Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

A University Teaching Trust

Title:	Clinical, Quality and Safety Report
Report to:	Trust Board
Date:	2 October 2017
Security Classification:	Public Board Meeting

Purpose of Report:

The purpose of the Clinical Quality and Safety report is to provide the Trust board with an overview of the clinical quality and safety activities and patient experience of our services. This report outlines key aspects of quality and safety and identifies areas which may require further work to address variation in standards of practice. The report should be read alongside the Integrated Performance and Quality Dashboard.

Recommendations:

The Trust Board is asked to consider the report and discuss any further actions or assurance they require in respect of the Clinical Quality and Safety of Trust services.

Report Sponsor:	Mary Sexton, Executive Director of Nursing, Quality and Governance
Comments / views of the Report Sponsor:	This report highlights the key work undertaken across all Trust services and demonstrates that ensuring patients and carers have a positive experience/outcome remains a priority.
Report Author:	Name: Mary Sexton Title: Executive Director of Nursing, Quality and Governance Tel Number: 020 8702 3032 E-mail: mary.sexton2@beh-mht.nhs.uk
Report History:	Regular Report bi-monthly
Budgetary, Financial / Resource Implications:	None
Equality and Diversity Implications:	None
Links to the Trust's Objectives, Board Assurance Framework and / or Corporate Risk Register	Action taken will assist in delivering our objective of providing excellent care and Happy Staff

List of Appendices:

None

Report

1. Introduction and Background

1.1 The Clinical Quality and Safety Report supplements the Integrated Performance and Quality Dashboard by outlining the key clinical quality and safety areas which the Executive Director of Nursing, Quality and Governance would like to bring to the attention of the Board.

2. Patient Safety

2.1 Infection Control and PLACE Summary Report September 2017 Audits

2.1.1 The infection control audit monitors compliance with the "Hygiene Code" and the Trust 'Hand Washing policy', these are carried out by infection control link nurses (ICLNs), the target rate is 90%. All areas were audited by the ICLNs in July and August demonstrated compliant; there was a 4.56% variance of compliance between wards that were audited by ward staff with an average compliance of 96.73% and those conducted by the infection control team with an average compliance score of 92.17%. The overall compliance rate for July and August was 94.45%.

2.1.2 The hand washing audit monitors compliance with the hand washing policy and the dress code policy. The audits are carried out monthly in inpatient areas and quarterly in out-patient services. All inpatient areas audited in July and August were compliant, with an average compliance of 93.45%. The community carried out twenty eight hand hygiene audits in total in July and August. Three of the twenty-five audits carried out were below the Trust target of 90% (80%, 66.67% and 50%). Reasons attributed to the low scores ranged from non-compliance with the dress code (bare below the elbow, presence of nail vanish and wearing wrist watches or bracelets) to missing steps on their hand hygiene technique. All non-compliant issues were addressed appropriately, with staff being offered a hand hygiene refresher course and referred to the dress code policy.

2.1.3 All twenty seven in-patient areas audited in July were in compliance with the national cleaning target of 95%; however six inpatients wards were below the Trust target of 97% (Sussex, Fairland, Finsbury, Haringey, Trent and Thames). The Trust-wide average in patient cleaning score compliance for July was 97.1%.

2.1.4 The Trust audited twenty four out-patient areas in July. The Trust wide compliance rate was at 97.3% (this excludes guest Trust scores), scoring above both the national average and the Trust target (95%). However, the Guest Trust average cleaning score for July was 96.5%, above the national average cleaning score but below the Trust cleaning average score of 97%. All issues that were non-compliant were addressed following the audit.

2.2 Training

2.2.1 Infection Control training uptake is at 90.3%, an improvement on recent months.

2.3 Outbreaks and Notifications

2.3.1 In July, the Trust reported an outbreak of diarrhoea and vomiting in Haringey Community Services, six members of staff were affected. All necessary precautions were instigated put in place to contain the infection with positive effect.

2.3.2 The Trust was identified as a contact by Public Health England (PHE) to an Invasive Streptococcus A infection in July 2017. All necessary precautions (30 days surveillance)

were instigated. No cross infection occurred during the surveillance period and the case was closed by PHE.

2.3.3 The Trust reported one case of Clostridium Difficile toxin positive on Phoenix ward. No other patients or members of staff were affected; the case is now closed.

2.3.4 One case of Hepatitis B infection was reported to the infection control team by Fairland Ward, the index patient had been a transferred from South London and Maudsley Foundation Trust. All required precautions and protocols were put in place to prevent and contain the infection.

2.4 Patient-Led Assessments of the Care Environment (PLACE)

2.4.1 PLACE inspections are self-assessment of a range of non-clinical services which contribute to the environment in which healthcare is delivered in both the NHS and independent/private healthcare sector in England. These voluntarily assessments were introduced in April 2013 to replace the former Patient Environment Action Team (PEAT) assessments. The PLACE programme aims to promote a range of principles established by the NHS Constitution through focussing on the areas which matter to patients, families and/or carers.

2.4.2 The PLACE program is designed to promote patients safety principles and values such as putting patients first; actively encouraging feedback from the public, patients and staff to help improve services; striving to get the basics of quality of care right and facilitating the involvement of patients, the public and other bodies with an interest in healthcare. The assessments are carried out to identify how providers are performing against a range of criteria giving the organisation a clear picture of how their environment is seen by those using it, and how they can improve it.

Table 1: Showing the PLACE 2017 Results for Barnet, Enfield and Haringey

RRP	Cleanliness (CLN)	Ward Food	Privacy, Dignity and Wellbeing (PDW)	Condition Appearance (CAM)	Dementia (DEM)	Disability (DIS)
BEHMHT	**99.57%**	**90.09%**	**86.86%**	**96.30%**	**82.00%**	**84.12%**
National Average	**98.1%**	**89.5%**	**82.3%**	**93.8%**	**76.9%**	**79.7%**

2.4.3 At organisational level in 2017, the Trust performed well and scored above the national average on all the six domains assessed as indicated in Table 1 above.

2.4.4 At site level, the organisation performed well on the cleanliness domain on all sites inspected scoring above the national average as indicated in table 2.

2.4.5 On the other domains, St Michaels, Edgware and Chase Farm performed well; they all scored above national average for 5 of the 6 domains inspected in 2017. St Ann's scored above the 2017 national average in one domain; scores were low against the national average in domains for dementia and disability.

Table 2: Showing the site results against the national level PLACE 2017

Site Name	CLN Score %	Ward Food Score %	PDW Score %	CAM Score %	DEM Score %	DIS Score %
EDGWARE COMMUNITY HOSPITAL	99.18%	97.76%	81.18%	95.86%	87.96%	83.61%
CHASE FARM HOSPITAL	99.70%	88.72%	89.00%	98.68%	83.02%	87.40%
ST. ANN'S HOSPITAL	99.02%	87.50%	80.29%	87.22%	66.84%	64.03%
SPRINGWELL	100.00%	90.74%	90.13%	93.86%	86.03%	86.96%
ST MICHAELS	99.61%	96.27%	85.26%	91.91%	89.12%	90.40%
NATIONAL AVERAGE	98.38%	90.19%	83.68%	94.02%	76.71%	82.56%

2.4.6 All areas of non-compliance are in the process of being actioned by the relevant leads/ wards. Monitoring of all action plans is through the Environmental Operational Action Group (EOAG) which meets once a month in each borough; progress from borough meetings is reported to the Infection control committee.

3. Safeguarding Children and Young People and Adults at Risk

3.1.1 We are keen to create a culture of continuous safeguarding practice improvement where issues such as possible abuse and neglect are recognised at every level. In order to support this a number of initiatives are taking place. The safeguarding team are now providing quarterly safeguarding updates for each of the borough clinical governance meetings to ensure there is a collective understanding of safeguarding activity and requirements at a local level. The easy read leaflet for service users "say NO to abuse" and their families has been updated to reflect the newer categories of abuse such as hoarding and modern slavery. This leaflet has been circulated to the clinical areas. A safeguarding newsletter is being developed for staff and this will be circulated over the next few weeks.

3.1.2 Our Safeguarding Strategy (2015 -2018) is supported by a three year work plan. The plan of work for year two has been agreed by the Integrated Safeguarding Committee. A particular focus for 2017-18 will be the re-launch and promotion of a "Think Family" approach to safeguarding.

3.1.3 During August 2017 our new safeguarding adult lead, Nhamo Paz has commenced in post, the team now have a full complement of safeguarding personnel. Information regarding the team has been communicated to staff in a variety of formats, including the CQC handbook for staff and the Trust intranet.

3.1.4 We continue to work proactively with the local Safeguarding Boards for children and adults and we have provided all six boards with partner statements to include in their respective annual reports.

3.1.5 As previously reported, the safeguarding team continue to lead on the innovative pilot project "LINKS" which aims to improve our responses to service users who disclose domestic violence and abuse. We have provided an interim report to NHS England which demonstrates the clear benefits of having a dedicated Independent Domestic Violence Advisor (IDVA) placed directly with the mental health teams.

LINKS
Towards a better response to domestic violence & abuse in mental health

3.1.6 A clear positive impact has been the significant increase in the number of referrals being made to the Barnet Domestic Violence and Abuse support services since the start of the project. During 2015-16 just 8 referrals were made in total from BEH-MHT. Since commencing the project in January 2017, 23 referrals have been made. Indications are that this trend will continue as staff undertake specialist training and become more aware of the role of the mental health IDVA. In addition we are seeing an increase in the number of referrals now being made to the Multi-Agency Risk Assessment Conference (MARAC) by Barnet mental health teams; since April 2017 6 referrals were made following case discussions with the IDVA.

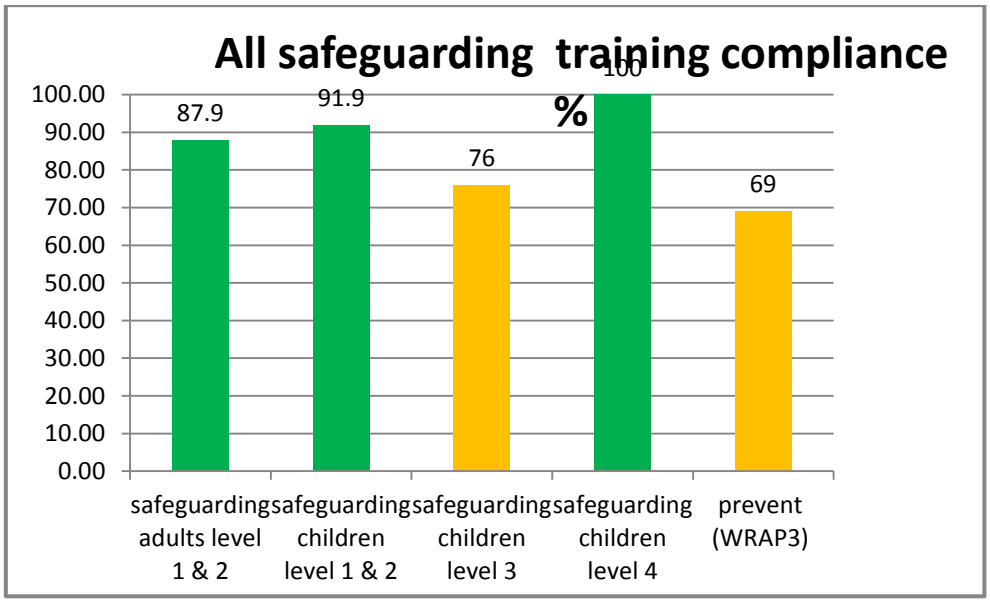
3.1.7 So far the project has shown significant benefit to service users and staff working in Barnet. Full evaluation of the project will be completed in early 2018. The LINKS project group seek continued support from NHS England and other possible funding streams to ensure this vital work continues and can be expanded. The project is supported by the Integrated Safeguarding Committee and quarterly progress reports are provided.

3.1.8 The LINKS project group are pleased to report that we have been shortlisted for the HSJ Awards 2017 under the category of “Innovations in Mental Health”.

3.2 Safeguarding Training

3.2.1 The target for all safeguarding training is 90%. Level 1&2 training for adults and children has remained consistently high at around 90% compliance. As previously reported the group of staff required to complete level 3 safeguarding children training was increased in Q3 2016 resulting in a fall in compliance to 45%. Despite changes in personnel the safeguarding team have ensured uptake to achieve the current compliance of 76%. The safeguarding children lead is currently offering additional training sessions to in-patient teams with low compliance.

3.2.2 The graph below shows all safeguarding training compliance as a percentage at the end of August 2017.



4. Essence of Care Pressure Ulcer Audit

4.1 The Tissue Viability Service (TVS) developed an audit tool based on the Essence of Care Pressure Ulcer Benchmark to measure compliance in clinical practice against the key standards of pressure ulcer prevention and care. A series of audits have been carried out across the District Nursing Service (DNS) and Magnolia Unit since 2009 and this report contains the findings of the current audit (2017) and compares the results from previous years' to demonstrate areas that have improved and areas that require attention.

4.2 Since previous audits 79 clinicians from the Trust have attended the TVS Education and Training events focussing on Pressure Ulcer Prevention and Management strategies during 2015-17. A further 76 clinicians from the Trust attended wound management study days during 2015-17, where Pressure ulcer description and prevention strategies were included.

4.3 The results for the 2017 audit in, Table 1, demonstrate improvements in the overall Assessment, Planning and Interventions of care categories but there is a significant decrease in the number of evaluations documented. These findings support the action plans presented by the Teams at the Pressure Ulcer Prevention (PUP) Forum, which demonstrates their successes in maintaining focused improvement in this aspect of care. There may be a number of explanations for a decrease in the percentage of evaluations recorded. These include; Piloting of mobile working devices to access RiO remotely in one DN team reducing documentation of evaluations in patient held records, piloting of the 'Store & Forward' RiO Function, many Community Nurses have to wait until they have returned to base to enter data onto RiO Progress notes and increasing workloads with current vacancies across all teams.

Table 1:

	Pressure Ulcer Risk assessments	Care Planning	Appropriate Interventions	Evaluations of Care
2017	74%	63%	77%	61%
2015/16	69%	60%	73%	84%

5. CQC MHA monitoring visits and actions

5.1 Finsbury Ward – 13/06/17

5.1.1 We received written feedback from this visit on 21/06/2017. As reported in July concerns were raised in relation to evidence of capacity to consent assessments; evidence of patient involvement in the care planning process and delays in patient's rights being explained following admission. The ward layout was identified as compromising privacy and dignity with regards to patients needing to walk from the dormitory through a communal area to use the bathroom. In addition the lack of a seclusion room on Finsbury Ward and the need to transfer a patient requiring seclusion to a room on another ward via a public corridor and a communal area was highlighted.

5.1.2 The response detailed arrangements put in place by the ward to maintain improved oversight of care planning and capacity assessment recording, and described the mitigation measures implemented in respect of the ward's physical environment pending the rebuild of the St. Ann's site. No action was taken in respect of the commissioner's concerns about explanations of rights, since it could be demonstrated that the particular concerns raised were not correct.

5.2 **Beacon Centre – 15/06/17**

5.2.1 The overall feedback was positive. The commissioner highlighted some negative service user feedback in relation to the ward's interior decoration, the availability of activities and the communication style of some members of staff. Concerns were raised that the service users didn't feel sufficiently involved in the care planning process.

5.2.2 The response detailed the arrangements put in place to investigate and resolve the concerns raised by service users to the commissioner, including assurance that the necessary funds have been secured to promptly redecorate the ward.

5.3 **CQC Unannounced Comprehensive Inspection - Phoenix Ward, 04/09/17 – 05/09/17**

5.3.1 Verbal feedback was received on 05/09/17. The inspectors recognised the significant progress that has been made to address the regulatory breaches that had been previously raised by CQC inspectors. The positive impact the change in leadership over last few months was acknowledged, although further work is required to deliver and fully embed improvements. The inspectors reported that service users were on the whole "happy" with the level of care they were receiving. They were impressed by risk management and physical health monitoring within the ward. The inspectors received positive feedback from staff regarding the support they receive; they were given positive feedback from staff and service users in respect of ward manager. Concerns were raised regarding environment and layout and the absence of designated outdoor space. Concern was raised regarding patient specific medication management. We do not expect to receive the full report and rating for some weeks.

6. Patient and Carer Experience

6.1 Friends and Family Test (FFT)

6.1.1 Table 1 shows the FFT results from 1 June 2017 to 1 September 2017 by Borough. The overall percentage of service users/carers that would recommend our services to friends and family was 88%, the same as the previous reporting period (April 1 to May 31 2017).

Barnet Summary Results Family and Friends Test 1 June –1 Sept 2017

Area	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Barnet	89.85%	1.67%	598	337	199	36	4	6	16
Summary	89.85%	1.67%	598	337	199	36	4	6	16

Enfield Summary results family and Friends Test 1 June –1 Sept 2107

Area	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Enfield	89.23%	3.16%	569	309	188	37	7	11	17
Summary	89.23%	3.16%	569	309	188	37	7	11	17

Haringey Summary Results family and Friends test 1 June – 1 Sept 2017

Area	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Haringey	88.23%	1.57%	319	165	119	15	2	3	15
Summary	88.23%	1.57%	319	165	119	15	2	3	15

Specialist Summary Family and Friends Test 1 June – 1 Sept 2017

Area	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Specialist	80.35%	7.29%	439	175	174	46	22	10	12
Summary	80.35%	7.29%	439	175	174	46	22	10	12

6.2 Table 1: FTT responses 1 June 2017 – 1 September 2017

6.2.1 As in the previous reporting period the lowest performing area is Specialist services whose overall results have just met the Trust benchmark of 80%, a 1.33% improvement on the previous period. The Borough of Haringey continues to demonstrate an upward trend with an overall recommendation of 88.23% however they are also the Borough with the least number of returns by some 40%. Enfield's recommendation rate dropped by 6.74% which is the same for the same period last year and is believed to reflect the reduction in surveys submitted by the School Nursing Service who work term time only.

6.2.2 Managers are being encouraged to increase return rates for the FFT and Patient and Carer surveys. Managers are able to check the FFT feedback on at least a weekly basis and act upon any feedback as quickly as possible using the "You Said We Did" poster or equivalent to inform patients of what is being done to address the feedback received.

6.2.3 The free text from all the surveys submitted is shared via the Borough Deep Dives and local clinical governance meetings.

6.3 Patient and Carer Experience Survey

6.3.1 An average of 1,000 responses was received between the months of April 2017 – July 2017 but August witnessed a significant drop which will impact on figures for Quarter Q2. Monthly satisfaction rates demonstrate a steady trend since the start of the financial year 2017. Work is on-going with staff to try increasing the number of returns. This includes the piloting of the postcard survey in the wellbeing clinic in Enfield CAMHs and the Victoria Unit in Haringey.

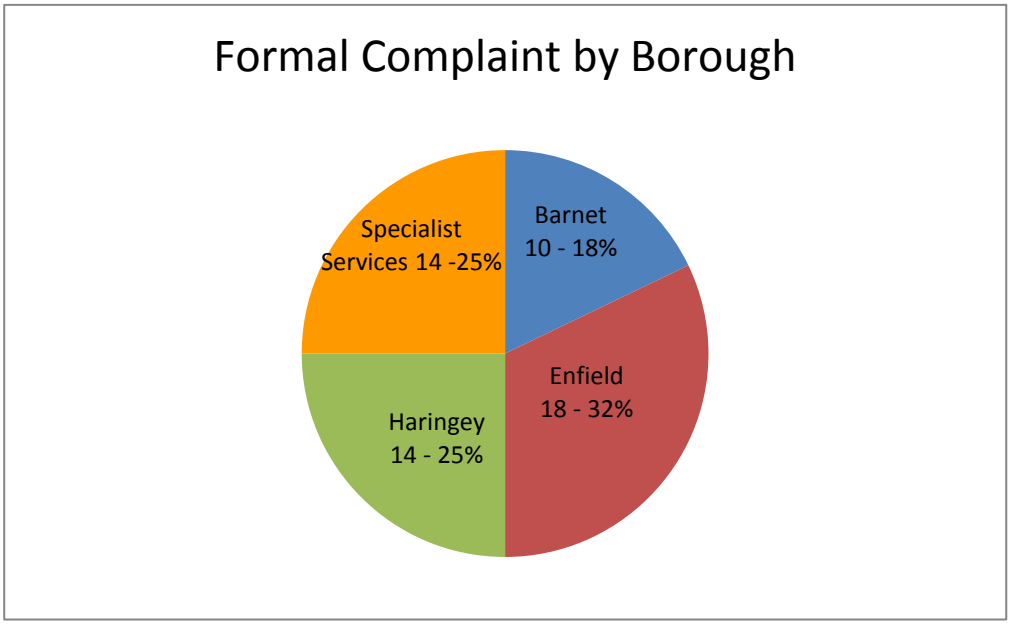
6.3.2 Table 2 shows the satisfaction rate from service /user carer surveys received April 1 - September 1 2017.

6.3.3 The information pages for the patient experience team on both the intranet and the internet have been updated with further reviews to take place. At present the intranet has been completed with a separate page with all the survey links and details on how to contact to make amendments. Work is ongoing with the internet page as we try to establish a link which will allow service users and carers alike to complete and submit the Trust survey online.

Table 2: Overall Summary

6.4 **Complaints**

6.4.1 **Table 3** below gives an overview of the Trust complaints activity from June 1 2017 - September 1 2017 broken down by Borough.

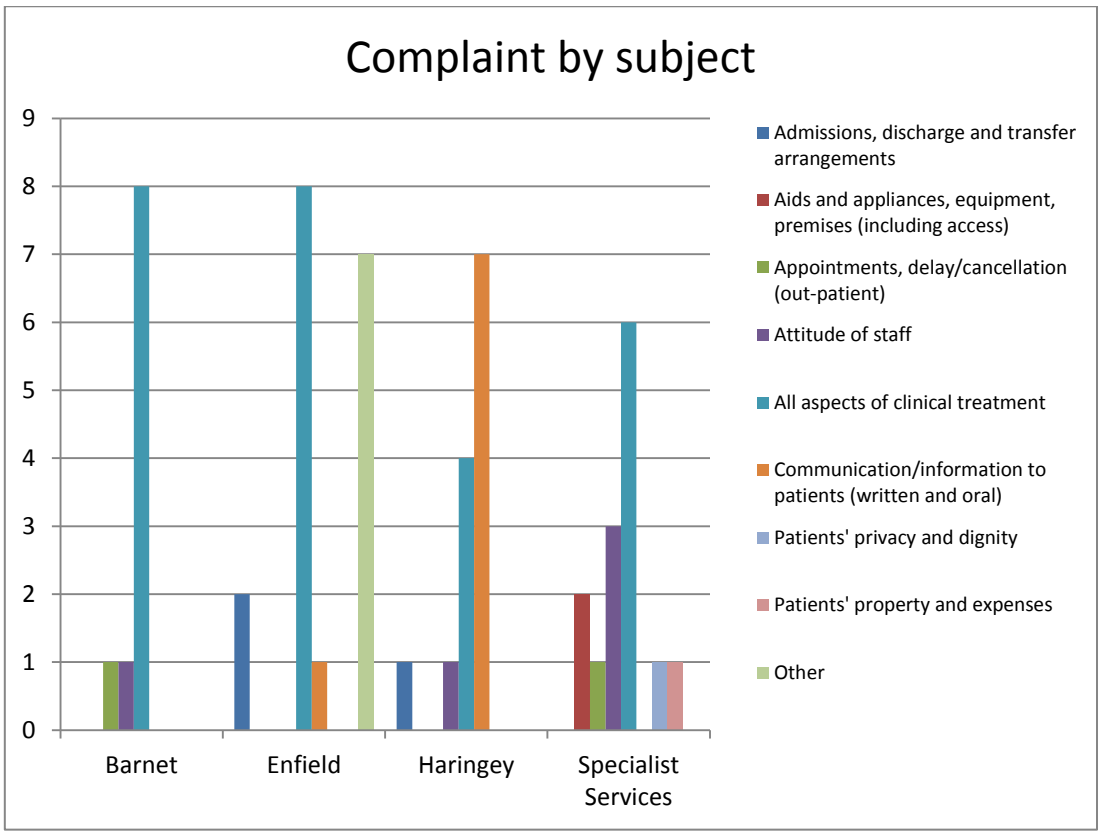


6.4.2 The pie chart reflects a steady position across all Boroughs and services. There has been some key learning and improvements made from recent complaints which include the following:

1. Inclusion of Enfield Health logo on the complaints leaflet
2. A series of workshops on compassionate care in Magnolia Unit Enfield
3. A catering pilot on the inpatient wards in Haringey
4. Development of an information leaflet for use in CAMHS Enfield

6.4.3 The patient experience managers are continuing to work with some teams on a variety of projects including:

1. Weekly attendance at community meetings on Phoenix eating disorder ward in Haringey
2. Weekly attendance at community meetings Fairlands Ward, Haringey
3. Quarterly carers bulletin Ken Porter Ward Barnet



6.4.4 The graph above indicates the formal complaints received by type and Borough. Clinical care and communication remain consistently at the top and this is reflected in other types of concerns and complaints received.

6.4.5 Work continues with the Datix Team to redefine the subject areas so more focus detail can be provided by this data and shared back with the services to link with quality improvement.

6.4.6 Table 4 shows compliance rate of response to complaints across the Trust at 3 days (acknowledgement) and 25 days (final response).

	June	July
Acknowledged in 3 days	95%	87%
Met compliance of 25 days	74%	62%

6.4.7 The 25 day response rate was significantly impacted by breaches in the formal complaints process in both Haringey and Barnet. Work has been done with staff in both Boroughs to understand and address the issues identified and the whole complaints process is being reviewed with a task and finish group to be set up in preparation for the policy review in the autumn. New training dates for resolving complaints have been released and two sessions run already, one in Haringey and one in Enfield. This is a localised workshop of 3 hours rather than the traditional 6 hours and focuses on the role of the investigator.

7. Clinical Activities, Supporting Staff – Nursing Initiatives

7.1 Preceptorship Development

7.1.1 The Non-medical education team have undertaken a review of our preceptorship programme and preparation is being finalised to welcome approximately 50 new registrants in September 2017. A proposal for academic accreditation for a Preceptorship module was submitted to Middlesex University; we are expecting accreditation to be ratified in September 2017.

7.1.2 Once ratified the preceptorship module will be offered on an optional basis; upon successful completion of the module, 30 academic credits at level 7 (Masters Level) will be awarded by the University of Middlesex.

8. Enfield Community Services

8.1 Health Visiting

8.1.1 There continues to be concern regarding the funding and staffing for the service. Discussions are on-going with London Borough of Enfield commissioners. The service is delivering all aspects of the Healthy Child Programme, Universally for New Births, 6-8 week review and 2 year review and targeting antenatal and 1 year review for those families who are identified as having safeguarding concerns or parental concerns. July saw 99% compliance with new birth contacts by 14 days. Recruitment is still paused and caseloads are increasing, impacting on staff morale. This is recorded on the risk register.

8.2 School Nursing

8.2.1 The service is readjusting following retirements and resignations at the end of Summer Term. A new Operational Clinical Lead has started in post and will be working with the teams to reinvigorate the service. All Special Needs schools will now come under the Specialist Children's service. The service will be continuing to work to the 'non-ratified' Key Performance Indicators, meeting the Healthy Child Programme 5-19 years.

9. Allied Health Professionals (AHP)

9.1 The Third Trust Allied Health Professions Conference

9.1.1 Our third Trust (AHP) conference is being held on 1 November 2017. The day will focus on new models of intervention building on the NHS England AHP Strategy: AHPs into Action which focuses on sharing new ways of working and resulting service improvement. Maureen Drake, Clinical AHP Fellow from the NHS England Chief Allied Health Professions Officers Team, will provide us with up to date information on all the teams current work streams.

9.1.2 There will be presentations from AHPs on local innovations, our Chief Executive, and our Trust Quality Improvement Team. It will also provide an opportunity for our AHPs to network and share with colleagues through poster presentations and other media information on their areas of work. This will assist in sharing examples of good practice.

9.2 AHP Parity of Esteem Health Education England funded Project Update

9.2.1 The baseline survey closure date was extended until 13 September; as of 31 August 114 responses had been received. An initial analysis of the quantitative data was shared at the steering group meeting on 7 August 2017.

9.2.2 The survey design has enabled us to see who has responded and therefore interviews will be planned to explore the new ideas expressed in the data capture.

9.2.3 At the September meeting of the North Central East London AHP Network, a workshop to provide an update on the project progress forms part of the agenda. It is an opportunity to explore with colleagues the survey questions and new models of intervention.

9.3 **SWAP II Project Health Education England funded Project Update.**

9.3.1 The project is not only looking at the requirements of the Trust's AHP Support Workers but also AHP Support Workers employed by the Royal Free Hospitals London NHS Foundation Trust. This will ensure the course design is appropriate across different care settings.

9.3.2 On 28 July initial approval from Middlesex University to continue developing the proposal was received. The plan is to develop the Modules during October – December ready for submission to the Accreditation Panel in January 2018.

Ends.