers.

Summary

This report has highlighted the results of our Equality Delivery System, Workforce Race Equality System and Gender Pay Gap. It outlines our priority actions for making improvements in all areas and our ambition to provide high quality care to everyone who uses our services as well as the best experience for all our staff.

It is fair to say that there have been challenges in terms of engagement and provision of data to advance our performance in relation to equality and diversity, particularly in relation to the people who use our services. We recognise a change of direction whereby:

- We have multi-disciplinary involvement in the Trust’s refreshed Equality and Diversity Committee
- We are committed to promoting the collection and review of patient outcomes data as part of our performance management processes
- We are identifying senior team members who will act as the points of contact for community engagement and equalities
- We will encourage engagement from corporate areas such as patient experience, clinical audit, medical education and research and development
- Estates & facilities - Access and signage to be improved
- The Workforce team will deliver on key projects e.g. recruitment and selection and leadership development
## EDS Action Plan

<table>
<thead>
<tr>
<th>Action</th>
<th>By who and when</th>
<th>Expected outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prioritise collection, review and action on service performance by major protected characteristics - age, disability, ethnicity, marital status, religion, sex, and sexual orientation)</td>
<td>Chief Operating Officer, Director of Nursing and Director of Workforce and OD with support from health informatics and Head of Equalities – June 2019</td>
<td>We have 10-15 meaningful KPIs from the core Trust dashboard which we report on regularly and are able to use as evidence to illustrate progress on the EDS</td>
</tr>
<tr>
<td>All services to show what they have done to meet the relevant goals and outcomes of the EDS</td>
<td>All Clinical Directors with support from Head of Equalities - June 2019</td>
<td>Trust able to show stakeholders how its services are performing at division level for the major protected characteristics</td>
</tr>
<tr>
<td>EDS grading sessions to be held in between March and June in partnership with Camden and Islington and The North Middlesex, with the outcomes shared widely</td>
<td>Head of Equalities and Clinical Directors March – June 2019</td>
<td>Well attended events held in all boroughs and Trust grades and from stakeholders more positive</td>
</tr>
<tr>
<td>All services to use the standard data collection headings (with format modified to suit their settings)</td>
<td>Head of Equalities, Chief Operating Officer/Director of Nursing and Governance - June 2019</td>
<td>An agreed minimum dataset in place, active on RiO and available to all staff</td>
</tr>
<tr>
<td>Re-launch information campaign to get service users to disclose their protected characteristics and staff to recording them</td>
<td>Head of Equalities, clinical divisions’ SMGs - June 2019</td>
<td>Month on month increase in the proportion of service users disclosing top six protected characteristics</td>
</tr>
<tr>
<td>A sub-committee of the Trust board to review key service indicators by protected characteristics at least twice a year</td>
<td>Head of Equalities - June 2019</td>
<td>The Trust is able to demonstrate that it formally reviews outcomes by protected characteristics across key performance indicators in the Trust dashboard and uses the data to inform service developments or reduce health inequalities</td>
</tr>
<tr>
<td>Continue to support and expand the membership of self-organised, staff-led equalities groups to improve engagement with staff from diverse backgrounds and their perceptions of the Trust as an equal opportunities employer,</td>
<td>Workforce and all senior leaders April 2019 - December 2020</td>
<td>Over all membership reflects 10% + (300+) of eligible staff by April 2019 and 20% (600+) by the Dec 2020 with each group having an active programme of activities</td>
</tr>
<tr>
<td>Where the Trust acts on WRES, Gender Pay Gap, EDS and all other equalities performance measures the outcomes are publicised in take 2, Team brief and online</td>
<td>Workforce, Communications from May 2019</td>
<td>At all levels the Trust is seen to act on the outcomes of equalities performance reviews and is successfully reducing any inequalities over a stated period of</td>
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<td>Trust Board Page 239</td>
</tr>
<tr>
<td>Action</td>
<td>By who and when</td>
<td>Expected outcomes</td>
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<tr>
<td>In response to stakeholders’ previous requests for</td>
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<td>We can show that of the community and stakeholder interest we need to engage with locally and Trust wide in the majority of instances we engaged contractively and directly with the majority of groups</td>
</tr>
<tr>
<td>• On-going dialogue with key staff in the clinical divisions/Boroughs about developments in general, but initiatives to improve equalities in particular</td>
<td>From June/July 2019 Clinical Directors with support from patient experience, enablement and communication to hold regular meetings with stakeholder groups</td>
<td>Through the EDS process and comments at events such as the AGM, stakeholders will report better engagement in general and understanding of the Trust’s journey in particular</td>
</tr>
<tr>
<td>• A sign-posted front door – clear information about how to access service and key staff</td>
<td>Communications use all channels to clearly signal the entry points to Trust services. June/July 2019 Clinical divisions to be supported to communicate with service users, carers and other stakeholders on what we are doing to improve services in general and for specific disadvantaged groups, from June 2019</td>
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<tr>
<td>• More/ better information about what the Trust is doing and how they can be involved</td>
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<tr>
<td>Improve the co-ordination and engagement with community and service user groups</td>
<td>Director of Nursing and Associate Director of Communications. From June 2019</td>
<td>Ability to show a good range of engagement on wide range of topics and that we have taken and used feedback constructively</td>
</tr>
<tr>
<td>Use the Equality, Diversity and Human Rights Committee chaired by the Chief Executive to drive service level improvements in patient and staff equalities outcomes, from February/March 2019</td>
<td>All senior staff. From March 2019</td>
<td>Committee meets regularly with an agreed work programme and set of priorities which it delivers to promote measurable improvements in key areas.</td>
</tr>
<tr>
<td>Use the Equalities, Diversity and Human Rights Forum, to give all staff with an interest the opportunity to contribute to the development of Trust policies and initiatives.</td>
<td>All senior staff. From March 2019</td>
<td>The forum meets regularly and generates at least one novel and actionable idea at each meeting which is taken forward.</td>
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</tbody>
</table>
## Appendix 2

### Action plan to improve our WRES scores

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead and Timescale</th>
<th>Expected outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicators 1, 2, 7 and 8: Equal opportunities in recruitment, selection career development</strong></td>
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<tr>
<td>From 1 April the recruitment team will monitor and report on the following:</td>
<td>Head of Recruitment and Retention</td>
<td>• More staff from all backgrounds, but particularly BME and disabled staff, report greater positive belief in the fairness of the Trust’s equal opportunities practice in the recruitment, selection and career progression of staff in the 2019 national staff survey.</td>
</tr>
<tr>
<td>• Enforcement of the policy that at least one member of all interview panels must come from outside of the team in which the post is based</td>
<td>On-going</td>
<td>• Increase in the proportion of BME staff recruited to band 8 and above posts.</td>
</tr>
<tr>
<td>• As part of values-based recruitment, at least one member of all selection panels must have completed the Trust-approved recruitment and selection training</td>
<td></td>
<td>• Increase in the proportion of BME candidates being appointed from interview.</td>
</tr>
<tr>
<td>• All internal secondments and acting-up opportunities must be openly advertised and recruited through TRAC, the Trust recruitment system</td>
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<td>• Increase in the proportion of White staff in band 3 and 5 HCA and nursing roles.</td>
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<tr>
<td>• From June 2019 all advertising and job promotional material will be designed to attract a broader range of staff into bands and staff groups where they are underrepresented</td>
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<td></td>
<td>Deputy Director Workforce &amp; OD, Head of Learning and Development and BTN steering group</td>
<td>• At least 15 band 5, 6 and 7 BME staff participate in the first programme.</td>
</tr>
<tr>
<td>In partnership with the BTN offer an ‘official’ Trust positive action programme</td>
<td>First cohort to be recruited in April 2019</td>
<td>• Of those who participate, all show an increase in their promotion-seeking activities as measured at three and six months.</td>
</tr>
<tr>
<td>• From April offer a Trust based 3 day BME leadership programme jointly commissioned with WLMHT as an additional module for BME staff participating in core management and leadership development programmes</td>
<td>Proposed mentoring programme to be submitted to ELT in May 2019</td>
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<td>Action</td>
<td>Lead and Timescale</td>
<td>Expected outcomes</td>
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<tr>
<td>Continue the BTN listening lunch programme as a bi-monthly event as a way to highlight diverse pathways into senior positions</td>
<td>BTN Steering Group and Head of Equalities On-going</td>
<td>• Full programme of events throughout 2019-20 with attendance averaging 25 per session</td>
</tr>
<tr>
<td>BTN and Workforce to host at least two career development/learning at work days in 2019-20 (w/b 13 May and w/b 21 Oct)</td>
<td>Head of Learning and Development and Head of Equalities with BTN Steering Group On-going</td>
<td>• At least 25 staff take the opportunity to develop elements of their promotion seeking skills</td>
</tr>
<tr>
<td><strong>WRES Indicator 3: Reduce the gap between BME and White staff entering formal ER process</strong></td>
<td></td>
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<tr>
<td>With the support of the BRAP consultancy offer all managers in Enfield ½ day sessions on the enhanced reflective review model</td>
<td>Head of Business Partnering and Head of Equalities dates set for March-April 2019</td>
<td>• At least 60% of eligible managers attend a session</td>
</tr>
<tr>
<td>As part of the support package, develop a version of the decision-tree appropriate for mental health and include its use in the training for managers</td>
<td>Deputy Director of Workforce and Head of Business Partnering May 2019</td>
<td>• Over following six months overall number of new ER cases falls and disproportionality falls as well</td>
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<tr>
<td><strong>WRES indicators 5 and 6: Reduce the gap between BME and White staff experiencing bullying and harassment and violence from all sources</strong></td>
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<tr>
<td>Promote Living Our Values with greater emphasis on staff behaviours towards each other</td>
<td>Workforce heads of service with clinical directors January – June 2019</td>
<td>• Reduction in staff experiencing bullying and harassment as recorded in the pulse check surveys</td>
</tr>
<tr>
<td>• Raise the profile in induction from January 2019</td>
<td></td>
<td>• Evaluation of appraisals training shows more staff understand how to live and evaluate our values in their daily work</td>
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<td>• Embed into 2019-20 appraisals training</td>
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<td>• Paper to ELT accepts revised categories and criteria for the 2019 awards and encourage staff to actively demonstrate how they live our values</td>
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<td>• Fully align the 2019 celebrating excellence awards with the Trust values</td>
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<tr>
<td>Create and deliver an on-going communications and poster campaign to remind service users and carers that we do not tolerate abuse or violence of staff</td>
<td>Head of Equalities and Communications team June 2018 – June 2019</td>
<td>• Refresh campaign in summer 2019 with articles in Trust Matters magazine and new posters</td>
</tr>
<tr>
<td>Action</td>
<td>Lead and Timescale</td>
<td>Expected outcomes</td>
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</table>
| Develop and implement a formal process and support package for all staff who have been victims of violence or abuse at work. This to include appropriate physical and mental health support | Director of Nursing, Head of Psychological Therapies and frontline managers supported by Head of non-clinical risk and business partnering team by Qtr. 2 2019 | • Of the relevant cases notified on incident recording database, 95% of the staff involved are offered the support package  
• At least 90% of staff who have been victims of violence or abuse which goes forward to a prosecution are supported  
• Staff perceptions improve in 2018 staff survey  
• More staff feel supported as measured in the 2018 national staff survey  
• Positive feedback on usefulness of employee assistance programme from those who used it for support |
| Learning and Development have run a series of anti-bullying and harassment courses in December 2018 and January 2019 – propose to extend the programme throughout 2019 | Heads of Learning and Development and Equalities March 2019 – April 2020            | • Wider package developed and rolled out throughout 2019-20  
• Positive evaluations of the courses from participants over the medium to longer term with measurable improvements in their ability/confidence in addressing B&H behaviours and environmental risks |
Title: Mental Health Law Committee – Annual Report

Report to: Trust Board

Date: 23 May 2019

Security Classification: Public Board Meeting

Purpose of Report:

To provide an update to the Board on the work of Mental Health Law Committee since its last annual report in May 2018, with a view to providing assurance on the appropriate implementation by the Trust of the Mental Health Act and Mental Capacity Act.

To review and recommend to the Board the Mental Health Law Committee terms of reference, membership, attendance and proposed work plan for 2019/20.

Recommendations:

Board members are asked to:

1) review the Committee’s annual report, terms of reference, membership and proposed work plan;

2) consider any further actions that may be required.

Report Sponsor: Cedi Frederick, Non-Executive Director

Comments / views of the Report Sponsor:

Report Author: Name: Michael Chalmers
Title: Head of Mental Health Law
Tel Number: 020 8702 710
E-mail: michael.chalmers@beh-mht.nhs.uk

Report History: Annual Report

Budgetary, Financial / Resource Implications: The Mental Health Law Committee monitors trends in the use of compulsory powers, which are necessarily attended by trends in the resources required to safely facilitate, administer and monitor their operation.

Equality and Diversity Implications: In line with the principles underlying the Act, MHL Committee oversees all mental health law related activity, monitoring the impact of mental health law across protected characteristics as defined by the Equalities Act.

Links to the Trust's Objectives, Board Assurance Framework and / or Corporate Risk Register: The assurance provided to the Board by Mental Health Law Committee primarily relates to the objective of excellent care.

List of Appendices:
- None
1. **Introduction**

1.1 The purpose of this report is to provide the Board with a comprehensive update on the work of the Mental Health Law Committee over 2018/19, and to recommend to the Board the Committee’s terms of reference, membership and work plan for 2019/20.

2.2 In order to inform consideration of the appropriateness of the current membership, and whether any other actions may be indicated in respect of ensuring appropriate representation at meeting, an attendance report for current members at Committee meetings in 2018/19 is included.

2.3 In July 2018 Cedi Frederick and Neil Brimblecombe took over from Paul Farrimond and Charles Waddicor as Committee chair and second NED member. The Committee wishes to express to the Board its gratitude and esteem for Paul and Charles’ leadership and contribution over their long tenures on the Committee.

2. **Annual review of Mental Health Law Committee activity**

2.1 **Terms of reference, membership & reporting to the Board**

- The Committee discussed attendance, representation, terms of reference and conflicts of interest in order to ensure satisfactory assurance to the Board on the composition and operational effectiveness of this sub-committee.

- The Committee reviewed and approved its work plan for the year in line with the CQC’s areas of focus and visit methodology, to ensure that assurance can be provided to the Board on all key mental health law regulatory priorities.

- The Committee has assured the Board that it has fulfilled its work plan and terms of reference for the previous year.

2.2 **Implementation of the law**

- The Committee oversaw gap analyses and action planning with respect to the implementation of major legal and policy developments such as the Mental Health Units (Use of Force Act) 2018 and the NICE guidance on decision making and mental capacity, and was apprised of key updates in mental health case law and the arrangements made to raise staff awareness of these.

- The Committee oversaw the review, and approved new versions, of:
  - MHA Information Policy
  - Consent to Treatment Policy
  - Informal Patients Policy
  - Selection of Second Professionals for Renewals of Detention Policy
  - Responsible Clinician and Nominated Deputy Allocation Protocol
  - Missing Patients and AWOL Policy

- The Committee oversaw the review of the information that the Trust provides to voluntary inpatients about their legal status and rights, incorporating CQC and service user feedback.
- The Committee oversaw the implementation of new Service Level Agreement with North Middlesex Hospital which provides for the formal delegation of Mental Health Act powers and duties to the Trust’s mental health law department and psychiatry liaison service in respect of patients detained under the Mental Health Act, and for the remuneration for these services.

- The Committee was apprised of the review and restructuring of mental health act administration services on the Chase Farm site, designed to mitigate the risks to service provision which had attended operating two separate administration offices on the same site.

- The Committee was apprised, and support the implementation, of a collaborative QI project between the mental health law department and Thames Ward aimed at improving compliance with the Code of Practice provisions concerning offering service users the opportunity to develop advance statements of wishes and feelings.

- The Committee regularly reviewed the minutes of its two sub-committee meetings: the Associate Hospital Managers Sub-Committee and the Inter-Agency Mental Health Law Monitoring group, keeping up to date with key issues and actions, and retaining a strategic oversight of the work and functioning of those groups.

- The Committee was regularly apprised of updates in mental health and capacity law, including:
  - the interim and final reports of the independent review of the Mental Health Act;
  - the progress through parliament of the Mental Capacity (Amendment) Bill, which proposes the replacement of the Deprivation of Liberty Safeguards (DoLS) with a new legal framework called “Liberty Protection Safeguards”;
  - the consultation for the new Mental Capacity Act Code of Practice;
  - the proposal for, consultation on, and eventual abandonment of changes to the Mental Health Tribunal’s procedures which would have limited patients’ access to: pre-hearing medical examinations and to full hearings in uncontested cases;
  - updates to (and assurance with respect to) the Mental Health Tribunal’s minimum requirements specification for hearings held in hospitals;

2.3 Training

- The Committee approved the Trust’s regular mental health law training programme comprising bi-monthly “Mental Health Act and Code of Practice” and “Mental Capacity Act and Deprivation of Liberty Safeguards” sessions alternating between the main hospital sites, and noted that the mental health law department also provides tailored training sessions to individual clinical teams upon request.

- The Committee noted that the Head of Mental Health Law also provides “Mental Capacity Act and Deprivation of Liberty Safeguards” training as part of the Trust’s bi-monthly mandatory level 2 safeguarding training.

- The Committee noted the training provided to Associate Hospital Managers at their thrice-yearly Sub-Committee meetings, sessions were provided on: the final report of the independent review of the MHA, the interface between the Deprivation of Liberty Safeguards (DoLS) and the Mental Health Act, and on the interpretation of the legal criteria to be applied in specific types of hearings.
• The Committee oversaw the provision of joint training and debate events for consultant psychiatrists and Associate Hospital Managers on the independent review of the Mental Health Act final report and on the interpretation of contentious aspects of the Mental Health Act’s criteria for detention.

2.4 Care Quality Commission

• The Committee reviewed feedback and action plans from every CQC Mental Health Act monitoring visit, discussed key themes and discuss strategies to raise standards and effectively monitor progress. The Committee also reviewed an annual report examining the themes of the issues raised by the CQC such visits over the year, and comparing these with the themes raised in previous years in order to identify trends and priorities for action.

• The Committee reviewed the CQC’s annual “Monitoring the Mental Health Act” report for 2017/18, and the Trust’s local response report comparing national with local findings and aimed at providing assurance that the Committee’s work plan adequately addresses the CQC’s stated areas of concern nationally. Upon reviewing these reports the Committee agreed henceforth to include a summary of the Trust’s audit results relating to care planning from its Quality Assurance audit programme on the Mental Health Law Committee's annual work plans.

• The Committee reviewed the chapter of the CQC’s annual “State of Care” report relating to the Deprivation of Liberty Safeguards (DoLS), noting that the difficulties experienced locally in the implementation of DoLS are reflected nationally.

• The Committee considered the CQC’s national review of AMHP services, noting that recruitment of AMHPs appears to be problematic both locally and nationally. The Committee oversaw an initial scoping exercise which highlighted widespread support for the idea of training nursing staff as AMHPs from both ward and community team managers, but no members of nursing staff who are already trained as AMHPs and who could be warranted locally. The Committee supports consideration be given to offering AMHP training to nursing staff and has agreed actions to that effect.

• The Committee was apprised of the CQC’s plans to conduct, in late February 2019, a focussed MHA monitoring visit examining the implementation of Community Treatment Orders in the borough of Haringey, noting that it is several years since the CQC has undertaken this kind of focussed visit in London and that it will effectively be trialling a new inspection methodology. The inspection report is expected to be available for review at the Mental Health Law Committee meeting in April 2019.

2.5 Associate Hospital Managers

• The Committee regularly discussed issues and concerns expressed by Associate Hospital Managers through their representatives on the Committee, and oversaw actions aimed at addressing issues raised.
  o The Committee was pleased to note positive feedback from AHMs about the overall standard of reports submitted for hearings, and about the more nuanced policy now in operation within the forensic service with respect to patients’ access to tobacco products, which had been modified in light of concerns expressed by AHMs to the Committee.
  o The Committee was disappointed to note that AHMs still are highlighting examples of reports which are of poor quality, and agreed actions aimed at driving improvement.
The Committee noted that an issue of long-standing concern to AHMs is the practical difficulty in applying the criteria for detention to scenarios in which the absence of suitable after-care arrangements are the acknowledged by all parties to be the only material impediment to discharge. As a result the Committee oversaw the provision of joint training and debate event for AHMs and clinical staff examining the case law relevant to such situations.

- The Committee discussed and supported the continuing work of the London Mental Health Act Network, whose projects include the formulation of standardised training materials for AHMs working across London, and the review of essential standards for the conduct of Associate Hospital Managers hearings.

- The Committee was pleased to note feedback and learning from a post-recruitment workshop event that was held with the newly recruited AHMs, and agreed actions to ensure that learning and actions resulting from the workshop are clearly documented and shared.

- The Committee was pleased to note that the regular attendance of executive directors at AHM sub-committee continues to have a very positive effect on the spirit and level of AHM engagement at these important meetings.

- The Committee noted that the current AHM contracts expire at the end of 2019, and that the Code of Practice requires a review of on-going suitability to take place prior to any re-appointment. The Committee agreed actions for AHM representatives to consult with colleagues and bring forward proposals for a suitable review procedure for consideration by Committee members at the meeting taking place in April 2019.

### 2.6 Service users, carers and advocacy

- The Committee has a standing agenda item for service user representatives to raise issues or concerns from the perspective of service users in relation to the implementation of mental health law but no service user representative has attended a Committee meeting since July 2017, and Committee’s consideration of direct service user input over the last year has been limited to a summary of feedback forms completed by service users with respect to their detention at the Trust’s place of safety suite under Section 136 (police power to remove a person from a public place).

- The long-standing absence of any significant service user input into the Trust’s mental health law policy development or monitoring has been frequently raised and debated as a matter of profound concern to the Committee. The Committee was pleased to note that the Head of Patient Experience expects shortly to implement an “Experts By Experience” bank, which it is hoped will provide a framework for supporting more comprehensive service user consultation and engagement across the Trust, and the Committee has agreed actions aimed at utilising this bank to secure increased service user involvement into the work of the Committee in the new financial year.

- The Committee regular updates as to Haringey CCG’s re-tendering of the IMHA service contract: its awarding to a consortium from MIND, their subsequently pulling out of the contract, and its eventual awarding to POhWER at very short notice prior to the revised contract implementation date. Due to these upheavals IMHA service representation at the Committee has been limited over the last year, but representatives from the new provider attended the Committee meeting in January 2019 and the Committee was apprised of the arrangements made by the IMHA provider and the trust to ensure a smooth transition and handover. The Committee has a standing agenda item for issues related to the IMHA service.
2.7 Monitoring and reports

- The Committee reviewed an internal audit on the Trust’s compliance with the Mental Capacity Act, conducting by external auditors at the behest of the Trust’s Audit Committee, and reviewed the resultant action plan to address its findings.

- The Committee regularly reviewed a wide range of audits and reports in relation to the practical application of mental health law across the Trust, identified patterns and key themes and oversaw actions taken by services to address variations in practice identified. Amongst internal audit reports reviewed were:
  - annual MHA activity comparison report;
  - annual MHA hearings report
  - annual s.136 activity report;
  - annual MHA holding powers report;
  - annual MCA/DoLS report;
  - annual audit of capacity to consent to treatment assessments upon admission to hospital under the MHA;
  - quarterly MHA rights audit reports;
  - audit of the quality of reports submitted for AHM hearings;
  - audit on the provision of AMHP assessment reports by local authorities;
  - a summary of quality assurance audit results with respect to care planning;
  - equalities monitoring of the application of the MHA within the Trust (both as part of many of the reports listed above, and through a dedicated annual MHA Equalities Report)

- The Committee was very concerned to note the consistently and unacceptably high levels of overrepresentation of black people in the Trust’s use of mental health act detention powers. The Chair has written to the Trust’s Chair and Chief Executives to highlight these concerns and to request that urgent consideration be given as to what actions will be taken to reduce the levels of over-representation and suggesting, as a first step, the organising of a positive, community-focussed event at which ideas can be heard and debated.

- The Committee noted that MHA rights audits are provided by the Mental Health Law Department to each borough’s monthly SMG meeting, in order to facilitate operational monitoring and action planning in relation to trends and variations in compliance within and between services.

- The Committee was pleased to note that a ward-level report is now available on RiO which enables staff to quickly identify patients for whom mental capacity and (where relevant) best interests assessments have not been completed since their admission.
3. Terms of reference

Terms of Reference for the Mental Health Law Committee

3.1 Purpose

3.1.1 The Mental Health Law Committee is a sub-committee of the Trust Board.

3.1.2 The overall aim is to provide assurance to the Board on all matters relating to the functions of Hospital Managers (MHA Associate Hospital Managers) and all aspects of the Mental Health Act (MHA) 1983, its subsequent amendments and the Mental Capacity Act 2005.

3.1.3 The Committee will monitor, review the adequacy of the Trust’s processes for administering the Mental Health Act and guiding professionals in relation to the Mental Capacity Act, and formally submit an annual report on its activities and findings to the Trust Board.

3.1.4 The Mental Health Act Code of Practice provides that:

“Organisations (or individuals) in charge of hospitals retain responsibility for the performance of all hospital managers’ functions exercised on their behalf and must ensure that the people acting on their behalf are competent to do so. The organisation (or individual) concerned should put in place appropriate governance arrangements to monitor and review the way that functions under the Act are exercised on its behalf. Many organisations establish a Mental Health Act steering or scrutiny group especially for that task, and whilst recognising that the Act is a legal framework for the delivery of care, also monitor and review via clinically-focussed forums. Ideally, such forums should have representation from the Board or registered manager.”

MHA Code of Practice (2015) – paragraphs 37.10 & 37.11

The Mental Capacity Act 2005 provides that:

“It is the duty of a person to have regard to any relevant code if he is acting in relation to a person who lacks capacity and is doing so in […] a professional capacity.”

Mental Capacity Act 2005 s.42(4)(e)

3.2 Duties

3.2.1 To oversee all the duties of the Hospital Managers as set out in Chapter 37 of the Mental Health Act Code of Practice. This will include:

- the scheme of delegation of Mental Health Act duties
- to make recommendations to the Board regarding the Trust’s mental health law compliance
- to approve the appointment/reappointment of Associate Hospital Managers
- to approve mental health law policies
- to give direction to the tri-annual AHM Sub-Committee meeting
- to review the CQC’s Mental Health Act visit summaries and resulting action plans, and to monitor the implementation of those action plans
- to approve the Trust’s mental health law training framework
3.3 Objectives

3.3.1 To ensure that the statutory duties of the Trust Board under the Mental Health Act (1983) and subsequent amendments are exercised reasonably, fairly and lawfully, and to oversee the provision of guidance to Trust staff in implementing the Mental Capacity Act with regard to its Code of Practice. To satisfy itself of this, the committee will:

- be assured that procedures to inform detained patients and nearest relatives about the applicable provisions of the Mental Health Act (1983) and of their rights are in place and operating properly
- regularly receive and consider relevant statistical information relating to compulsory admission and detention of patients (including data regarding ethnicity, age and gender)
- to monitor the application of the Mental Health Act and Mental Capacity Act against local and national benchmarks and relevant CQC regulatory standards as detailed in the appendices to CQC Handbook for Mental Health Service Providers
- to ensure that appropriate arrangements are in place and are operating satisfactorily, for the completion and review of relevant legal documentation relating to the compulsory admission and detention of patients and automatic referrals to the Mental Health Tribunal
- to ensure the organisation supports the CQC Mental Health Act Reviewers in visits to Trust facilities and that it responds appropriately to any reports following such visits
- to provide information to the Trust Board relating to Associate Hospital Managers’ Hearings and Mental Health Tribunals, including issues relating to the service provision
- to commission a programme of training and on-going development for MHA Associate Hospital Managers
- to recommend to the Trust Board the appointment of new MHA Associate Hospital Managers
- to ensure a process is in place to maintain high standards and to review the competencies of MHA Associate Hospital Managers
- to audit the process and outcomes of Mental Health Act hearings/appeals
- to ensure appropriate processes are in place to check the quality of relevant documentation through planned and random auditing and checking
- to consider comments and recommendations relating to Serious Untoward Incidents and complaints involving people detained under the MHA or subject to the provisions of the Mental Capacity Act (2005)
- to take account of the delegated functions in respect to Approved Mental Health Professionals (AMHPs) within the context of secondment agreements with relevant local authorities

3.4 Specific Responsibilities of the Mental Health Law Committee

Inputs: The Mental Health Law Committee will receive the following inputs:
- Associate Hospital Managers Sub-Committee and Representatives
- Care Quality Commission
- Service User Representatives
- Mental Health Law Department

The Mental Health Law Committee can request a report on any subject or issue relevant to its terms of reference.

| Outputs: | Meetings of the Mental Health Law Committee shall be formally recorded and once approved, submitted to the Trust Board at the next opportunity. After each meeting of the Committee, the Chair of the Committee shall make a report to the next meeting of Trust Board and draw to its attention any issues that require its particular attention, or require it to take action. The Mental Health Law Committee shall submit an Annual Report to the Trust Board (May), incorporating a review of the Committee, progress against its work plan, reporting arrangements, frequency of meetings and attendance records. Ratification of the Mental Health Law Policy. |

| Responsible for the following Strategies and Policies: | Advance Care Planning Policy, Missing Patients and AWOL Policy, Consent to Treatment Policy, Deprivation of Liberty Safeguards (DoLS) Policy, Mental Capacity Act Policy, Mental Health Act Information Policy, Selection of Second Professionals for Renewals of Detention Policy, Informal Patients Policy, Reports for Mental Health Act Hearings Policy, Responsible Clinician and Nominated Deputy Allocation Protocol |

| Key Performance Indicators: | None. |

| Sub-Committees: | Associate Hospital Managers Sub-Committee |
3.4 Meeting Arrangements for the Mental Health Law Committee

**Chair:**
The Chair of the Mental Health Law Committee shall be a Non-Executive Director with Mental Health Act responsibility, appointed by the Trust Board.

In the absence of the Chair, the members of the Mental Health Law Committee present will elect the other Non-Executive Director to chair the meeting.

**Other Members:**
In addition to the Chair of the Committee the membership of the Committee shall include:

- A second Non-Executive Director
- Two Mental Health Act Associate Hospital Managers
- Executive Director of Nursing, Quality and Governance
- Medical Director
- Head of Mental Health Law
- Borough / Service Line Representatives
- Local LSSA Mental Health Service Managers / Leads
- Service User Representatives
- Representatives of the Trust's IMHA and IMCA service providers
- Head of Patient Experience

The Trust Board will review Committee membership annually as part of the Committee Effectiveness Review.

Additional members may be co-opted as required.

Other Directors or Officers of the Trust may attend by invitation.

**Quorum:**
Four members to include:

- one Non-Executive Director
- one Executive Director
- one MHA Associate Hospital Manager
- the Head of Mental Health Law or representative

Any Non-Executive Director may attend a meeting of the Mental Health Law Committee and will count towards the quorum.

**Deputies:**
A member of the Committee may appoint a named deputy to attend a particular meeting in their place. A deputy should be nominated only in exceptional circumstances, for a particular meeting and not as a way of a committee member regularly avoiding attendance at meetings.

On each occasion the member should approach the Committee Chairman, cc the Head of Mental Health Law, to ask agreement for the named deputy to attend in their stead, to count towards the quorum and to have full voting rights.

If it appears that the meeting will have a minority of full members, the Chairman will confer with the Head of Mental Health Law as to whether the meeting should be re arranged.

**Voting:**
In accordance with Standing Orders, if it is necessary to resolve an issue at a meeting of the Committee by way of a vote, this shall be determined
by a majority of the votes of the Members present and voting and, in the case of any equality of votes, the person presiding shall have a second or casting vote.

### Declaration of Interests

All members must declare any actual or potential conflicts of interest relevant to the work of the Committee, which shall be recorded in the Minutes accordingly. Members should exclude themselves from any part of a meeting in which they have a material conflict of interest. The Chair will decide whether a declared interest represents a material conflict.

### Frequency of Meetings:

Meetings to be held quarterly, with additional meetings to be convened as required.

### Frequency of Review of the Committee’s terms of reference:

The Committee will carry out an annual review of its performance and function in satisfaction of these Terms of Reference and report to the Board on any consequent recommendations for change.

### Support Arrangements:

The Head of Mental Health Law will be responsible for providing secretarial support to the Committee. Agendas for forthcoming meetings will be agreed with the Committee Chair and papers distributed to members in advance of the meeting as agreed. Meeting papers will also be available to other members of the Board for information.

The Committee will establish a Work Programme, summarising those items that it expects to consider at forthcoming meetings.
4. **Member attendance 2018/19**

<table>
<thead>
<tr>
<th>Members</th>
<th>May</th>
<th>July</th>
<th>Oct</th>
<th>Jan</th>
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<tr>
<td>Chair, Non-Exec Director</td>
<td>Paul Farrimond</td>
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<td>Linda McQuaid</td>
<td>Linda McQuaid</td>
<td>Clare Scott</td>
<td>Amanda Pithouse</td>
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<td>Medical Director</td>
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<td>BEH Specialist Representative</td>
<td>Alex Acosta-Armas</td>
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<td>BEH Haringey Representative</td>
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<tr>
<td>Head of Mental Health Law</td>
<td>Michael Chalmers</td>
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<td>Head of Patient Experience</td>
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<td>Nikki Plastiras</td>
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<tr>
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<td>IMHA/IMCA Provider</td>
<td>Robert Edmonds (MIND)</td>
<td></td>
<td>David Beer / Kelly Foley (POhWER)</td>
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<td>Enfield SU Representative</td>
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5. **Proposed Committee work plan for 2019/20**

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<td><strong>Review of MHLC membership, terms of reference and work plan</strong></td>
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6. Conclusions

6.1 The Mental Health Law Committee continues to meet quarterly to review standards and progress made in relation to the mental health law governance agenda, in line with a comprehensive annual work plan. However, the Committee continues to face challenges in attracting representation from service user organisations, which has had a negative impact on the Committee’s effectiveness. It is anticipated that the forthcoming service user involvement bank will facilitate significantly improved service user input into the work of the Committee.

6.2 The Committee continues to review a wide range of performance and equalities data in respect of the application of mental health law across the Trust, enabling the formulation and tracking of targeted actions to address variations. The Committee was pleased to note through its annual reporting cycle examples of significantly improved compliance in key areas of regulatory focus, such as explanations of rights to detained patients. However in other key areas, such a service user participation in care planning and assessments of capacity to consent to treatment, the Committee was disappointed to note that sustained improvement continues to be elusive. These areas are now the focused on of dedicated work streams as part of the Trust’s new “Brilliant Basics” forum, and it is hoped that the sustained focus this brings will facilitate more effective action to bring about sustained improvement.

6.3 Close attention continues to be paid to developments in the CQC’s areas of focus and visit methodology to ensure that the mental health law audit programme and governance arrangements effectively anticipate and address all regulatory priorities. The Committee is concerned that current assurance arrangements with respect to the completion of action plans submitted in response to CQC MHA monitoring visits are not sufficiently robust.

6.4 The AHM Sub-Committee meetings continue to be very well attended, and the regular attendance of Executive Directors to update attendees on the wider business of the Trust has made a significant difference to the positive spirit and level of engagement at the meetings.

6.5 The Committee’s priorities for the forthcoming financial year will be:

1. To closely monitor the significant legislative changes expected with respect to both the Mental Health Act and Mental Capacity Act, and to provide assurance to the Board that all relevant practice and resourcing implications of those changes have been comprehensively identified and planned for.

2. To lead efforts to reduce the degree of overrepresentation of black people in the use of MHA detention powers within the Trust.

3. To significantly increase the level of direct service user input into the Trust’s mental health law monitoring, procedures and training.

4. To strengthen the Committee’s assurance role with respect to the monitoring of CQC MHA visit action plans, and to recommend to the Board revised terms of reference to that effect.

5. To drive and support improvements in operational / service level monitoring and assurance processes with respect to key areas of CQC mental health law focus.

6. To oversee preparations for (and subsequent actions plans arising from) the forthcoming CQC well-led inspection insofar as it relates to the implementation and governance of mental health law.