NOTICE OF MEETING

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

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Tuesday 15 July 2014 at 10:00 a.m.
Civic Centre, High Road, Wood Green,
London N22 8LE

Councillors: To be advised (L.B.Barnet), Alev Cazimoglu and Anne Marie Pearce (L.B.Enfield), Gideon Bull (Chair) and Pippa Connor (L.B.Haringey)

AGENDA

1. WELCOME AND APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

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

a) must disclose the interest at the start of the meeting or when the interest becomes apparent; and
b) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

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

3. BARNET, ENFIELD AND HARINGEY MENTAL HEALTH SERVICES; FINANCIAL REVIEW - FINAL REPORT (PAGES 1 - 44)

To consider the report of the Barnet, Enfield and Haringey Mental Health Services; Financial Review.

4. CQC INSPECTION REPORT - TRUST HEADQUARTERS (PAGES 45 - 80)

To consider the two latest CQC reports in respect of Barnet, Enfield and Haringey Mental Health Trust.

5. BARNET, ENFIELD AND HARINGEY MENTAL HEALTH TRUST QUALITY ACCOUNT 2013-14 (PAGES 81 - 116)

To receive the 2013-14 Quality Account for Barnet, Enfield and Haringey Mental Health Trust.

7 July 2014

Mental Health STRATEGIES

Barnet, Enfield and Haringey Mental Health Services

FINANCIAL REVIEW

– Final report

March 2014

CONTENTS

1. INTRODUCTION

This document reports the findings of a project carried out between 20th December 2013 and 14th March 2014 to review whether local NHS mental health commissioners can afford the range of adult and older people's mental health services currently provided to them by the Barnet, Enfield and Haringey Mental Health Trust (BEH-MHT).

Commissioners from Barnet, Enfield and Haringey were seeking to ensure that they secure the best possible value for money from the investment made in mental health care, and to consider all ways in which local service models could be redesigned to secure both efficiencies and cost savings. This project is intended to provide both a body of evidence to inform this process, and independent recommendations as to specific actions which could be taken.

The project's specific objectives were to provide:

a) An assessment of the potential gap between the investment provided by the commissioners to BEH-MHT and the realistic expected cost of providing the range and volume of services currently specified.

b) An assessment of high level options to address that gap, including the potential contributions of:

- capping activity levels and/or changing access thresholds
- decommissioning of services
- estates rationalisation
- service redesign, including improvements in integrated care and/or workforce redesign

The scope of this project included all local mental health services for adults. It therefore did not include:

- Child and adolescent mental health services
- Services provided by BEH-MHT to residents of other boroughs
- Specialist mental health services which are commissioned via regional or national specialist commissioning arrangements

The main body of the report is structured in two main sections:

- section 2 explains our findings on the level of the financial gap, from a range of perspectives
- section 3 explains our findings on opportunities which may be available to meet that financial gap

The report contains finally our conclusions and recommendations.

2. ASSESSMENT OF ''THE GAP''

This section provides an assessment of the potential gap between the investment provided by the commissioners to the Trust and the realistic expected cost of providing the range and volume of services currently specified. The gap can be described or measured in different ways:

- *Benchmarking assessment*: the level of investment per capita compared with other areas, and between the 3 CCGs
- *Contractual assessment*: the level of under/overperformance based on traditional activity unit prices
- *Cash assessment:* the level of investment by the 3 CCGs compared with the costs of the Trust services

We have considered each of these three types of assessment in turn, using appropriate data to measure each type of 'gap'.

Where we have compared investment or activity per capita, we have weighted the population data as follows:

Investment per capita: adult populations are weighted for need, using the standard DH method; all populations are adjusted for the market forces factor.

Activity per capita: adult populations are weighted for need, again using the standard DH method

Populations are derived from the 2011 Census.

2.1. Benchmarking assessment

How does the level of investment per capita compare with other areas?

To compile a comparator group, we have used the 'Nearest Neighbours' model published by the Chartered Institute of Public Finance and Accountancy. For any given local authority, the model will produce a list of other local authorities which are most similar, on a statistical basis, taking into account a number of socio-demographic factors. We have compiled separate lists for the boroughs of Barnet, Enfield and Haringey (Figure 2.1).

Figure 2.1: Borough comparator groups

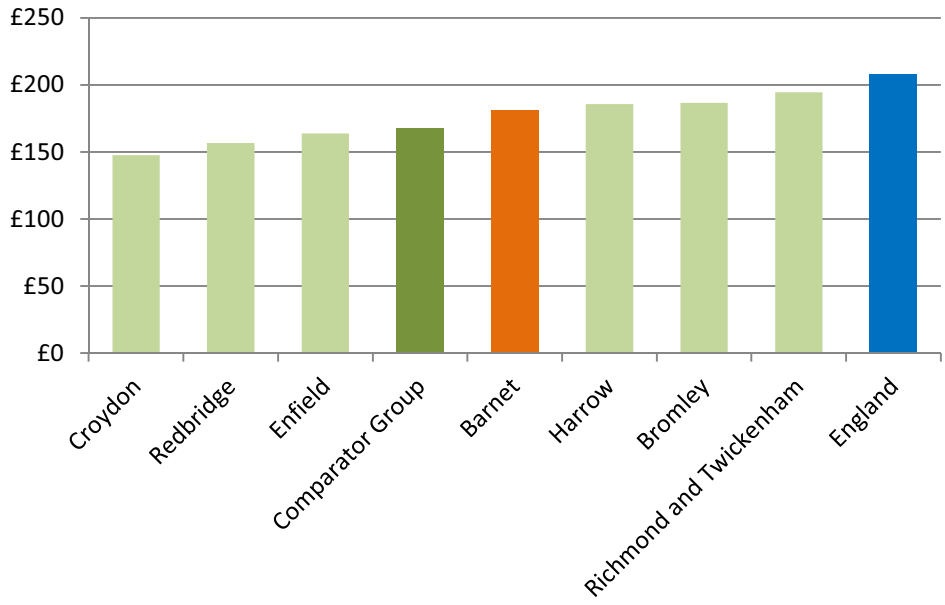
Barnet	Enfield	Haringey
Bromley	Croydon	Brent
Croydon	Ealing	Ealing
Enfield	Harrow	Hounslow
Harrow	Hounslow	Lambeth
Redbridge	Redbridge	Lewisham
Richmond and Twickenham	Waltham Forest	Waltham Forest

As much of the analysis is at a trust level, we have also compiled a list of 9 trust comparators. Where possible, we have used the trusts which serve the areas in the boroughs list above. The trust comparator group is:

- Berkshire Healthcare NHS Foundation Trust
- Central and North West London NHS Foundation Trust
- East London NHS Foundation Trust
- North East London NHS Foundation Trust
- Oxleas NHS Foundation Trust
- South Essex Partnership University NHS Foundation Trust
- South London and Maudsley NHS Foundation Trust
- South West London and St George's Mental Health NHS Trust
- West London Mental Health NHS Trust

Programme budgeting 2011/12[1] shows that the 3 CCGs' overall investment in mental health services (primary and secondary care for all ages) is lower than the England average (Figures 2.2, 2.3 and 2.4). Barnet spends slightly more than its comparator group average, while Enfield and Haringey spend slight less. Enfield spends slightly less than Haringey and Barnet (Figure 2.5). It should be noted that all three comparator groups have an average below the England average i.e. after allowing for deprivation, this tends to be an area which invests less than might be expected in mental health services.

Figure 2.2: Barnet CCG - Overall mental health investment per weighted capita adjusted for market forces factor 2011/12



[1] Programme budgeting is an analysis of total commissioning expenditure by healthcare condition (for example, mental health, cancer) in all NHS settings (for example, primary care and secondary care)

Figure 2.3: Enfield CCG - Overall mental health investment per weighted capita adjusted for market forces factor 2011/12

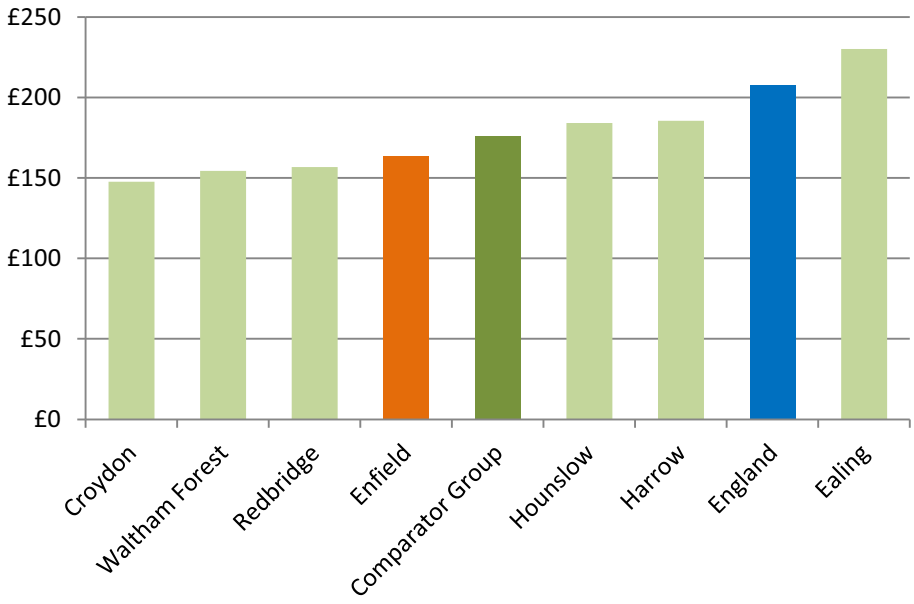


Figure 2.4: Haringey CCG - Overall mental health investment per weighted capita adjusted for market forces factor 2011/12

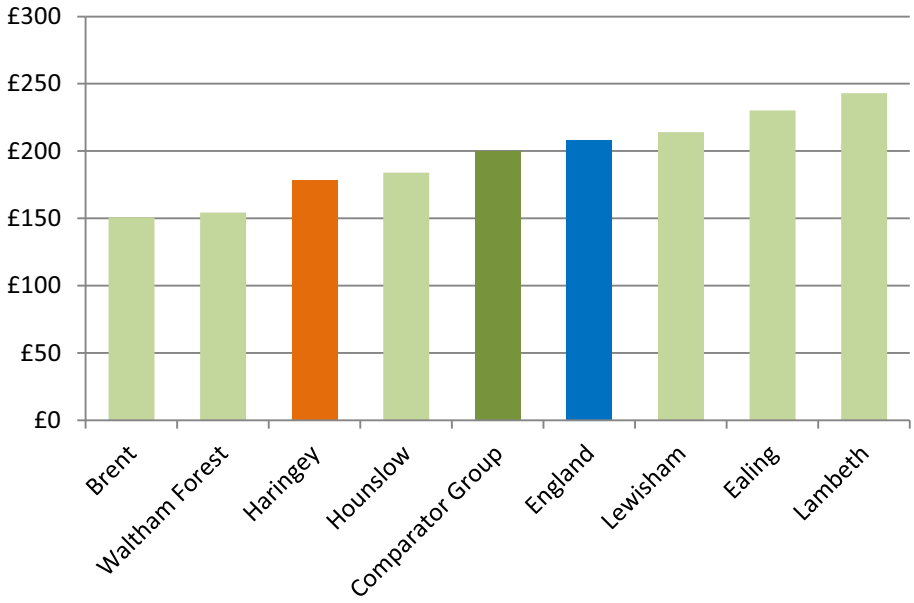
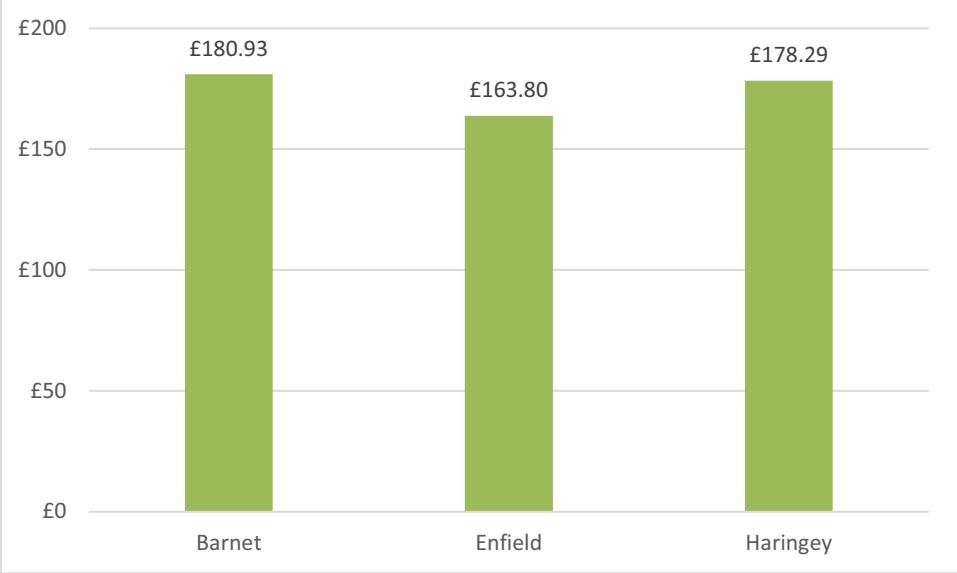
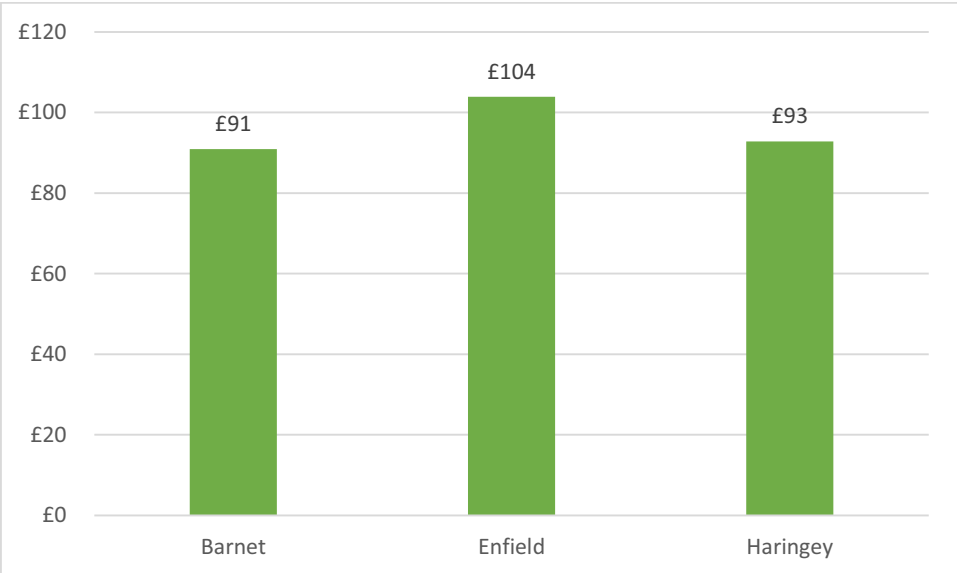


Figure 2.5: Overall mental health investment per weighted capita adjusted for market forces factor 2011/12



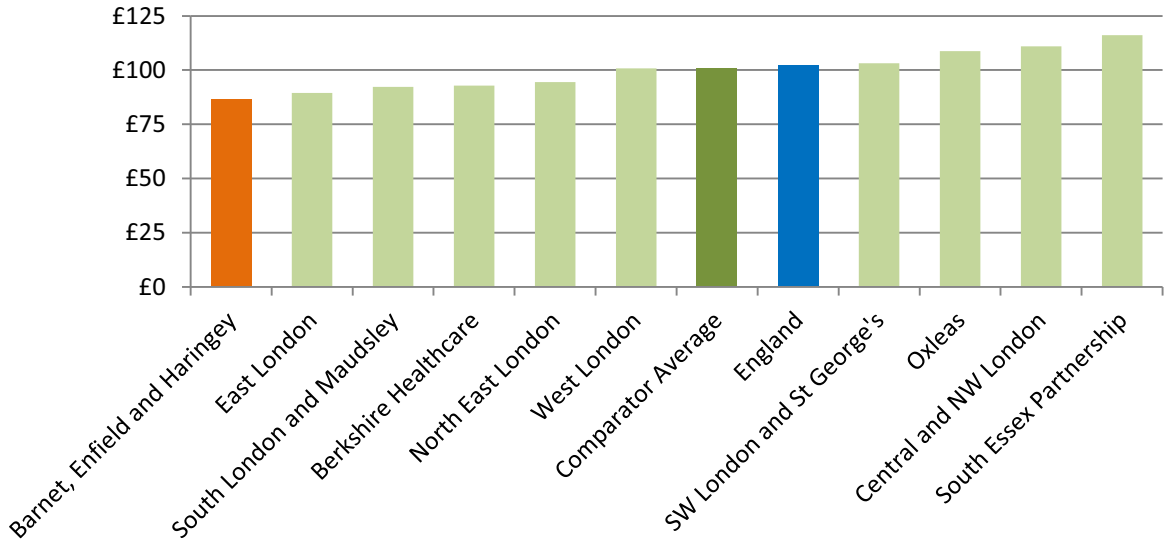
Data provided by the 3 CCGs listing their total investment in mental health services provides a slightly different picture. Programme budgeting includes an estimate of all health costs incurred in treating mental health, including primary care, while this locally provided data only includes secondary care, IAPT and third sector providers. Enfield's investment per capita is slightly more than Barnet and Haringey (Figure 2.6) and all the figures are lower than for programme budgeting data.

Figure 2.6: Mental health investment per weighted capita adjusted for market forces factor 2013/14 forecast



Care cluster reference costs show that the Trust has lower costs per capita for adult and older adult mental health services than the England average and its comparator trusts (Figure 2.7). The costs represent the total costs included within the 2012/13 care cluster reference cost return i.e. costs for admitted care, non-admitted care and initial assessments.

Figure 2.7: Care cluster costs – per weighted capita adjusted for market forces factor 2012/13



We have compared the Trust cluster unit costs with the national average. The results should be reviewed with some caution as care cluster reference costs are a relatively new method of costing, and there are concerns at a national and local level about their data quality. Given that this dataset is however beginning to be cited both nationally and locally, we have included it here for completeness.

23% of Trust days were associated with service users who have not been allocated to a cluster. The average for England was 13%. The costs for unclustered users are recorded under Cluster 99 (Figure 2.8). If the Trust 2012/13 activity levels were costed at the national average, the Trust would have incurred additional costs of £26m. The only Trust unit cost which was higher than the national average was cluster 21 (Cognitive impairment or dementia (high physical or engagement). The comparatively high use of continuing care beds, discussed below, may have contributed to this variance.

Figure 2.8: Trust cluster costs compared to the national average adjusted for market forces factor, using actual activity 2012/13

Cluster	BEH Actual	If at mean	Difference
	£'000	£'000	£'000
Cluster 00: Variance (unable to assign mental health care cluster code)	9	33	-23
Cluster 01: Common mental health problems (low severity)	590	703	-113
Cluster 02: Common mental health problems (low severity with greater need)	887	1,188	-301
Cluster 03: Non-psychotic (moderate severity)	2,670	3,677	-1,007
Cluster 04: Non-psychotic (severe)	1,862	2,012	-150
Cluster 05: Non-psychotic (very severe)	2,776	5,252	-2,477
Cluster 06: Non-psychotic disorders of over-valued ideas	777	1,595	-818
Cluster 07: Enduring non-psychotic disorders (high disability)	3,237	4,121	-884
Cluster 08: Non-psychotic chaotic and challenging disorders	2,418	3,023	-605
Cluster 10: First episode psychosis	3,516	3,812	-295
Cluster 11: Ongoing recurrent psychosis (low symptoms)	8,211	8,704	-492
Cluster 12: Ongoing or recurrent psychosis (high disability)	6,619	8,088	-1,469
Cluster 13: Ongoing or recurrent psychosis (high symptom and disability)	9,761	12,112	-2,351
Cluster 14: Psychotic crisis	3,627	5,916	-2,289
Cluster 15: Severe psychotic depression	736	1,676	-940
Cluster 16: Dual diagnosis	598	1,185	-586
Cluster 17: Psychosis and affective disorder (difficult to engage)	1,940	3,234	-1,294
Cluster 18: Cognitive impairment (low need)	870	1,273	-404
Cluster 19: Cognitive impairment or dementia (moderate need)	3,152	4,678	-1,526
Cluster 20: Cognitive impairment or dementia (high need)	2,500	3,664	-1,164
Cluster 21: Cognitive impairment or dementia (high physical or engagement)	1,705	1,376	329
Cluster 99: Patients not assessed or clustered	6,155	13,784	-7,629
ALL CLUSTERS	64,617	91,106	-26,489

The NHS Benchmarking Network report[2] shows that for the Trust at March 2013:

- Adult acute beds per weighted capita were at the median (Figure 2.9). The report does not include information on out of area placements or 'interim' (temporary) beds
- PICU beds per weighted capita were between the median and lower quartile (Figure 2.10)
- Older adult acute beds per unweighted capita were the second lowest in the database
- Longer term complex and continuing care beds for older adults per unweighted capita were the highest in the database, with only 9 providers showing such beds (Figure 2.11). The Trust had 71 beds per 100,000 population, while the median was 14 beds.

Local service models for community services vary between trusts. For the purposes of benchmarking the Network report includes the following services within the definition of community mental health services:

- Generic CMHTs
- CRHTs
- Assertive outreach
- Early intervention

[2] *NHS Benchmarking Network Mental Health Benchmarking 2013. Includes data from 56 NHS Mental Health Providers, including 4 Welsh Boards. The Trust code is T28. We have not been able to identify other trusts as trusts provide data on the understanding that it remains confidential.*

- Early onset psychosis
- Assessment and brief intervention (including primary mental health teams)
- Rehabilitation and recovery
- Older people
- Memory services
- Other adult community mental health teams

The report shows that for the Trust community mental health services at March 2013:

- Caseload numbers per unweighted 100,000 population were between the median and upper quartile (the report does not provide the community indicators using a weighted population)
- Contacts per unweighted 100,000 population were between the median and upper quartile

Figure 2.9: Adult acute beds per 100,000 weighted population

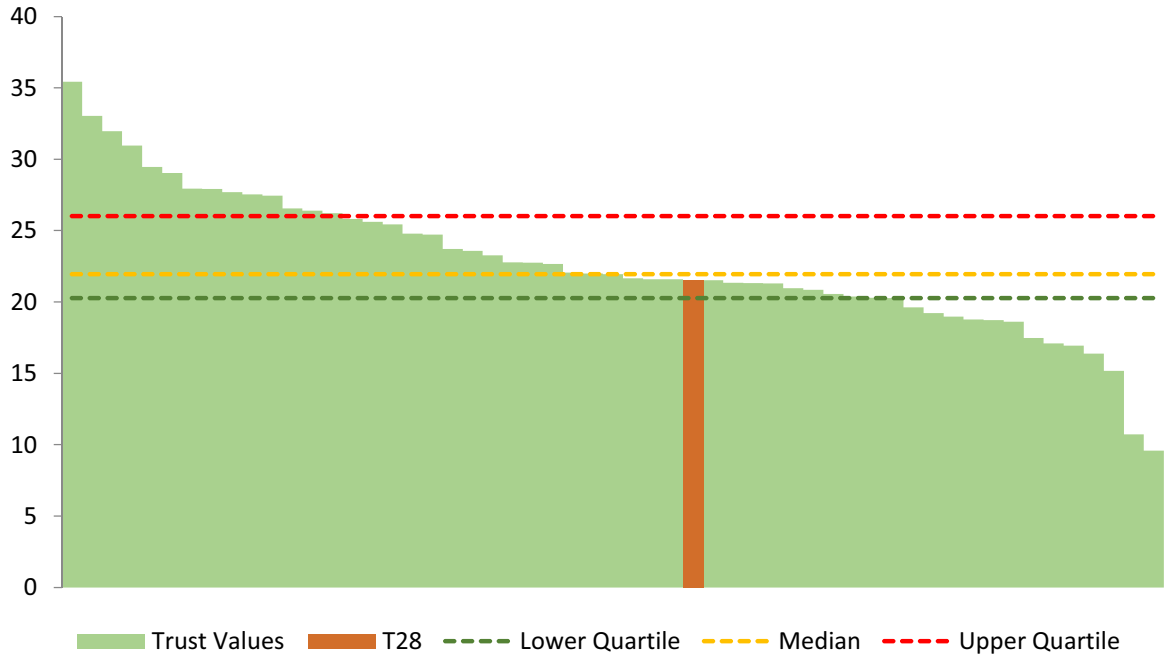


Figure 2.10: PICU beds per 100,000 weighted population

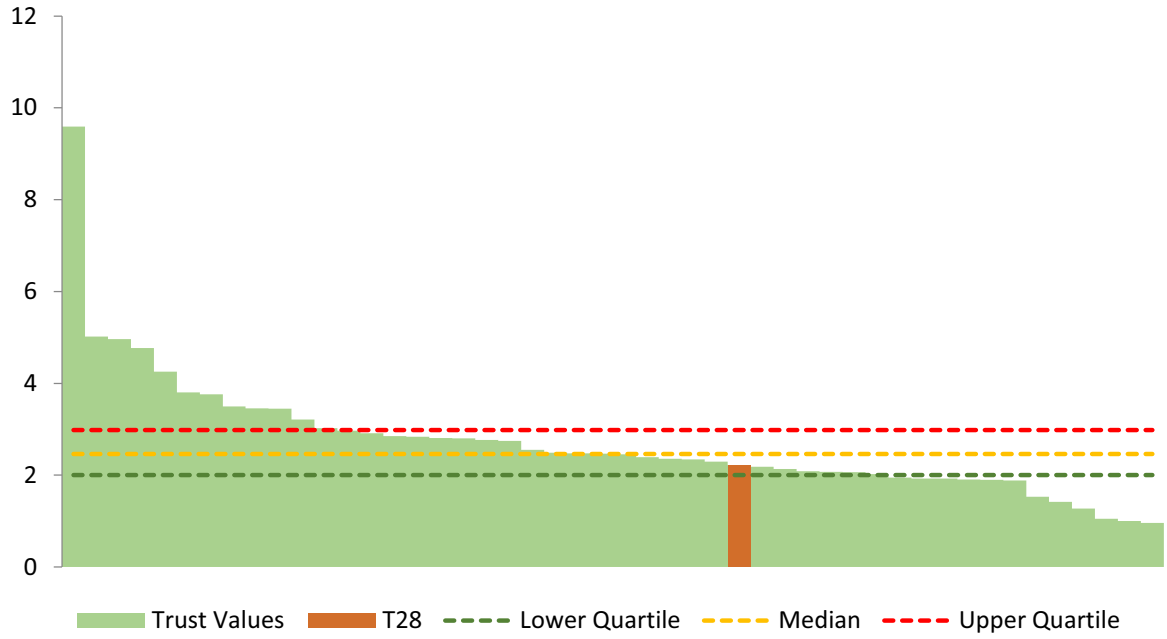
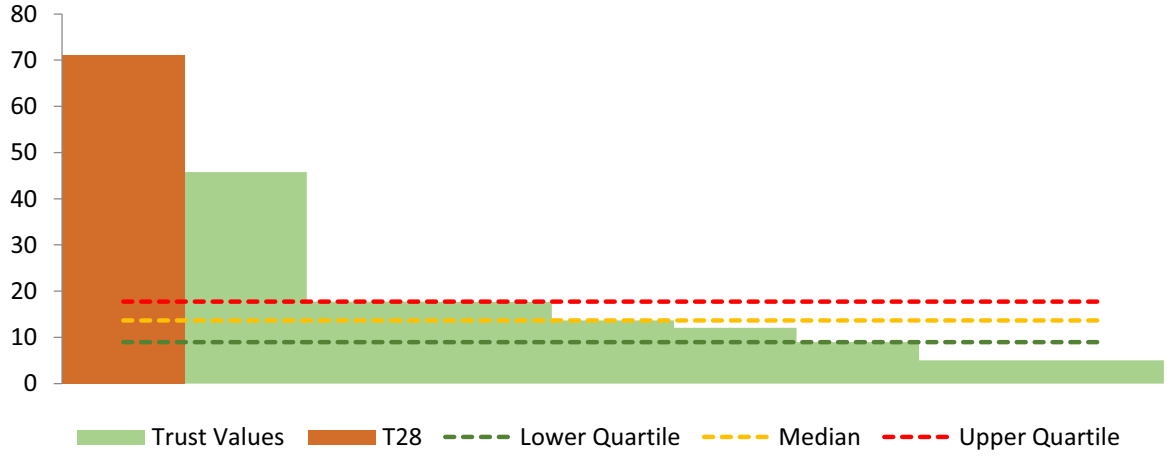


Figure 2.11: Longer term complex/continuing care beds for older adults per 100,000 unweighted population



How does the level of investment in BEH-MHT compare between the three CCGs?

Figure 2.12 shows the value of the CCG mental health contracts with BEH-MHT. The contracts cover adults, older adults, CAMHs and other mental health services. The majority of 'other' is IAPT, which only Barnet and Enfield purchase from the Trust.

Figure 2.12 Mental health contract values with the Trust 2013/14

	Barnet	*% of total contract*	Enfield	*% of total contract*	Haringey	*% of total contract*
	£		£		£	
Adults	17,298,548	*64%*	17,513,309	*57%*	22,723,444	*73%*
Older adults	4,937,282	*18%*	8,710,749	*28%*	5,442,985	*18%*
CAMHs	3,297,454	*12%*	3,219,642	*11%*	2,756,227	*9%*
Other	1,495,325	*6%*	1,132,836	*4%*	130,442	*0%*
Total contract	**27,028,609**		**30,576,536**		**31,053,098**	

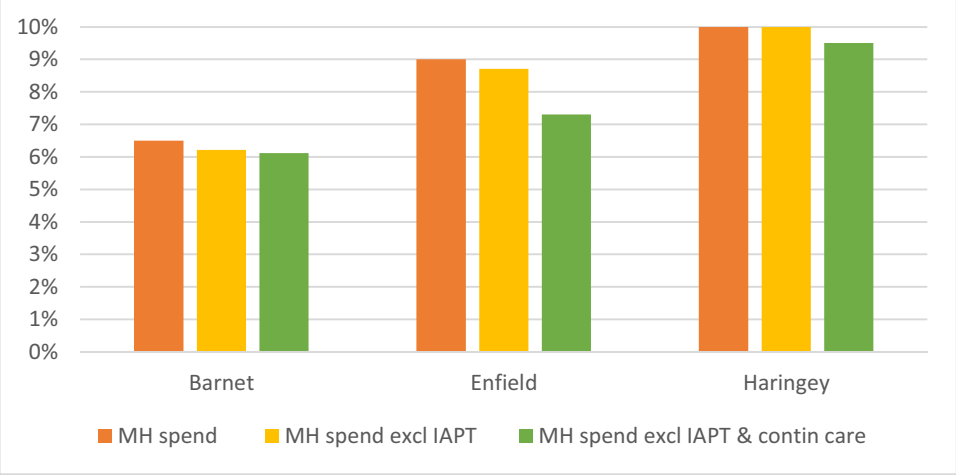
We have compared the level of investment in the Trust by CCG in 3 ways:

- Level of mental health investment in the Trust as a proportion of total CCG NHS spend
- Level of mental health investment per head of population
- Level of activity provided for local residents compared with the contract value

Comparison of mental health investment in the Trust as a proportion of total CCG NHS spend

Barnet invests a lower proportion of its total spend on the Trust than Enfield and Haringey (Figure 2.13). Haringey invests the highest proportion of its total spend on the Trust. The difference between the 3 CCGs is slightly less if spend on IAPT and continuing care are excluded.

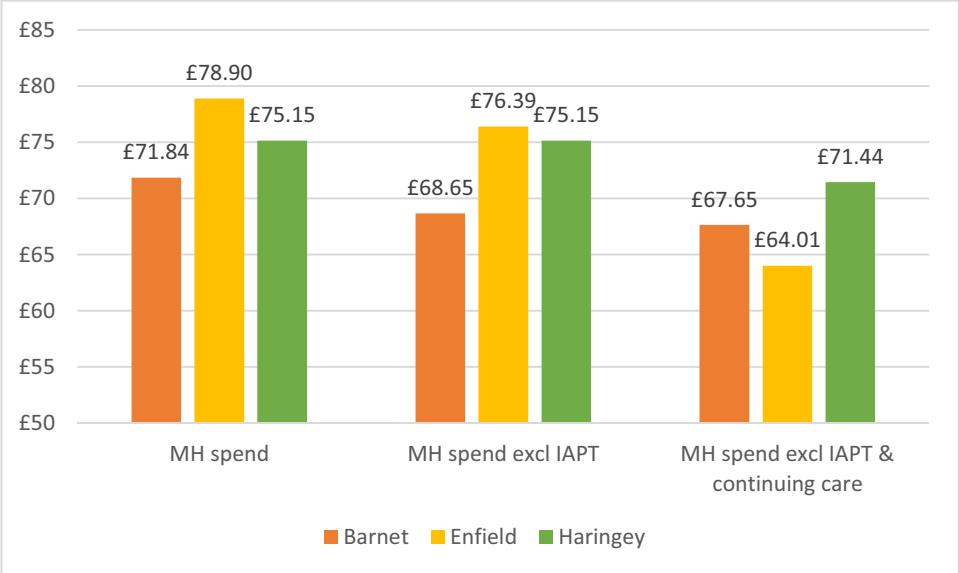
Figure 2.13: Investment in BEH-MHT as % of total CCG spend 2013/14



Comparison of mental health investment in the Trust per head of population

We have compared the CCG contract values per head of population. Overall Barnet invests less per capita in the Trust than Enfield or Haringey (Figure 2.14). However, this comparison is somewhat misleading, as there are some significant differences in the level of investment per capita between the 3 CCGs with regards to IAPT and older adult continuing care beds. Figure 2.14 therefore also compares spend per head with the Trust excluding IAPT and continuing care. Although Enfield's overall spend per head is higher than the other 2 CCGs, their spend per head is lower than the other 2 CCGs if one excludes spend on IAPT and continuing care.

Figure 2.14: Total mental health contract value with BEH-MHT per weighted capita adjusted for market forces factor 2013/14



We have also compared contract values per capita separately for adult and older adult services:

- ***Adult mental health services –*** Barnet spends 10 % more per head than Enfield, and 7% more than Haringey (Figure 2.15). This is due to their £1.9 million investment in continuing care (Enfield invests £7k and Haringey zero). Investment in acute inpatients and community services is very similar between all 3 CCGs (Figure 2.16).

- ***Older adult services*** - Barnet's contract value is half that of Enfield and Haringey (Figure 2.17). Enfield invests significantly more in continuing care, while Haringey investment in older adult acute services is three times higher than for the other two CCGs (Figure 2.18). We have been told by the Trust that there may be some mis-coding with regards to Haringey as the CCG does not invest in continuing care. The matter is being investigated, and the actual resource distribution may therefore be somewhat different for Haringey.

Figure 2.15: Adult spend with BEH Trust per weighted capita adjusted for market forces factor (2013/14 contract values)

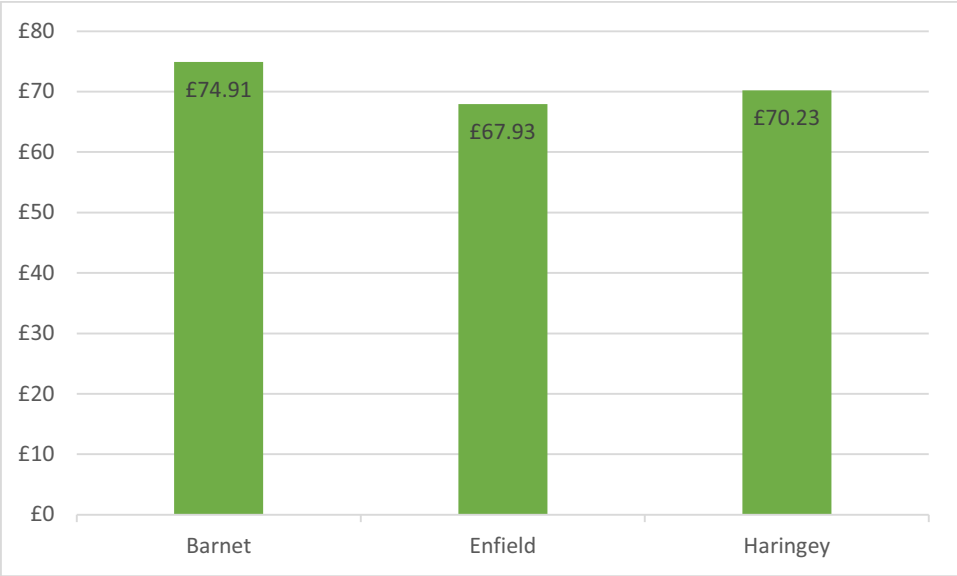


Figure 2.16: Adult spend with BEH Trust per weighted capita adjusted for market forces factor (2013/14 contract values) by service line

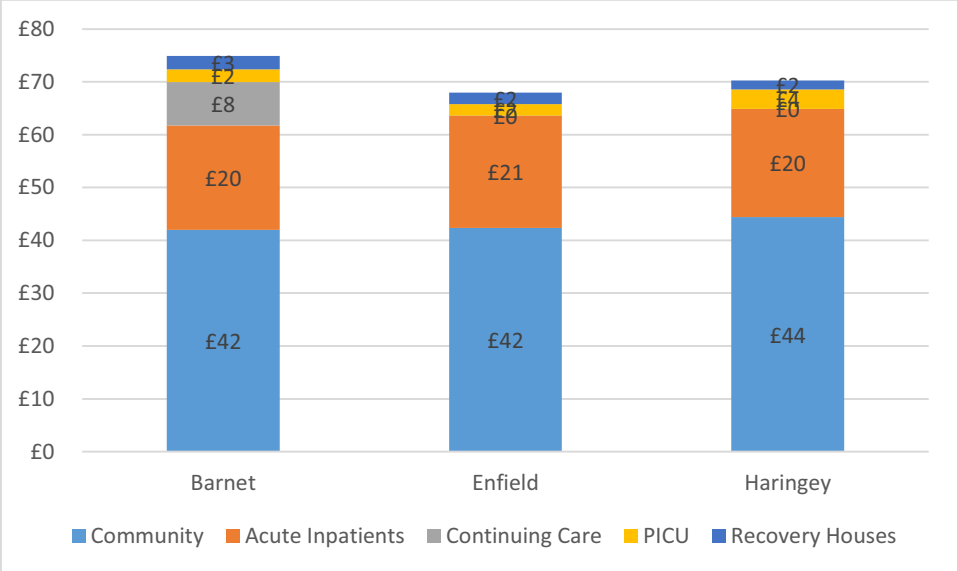


Figure 2.17: Older adult spend per unweighted capita adjusted for market forces factor (2013/14 contract values)

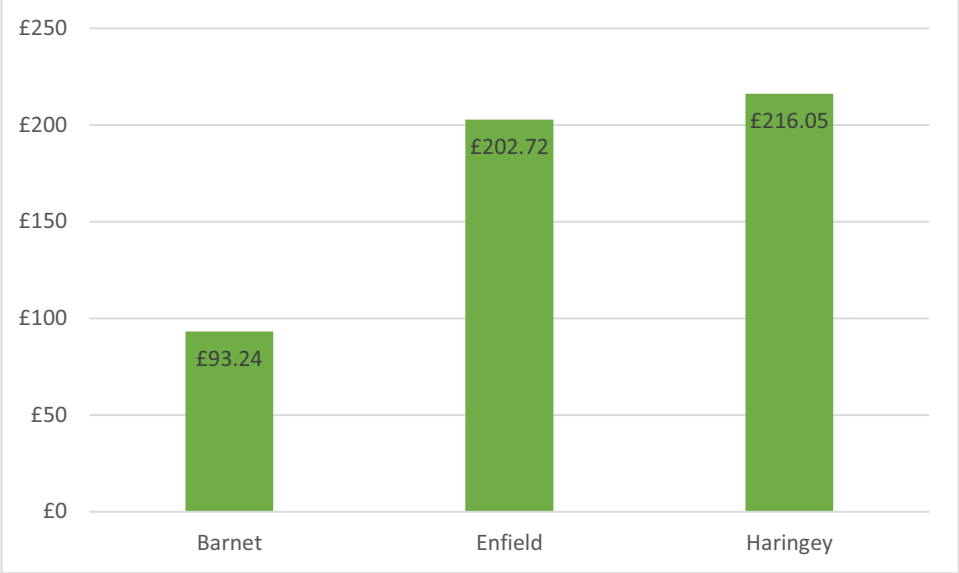
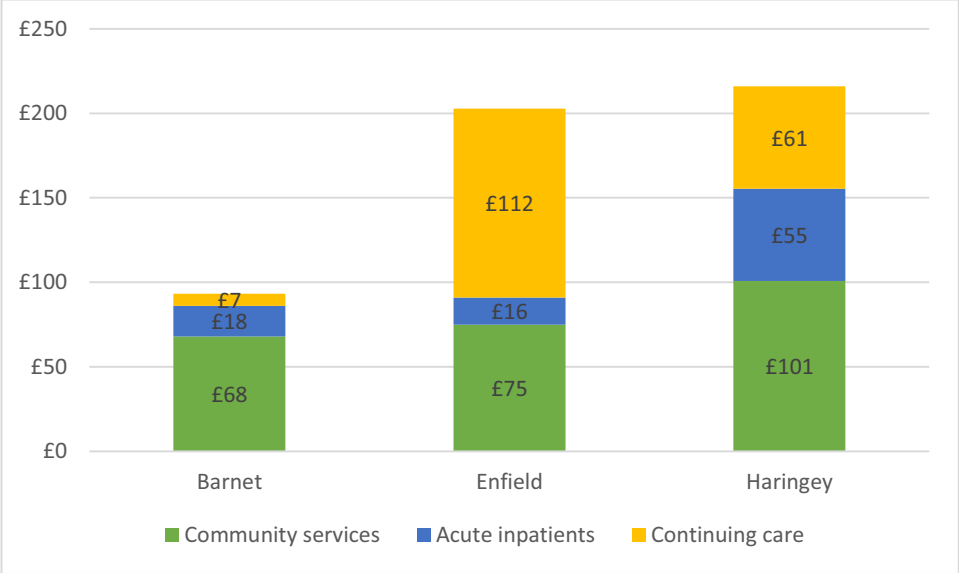


Figure 2.18: Older adult spend per unweighted capita adjusted for market forces factor (2013/14 contract values) by service line



Level of activity provided for local residents compared with the contract value

We have compared the level of activity provided by the Trust with the size of the CCG contracts. Service line unit prices vary between the 3 CCGs, depending on the size of their contract and the level of activity in the plan, for example the unit cost for adult acute inpatients ranges from £323 to £356 (Figure 2.19).

Figure 2.19: Adult acute inpatient unit price per bed day 2013/14

	Cost £	Activity OBDs	Unit Price £
Barnet	4,556,441	14,108	323
Enfield	5,481,018	15,104	363
Haringey	6,612,990	18,582	356

To get a sense of the level activity provided for the level of investment, we have used trust wide unit prices to compare 2013/14 planned and forecast level of activity with the CCG contract values.

Figure 2.20 shows that Barnet receives considerably higher levels of activity for its level of investment than Enfield and Haringey, when one compares planned activity levels with the value of the contract. A comparison of forecast activity levels with contract values shows a similar picture, although the differences between contract value and value of level of activity received are greater (Figure 2.22). There is also a small (£264,000) apparent cross-subsidy of other CCGs beyond the local three CCGs.

Figure 2.20: Comparison of planned activity levels with value of contract by CCG 2013/14

	Barnet £'000	Enfield £'000	Haringey £'000	Other CCGs £'000	Total £'000
Contract value	27,029	30,577	31,053	1,721	90,380
Trust unit price x planned activity (sum of individual service lines)	29,406	29,824	29,164	1,986	90,380
Difference	-2,377	752	1,889	-264	0

Figure 2.21: Analysis of differences in Figure 2.20 by service line

		Barnet £	Enfield £	Haringey £
Adults	Community Rehabilitation	-56,803	-11,154	72,231
	Complex Needs	-293,039	-84,066	395,168
	Day Therapy	1,594	-1,208	-752
	Dual Diagnosis	-240	-16,126	28,948
	Early Intervention Services	-330,529	166,007	171,571
	Emergency Assessment Centre	143,824	-200,391	66,776
	Home Treatment Teams	-121,981	-305,785	450,088
	Occupational Therapy	-87	32	55
	PCMHT	-556,929	283,649	300,725
	Personality Disorder	145,381	95,658	-200,514
	Psychology	2,098	-9,898	10,252
	Support and Recovery Teams	-217,299	425,476	-144,896
	Wellbeing Teams	-194,736	111,095	76,494
	Adult community sub total	*-1,478,744*	*453,290*	*1,226,145*
	Acute Inpatients	-345,673	232,823	156,293
	Continuing Care	-869	869	0
	PICU	-44,773	21,368	23,405
	Recovery Houses	-61,317	-93,778	155,095
	Adult inpatient sub total	*-452,632*	*161,282*	*334,793*
	Adults total	**-1,931,376**	**614,573**	**1,560,938**
CAMHS	CAMHS Community Services	-239,608	145,934	73,146
Older People	Community Mental Health Teams	185,207	-11,882	-122,879
	Day Services	-50,060	25,830	2,836
	Memory Treatment Clinic	-184,362	-60,586	246,704
	Occupational Therapy	-94	124	-1,226
	OP Home Treatment Teams	-43,806	-28,557	78,102
	Physiotherapy	-65	0	183
	Psychology	-1,134	-20,959	26,205
	Older people community sub total	*-94,314*	*-96,029*	*229,925*
	Acute Inpatients	-69,198	31,899	37,299
	Continuing Care	-41,772	54,335	-12,451
	Older people inpatients sub total	*-110,970*	*86,235*	*24,847*
	Older people total	***-205,284***	***-9,795***	***254,772***
Other	Adults ADHD	-1,007	1,463	578
	Eating Disorders referrals	-17	-14	-14
	Eating Disorders attendances	244	144	160
	Other total	**-780**	**1,593**	**724**
	GRAND TOTAL	**-2,377,049**	**752,305**	**1,889,580**

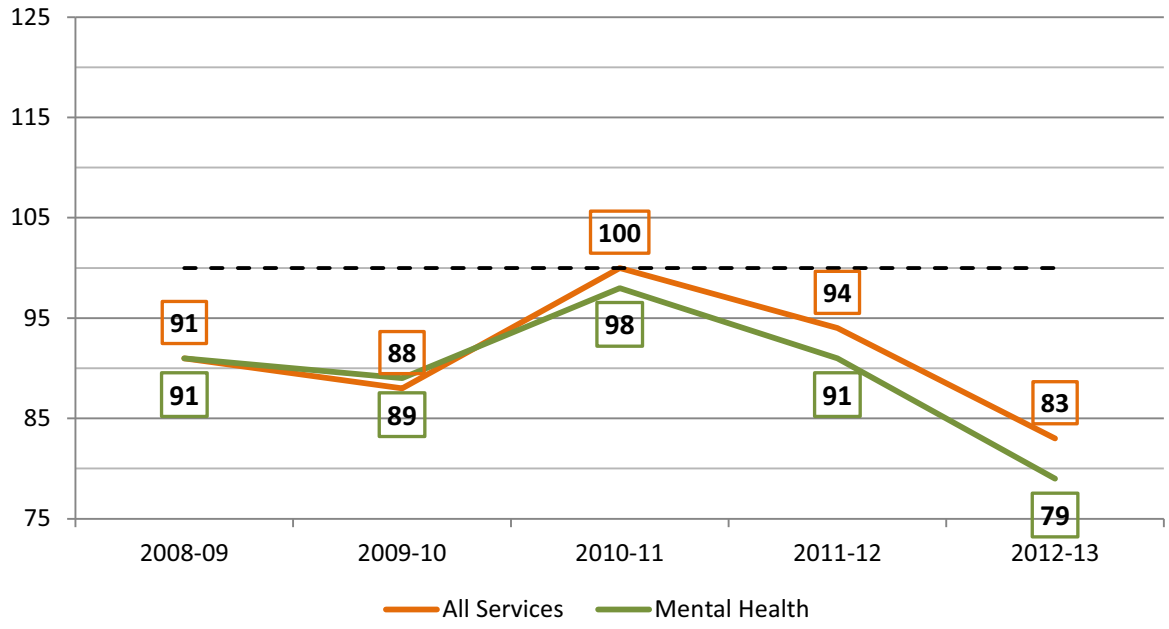
Figure 2.22: Comparison of forecast activity levels with value of contract by CCG 2013/14

	Barnet £'000	Enfield £'000	Haringey £'000
Contract value	27,029	30,577	31,053
Trust unit price x forecast activity (sum of individual service lines)	31,911	32,021	29,050
Forecast external placements	601	555	463
Difference	-5,483	-1,999	1,540

What is the trend in the Trust reference cost index (RCI)?

The Trust RCI has fluctuated over the years (Figure 2.23). From 2011/12 the RCI included mental health care cluster costs rather than the traditional activity costs. Whilst the exact figures should be taken with caution, there is a clear and a continuing trend of the Trust's costs being low for the basket of care it provides.

Figure 2.23: BEH-MHT Reference Cost Index 2008/09 to 2012/13



Benchmarking assessment conclusion

Programme budgeting shows that Enfield and Haringey may invest less overall in mental health services per capita than other CCGs in their comparator group, while Barnet may invest more. However, it is hard to draw any strong conclusions without having a better understanding of the range of mental health providers in each area, and being more confident in the data quality of the national data sets.

There are substantial differences between service arrangements across the three CCGs. Barnet invests a lower proportion of its total budget in BEH-MHT than the other two CCGs, and Haringey invests the highest proportion. Barnet invests less per capita in the Trust overall, but this figure hides significant differences in investment by service line. Enfield has the lowest investment per capita if one excludes IAPT and older adult continuing care.

Barnet's spend per capita on adult mental health services is considerably higher than the other 2 CCGs due to its investment in adult continuing care. However its spend on older adult mental health services is half that of Enfield and Haringey. Enfield invests substantially more in continuing care, while Haringey's investment in older adult beds is three times higher than for the other two CCGs.

CCG service line unit prices vary between the three CCGs, depending on the relationship between the level of planned activity and the value of the contract. Using Trust wide unit prices, Barnet receives substantially higher levels of activity for its level of investment than Haringey. Enfield also receives more activity for its level of investment.

2.2. Contractual assessment

What are the financial implications of current levels of under/overperformance based on traditional activity unit prices?

Month 8 2013/14 activity and finance reports forecast an overspend of £4.9m for 2013/14. This figure reflects activity differences rather than actual over and underspends.

After taking account of external placement costs, all 3 CCGs are forecast to overspend (Figure 2.24). The reason that Haringey shows an overspend in Figure 2.24, but an under spend in Figure 2.22 is because Figure 2.24 uses different unit prices for each CCG, while in Figure 2.22 trust wide unit prices are used.

Figure 2.24: Forecast financial variance 2013/14 – difference between planned activity and forecast activity

	Barnet £'000	Enfield £'000	Haringey £'000	Total £'000
Forecast over/under spend per activity & finance report M8	2,988	2,318	-372	4,934
Forecast external placements	601	555	463	1,620
Total forecast over spend	***3,589***	***2,874***	***91***	***6,554***
Total forecast over spend as % of contract value	13%	9%	0%	7%

Data source: Activity and finance report M8 2013/14. Overspend is shown in black and underspend in red

Figure 2.25 analyses the financial variances by service. The most significant variances are:

- *Adult acute inpatients and external placement*s form the most substantial area of overspend (£5.8m)
- The major area of overspend in o*lder adults community services* are the memory treatment clinics.
- In *CAMHS community services* Barnet is forecasting a significant overspend, while Haringey shows a significant underspend.

Figure 2.25: Forecast financial variance 2013/14 by service

		Barnet £'000	Enfield £'000	Haringey £'000	Total £'000
Adults	Community services	*494*	*911*	*-1,493*	*-89*
	Acute Inpatients	1,448	705	2,017	4,171
	Continuing Care	-16	-8		-24
	PICU	263	317	-417	163
	Recovery Houses	-33	-11	-7	-51
	Total adults	*2,156*	*1,914*	*100*	*4,170*
CAMHS	*CAMHS Community Services*	*460*	*86*	*-412*	*134*
Older People	Community services	*458*	*-250*	*480*	*688*
	Acute Inpatients	-16	389	-275	98
	Continuing Care	-31	216	-262	-77
	Total older adults	*410*	*356*	*-58*	*709*
Other	*Total other*	*-37*	*-38*	*-3*	*-78*
Total per activity and finance report		***2,988***	***2,318***	***-372***	***4,934***
	External placements	601	555	463	1,620
Grand total		**3,589**	**2,874**	**91**	**6,554**

Data source: Activity and finance report M8 2013/14. Overspend is shown in black and underspend in red

There has been some discussion concerning whether local services subsidise specialist mental health services. Trust data indicates that the opposite is true (Figure 2.26). Enfield Community Services are forecasting a small deficit (£282k).

Figure 2.26: Specialist services contract performance (forecast 2013/14 outturn)

	Eating Disorders £	CAMHS Tier 4 £	Forensic £
Surplus	446,251	550,939	1,382,351

We had hoped also to measure the 'contractual gap' by using PbR care cluster data. This is not possible as the PbR reports do not include those service users in external placements, recovery houses or bed and breakfast placements. The absence of these service users has a material impact on the reports: while the activity and finance report forecasts an overspend, the PbR report forecasts an underspend. We therefore do not think that the PbR data can be used reliably for these purposes.

Contractual assessment conclusion

Trust activity and finance reports, using traditional activity unit prices, forecast an overspend of £4.9m for the three CCGs. After taking account of forecast external placements the overspend increases to £6.5m, with an overspend of £3.6m for Barnet, £2.9m for Enfield and £91k for Haringey. Adult acute inpatients form the most substantial area of overperformance for all three CCGs.

2.3 Cash assessment

How does the level of investment by the 3 CCGs with BEH-MHT compare with the costs of Trust services?

During 2013/14 the Trust has experienced severe pressure on its adult acute inpatient beds due to an increase in the number of patients needing to be admitted. In December they estimated that the additional costs incurred equated to an additional £5.3m for 2013/14. The additional costs are for:

- Keeping open 2 Trust wards which were due to be closed
- Using private placements
- Using bed and breakfast accommodation to provide additional capacity for patients whose inpatient care has concluded, but who have no suitable accommodation to be discharged to.

Updated forecast figures for 2013/14 show that the additional costs may be slightly higher (Figure 2.27).

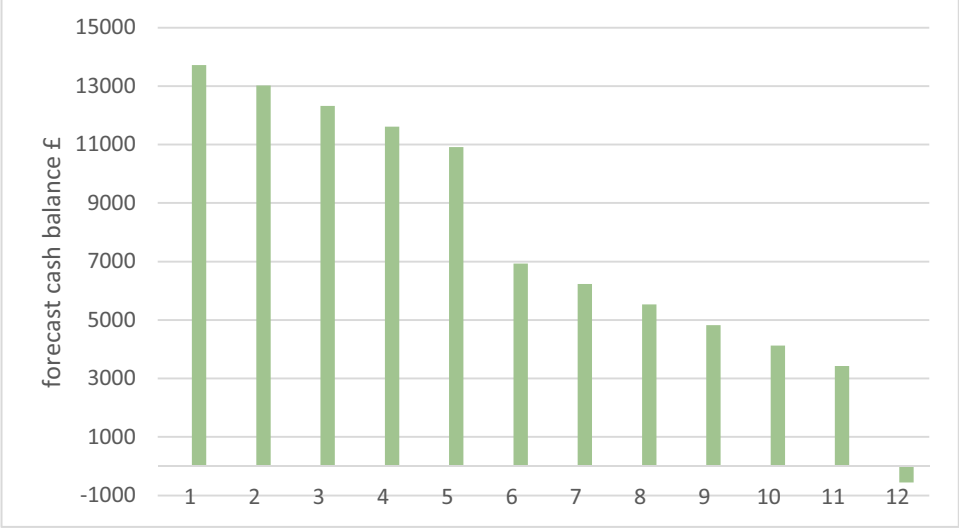
Figure 2.27: Financial impact of over performance in adult acute inpatients

	2013/14 Plan Bed days	2013/14 Forecast Bed days	variance Bed days	Trust unit price £	Additional costs £
ADULT ACUTE					
Barnet	14,108	18,593	4,485	347.47	1,558,403
Enfield	15,104	17,048	1,944	347.47	675,482
Haringey	18,582	24,251	5,669	347.47	1,969,807
Total adult acute	***47,794***	***59,892***	**12,098**	**347.47**	**4,203,692**
EXTERNAL PLACEMENTS					
Barnet	0	1,052	1,052	571.28	600,987
Enfield	0	972	972	571.28	555,284
Haringey	0	811	811	571.28	463,308
Total external placements	***0***	***2,835***	**2,835**	**571.28**	**1,619,579**
GRAND TOTAL	**47,794**	**62,727**	**14,933**		**5,823,271**

Latest Trust forecasts for 2014/15[3] indicate that:

- The 2014/15 budget shows a surplus of £1.9m. The baseline pay budget assumes the wards that could not be closed during 2013/14 remain open, as well as the additional ward opened during the year. The budget includes £3.7m to offset the increased activity in adult acute wards which in 2013/14 resulted in higher expenditure on bank and agency staff and private placements.
- However, the Trust is forecast to have a negative cash balance by the end of 2014/15 due to monthly negative cash flow movements (Figure 2.28). This trend continues the erosion of the cash balance which also occurred during 2013/14. The cash balance at the start of 2013/14 was £18m and is forecast as £ 14m at M12 2013/14.
- There are two reasons for this disparity: unfunded emergency activity and a challenging Cost Improvement Programme (CIP).The 2014/15 CIP is £14.9m, which represents 8% of 2013/14 forecast operating expenses. Less than half the savings have been identified. Most of the identified savings are regarded as risky (Figure 2.29). Non delivery of the CIP programme would impact on the Trust's planned surplus.

Figure 2.28: Cash flow forecast 2014/15 by month



[3] *1. Update on Budget Setting and Business Planning Process for 2014/15 – a report to Finance and Investment Committee 21 January 2014. 2. High level cash flow forecast as at 5.2.14*

Figure 2.29: Draft CIP programme 2014/15

Draft CIP Programme 2014/15 **Appendix 2**

Service Line	CIP Scheme	Estimated Start Date	Solid	Agreed but Risky	Yet to be identified	Total	Target	Notes on Risky Schemes
C&E	Closure of Refuge House	01/09/2014			136	136		This scheme was identified some time ago, it may no longer be feasible given the current activity pressures.
C&E Subtotal			**0**	**0**	**136**	**136**	**0**	
DCI	Day Hospital	01/06/2014		110		110		This scheme is risky as it is dependant on CCG commissioning intentions and their CQUIN.
	Memory Clinic efficiencies			45		45		
	Continuing Care beds	01/04/2014		525		525		This scheme is risky as it is dependant on there being sufficient beds empty to sell and also on demand.
DCI Subtotal			**0**	**680**	**0**	**680**	**0**	
SCNP	CAMHS Tier 3 Reorganisation	01/04/2014		544		544		This scheme has slipped from 2013/14 due to the start of the Service Line Review. A re-worked paper is due to be presented to Exec Board in January 2014, and the consultation paper is ready for circulation.
	CAMHS Consultants on Call	01/04/2014		110		110		A consultation paper is being prepared on this, which again slipped from 2013/14.
	Merge PD and CCT	01/04/2014		67		67		
	Additional CAMHS Tier 4 beds	01/04/2014		275		275		
SCNP Subtotal			**0**	**996**	**0**	**996**	**0**	
Psychosis	Psychosis Re-organisation	01/04/2014		700		700		This scheme is being worked up, but is risky due to consultation reducing the level of savings that can be achieved.
Psychosis Subtotal			**0**	**700**	**0**	**700**	**0**	
Forensic	Camlet 2 - addtiional beds	01/04/2014		150		150		
Forensic Subtotal			**0**	**150**	**0**	**150**	**0**	

Draft CIP Programme 2014/15 **Appendix 2**

Service Line	CIP Scheme	Estimated Start Date	Solid	Agreed but Risky	Yet to be identified	Total	Target	Notes on Risky Schemes
Estates	Estates savings	01/04/2014			1,400	1,400		Detail to be worked up however the Director of Estates is confident of this level of savings.
Estates Subtotal			**0**	**0**	**1,400**	**1,400**	**0**	
Corporate	IT staff restructure	01/04/2014		60		60		
	Finance	01/04/2014	80			80		
Corporate Subtotal			**80**	**60**	**0**	**140**	**0**	
ECS								
Trustwide	Allowances Review	01/04/2014		250		250		This scheme has slipped from 2013/14 as it is dependant on the job planning process. This process is underway with job plans being updated by Clinical Drectors.
	Service Line Review	01/07/2014		3,000		3,000		Work on this scheme has already started with a paper to be presented to the Board in January outlining the options for a new Service Line structure.
	Unidentified				7,401	7,401		
Trustwide Subtotal			**0**	**3,250**	**7,401**	**10,651**	**0**	
Total			**80**	**5,836**	**8,937**	**14,853**	**0**	

Cash assessment conclusion

The Trust's forecast cash position is poor, as the Trust's expenditure continues to be higher than its income. The Trust faces a challenging CIP for 2014/15. If it is unable to quickly identify realistic cash releasing savings, the Trust's cash position could be negative by the end of 2014/15.

2.4. Discussion

In this section we have assessed the potential gap between the investment provided by the commissioners to the Trust and the realistic expected cost of providing the range and volume of services currently specified. Our analysis shows how the 'gap' can be described and measured in different ways:

- Benchmarking data as to overall levels of investment are of uncertain quality, and should not be relied on for detailed decision-making purposes. The conclusions we can most confidently draw are that overall levels of investment in local mental health services appear not to be high, allowing for levels of need and relative cost – and that the costs of services provided by the Trust appear not to be expensive.

- Local data reveal many important differences in service arrangements between the three CCGs. Barnet invests a lower proportion of its total budget in the Trust than the other two CCGs.

- CCG investment per capita varies significantly by service line. Barnet invests considerably more in adult mental health services, but significantly less in older adult services. Haringey invests substantially more in older adult beds, while Enfield spends more on continuing care.

- The level of activity the CCGs receive for their level of investment varies significantly. Barnet receives considerably higher levels of activity for its level of investment than Haringey. If the three CCGs used the same trust-wide unit price, and considering the current level of forecast activity including external placements, Barnet's contract value would cost £5.5 million more, Enfield's would cost £2 million more, and Haringey's would cost £1.5 million less.

- The Trust is forecasting an overspend of £4.9m for 2013/14, using traditional activity unit prices. After taking account of external placements the overspend increases to £6.5m. This total is made up of an overspend of £3.6m for Barnet, £2.9m for Enfield and £91k for Haringey. Adult acute inpatients form the most substantial area of overspend for all three CCGs.

- Most pressingly, the Trust faces a worsening cash position month on month with its expenditure exceeding its income. Historically, it appears that the Trust has managed to provide typical to high levels of activity at typical to low prices; this has become unsustainable as a result of unplanned levels of acute inpatient activity, and a very high level of CIP expectation. This expectation requires the Trust to deliver similar activity levels with considerably less cash investment. Without rapidly finding realistic cash releasing savings, the Trust's cash position is likely to be negative by the end of 2014/15. This cash gap is probably the most certain of these various ways of assessing the scale of the current problem.

3. ASSESSMENT OF HIGH LEVEL OPTIONS

This section contains the findings of the work we have done to assess options for addressing the cash gap.

3.1. Additional investment

If, as there appears to be, there is a significant cash gap between the current and expected cost of services, there is clearly a theoretical option that additional investment could be made by the CCGs into the Trust's services. We have, however, raised this as an option with the Chief Officers of each of the CCGs, and been given a very clear indication that, given the wider financial pressures, this is wholly unrealistic. It therefore appears that the cash gap will have to be met by a mix of genuine efficiency savings and service reductions. The rest of this report is written on that presumption.

3.2. Bed management / acute overspill

With the exception of the CIP, the problems of acute overspill appear to be the largest cost pressures currently facing the mental health system locally. We have therefore undertaken an analysis of data which could help to provide context and understanding for the local problem. It should be noted that this local problem exists in the context of a much wider problem facing mental health services across the country; Mental Health Strategies are encountering high levels of acute bed pressure in many other locations.

3.2.1. Adult acute inpatients

2012/13 benchmarking

The latest NHS Benchmarking Network report[4] shows that for BEH-MHT for the year 2012/13:

- Adult acute bed days per 100,000 *unweighted* population were at the median (the report does not provide this indicator using a weighted population)
- Adult acute admissions per 100,000 *weighted* population was between the median and lower quartile (Figure 3.1)
- Median length of stay excluding leave was between the median and upper quartile (Figure 3.2)
- Delayed transfers of care were joint highest at 11% (Figure 3.3)

The needs weighting index for the overall BEH Trust area is 1.22. The median level of bed days could therefore be considered to be a relatively low level of acute inpatient activity, given local needs. We noted, however, in figure 2.9. above that the weighted level of beds is close to the median. It therefore appears that a contributory factor to the local problem is the relatively slow throughput, and in particular the high level of DTOCs. In the context of high DTOCs, and slightly high lengths of stay, it is unsurprising that this has fed through to low rates of admission, difficulties in accessing beds, and, from 2013/14, persistent use of overspill beds.

[4] *NHS Benchmarking Network Mental Health Benchmarking 2013. Includes data from 56 NHS Mental Health Providers, including 4 Welsh Boards*

Figure 3.1: Adult acute admissions per 100,000 weighted population

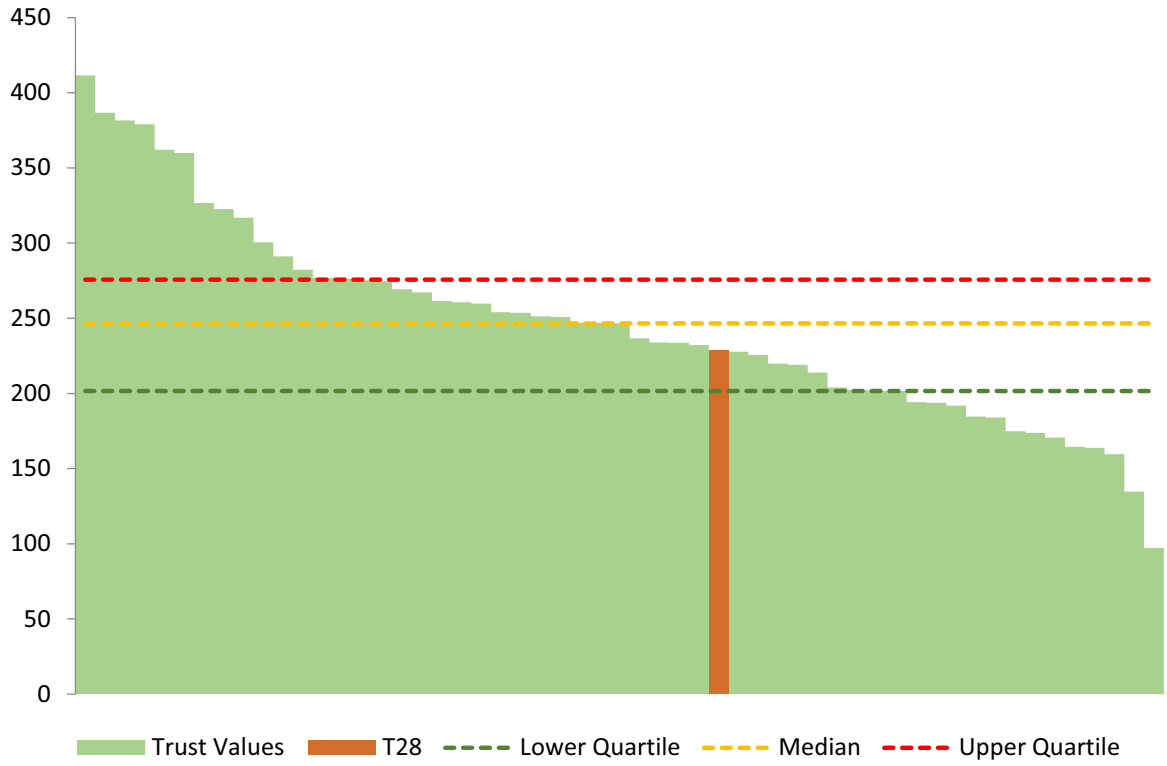


Figure 3.2: Median length of stay excluding leave

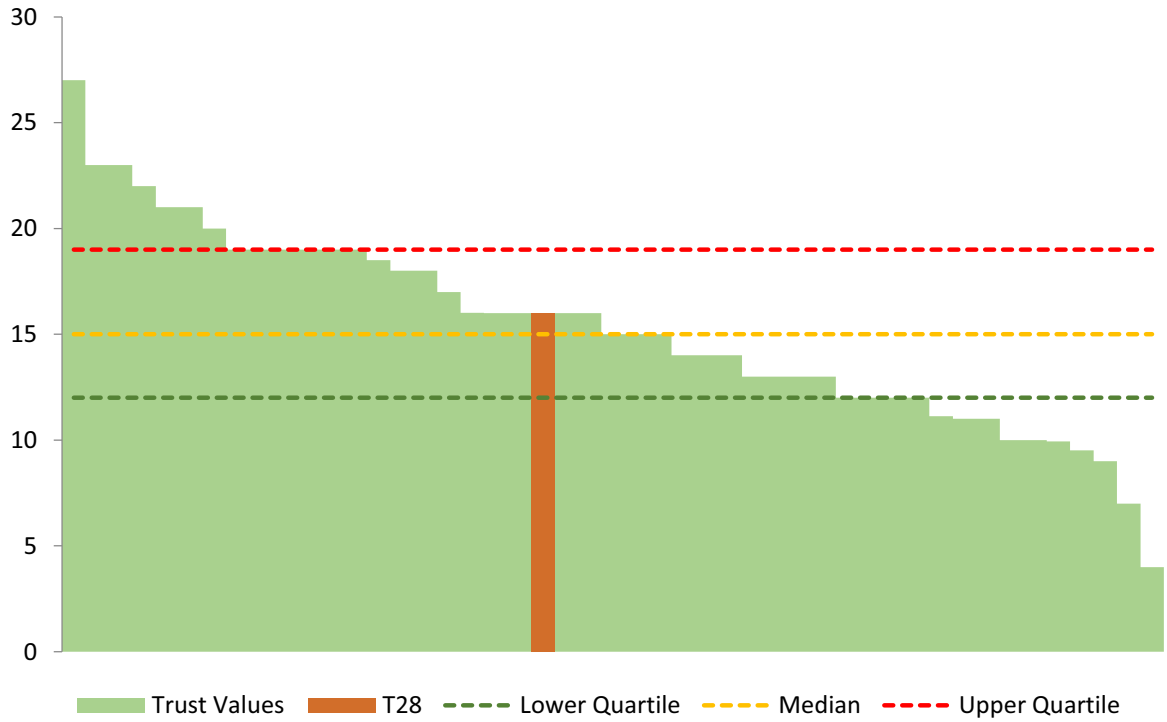
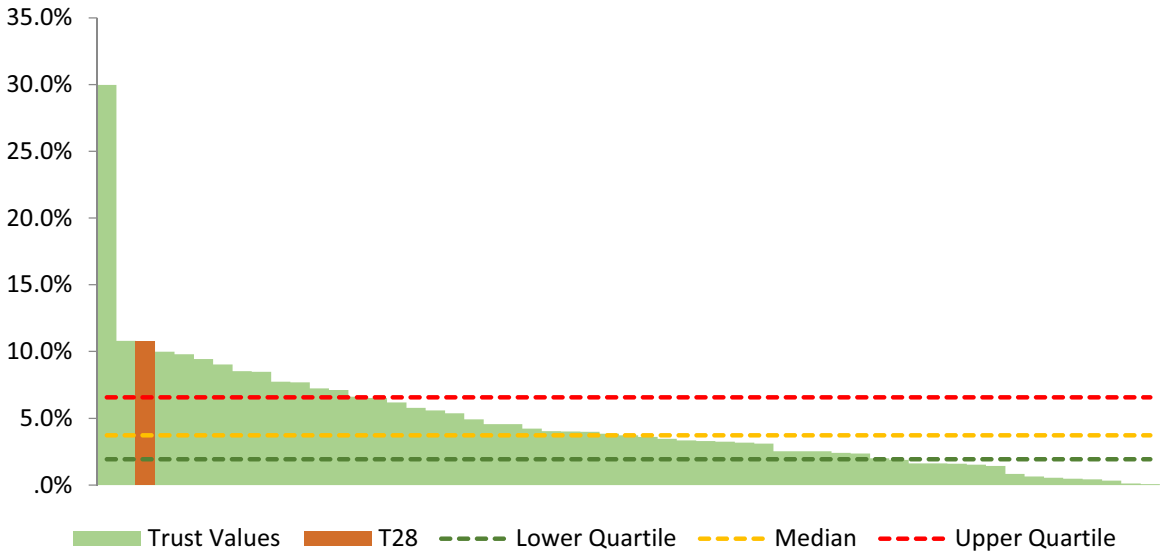


Figure 3.3: Percentage of bed days (excluding leave) lost due to delayed transfers of care



2013/14 forecast for adult acute inpatients including external placements

Trust data shows that:

- Adult acute bed days including external placements are forecast 31% higher than planned (Figure 3.4). There is variation between the CCGs: Barnet's forecast is 39% higher, Haringey 35% and Enfield 19%.
- Planned adult acute bed days per weighted capita are similar between the 3 CCGs. Forecast bed days including placements per weighted capita vary due to the increases described above (Figure 3.5).
- Bed days (including placements) have increased by 12% from 2011/12 to 2012/13 (Figure 3.6). The greatest increase has been in Haringey (19%).

Figure 3.4: Adult acute bed days including external placements – planned and forecast 2013/14

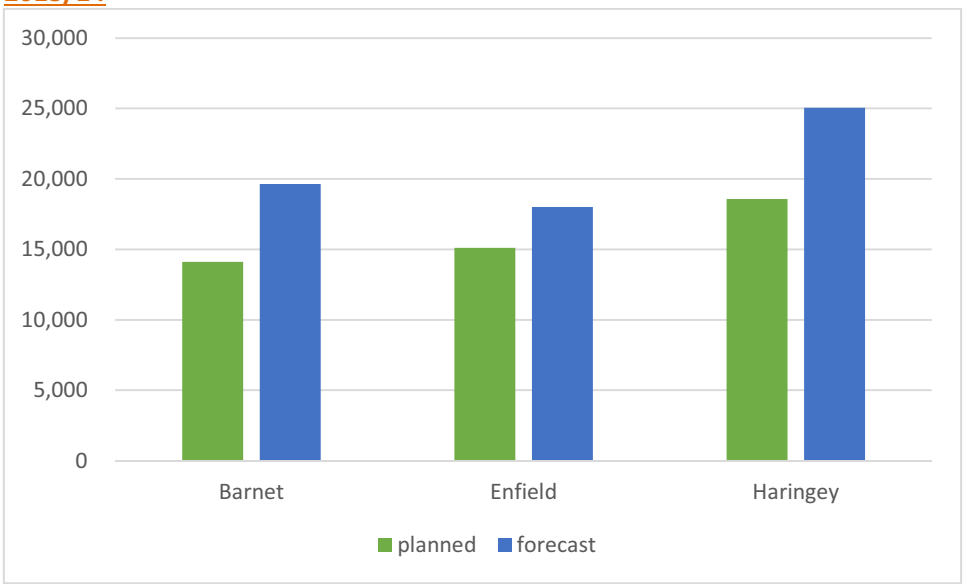


Figure 3.5: Adult acute bed days including external placements per 100,000 weighted population – planned and forecast 2013/14

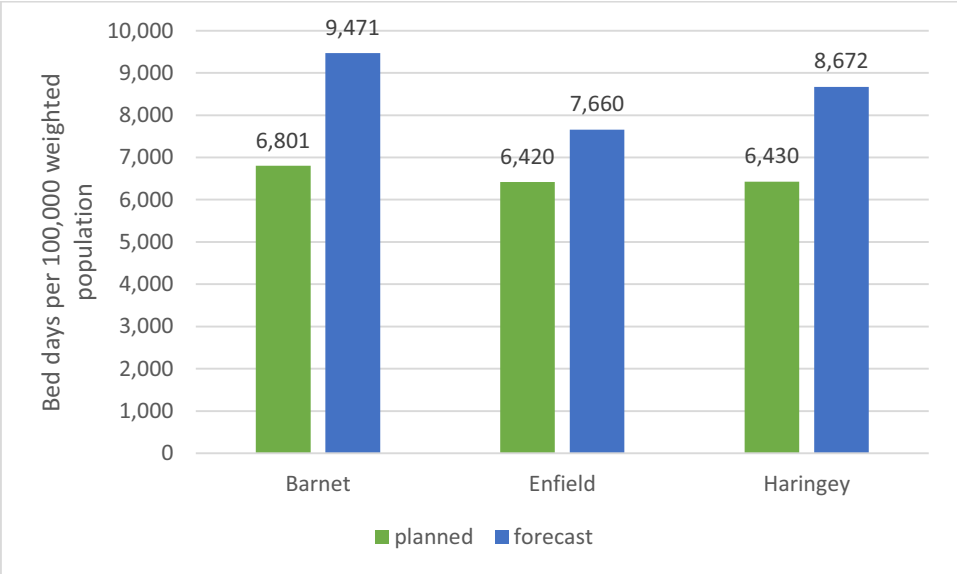
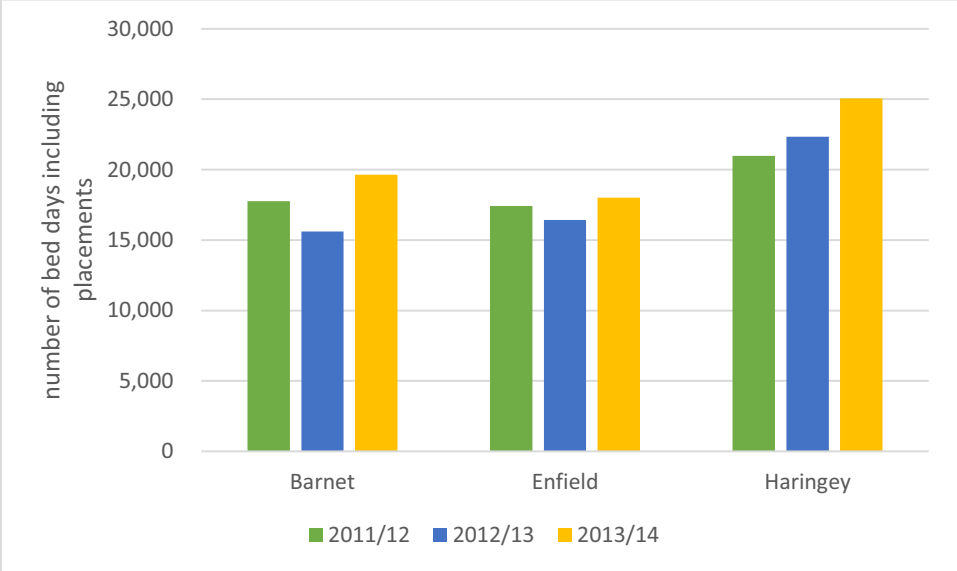


Figure 3.6: Adult acute bed days including external placements 2011/12 to 2013/14



Trust adult acute beds

The following analysis refers to adult acute activity in Trust beds only i.e. it does not include external placements:

- The number of bed days is forecast to increase by 7% from 2011/12 to 2013/14. The trend varies between CCGs: Enfield bed days are forecast to slightly decrease, while Haringey bed days are forecast to increase by 16% (Figure 3.7).
- The number of overall admissions is forecast to decrease from 2011/12 to 2013/14 by 6%. Admissions for Enfield are forecast to decrease by 14%, while admission numbers for Haringey are forecast to remain level (Figure 3.8).
- Patterns in length of stay have changed little over the three years (Figure 3.9). Haringey has the lowest proportion of 0 -28 days length of stay, and there has been some deterioration against this target for both Enfield and Haringey. Figures 3.10 to 3.12 provide further detail on length of stay by CCG.
- Total bed days lost through delayed transfers of care remained static for 2011/12 and 2012/13. Lost bed days are forecast to increase by 29% in 2013/14 to 6,475. These represent approximately half of the forecast excess acute bed days over plan. The cost of these bed days is £2.2 million, using the trust wide unit price.
- Haringey has a higher number of lost bed days and a higher proportion of bed days represented by lost bed days (Figures 3.13 and 3.14). A paper recently produced by Enfield CCG recommends a number of actions for the Trust, CCGs and local authorities to address the problems of delayed transfers of care (Figure 3.15). The Trust also has commenced a QIPP project with the aim of reducing the number of delayed transfers of care over the next year.

Figure 3.7: Number of bed days in Trust adult acute beds

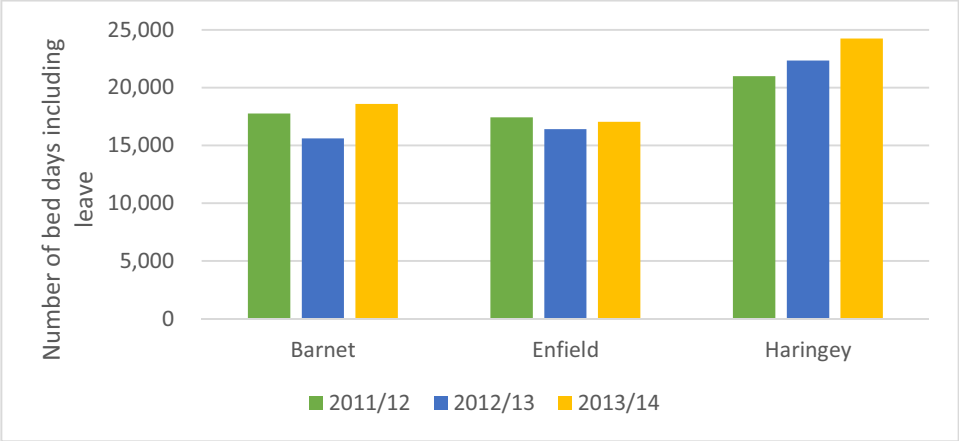


Figure 3.8: Number of admissions to Trust adult acute beds

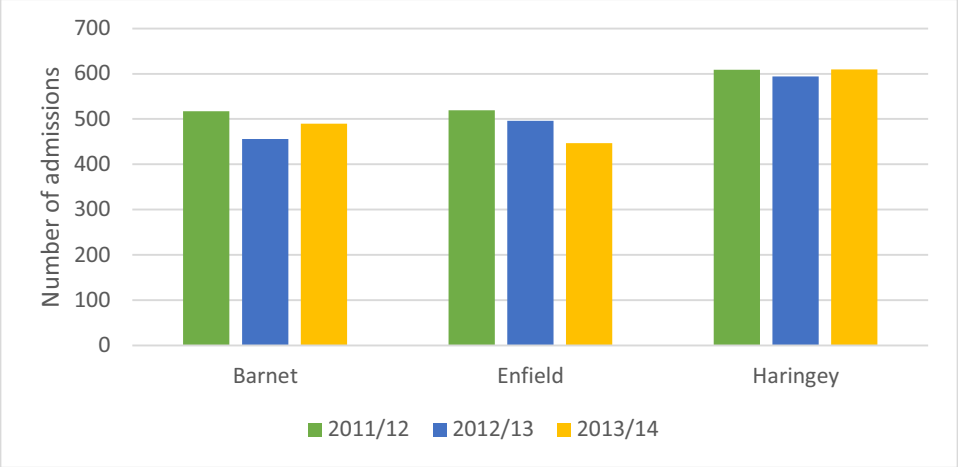


Figure 3.9: Percentage of discharges with length of stay 0 – 28 days

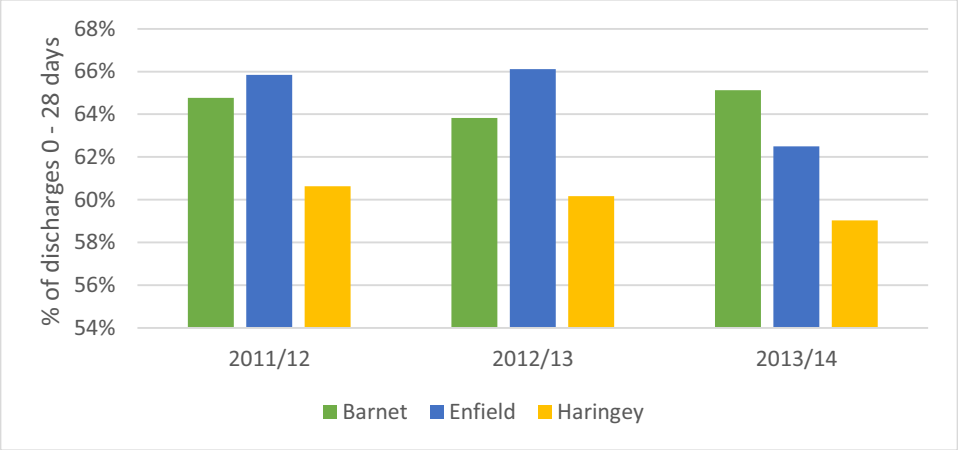


Figure 3.10: Length of stay – Barnet

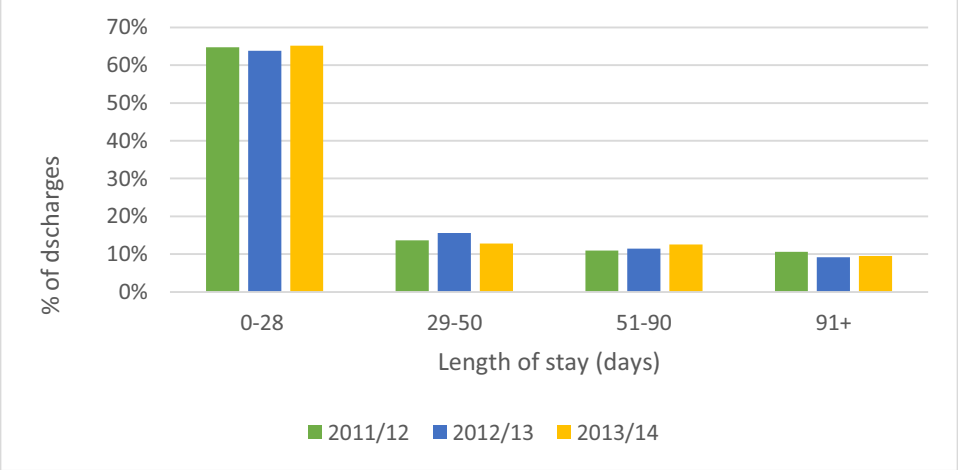


Figure 3.11: Length of stay - Enfield

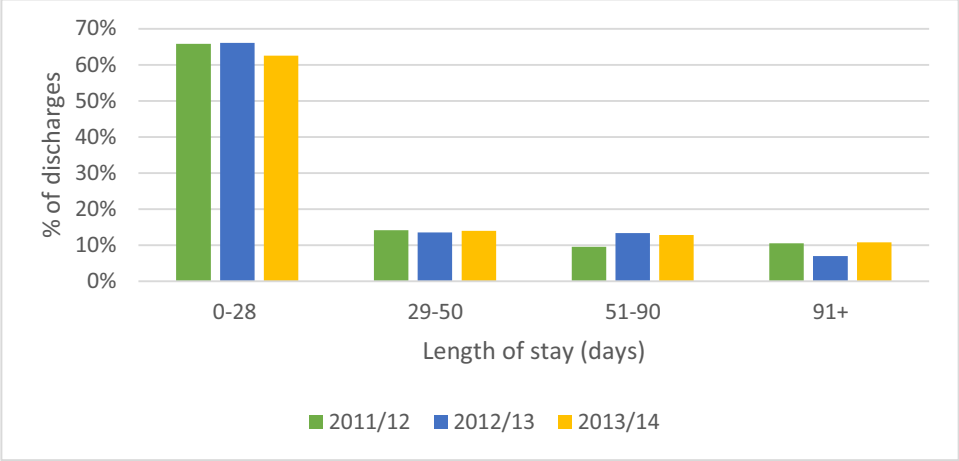


Figure 3.12: Length of stay – Haringey

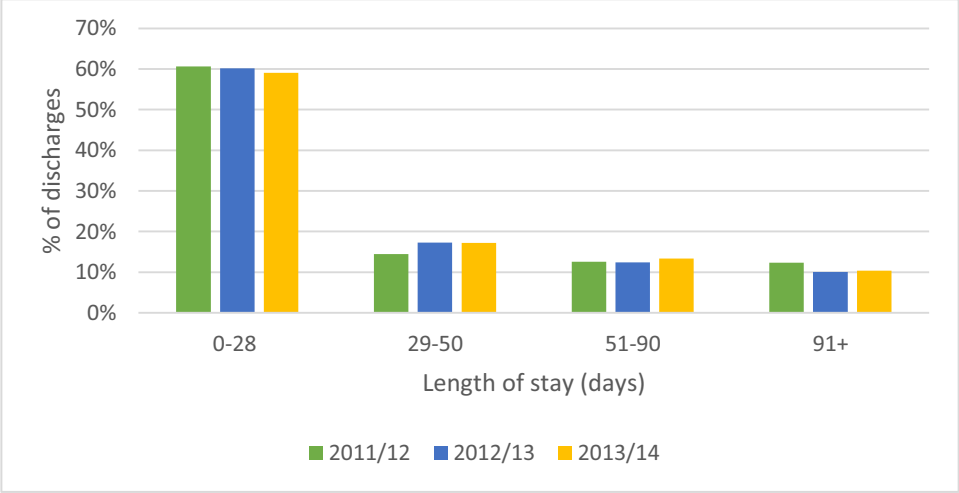


Figure 3.13: Delayed transfers of care – number of bed days lost

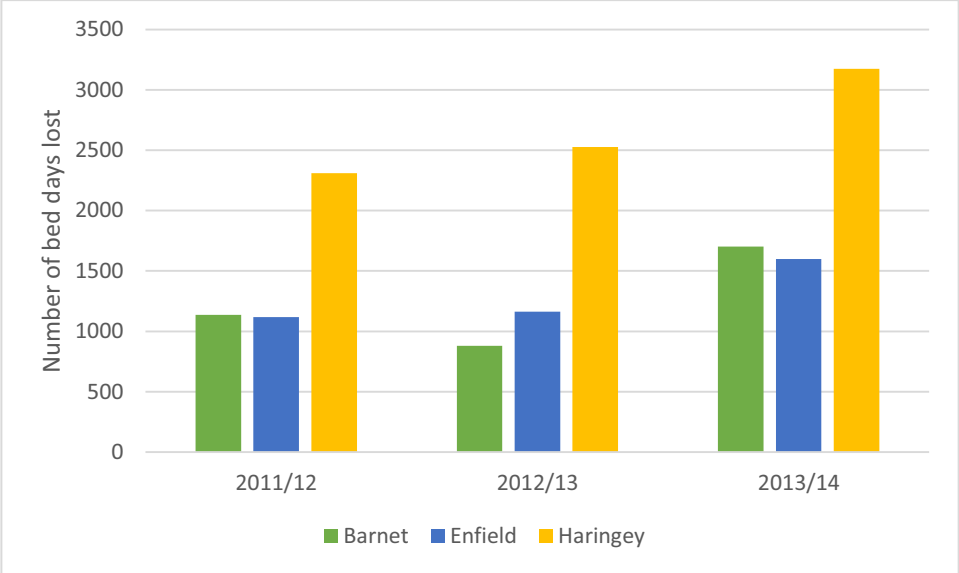


Figure 3.14: Lost bed days as percentage of total Trust acute bed days (including leave)

	2011/12	2012/13	2013/14
Barnet	6%	6%	9%
Enfield	6%	7%	9%
Haringey	11%	11%	13%
Total	8%	8%	11%

Figure 3.15: Recommendations to address the problems of delayed transfers of care

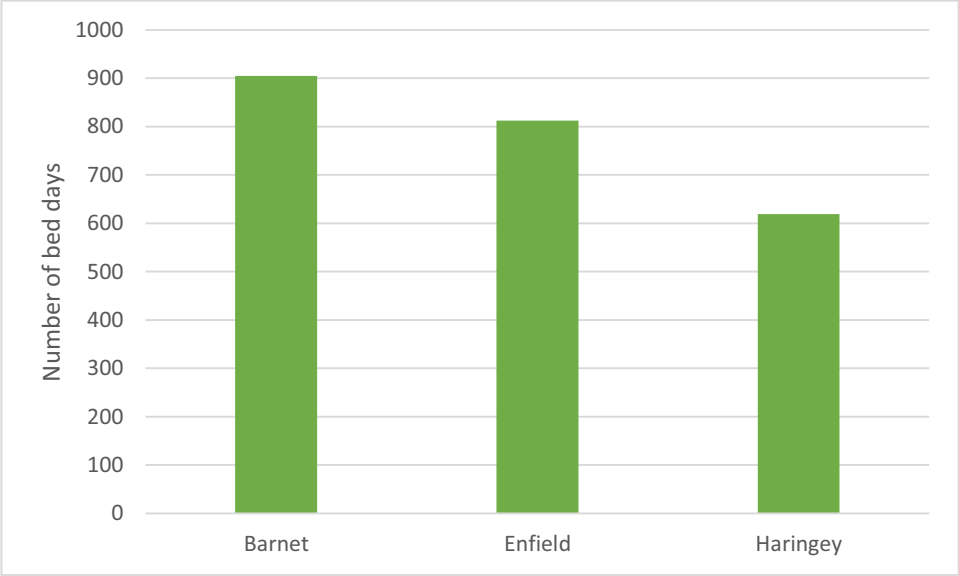
- Lead Mental Health Commissioners facilitates a one off meeting with BEHMHT and Housing Officers/Social Services to Case manage the current cohort of discharged patients out of bed and breakfast and into more appropriate accommodation.
- Each commissioner undertake a stocktake of the current state of the local supported accommodation strategy and if required initiate a review/update leading to the implementation of a Strategy which ultimately brings to an end the use of Bed and Breakfast accommodation for recently discharged vulnerable patients with mental health problems.
- The Trust and commissioners discuss openly adopting the practice of discharging patients back to the Homeless Persons Unit or similar facility rather than Bed and Breakfast accommodation.
- Local authority(s)/Trust and Commissioners agree to adopt the strict definition of delayed transfers of care outlined in section 3 above. This will make the distinction between a delayed discharge and delayed transfer of care.
- A senior officer from both the Local Authority and CCG become standing members of the 'Code Black' meeting when convened. Those attending must have authority in two respects – to be able to authorise funding for placements if required and also accept organisational responsibility for a delayed transfer of care under the definitions outline above.
- The Trust, Local Authority and CCGs adopt the attached draft protocol for avoiding delayed transfer of care or at least minimising them.
- Daily bed states from BEHMHT are shared with CCG mental health commissioners showing bed utilisation, admissions and discharges and number of patients in the private sector. In addition a weekly breakdown of DTOCs and reason for the delays and responsibility are provided to Commissioners by BEHMHT.
- If required the CCG Commissioners will use this information to invoke the Escalation procedure attached to the Protocol to senior officers in the Local Authority and CCG. Once this practice has been adopted it is likely to ensure regular attendance at the 'Code Black' meetings with individuals of appropriate authority to ensure decisions are taken at the appropriate level.

Source: Enfield CCG February 2014 – Pressures on acute adult inpatient services position paper

3.2.2. External placements

External placements for adult acute inpatients were not used in 2011/12 and 2012/13. In 2013/14 2,336 bed days are forecast (Figure 3.16).

Figure 3.16: Number of external placement bed days 2013/14 forecast



3.2.3 Trust PICU beds

Data provided to us by the Trust shows that:

- The overall number of PICU bed days was similar in 2011/12 and 2012/13. In 2013/14 they are forecast to increase by 8%. The three CCGs show different trends in the use of PICU over the three years (Figure 3.17).
- The number of admissions is forecast to increase by 23% from 2012/13 to 2013/14. This is due to a significant increase in Barnet (Figure 3.18).

Figure 3.17: Number of Trust PICU bed days

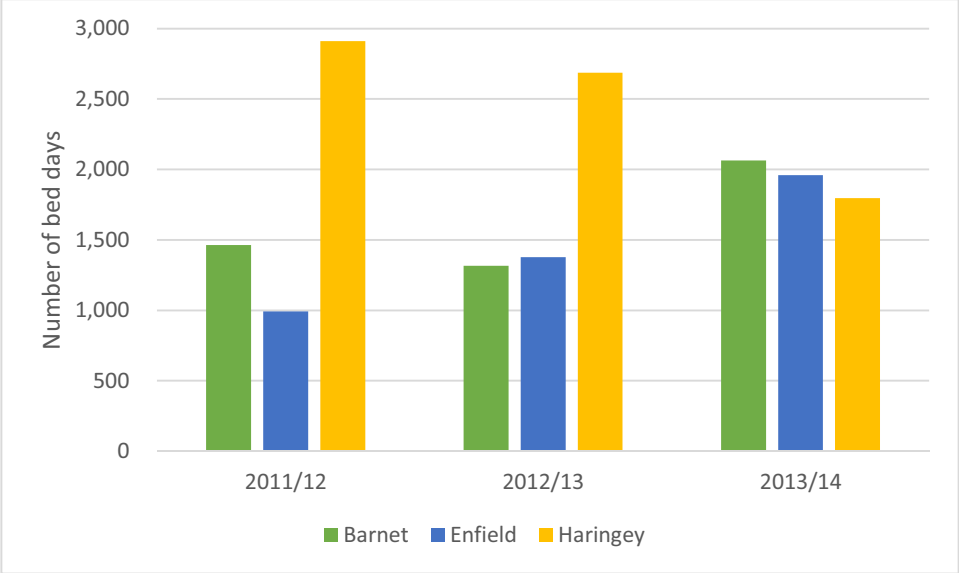
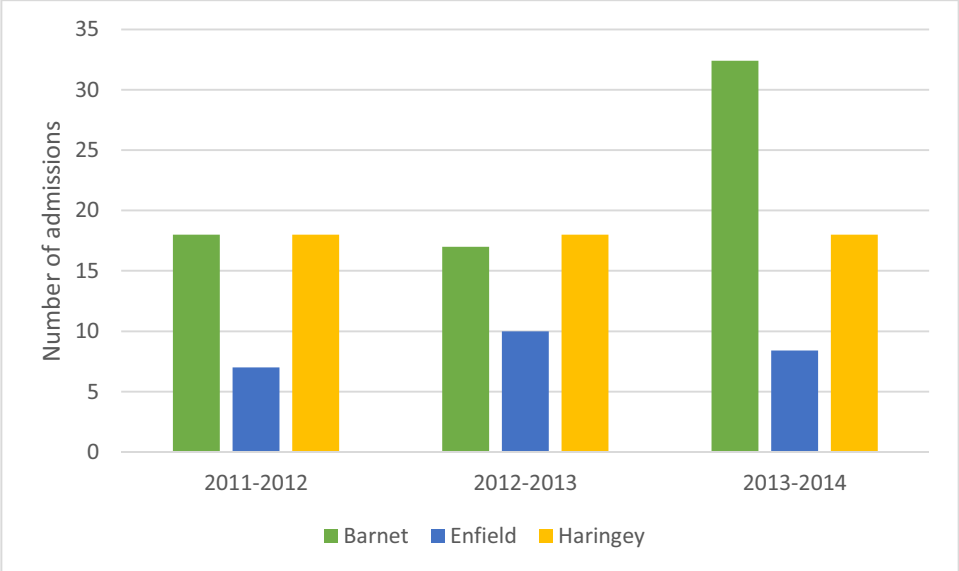


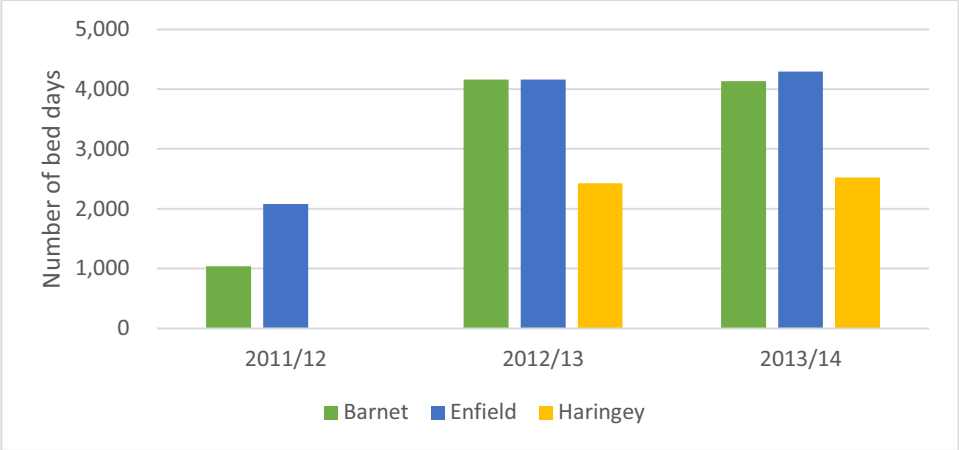
Figure 3.18: Number of admissions to PICU



3.2.4. Recovery Houses

Recovery houses opened in later 2011/12 and therefore 2012/13 saw a significant increase in the use of recovery houses with a threefold increase in bed days. The number of bed days in 2012/13 and 2013/14 is forecast to be fairly similar. (Figure 3.19).

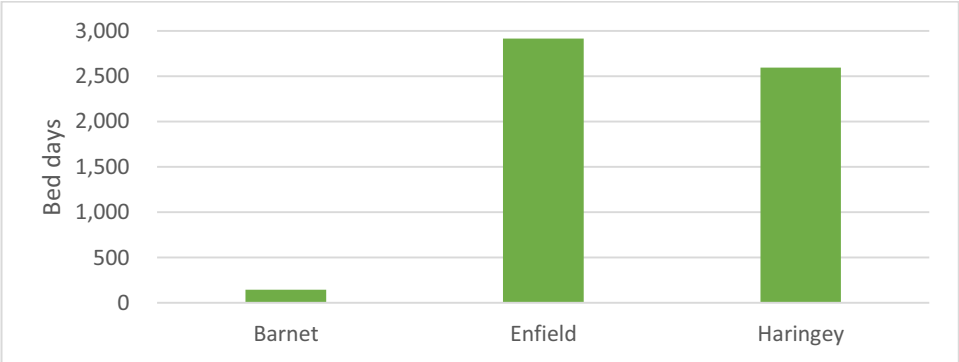
Figure 3.19 Number of bed days in recovery houses



3.2.5. Bed and breakfast

Bed and breakfast facilities were not used in 2011/12 and 2012/13. 5,653 bed days are forecast in 2013/14, the majority of them in Enfield and Haringey (Figure 3.20).

Figure 3.20: Number of Bed and Breakfast bed days 2013/14 forecast



Based on this range of evidence, it currently appears implausible that the financial pressures arising from acute beds are likely to reduce in the immediate future. None of our interviewees had any real optimism that pressure on acute beds was likely to fall. However, there were views that the Trust could do more to manage throughput and reduce delayed transfers of care. As well as actions from the Trust and CCGs, this could require actions from the three local authorities, and it is currently unclear how likely those would be.

3.3. Estates

All of our interviewees have discussed this issue with us. There appears to be an almost universal view that there is a financial opportunity to be realised by reducing the number of sites from which the Trust provides its main inpatient services. To provide some context for this, we have benchmarked the Trust internal site floor area against income, staff numbers and number of beds (Figures 3.21, 3.22 and 3.23).

The estates information is from the most recent (2011) return to the Estates Return Information Collection (ERIC); Income/staff/beds data are taken from the Binleys database.
The Trust position is lower than the comparator average for all 3 benchmarks. Whilst this is of course not conclusive, it is indicative that the Trust is starting from a position which is not significantly expensive, in terms of the scale of its estate. This would be consistent with its typical reference cost index.

Figure 3.21: Gross internal site floor area (m²) per £1m income

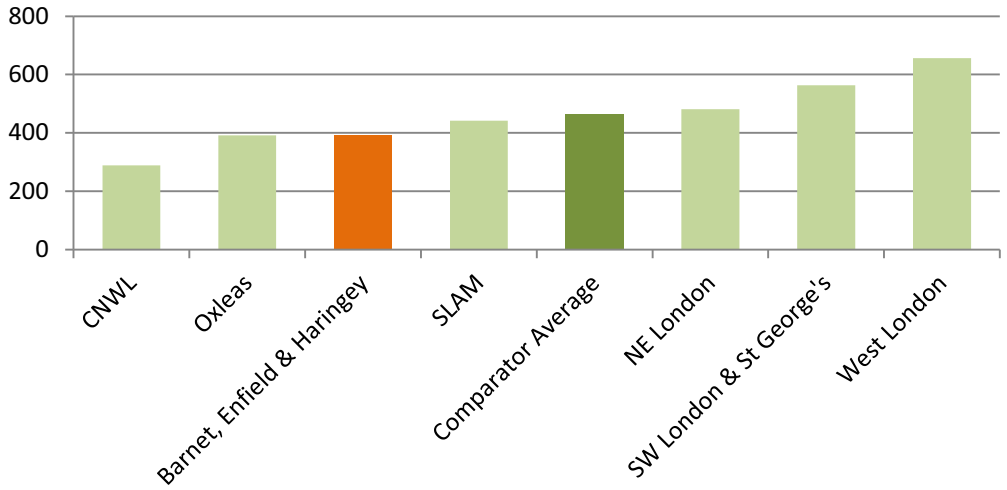


Figure 3.22: Gross internal site floor area (m²) per 100 staff

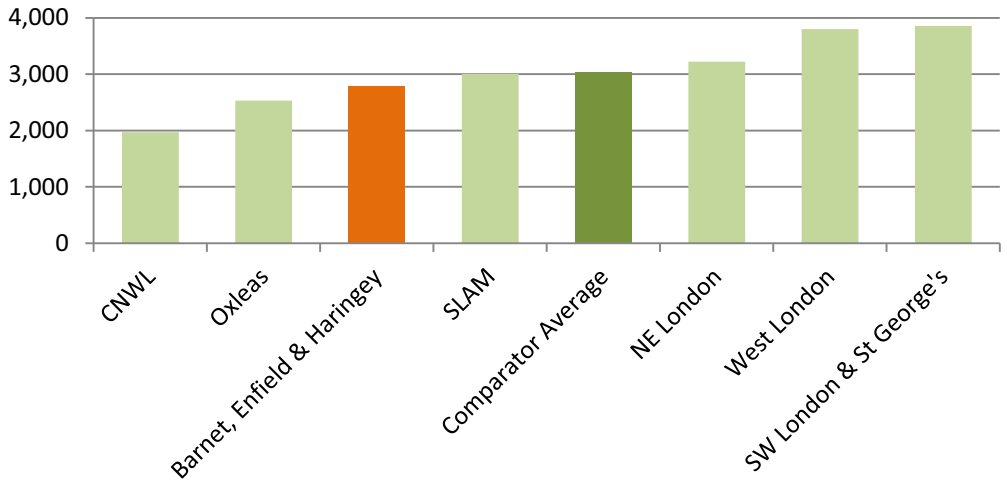
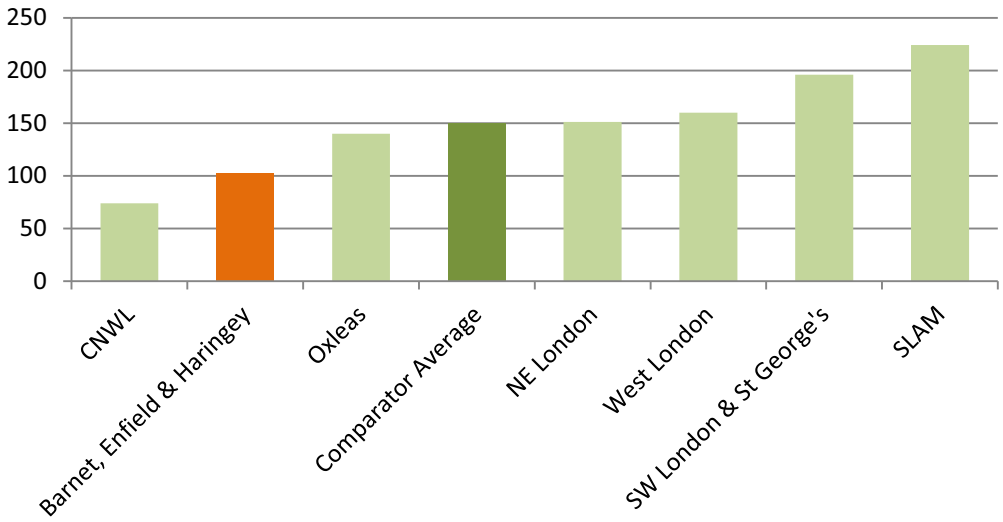


Figure 3.23: Gross internal site floor area (m²) per bed



The Trust is reviewing the use of estates through the Finance and Estate Sub-Group. Initial work suggests that there are not substantial estate savings to be made, because the scale of capital investment required for a major estate rationalisation would increase capital charges and depreciation to such an extent that it would more than offset the other revenue savings possible.

We have discussed this issue with senior staff from the Trust, who have advised us that they are currently conducting an option appraisal of alternative site configurations. This, we understand, currently suggests that the cheapest option would be for the Trust to relocate its services from the Springwell Unit at Barnet Hospital, so that it would then have only one inpatient site in Barnet, and to proceed with redevelopment of St Ann's Hospital in Haringey. The Trust currently estimate that these changes could lead to estates related recurrent savings of approximately £3 million in total in the medium term, although this estimate is not yet internally or externally validated.

The Trust, we understand, has also examined the option of centralising all its inpatient services onto one main site. However, this would require major capital investment as there is not sufficient existing vacant space available on any of the Trust's sites. The Trust estimate that the significant additional capital charges that would be incurred would more than outweigh the revenue savings, and this solution would therefore be more expensive overall that the current estate configuration.

Estates-related savings would of course require several years to realise; we understand that it is possible that some level of transitional funding could be available to support such a reconfiguration, if it were agreed.

We understand that some smaller savings have been identified as potentially available from reconfiguration/better utilisation of smaller premises, but that these are at only modest levels.

3.4. Other service redesign

3.4.1. Current commitments

Key commitments made in the local mental health commissioning strategy, and mirrored in the Trust's Clinical Strategy include, with our view of their likely financial effects:

Further extending capacity in primary care, including co-location of some Trust services	We are aware that this is hoped to reduce costs within secondary care services. It is however unclear what mechanism is expected to achieve that. There are risks that: these will be additional, rather than replacement services; freed Trust capacity will not be withdrawn, but used for other services.
Further development of IAPT	This may reduce demand on other public services, but is not likely to reduce demand on specialist mental health services; there is a risk that it could be increased
Delivering services as close to people as possible	Dispersing services and/or travelling to see patients is typically more costly than more centralised arrangements
Specific service developments in ADHD, autism and personality disorder	These developments address perceived gaps in services, rather than cost pressures
Increasing assessment and treatment services for dementia	Increasing the detection rate and intervention rate for people with dementia is not likely to produce any financial saving, and could produce additional costs

We are not aware of any specific financial provisions underpinning these commitments. None of these appear likely to be cash-releasing. It is currently difficult to see how additional investment could be found to support these initiatives, however desirable they may be from a clinical perspective.

However, there are also commitments which could be cash-releasing:

Reduce the numbers entering secondary care mental health services	This is a key issue. The overall pressure on the specialist mental health system needs to fall, and this can only be achieved by reducing the number of referrals into it
Develop local rehabilitation services for people requiring 12-18 month lengths of stay (instead of out-of-area placements)	There is a potential savings opportunity here. Aggregate commissioning at a local level, with rigorous throughput management could be cheaper (and clinically preferable) to spot purchased alternatives
Deliver alternatives to hospital admission, including home treatment teams and recovery houses	This will be essential to reducing the £5.8 million unfunded activity. Some invest-to-save could well be justified, particularly in home treatment services. Avoiding admissions completely has a greater impact on bed use than shortening lengths of stay
Implement RAID services	This will create costs rather than save money within the mental health service – but there is good evidence that savings can be made within acute services, if beds are closed as lengths of stay reduce, particularly for older people
Remodel day services	Such services can be remodelled and save money if the alternatives are based on (a) use of mainstream services (b) non-estate-based options (c) shorter lengths of use (d) peer support / recovery-focussed models

Given the current serious financial position, it appears that it may be necessary to focus both commissioner and provider time and effort on the commitments which are most likely to produce financial benefits.

Within the Trust's CIP programme, £110,000 has been earmarked as arising from day hospital savings. It is not clear that any other savings have been identified which specifically relate to the cash-releasing commitments identified here.

3.4.2. Other savings opportunities

In local discussions, only the following further ideas have come forward:

- capping caseload and activity levels at affordable levels, even if this results in waiting lists for some services
- subcontracting some provision to third sector providers, with assumed lower wage costs
- pursuing greater integration of mental health and acute services, in the hope of making acute sector savings

In terms of the potential for rapid impact, within the timescales required, only the first of these has any real potential for early cash-releasing savings. Each reduction of 1% in the overall caseload of the Trust's community mental health services (with consequent reductions in staffing levels) would save approximately £620,000, assuming that the reductions were distributed evenly across teams. It is far from clear that subcontracting services would result in significant savings, and there is no convincing evidence that general integration of physical and mental health care produces any savings in the cost of mental health services.

4. CONCLUSIONS

The recurrent cash gap between commissioner investment and Trust costs is of the order of £15 million. There is no evidence that the Trust is significantly expensive as a provider, and its specialist services are financially supporting rather than draining local services. There is also very clearly no additional investment available. With some exceptions (referred to below) the models of care on offer do not differ significantly from those typically available. On those assumptions, what follows are our recommendations; these are clearly not the only course of action available, but they represent what we would do if we faced the responsibilities which you now face.

We make no recommendations regarding rebasing between commissioners. There is clearly a case for this, but, firstly, any rebasing makes no overall change to the overall financial position facing the NHS in Barnet, Enfield and Haringey; and, secondly, these are win-lose choices where it is impossible for us to advise four clients simultaneously. We are recommending only options which have the potential for closing the overall gap between NHS available finances and mental health costs across the three boroughs.

We should also stress that what follows represents what we would regard as the necessary elements of a financial recovery plan; it does not represent everything which commissioners and providers need to or could do, as many such actions are beyond the scope of this project.

Recommendation One
Halt or withdraw from all commitments which involve new expenditure on additional mental health services. Specifically withdraw from or halt: additional developments in primary care; IAPT expansions; new services for people with dementia; service developments for personality disorder, autism and ADHD. This will save nothing, but will prevent the cash gap worsening.

Recommendation Two
Redirect a proportion of the cost of acute overspill into significant expansion of home treatment services, with continuing funding explicitly linked to reductions in admissions and lengths of stay. Ensure that the resource is ringfenced to respond to cases at genuine risk of admission, and does not get diverted into less urgent work; we understand from local threshold audit work that local CRHT teams fulfil functions which would elsewhere fall to CMHTs. Assessing the exact financial potential here requires detailed modelling beyond the scope of this report, but the total cost of the acute overspend is currently £5.8 million. All of this sum should be considered as a savings target, net of any reinvestment in CRHT.

Recommendation Three
Commence robust negotiations with the respective local authorities as to the management and placement of people no longer requiring mental health inpatient care. We support the plan of action proposed to reduce DTOCs; for full effect this will obviously need full involvement of the local authorities. Each agency needs fully to respond to its respective statutory responsibilities – there is no good reason whatever, for example, for the NHS to be buying bed-and-breakfast accommodation. Eradicating DTOCs could save £2.2 million. It should be noted that this effectively forms part of the £5.8 million referenced in recommendation two. It should not therefore be double-counted.

Recommendation Four
Pursue the site consolidation opportunities as a matter of urgency. It is essential that the NHS speaks with one voice on this issue, such as to ensure the necessary political and community support. The estimated opportunity is at least £3-4 million, with the possible option for transitional financial support – which should also be pursued urgently. In conjunction with other recommendations, which could reduce the required size of the Trust's estate, it is possible that greater savings could be found here.

Recommendation Five
Pursue strongly the opportunities for local aggregate commissioning rather than spot purchasing of rehabilitation services. This is a genuine win-win for local services. Financial benefits can only be appraised following a patient-by-patient review of individual cases, which should be undertaken urgently.

Recommendation Six
Take forward the plans to remodel day services, emphasising short-term and mainstream options, linked to peer support and third sector models. It is possible that this could yield savings ahead of the £110,000 already proposed.

Recommendation Seven
Undertake a rapid and rigorous review of caseloads of and referral patterns to community teams (including support and recovery, wellbeing, and community rehabilitation services), with the intention of reducing their net caseloads by at least 10%, and reducing the teams' size accordingly. This is clearly something of an arbitrary figure, but supported by similar caseload review work elsewhere – it would obviously need local validation following caseload assessment. The intention should be to discharge people with long-term stable needs, and to reduce referrals of relatively less severe needs. This should be linked to the development of peer support – and to the refocussing of the work of primary care mental health services to ensure continuing support for people with stable longer-term needs, if needs be by reducing their work with common mental health problems. To be effective, this action would need to be linked to long-term agreement and management of sustainable caseload and activity volumes, to ensure that the reduced caseloads remain reduced. This has the potential to enable up to £1.3 million in recurrent savings.

Recommendation Eight
Recommission all continuing care services, seeking the most economically advantageous offer. These are a highly unusual part of the local service model, and there is a reasonable prospect that better value for money could be secured. Even if the direct service cost were unchanged, this programme would support estate consolidation. If 10% savings could be found, this would realise approximately £860,000.

It should be stressed that the financial estimates in these recommendations are very broad and high-level only. All would require detailed assessment, and service and financial modelling. The purpose in including them here is to enable a very broad assessment of whether the cash gap appears to be capable of being bridged. This very broad assessment appears to suggest that there <u>are</u> identifiable courses of action which could yield recurrent savings at levels broadly similar to the cash gap, when taken together with other CIPs proposed within the Trust – although, taken together, they of course represent a course of action which we are conscious will prove difficult and controversial.

Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Trust Headquarters

St Ann's Road, Tottenham, London, N15 3TH

Tel: 02084425732

Date of Inspections: 13 March 2014
12 March 2014
11 March 2014
10 March 2014

Date of Publication: May 2014

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Care and welfare of people who use services	✓ Met this standard
Management of medicines	✗ Enforcement action taken
Supporting workers	✗ Action needed
Records	✓ Met this standard

Details about this location

Registered Provider	Barnet, Enfield and Haringey Mental Health NHS Trust
Overview of the service	Barnet, Enfield and Haringey Mental Health NHS Trust operates community mental health teams in the boroughs of Barnet, Enfield and Haringey. These teams provide care and treatment to people experiencing mental health issues in the community.
Type of services	Community based services for people with mental health needs Hospital services for people with mental health needs, learning disabilities and problems with substance misuse Community based services for people who misuse substances
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Nursing care Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Trust Headquarters had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Management of medicines
- Supporting workers
- Records

This was an announced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 10 March 2014, 11 March 2014, 12 March 2014 and 13 March 2014, checked how people were cared for at each stage of their treatment and care and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information given to us by the provider and were accompanied by a pharmacist. We reviewed information sent to us by commissioners of services, talked with commissioners of services, talked with local groups of people in the community or voluntary sector and were accompanied by a specialist advisor. We used information from local Healthwatch to inform our inspection.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

This inspection was a follow up to our inspection in May 2013 when we found that the Community Mental Health Teams we inspected were not compliant with regulations 9, 13 and 20 of the Health and Social Care Act (2008).

For this inspection, we visited the Crisis Resolution and Home Treatment Teams in Barnet, Enfield and Haringey on consecutive days. These teams had reconfigured in November 2013 and were working in a different way to the teams that we visited in the previous inspection.

We found that staff had been through a period of adjustment to their new roles. We were told by staff that "things are settling down" after a period of initial bedding in. We spoke with people who used the services in the three boroughs. Most people were positive about the support they had received from the services. One person told us "I was cared for really well and given options". Another person told us the staff were "very caring and listening". Other people told us that sometimes their visits were not at the times they were expecting or that they had been cancelled. Overall, we found that there had been an improvement in the feedback we received from people who used the service from the previous inspection.

We checked the management of medicines in the teams we visited. We found that some actions, which had been identified in action plans sent to us by the Trust after our previous inspection, had not been completed, such as training for non-nursing staff who supervised medicines. We also found that some issues relating to medicines management, which had been identified by the trust in audits in September 2013, had not been addressed in practice, such as regular temperature monitoring of medicines storage areas in the Enfield and Barnet teams. We found that there were some gaps in the prescription charts in the Haringey and Barnet teams which meant that there was no evidence that people had received some doses of their essential prescribed medicines, which may have placed them at risk. We found that the trust was not following policies it had in place regarding management of medicines. This meant that the service continued to be non-compliant with Regulation 13, management of medicines, and the Trust had not made the changes which were indicated in the action plan that they sent to us following the inspection in May 2013.

Staff in the teams we visited told us that there had been a difficult time when the teams were established but they felt that there was improvement in the services which they were delivering. There had been significant absence rates due to sickness and vacant post. We found that through this change process staff had not been sufficiently supported as they had not received regular managerial and clinical supervision or specific training in relation to their roles.

We checked records in the three teams we visited. We found that there had been an improvement in the recording since the previous inspection. We saw that most care plans and risk management plans were reviewed regularly and progress notes were kept up to date and provided a record of the work which was carried out in the team which ensured a safe service.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 03 June 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have taken enforcement action against Trust Headquarters to protect the health, safety and welfare of people using this service.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

During our previous inspection in May 2013, we found that people using the Haringey Home Treatment Team did not always consider that their care met their needs. This was because people who used the service did not have choices about the staff who visited them, there was no evidence that people could choose what times staff visited them and there was no agreed amount of time that staff would spend with people.

In November 2013, the teams had been reconfigured and they were now called Crisis Resolution and Home Treatment (CRHT) teams. We heard from the management in the trust and in the teams we visited in Barnet, Enfield and Haringey that the changes had brought the need to embed new systems. In all the teams we visited we were told by staff that there were vacancies which had had an impact on the service delivery. However, we were told that these issues were being addressed through recruitment.

During this inspection in March 2014, we spoke with people who used the CRHT teams in Barnet, Enfield and Haringey. Most of the feedback we received from people who used the services was positive.

People who used the Enfield service told us "I was cared for really well", and "They [the CRHT staff] helped me through a difficult time. One person told us that the staff were "usually on time – any changes and I get a call". People told us they were able to choose times. However, one person told us that they had had problems contacting the team but that "they were good when they reached me".

People who used the Barnet service told us that the staff were "superb" and that the team was "very caring and listening". People who used the Barnet service told us that they had a 'time window' when they could expect people to visit them and this system was agreed with them when they started using the service.

People who used the Haringey service told us "they gave me an ear and they listened, it

helped a lot". Another person told us the service was "good". However some people told us they "never saw the same person twice" and two people told us that visits were late and that they had not been informed about this.

We saw the timeliness of visits and information that people received about their visits in advance was addressed during team meetings. In the records we checked in the three teams we saw that people were usually informed of the times of their visits and that the necessity of this was something that the staff teams were aware of.

We checked twenty two records in the three teams we visited. We saw that people had care plans which were up to date, risk assessments which included current risks and that risk management was addressed in the care planning documentation.

We observed handover meetings in each of the teams we visited. We saw that risks were addressed during these meetings and those people who were felt to be at the highest risk were discussed. We saw that in the team meetings that staff were able to raise issues and concerns openly and that staff listened to each other when they spoke and shared information. This meant that staff were kept up to date with information which related to the care of people who used the service.

Management of medicines ✖ Enforcement action taken

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

At our previous inspection in May 2013, we found that the provider was non-compliant with regulation 13 of the Health and Social Care Act 2008 because people who used the services provided by the Haringey Home Treatment Team were not protected against the risks associated with medicines. This was because the provider did not have appropriate arrangements in place to manage medicines. We were sent an action plan by the provider to address these issues however, during the inspection in March 2014, we found that some of the actions which we had been told had been completed, had not been completed and some of the issues raised in the previous inspection had not been addressed. Therefore people who used the service continued to lack protection against the risks associated with the management of medicines.

At the previous inspection in May 2013, we had identified that in the Haringey Home Treatment Team staff did not have access to lockable bags to transport medicines in the community. On our visit to the Haringey Crisis Resolution and Home Treatment (CRHT) team in March 2014, we found that these were being used. However, this was not consistently happening in Barnet or Enfield. One member of staff in Barnet, told us "the locks break easily" and another member of staff told us "some of the bags don't have locks because they have been lost". In Enfield, staff told us that they did not always used locked bags to transport medicines. This meant that appropriate arrangements had not been made to ensure that safe keeping of medicines while they were in transit.

We checked the records of the fridge and ambient (room) temperatures where the medicines were stored in the three teams we visited. In Haringey CRHT team we saw that the temperatures of the fridge were logged however we saw that there had been days where the temperature had not fallen within the levels which were acceptable and action had not been taken. In March 2014 there had been seven times when the fridge temperature had been logged as being outside the acceptable 2-8C range. In Barnet and Enfield, we saw that there were no logs being taken of the ambient temperature where the

medicines were stored. This meant that there was a risk that medicines were not being stored appropriately.

During our previous inspection in May 2013, we saw that while nurses had received training and had their competency in medicines management monitored, staff who were not nurses, either unqualified staff or staff who were qualified in other disciplines such as occupational therapists and social workers, did not receive training related to medicines management. When we returned to carry out this inspection in March 2014, we found that this continued to be the case. This meant that people were not protected against the risks associated with medicines management because some staff who supervised and prompted people to take medication did not have specific training. This was counter to the policy which the trust had in place.

We checked prescription charts in the three teams we visited. In the Haringey team, we checked six prescription charts. We found gaps in the charts which we checked. For example, we saw that one person had eleven gaps in their chart in February 2014. We also saw that where a non-nursing member of staff had supervised medication for someone, this had not been countersigned by a nurse. In Barnet, we checked five prescription charts. We found one gap in a record where it was not clear whether someone had had medication or not. We also saw that there were inconsistencies in the way that non-nursing staff were recording supervision of medicines. We saw that nurses had not countersigned these entries and it was not clear who had administered or supervised medicines.

We looked at recent audits of medicines management undertaken by the provider. We saw that there had been a comprehensive audit where concerns had been identified in September 2013, but we did not see evidence that the issues had been addressed. For example, we saw that issues relating to incomplete records had been identified. However, during our inspection we saw that there continued to be gaps in the records. We saw that the absence of the monitoring of ambient temperatures where medicines were stored had been raised. However, during our inspection we saw that this had not been actioned in Barnet or Enfield. This meant that the provider had not learnt from concerns which had been identified and there was a risk that people would not be protected against the risks associated with medicines because the systems in place had not ensured actions had been taken.

We were provided with an action plan following the inspection in May 2013 and we found that some of the actions which had been identified had not been completed. The provider continued to be non-compliant with regulation 13 of the Health and Social Care 2008 (Regulated Activities) Regulations 2010).

After the inspection visit, we were informed by the trust that they had taken immediate action to address the concerns which we raised with them.

Supporting workers ✖ Action needed

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was not meeting this standard.

People were cared for by staff who were not supported to deliver care and treatment safely and to an appropriate standard.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with staff in the three teams we visited. We spoke with the assistant director, the clinical director and the service managers as well as the deputy team managers. The teams had been formed in November 2013 and had gone through significant change in terms of personnel. Most staff we spoke with told us that they had been supported by their immediate line managers however we were told that staff had not had time to receive formal clinical and managerial supervision which had been recorded. We were told by the management team across the three boroughs that group supervision was being developed but supervision "is not happening". We saw that one member of staff in the Enfield team had received supervision regularly. In the Haringey team we were shown supervision records for two members of staff. However, across the three teams, we did not see evidence that all staff were provided with consistent and regular managerial and clinical supervision during a period when their services had gone through significant changes. In each team we visited, staff told us felt supported by their deputy team managers. However, the lack of regular, formal supervision, both managerial and clinical, meant that there was a risk that staff did not receive regular support and information to ensure that they develop and learn in their roles.

We asked to see the records of team business meetings to ensure that development issues such as learning from complaints, incidents and audits were discussed across the teams. We saw that some meetings had taken place in each of the three teams. However, it was not evident that learning from complaints, compliments and incidents were discussed regularly in meetings held with staff in teams.

We saw that meetings had taken place in Barnet where issues were discussed at a managerial level however we did not see evidence that the learning which was indicated was filtered down to team levels in the three CRHTs. For example, in the Enfield team, we asked how information about complaints was fed back to the team. We were told that this was done through regular business meetings. However, we were also told that business meetings "haven't been happening". This meant that there is a risk that staff will not learn from complaints, compliments and incidents which take place across the trust.

We asked about training regarding meeting the needs of people who used the service. We were told that some training had taken place across the teams related to work with people with learning disabilities but in other areas, for example, working with people with dementia, there had not been specific training despite the service being 'ageless' which meant that people were not precluded from the service on the basis of their age.

We asked staff in the three teams about their access to training and we looked at the training records. In Haringey CRHT team staff told us that they have access to mandatory training. However, we saw some staff had not completed their mandatory training. Some members of staff told us that they are able to access additional training. However two members of staff told us that the opportunities for additional training "had reduced".

In the Enfield CRHT team we saw that some staff had not completed their mandatory training. One member of staff told us "It has been difficult to create time for training". Another member of staff told us "prior to the transformation staff had training"

In Barnet CRHT we spoke with staff who told us that they had completed their mandatory training. We were told that additional training was being organised. Across Enfield and Haringey, staff told us that they had not completed mandatory training. This meant that there is a risk that staff will not have the opportunity to ensure that their skills are up to date when they are providing care to people using the service.

Staff in the three teams we visited told us that they felt that improvements were taking place. For example, in Barnet, a member of staff told us "[deputy team manager] provides us with guidance and direction" and another person said "[deputy team manager] is excellent". In Haringey, a member of staff told us "Managers are really good, things are improving now" and another member of staff told us "[deputy team manager] has had mixed support...but the team works well together". In Enfield, one member of staff told us "I love working here. The team pulls together" and another member of staff told us "We are good at supporting each other". During our visits, in the three teams, we observed staff seeking advice and support from their managers and saw that staff appeared accustomed to approach their managers for informal advice and support through the shift.

Medical staff told us that they provided support to each other. Staff in the three teams told us that they felt supported by medical staff. Staff told us that they had received annual appraisals. However, the lack of formal support through a period of significant change meant that staff were not supported to ensure that that care and treatment they delivered was safe and of an appropriate standard.

Records ✓ Met this standard

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

During our previous inspection in May 2013, we found that people were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not always maintained and because staff told us that difficulties in accessing the electronic records and computer systems consistently had resulted in a negative impact on care and treatment for people who used the services.

During this inspection we spoke with staff about access to the electronic records and computer system and contingency plans in case of IT outages. Staff told us in all the teams we visited that they had access to RiO (the trust's electronic recording system) and this included temporary staff whose access was arranged in a timely manner. Staff were able to tell us the procedures to follow when the IT system was not working. Most staff told us that they did not have concerns related to their access to the IT systems in the trust.

In the three teams we visited, we checked twenty two records of current service users randomly selected in the teams we visited. We found that most records were maintained and of a sufficient quality and standard to ensure that information recorded about people who used the service was accurate and appropriate. For example, we saw that people had recorded visits accurately and promptly after visits. We found that there had been a significant improvement in the quality of record keeping since our last inspection across the teams.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Nursing care Treatment of disease, disorder or injury	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers** **How the regulation was not being met:** The registered person did not have suitable arrangements in place to ensure that persons employed for the purposes of carrying on the regulated activities were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard by receiving appropriate training, professional development, supervision and appraisal. Staff in the teams had not received regular managerial or clinical supervision since the teams were established in November 2013. (Regulation 23 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010)

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 03 June 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 30 May 2014 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Treatment of disease, disorder or injury	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: The registered manager had not protected service users against the risks associated with the unsafe use and management of medicines as they had not made appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purpose of carrying on a regulated activity because they had not ensured that the provider's medicine management policy was being adhered to. Some staff who had not received medicines management training were supervising medication. Some staff did not have access or were not using lockable bags to transport medicines. The temperatures of some of the rooms where medicines were stored was not being monitored. Audits which had been carried out regarding medicines were not being followed up. Some records were incomplete. (Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010).

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

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The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

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The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

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Records - Outcome 21 (Regulation 20)

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Glossary of terms we use in this report (continued)

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There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

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This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk

CareQuality Commission

Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Trust Headquarters

St Ann's Road, Tottenham, London, N15 3TH

Tel: 02084425732

Date of Inspections: 10 June 2014
09 June 2014

Date of Publication: June 2014

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Management of medicines	✓ Met this standard
Supporting workers	✓ Met this standard

Details about this location

Registered Provider	Barnet, Enfield and Haringey Mental Health NHS Trust
Overview of the service	Barnet, Enfield and Haringey Mental Health NHS Trust operates community mental health teams in the boroughs of Barnet, Enfield and Haringey. These teams provide care and treatment to people experiencing mental health issues in the community.
Type of services	Community based services for people with mental health needs Hospital services for people with mental health needs, learning disabilities and problems with substance misuse Community based services for people who misuse substances
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Nursing care Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Trust Headquarters had taken action to meet the following essential standards:

- Management of medicines
- Supporting workers

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 9 June 2014 and 10 June 2014, talked with staff and reviewed information given to us by the provider. We were accompanied by a pharmacist.

What people told us and what we found

This inspection was carried out to follow up our inspection in March 2014, when we found that the three Crisis Resolution and Home Treatment (CRHT) teams we visited were not compliant with regulations 13 (Management of Medicines) and 23 (Supporting Staff).

One inspector and one pharmacist inspector visited the CRHT teams in Barnet, Enfield and Haringey over two days. We spoke with staff in all of the teams, including unqualified nursing staff, medical staff, pharmacists, nurses, deputy team managers, team managers, service managers, the assistant director for the service and the Executive Director of Nursing, Quality and Governance. We looked at documentation on site and asked the trust to provide us with information following the inspection which we examined.

We checked the management of medicines in the Barnet, Enfield and Haringey CRHT teams. We found that all of the areas of non-compliance with Regulation 13 of the Health and Social Care 2008 (Regulated Activities) Regulations 2010 had been addressed, such as recording when staff supervised medicines in the community, training for non-nursing staff who supervised medicines, safe storage and transportation of medicines, and auditing of medicines management. We found that medicines were now stored and transported securely, and there was regular temperature monitoring of medicines storage areas in all three CRHT teams, which showed that medicines were being stored at the correct temperatures to remain fit for use.

We found that prescription charts were now completed fully and clearly, which meant that there was evidence that people were receiving their essential prescribed medicines. We found that staff who transported, supervised and prompted people to take medicines had received appropriate training to do so. We found that the CRHT teams were now following trust policies regarding management of medicines. Therefore the CRHT teams were now compliant with Regulation 13 of the Health and Social Care 2008 (Regulated Activities) Regulations 2010.

Staff told us that they felt supported. Additional staff had been recruited into post since our

previous inspection. All staff had received supervision. There were regular team meetings and additional local and service-wide clinical governance meetings where issues including complaints, concerns and incidents were discussed so that learning could be disseminated at all levels. Staff in all the teams and at all levels across the service demonstrated enthusiasm and commitment to providing a good service to people in Barnet, Enfield and Haringey.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

At our previous inspection in March 2014, we found that the provider was non-compliant with Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people who used the services provided by the Barnet, Enfield and Haringey Crisis Resolution and Home Treatment (CRHT) teams were not protected against the risks associated with medicines. This was because the provider did not have appropriate arrangements in place to manage medicines. We took enforcement action by issuing a warning notice to the trust requiring the trust to become compliant with Regulation 13 by 30 May 2014.

We returned to the trust on 09 and 10 June 2014 to inspect the management of medicines in the three CRHT teams. We found that the trust had taken immediate action on the issues we found in March 2014. Medicines were now being managed safely and according to trust policy.

We checked the training records for staff who administered, supervised or transported medicines to people in the community, and we found that they had now received appropriate training in medicines management to do this safely. We saw evidence that staff in the CRHT teams had read the trust policies on medicines management, and copies of these policies were available in each office. All qualified nurses in the CRHT teams had completed the trusts Medicines Management Competency workbook, except for two members of staff who were on sick leave.

Non-qualified staff and other professionals working within the CRHT teams had received Administering of Medication training. Staff we spoke with in all three CRHT teams were able to explain clearly how medicines were managed, and how they would deal with specific situations regarding medicines, such as if they were unable to make contact with someone who needed essential medicines. This meant that people were protected against the risks associated with medicines management because staff who administered or supervised medicines to people in the community had received appropriate training to do so.

We checked prescription charts and electronic care records related to medicines in all three CRHT teams. A yellow label system was being used to identify and record the level of support people who used the CRHT teams' services needed with their medicines. We found that prescription charts were now completed fully, and provided evidence that people were receiving their essential prescribed medicines. It was clear from both prescription charts and electronic care records which member of staff had supervised medicines. On the occasions staff were unable to supervise medicines, such as if they were unable to make contact with someone, clear records were made of the action taken to ensure that this person was not placed at risk because they had not received their medicines. This meant that appropriate arrangements were now in place to record the administration and supervision of medicines to people in the community.

We checked the records of the fridge and ambient (room) temperatures where medicines were stored in the three CRHT teams we visited. These records showed that medicines were being stored at the correct temperatures to remain fit for use. We saw that lockable medicines bags had been obtained and were now being used, so medicines were transported securely when staff took medicines to people in the community. This meant that appropriate arrangements were now in place to ensure the safe keeping of medicines.

We asked to see recent audits of medicines management undertaken by the trust. We saw that there had been significant input from the pharmacy department to provide training, monitor and advise on medication issues. The pharmacy department had implemented a Medicines Management Checklist and a Key Facts Prescription Endorsement sheet for the CRHT teams in April 2014 following our last inspection. The Medicines Management Checklists showed that medicines were being audited twice a week, and where concerns had been identified, that prompt action had been taken to address any issues.

Recent audits from 20 May 2014 to 06 June 2014 showed that the CRHT teams were now 100% compliant with medicines management. CRHT team staff in all three teams told us that the pharmacy team had provided valuable support. Therefore systems were now in place to monitor and address how medicines were managed.

Medicines in the CRHT teams were now being managed safely, and according to trust policy, for the protection of people who used CRHT team services.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

We visited the CRHT teams in Barnet, Enfield and Haringey and spoke with staff in all the teams. We checked the minutes from the team meetings in each team, as well as clinical governance meetings and the meetings which had taken place at management level. We also looked at information which was available to staff in their offices and observed interactions between team members.

We checked a random sample of supervision records in each of the teams and we checked the auditing and monitoring of supervision which was recorded for each team. We saw that staff received regular supervision. Supervision records showed that this time was used to discuss development and training goals for individuals as well as issues regarding the quality of work and level of support within the team. We saw that people were raising concerns and issues related to clinical practice during their supervision sessions and caseloads were discussed. This meant that staff, at an individual level, had the opportunity to address learning needs and receive up to date information regarding the service which meant that they were being provided with support.

We saw that all the teams had regular, minuted team meetings and clinical governance meetings. Feedback and information about incidents, complaints and compliments were discussed regularly which ensured that the teams embedded a learning culture that focussed on service improvement.

We asked staff about the support they received in the teams and received positive feedback including the following comments "things are a lot better", "We have had a lot more support" and "it feels that there have been a lot of changes in terms of support and the senior management are more visible". We were told that two of the teams (Barnet and Haringey) had been visited by non-executive directors in the trust. We spoke with one member of staff who had joined the team since our last inspection and saw that they had had a comprehensive induction which had included a period of shadowing other team members and initial training including medicines management.

Staff we spoke with at all levels across the teams. They displayed commitment to their work, to the service and to the trust as well as thoughtfulness and care towards the people they worked with to support. There were plans in place to provide service specific training.

We saw robust systems in place to ensure that staff were provided with support on an ongoing basis. For example, all supervision was logged and timetabled.

We saw that there had been considerable work done by staff at all levels in the organisation to address the non-compliance identified in the previous inspection in March and that there was a commitment from the trust management to ensure that the teams were supported to provide quality care.

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The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

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✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
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Website:	www.cqc.org.uk

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Agenda Item 5

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Barnet Enfield and Haringey Quality Account 2013 – 2014 Introduction from Maria Kane, Chief Executive

I am pleased to introduce to you my organisation's Quality Account for 2013-14. The Quality Account is a summary of the way in which Barnet Enfield and Haringey Mental Health NHS Trust promotes and monitors quality of care across the organisation. The Quality Account is developed in partnership with our service users, clinicians and stakeholders, by way of public workshops, local working groups, and regular quality meetings at all levels of the organisation, wherein the priorities for improving quality in the organisation in the coming year are agreed.

Barnet Enfield and Haringey Mental Health NHS Trust (BEH) is a large provider of integrated mental health and community health services. We currently employ 2836 staff and our annual income in 2013-14 was £193 million. The Trust provides specialist 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, including eating disorders services, drug and alcohol services, child and adolescent mental health services, and forensic services, providing assessment and/or treatment in secure conditions for individuals who may have come into contract with the Criminal Justice System. In addition to mental health services, we provide community services in Enfield. These services include sexual health, health visiting and nursing for long term illnesses including diabetes and heart failure. These multi-disciplinary teams have specialist skills and care for children, young people, adults and older people.

We have linked our Quality Account to the Trust's Clinical and Quality Strategy to drive forward change and to further develop a culture of care and compassion for all patients and provide better support for carers. A number of new initiatives have been implemented to improve access to our services for both patients and GPs; empowering GPs to be able to manage patients in primary care effectively through the development of the new Primary Care Academy which offers training and development support for local GPs; simplifying access to our services with simple and clear access routes into our services for urgent and routine referrals; establishing a 24 hour urgent referral service, providing immediate assistance and support to referrers and providing a response by the Trust's Urgent Care Team within four hours and providing a telephone Advice Line for GPs to raise any clinical issues with Trust Consultants and obtain advice and support.

Over the last three years, the numbers of patients being referred to us has increased by 11%. Over the same period, our funding has reduced by 13% in real terms, as our costs have risen faster than our income. This financial year we have received 31,067 referrals for mental health services, of which 28,770 were accepted by the service. An additional 2,251 patients were admitted to inpatient care in mental health services. In Enfield Community Services, we received 40,817 referrals, of which 40,717 were accepted by the service. An additional 14,017 patients accessed self-referral services in Enfield Community Services.

Over the last year we have had to address challenging targets, from both a quality and financial perspective in line with other NHS organisations, while managing an increasingly complex level of need in the population. Despite these challenges, we have made significant progress and have much to celebrate, while we recognise that there are still areas for further improvement which organization is committed to addressing. I am very aware that staff are under a lot of pressure to provide high quality, safe and compassionate care to patients. I want to say a big personal thank you to all staff for the fantastic work they have done this year. I continue to be very proud to work with staff who are so motivated and committed to caring for the people who use our services.

To the best of my knowledge, the information in this document is accurate.

Signed, Maria Kane (insert signature)

Follow-up on our 2013-2014 priorities

The Trust, agreed the following three priorities to improve the quality of care across our Trust, with input from staff, service users, carers and partnership organisations. As we had met our 2012-13 targets with regards to improving therapeutic engagement between staff and service users and their carers and ensuring all service users have an identified care goal, agreement was reached to add two new priorities for 2013-2014. Under Experience: Carers Strategy/Triangle of Care and under Effectiveness: Improve focus on patient identified care goals. As the target was not reached for improving communication with GPs, it was agreed that the Trust should continue to focus on further developing our partnerships with primary care colleagues as new strategies were being implemented to improve results.

Priorities for 2013 – 2014	
Safety - Improve communication with GPs	**65%**
Experience - Carers Strategy / Triangle of care	**87%**
Effectiveness - Patent Reported Outcome Measures (PROMs) *(% of patients who have submitted self-reporting outcome data)*	**30% MH ECS** TBC

- **Safety**
  We have continued to monitor our communication with our GP colleagues to ascertain if the new schemes which were implemented and imbedded improved the care delivered to our patients from both the Trust's perspective and those of our GPs. Communication protocols, new discharge and referral templates were introduced; a new telephony system is now in place in the Trust enabling provision of a tailored access point enabling GPs to receive accurate direction to services.

- **Experience**
  Triangle of Care is a process of developing the involvement and support offered to carers of mental health services users. It includes ensuring that carers are identified, provided with information, provided with support for their own needs, and are valued as an expert source in input into the assessment and planning of care for patients. Following feedback from our carers within the Mental Health Trust we have launched a carer's strategy which will enhance staff understanding the needs of carers, provide carers with crisis resolution strategies and monitor our carer involvement against nationally recognised benchmarks as provided through the triangle of care programme.

- **Effectiveness**
  Patent Reported Outcome Measures (PROMs) are mandatory this year as a part of our Commissioning for Quality and Innovation payment framework (CQUIN) which enables commissioners to reward excellence, by linking a proportion of healthcare providers' income to the achievement of local quality improvement goals. The Trust agreed two nationally accredited patient reported outcome measure tools to be implemented across mental health and community services. The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) was selected as our primary measure for mental health outcomes, and was launched in Triage services in November 2013. Triage teams are receiving weekly performance updates to monitor compliance. EQ-5D is a standardised instrument for use as a measure of health outcomes, and was launched in Diabetes, Respiratory and Musculoskeletal (MSK) services in November 2013.

Our priorities for 2014-2015

The following three priorities have been agreed by the Board following proposals made to them based on feedback from our Stakeholder Workshop in April 2014.

Priorities for 2014 – 2015
Safety **On-going improvement in Communication with GPs together with Improved Physical Health**
Experience **Improve Learning from incidents and patient feedback**
Effectiveness **Reduce Delayed Transfers of Care**

- **Safety**
  Action plans are in place to streamline the communication protocol, and improve the use of IT solutions to expedite communication. We will continue to monitor our communication with our GP colleagues to ascertain actions being implemented improve the care delivered to our patients. We want to ensure patients are supported to have regular physical health checks in the community and wards continue to conduct physical health checks upon admission. Issues relating to long term physical health conditions are discussed with GPs.

- **Experience**
  We will implement a new Carers Strategy and update the Patient Experience Strategy to include mystery shopping. Thematic analysis of lessons learnt to be instigated and develop an improved strategy for sharing lessons across services and with the public.

- **Effectiveness**
  "A lack of appropriate housing can be a significant contributor to delayed discharge from hospital. A lack of housing or support can also lead to increased readmission rates, over-use of residential care and, in some cases, the use of out of area or other high-cost services. Investment in housing and housing-related support can contribute significantly to reducing demand on acute and specialist services" - (Practical mental health commissioning 2011)

  The Trust recognises that housing needs are central to the care they deliver and so aims to Improve links with the various housing support departments to reduce delays in discharge due to housing issues. Developing effective alternatives to admission is good for service users and preventing delayed discharges ensures the appropriate use of acute admission beds. Progress will be monitored through the DTOC bi-weekly monitoring group.

Where are we now? Summary of 2013 - 2014 performance

The following information is a mix of Trust, National and Mandatory reporting on a core set of quality indicators selected to help monitor and compare the quality of our services year on year and against targets or benchmarks. All data includes Mental Health and Enfield Community Services unless otherwise stated.

***Table 1 – Quality Indicators for 2013 – 2014**, including previous achievement and benchmarking or internal targets. The last column shows national benchmarks indicated in white text, and internal targets in black text where no national benchmarks are available.*

Safety		2010 - 2011	2011 - 2012	2012 - 2013	2013 - 2014	National Benchmark / Internal Trust Targets
GP Communications	*Discharge letters within 1 week of discharge from inpatient services (previous target)*	55%	75%	79%	**New Quality Indicator initiated as below**	**95%**
	Assessment, review and discharge letters sent within 24 hours based on a sample of **320** records audited in 2013-2014.	n/a	n/a	n/a	**65%**	**98%**
	GP survey based on **79 surveys** returned in 2013-2014.	n/a	n/a	n/a	**44%**	**80%**
Patient Safety Incidents -	Number of incidents reported monthly (pcm) - based on a total of **6992** in 2013-2014.	369 pcm	408 pcm	472 pcm	**583pcm**	10% Increase in reporting
	Percentage patient safety incidents of which were severe or death - based on a total of **3605** incidents in 2013-2014.	n/a	n/a	**0.2%** Severe or Death	**1.19%** Severe or Death	2012-213 average 1.39%
7-day follow up after discharge from inpatient care - based on **1253** service users discharged from inpatient services in 2013-2014.		99.98%	99.81%	99.40%	**99%**	**97.44%**
Experience		2010 - 2011	2011 - 2012	2012 - 2013	2013 - 2014 Q1-4	National Benchmark / Internal Trust Targets
Triangle of Care – An evaluation of involvement and support offered to carers based on carer surveys, record keeping audits, team observations and interviews with staff, patients and carers in 2013-2014.		n/a	n/a	n/a	**87%**	**80%**
Patient and Carer Experience	Based on **221** responses to national mental health survey in 2012 (data issued in 2013)	n/a	66%	67%	**65%**	**64% -72%**
	Based on **18,556** responses to internal patient and carer survey in 2013-2014.	MH: 81% ECS: 90.5%	MH: 77% ECS: 90.5%	All Services 87%	**90%**	**80%**
Staff Survey - Staff would recommend this Trust - Based on **464** responses to national staff survey in 2012 (data issued in 2013)		66%	65%	70%	**69%**	**68% - 73.6%**

Complaints – number of complaints received by 1000 population in 2012-13	n/a	n/a	n/a	**0.24**	**0.34** (London MH Trusts average)
Staff training – compliance with mandatory training in Q1-3 2013-2014.	n/a	n/a	n/a	**85%**	**85%**
Crisis Resolution Home Treatment Team Assessment – the percentage of admissions to acute wards for which home treatment teams provided initial assessment out of 1735 inpatient admissions in 2013-2014.	n/a	n/a	98.7%	**98.04%**	95%
Effectiveness	2010 - 2011	2011 - 2012	2012 - 2013	**2013 - 2014 Q1-3**	**National Benchmark /** Internal Trust Targets
Trust wide PROMS – EQ-5D and SWEMWBS launched end of November : *(% of patients who have submitted self-reporting outcome data)*	n/a	n/a	n/a	**ECS 10% MH 30%**	**10% ECS / 30% MH**
Patient identified care goals – indicating development of patient identified goals and involvement in care planning based on an audit of 4572 patient records in Q1-3 2013-2014.	n/a	93%	94%	**95%**	**90%**
Emergency Readmissions– Based on 45 emergency readmissions to adult mental health wards out of 1625 BEH's CCGs admissions in 2013-2014.	n/a	4%	1.7%	**2.77%**	**<5%**

ORGANISATIONAL LEARNING

The Trust follows a clinical governance and assurance structure with the aim of identifying and celebrating good practice as well as identifying problematic areas quickly to ensure timely remedial action can occur. This governance process increases ownership of quality and safety improvements across all services in the organisation and ensures quality is at the heart of the Trust agenda. Our governance structure is made up of three components:

- **Deep Dive Committees**
  All of the service lines have their own monthly Deep Dive Committee meetings. These are chaired by the Director of Nursing / Deputy Director of Nursing to enable a deeper analysis and scrutiny of those service areas. It is a process that identifies both positive practice and areas in which further developments are required. Each area will produce an action plan to take to Service Line Clinical Governance Committees, which will monitor its implementation.

  The Deep Dive Meetings are responsible for monitoring the Trust's quality assurance systems operating within the seven service lines. The Deep Dive Meetings will ensure standards of quality and safety as indicated in the Care Quality Commission's regulatory requirements are met and identify actions to rectify concerns in order to drive the desired improvements throughout Trust services.

  In particular the meetings will focus on the key dimensions of the Regulatory Framework:
  - Service user involvement and information
  - Personalised care, treatment and support
  - Safeguarding and safety
  - Suitability of staffing
  - Quality and management

- **Service Line Clinical Governance Committees**
  This group holds a monthly meeting chaired by a service line clinical lead and attended by service line directors, clinical staff, and service users to review clinical governance information and updates from services. Teams feed back local clinical governance issues to this meeting. Deep Dive Action plans are signed off at this meeting prior to reporting progress at the next relevant Deep Dive meeting. Following the Deep Dive Committee, service leads will present their plans for improvement and actions they have completed to this committee.

- **Service Improvement Committee**
  This forum provides an opportunity for teams to present learning from improvement projects with colleagues in other services. It is both a celebration of successful improvements in organisational quality, and a chance for other trust leaders to learn from their peers. It is jointly chaired by the Medical and the Director of Nursing. The agenda focuses upon outlining how the service lines have overcome areas of concern and variation in order to drive improvement and improve patient experience.

  The Service Improvement Committees are responsible for disseminating positive clinical practice examples which have arisen from actions identified as required in the Deep Dive Committees.

In particular the Service Improvement Committee will focus upon the key dimensions of the Regulatory Framework:

- Service user involvement and information
- Personalised care, treatment and support
- Safeguarding and safety
- Suitability of staffing
- Quality and management

The following presentations have been delivered in the past year:

- See, Think Act - Improving Staffs Understanding of Patient Risks
- The Path To MSNAP Accreditation
- Peer Support – Enfield Mental Health Users Group
- Reflections On Pressure Area Care In A Forensic Setting -"Barriers, Road Blocks and Managing Diverse Clinical Opinion"
- QFI/Jonah Process
- The Club Drug Clinic
- Art Therapy focused Mentalisation Based Therapy Introduction - Portrait of Self and Other
- Update on Service Transformation
- Family Interventions within the Psychosis service line
- Mint Hosting the National Learning Disability Week
- Team Process Maps: A Journey through the why, what how and lessons learnt

Performance Review

Barnet Enfield and Haringey Mental Health NHS Trust considers that the data is as described for the following reasons: the indicators selected for this report were chosen based on several factors which ensure that this information provides an accurate and well-balance depiction of the quality of our services. Indicators must be based on data collected continuously and across all relevant services provided by the Trust. Data must be from a source which is quality reviewed for accuracy. The data must be based on information presented and discussed in quality and improvement forums at all levels of management to ensure that lessons and actions taken to improve services form a part of Trust governance.

Barnet Enfield and Haringey Mental Health NHS Trust intends to take (or has taken) the actions described in the following performance review tables to improve performance against targets, and so the quality of its services, by regularly monitoring and planning improvements through clinical governance and performance improvement structures. Data is provided to teams and service lines through deep dive meetings and performance meetings wherein areas for improvement actions are agreed and monitored. Where teams show significant improvements, these lessons are shared with colleagues in service improvement committees.

PATIENT SAFETY

GP Communication – *Key Priority*

Why did we choose to focus on this?	It was agreed that the Trust should continue to focus on improving shared care between mental health and primary care clinicians to support improved outcomes for both physical and mental health conditions for our service users.
What was our target?	Our target consisted of a series of communication standards (developed in collaboration with our commissioners), as well as a programme of work to redesign access to services and information to better meet the needs of our Primary Care colleagues.
What did we achieve?	This financial year, the Trust was set a more challenging target by our commissioners with regard to letters to GPs, moving the time frame from 1-2 weeks down to 24 hours. This target has proved challenging, and although we are not currently meeting our target we can see a quarter on quarter improvement demonstrating that the actions put in place to address the gaps in delivery are being effective. **GP Letters:** An audit of letters sent to GPs following assessment, review or discharge of patients has been conducted. Results indicate that although we are not yet meeting our targets, there has been an increase in compliance. A review of our administration systems and a mapping exercise identified areas for improvement in the communication process including a proposed email to fax communication protocol, and a need to review letter templates. The positive increase in results would indicate that the strategies which have so far been implemented are being effective in both increasing staff awareness of the Trust's objectives and also to re-assess how to better manage internal processes.

Trust results for GP letters - by quarter	communication sent within 24 hours	content average
Quarter 1	34%	76%
Quarter 2	40%	82%
Quarter 3	58%	87%
Quarter 4	52%	86%

The Trust has put in place a number of new services and monitoring processes to improve GP communication. GP views have been collected systematically through quarterly GP satisfaction surveys in each borough as well as through the Primary Care Academy. The strategy the Trust has taken to address some of the issues raised has been to utilise the Primary Care Academy to provide specialist training, provide communication through the GP newsletter and service transformation to respond to these issues.

Primary Care Academy: The Trust has been successful in securing £90k in funding from Health Education England. This will be used to develop our e-learning platform, and our Recovery Library. There has been strong service user involvement in all aspects of this programme, and there is now a designated administrator to assist. There is a regular Steering Board for the Primary Care Academies, attended by the Trust, Haringey Clinical Commissioning Mental Health lead, and service user representatives. We have planned sessions in all three boroughs for the next 6 months and will be delivered by Marc Lester, Deputy Medical Director assisted by Simon Harwin, Crisis and Emergency Service Line Manager. There has been excellent feedback from attendees at the sessions run to date, with more than half of attendees stating that they felt more confident with aspects of care and practice following the workshops. The Primary Care Academies have also achieved RCGP accreditation.

Crisis Referrals: As previously reported, the Trust responded to GP concerns about access to crisis services by introducing two new services: Triage Service and Crisis Resolution and Home treatment (CRHT). The Triage operates from 9am to 9pm Monday to Friday and provides face to face patient assessments for non-urgent or routine referrals. The new CRHT service operates 24 hours a day, 7 days a week, for urgent referrals for anyone in a crisis, assessing service users wherever they are at the point of referral e.g. GP surgery, A&E , their own home etc. Monitoring of the impact of this service transformation is on-going. A six-month review will be held in May 2014.

GP Survey: A survey designed jointly by the Trust and GP colleagues to evaluate GP satisfaction with the communication they have received from the Trust was carried out in October through to December and resulted in 37 responses across all three boroughs. 17 in Barnet with an average 31% satisfaction, 14 in Enfield with an average 60% satisfaction and 6 in Haringey with a 33% average satisfaction. The table shows overall satisfaction rates.

GP Satisfaction Survey - Quarter 3	
October	42%
November	49%
December	50%

GP Advice Line: In May 2013, the Trust introduced an advice line to provide GPs with access to generic clinical advice telephone conferences with psychiatrists within working hours. The objective was to address GP concerns which demonstrated a lack of clinical capacity amongst GPs and also enhance communication and help develop professional relations. From May to December, 144 appointments have been booked, with a breakdown by borough as follows: Barnet –101 Enfield – 30 Haringey – 13
Analysis of calls has shown the following breakdown of content:

Advice sought regarding:	Barnet	Enfield	Haringey	**Total**
Patient's deteriorating condition	11	3	2	16
Management of patient's condition	17	5	1	23
Medication Advice	41	10	6	57
Referral/service provision advice	11	5	1	17
Other	21	7	3	31
Totals	**101**	**30**	**13**	**144**

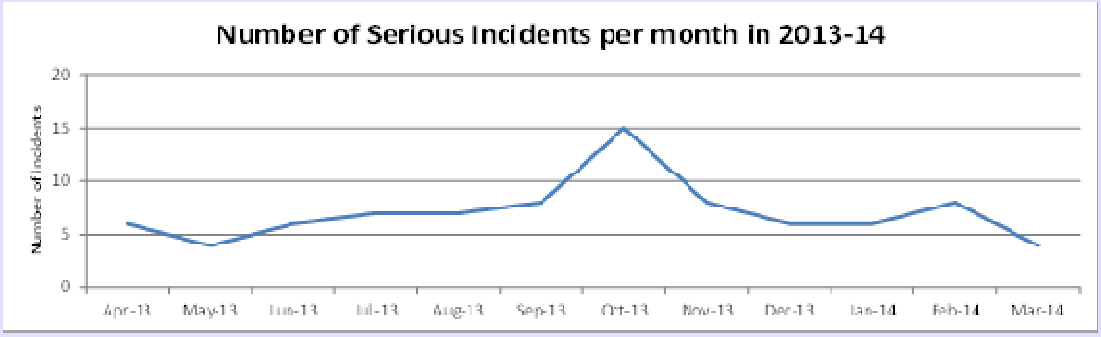
What needs to improve?

1. Standardised GP communication templates to be reviewed to fit service specifications in accordance with GP feedback.
2. Clinical staff to use NHS net email to send communication directly to safe haven faxes via email.
3. Regular newsletter to CCGs about progress, and regular briefings for meetings with three CCG Chairs and Accountable Officers.
4. The Trust is exploring a new system by which emails regarding patient progress can be entered directly into GP patient records.

How will we continue to monitor and report?

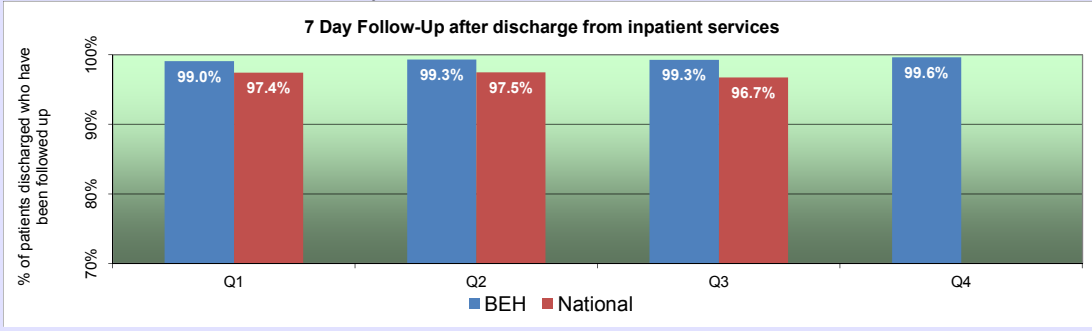
We will continue to monitor and report our progress to our commissioners through our Clinical Quality Review Group meetings and the Trust's own internal governance groups. Reviewing our GP survey to assess the success of changes made following implementation of actions taken.

Patient Safety Incidents

Why did we choose to focus on this?	All NHS trust are required to report incidents of harm, violence, or errors which could have a potentially negative impact on service users, visitors or staff. We are now required to report the number of patient safety incidents and the percentage of those which resulted in severe harm or death. The Trust has historically been in the lowest reporting percentile compared to other trusts. We have implemented many strategies to raise staff awareness of the importance of reporting all incidents as a means of learning and openness. Further improvements to patient safety have been developed through our participation in the Harm Free Care project and use of NHS Safety Thermometer, which collects information about harm from incidents based on individual service user experience. More information about Harm Free Care can be found on the following website: www.harmfreecare.org
What was our target?	To achieve a 10% increase on 2012-13 rates of incident reporting. To maintain high levels of harm free care, in line with national average.
What did we achieve?	Higher levels of reporting of incidents are an indication that a Trust is embracing a culture of transparency and learning. The Trust has set a target for increasing the rate of incident reporting from 2012-13 by 10%. Reporting in 2013-14 has increased by 24% from 2012-13. The Trust participates in the National Patient Safety Thermometer Harm Free Care Programme, which provides monthly census data of all patients seen across the country on a given day, and measures the level of harm experienced by those patients based on four categories; pressure ulcers, falls, urinary tract infections and venus thromboembolism. Barnet Enfield and Haringey has demonstrated 93% harm free care in 2013-14, in line with the national average for all trusts. Despite a rise in clinical incidents classified as serious in October 2013, incidents have levelled off, in line with previous months, and with a slightly lower cumulative number of incidents compared to the previous year (85 incidents in 2013-14 and 87 in 2012-13). The percentage of patient safety incidents resulting in severe harm or death for the Trust between April 2013 and March 2014 is 1.19%. This rate is below the 2012-13 national average of 1.39%.  A number of concerns regarding one of our Dementia and Cognitive Impairment (DCI) wards were identified and a robust action plan was created to address these issues. In May 2013 following discussions with multi-agency partners and regulators, a provider concerns framework was put in place in order to address the issues around safeguarding, standards of care, environment, and clinical leadership. This process led to improvements in several aspects of clinical standards in our DCI services, and across the organisation including: environmental layout, stability of clinical leadership, increased involvement of carers and family in care planning and risk assessments and improved methods of gaining feedback from carers and relatives. An important learning event for clinical staff was held in April to reflect on learning from the Francis Report. One year on from the publication of the Francis Report and *Patients First and Foremost* (the Department of Health's initial response to Francis) we brought together clinical staff from across the organisation, and from all specialties and grades, to think about what we have done so far to respond to Francis, and what more needs to be done. Joined

	by members of the Department of Health's Francis Implementation Team, the day focused on how the lessons from Francis translate to a mental and community health trust. We were encouraged to reflect on the human factors of Francis and how we can apply this learning to their own clinical practice.
What needs to improve?	A programme of on-going training is in place to raise awareness so that the Trust can learn from and make improvements through reporting and learning from incidents. A greater emphasis on thematic analysis is being implemented to identify areas of risk and allow for further team learning and service improvements. Action plans generated by discussion of these incidents at risk and governance meetings will be monitored. We have experienced some delays in investigation reports being completed within the 45 day timeline. In some cases this has been due to the complexity of the incident and the number of teams involved. We have undertaken a review in order to streamline the process and to ensure that all actions taken as a result of a serious incident are focused on learning. Further training for Enfield Community Service Staff has been delivered to improve investigation techniques and "learning lessons" to improve service delivery and patient care.
How will we continue to monitor and report?	Incident reports are monitored through Trust and local governance committees. Teams hold discussion about timeliness of response to incidents as well as a thematic analysis of the learning from incidents. Action plans are developed based on these discussions and preventative measures taken where necessary. Serious Incidents Review meetings are regularly held where discussions on implementing change are agreed. Service Managers are able to monitor both the recording and reviewing of incidents which are then discussed during meetings and supervision.

Follow-up after discharge

Why did we choose to focus on this?	The first seven days following discharge from hospital is the point at which service users are most vulnerable and at greatest risk of relapsing. The Trust aims to contact service users by means of face to face contact, if not, over the phone to establish their wellbeing and to monitor their progress. This is a mandatory indicator, and must be reported with the following text "Proportion of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care." However, it should be noted that all inpatients are on CPA and are therefore included in these figures.
What was our target?	To provide follow up care within 7 days of discharge to 100% of service users against the national target of 95%.
What did we achieve?	The Trust is maintaining its performance above nationally set benchmarks. Both internal auditing and national reporting indicate that the Trust (in blue in the graph below) is achieving an annual average of 99.3%. This figure is based on performance data of 1253 service users discharged from inpatient services in 2013-14. The National target for this indicator is set at 95% compliance.  ***The following table shows the data published by the Trust to the Health Sector Compensation Information System from April to December 2012.***

	proportion of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care	Q1 based on data submitted to HSCIC	Q2 based on data submitted to HSCIC	Q3 based on data submitted to HSCIC	Q4 based on data submitted to HSCIC
	lowest	94.10%	90.70%	77.20%	data not yet available
	BEH	99.04%	99.29%	99.28%	100.00%
	Highest	100.00%	100.00%	100.00%	data not yet available
	England	97.44%	97.47%	96.71%	data not yet available
What needs to improve?	If personal contact is not established to follow up and properly record client's wellbeing and needs, telephone contact with client or contact with a carer should be made to ascertain the client's current position.				
How will we continue to monitor and report?	Maintain high levels of compliance. Daily review of 7 day follow-up is managed and monitored by teams through daily review of discharge activity. Performance is also monitored through weekly exception reports, monthly service line meetings and at Board Committee level.				

PATIENT EXPERIENCE

Triangle of Care – *Key Priority*

Why did we choose to focus on this?	It was agreed that the Trust, having met its target for improving our therapeutic engagement with service users, change its priority to Triangle of Care. This is a process of developing the involvement and support offered to carers of mental health services users. It includes ensuring that carers are identified, provided with information, provided with support for their own needs, and are valued as an expert source in input into the assessment and planning of care for patients.
What was our target?	To develop a new carers strategy in consultation with carers group, local authority and other local stakeholders to support this practice.
What did we achieve?	The 'Triangle of Care' is described as a therapeutic alliance between service user, staff member and carer that promotes safety, supports recovery and sustains wellbeing. It involves listening, sharing and learning from each other, in an environment of safety, respect and honesty. The Triangle of Care covers 6 key standards: 1) Carers and the essential role they play are identified at first contact or as soon as possible thereafter. 2) Staff are 'carer aware' and trained in carer engagement strategies. 3) Policy and practice protocols re: confidentiality and sharing information are in place. 4) Defined post(s) responsible for carers are in place. 5) A carer introduction to the service and staff is available, with a relevant range of information across the care pathway. 6) A range of carer support services is available. The Trust monitors these standards through a range of surveys, service inspections and record audit. The following table shows our combined performance against these standards in 2013-14.

	2013-14 Q1	2013-14 Q2	2013-14 Q3	2013-14 Q4
Triangle of Care	77%	89%	91%	90%

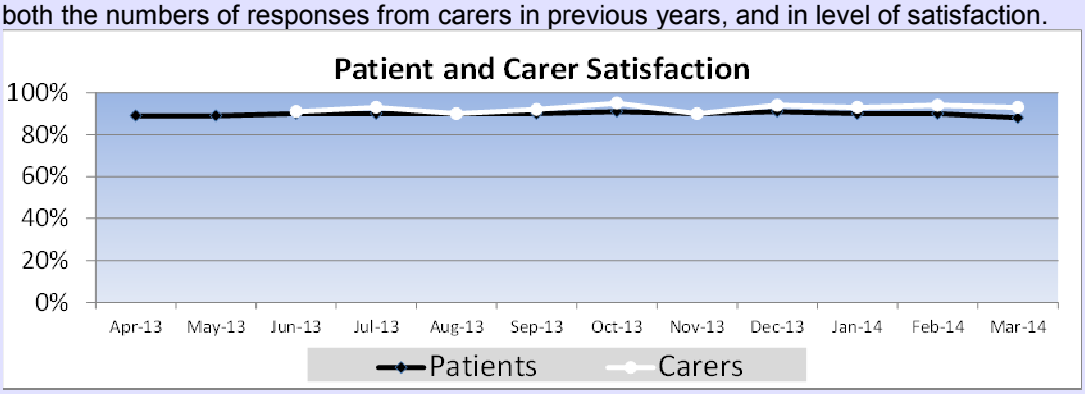
	The Trust has developed a Carers Strategy in collaboration with local carers groups and Barnet, Enfield and Haringey Local Authority. This strategy is due to be launched in 2014.
What needs to improve?	The Carers Strategy identifies a number of actions, which will be available on the Trust website following publication.
How we will continue to monitor and	The strategy identifies clear goals and standards which are measured through a number of sources of intelligence, including surveys, records audits, observation of teams and ward environments, and interviews with service users and carers.

Patient and Carer Experience

Why did we	To improve the quality of services that the Trust delivers, it is important to understand what service users think about their care and treatment. The Trust participates in the national
What was our target?	To maintain scores at the average national for mental health services in London. Internal survey target has been set to 80% satisfaction.
What did we achieve?	At the start of 2013, a questionnaire was sent to 850 people who received community mental health services. Responses were received from 221 service users at Barnet, Enfield and Haringey Mental Health NHS Trust. The overall Trust score is in line with the national and London-wide average scores recorded as "About the same; the trust is performing about the same for that particular question as most other trusts that took part in the survey."

2012 Mental Health Survey Results London and Urban MH trusts	BEH	CANDI	CNWL	East London	NELFT	Oxleas	SLAM	SWLSG	West London	National Rating
Overall	6.5	6.7	6.6	6.5	6.5	6.6	6.7	6.6	6.7	
How would you rate the care you have received from NHS Mental Health Services in the last 12 months?	6.7	6.8	6.9	6.9	6.7	7.2	7.1	6.9	7	
Have NHS mental health services involved a member of your family or someone else close to you, as much as you would like?	6.3	6.7	6.4	6.2	6.2	6	6.3	6.2	6.3	
Patient's experience of contact with a health or social care worker during the reporting period.	8.1	8.2	8.3	8.7	8.4	8.1	8.7	8.4	8.4	

Internal survey of 12,897 patients across all service lines indicates a rise in patient satisfaction within our services. 1,821 returns were received by carers who indicate a rise in both the numbers of responses from carers in previous years, and in level of satisfaction.



What needs to improve?	"You said – We did" boards to inform patients and carers of the initiatives which have been developed based on feedback from surveys was launched. Feedback to both patients and carers on service developments, survey results and action plans will be shared through the Trust website and newsletters. The national Friends and Family Test will be added to our local surveys, providing real time feedback which can be benchmarked nationally.
How we will continue to monitor and report?	Patient experience is an important area in which the Trust receives monthly feedback on its performance and this data is discussed in clinical governance groups. Teams use their feedback to identify local improvement plans and to share good practice.

Staff Survey: Would staff recommend this Trust?

Why did we choose to focus on this?	Barnet Enfield and Haringey Mental Health NHS Trust employs 2,583 individuals and one of its values is to support its staff to be the best they can be. Training and continual support by appraisals and supervision allow staff to feel heard and valued in their workplace. The people we employ to provide care are our most precious resource. Their wellbeing and views of our service will have a direct impact on the quality of care we provide. To help us measure staff satisfaction in the workplace, we will use the national staff survey. This will have an impact on the experience of our service users; therefore it is important that staff feel positive about the service provided by the Trust.
What was our target?	To achieve scores within the national average. To improve Trust wide communication with staff on all matters, including performance, achievements, promotions etc.

What did we achieve?

1436 members of staff completed the 2013 National NHS Staff Survey and 69% reported that they would recommend the Trust as a provider of care to their family or friends. This compares to a national average across other mental health providers of 71%.

	BEH score	median score	threshold for lowest 20%	threshold for highest 20%	lowest score attained	highest score attained
staff recommendation of the trust as a place to work or receive treatment	69.20%	71%	68%	73.60%	60.20%	80.80%

The two minute update "Take 2" launched last year has continued to help keep staff informed of Trust news and events and is being used by more staff to bring events and news to the attention of all staff.

After a hugely successful first year, the Trust's Listening into Action programme is ready to move onwards and upwards into its second year. The first set of teams have completed their projects and embedded new ways of working into day-to-day activity to improve services for patients and the working life of our staff. The programme makes a fundamental shift in the way we lead and work, putting staff, the people who know the most, at the centre of change, empowering them as individuals and within a team to get on and make change happen. This has been a great success with identifying quick fix initiatives as well as long term projects.

Staff training was identified as one area for improvement from the last survey. The Trust is now meeting its own internally set targets for compliance with mandatory training. To maintain and improve compliance rates, training registers are reviewed in each service line and teams review this data monthly to identify staff that have yet to complete or need refresher training. The Trust aims to maintain and exceed the target of 85% compliance by year end.

	Staff Count	Compliant	Trust	Corporate	C&E	DCI	ECS	Estates	Forensic	Psychosis	SCNP
Child Protection	2583	2064	84%	89%	72%	90%	96%	79%	70%	89%	77%
Adult Protection	2583	2064	84%	89%	72%	90%	96%	79%	70%	89%	77%
Equality and Diversity	2583	2064	84%	89%	72%	90%	96%	79%	70%	89%	77%
Fire Awareness	2583	2064	84%	89%	72%	90%	96%	79%	70%	89%	77%
Health and Safety	2583	2064	84%	89%	72%	90%	96%	79%	70%	89%	77%
Infection Control	2583	2064	84%	89%	72%	90%	96%	79%	70%	89%	77%
Information Governance	2583	2149	85%	89%	74%	88%	92%	87%	82%	94%	79%
Published compliance as at 31 December 2013			**85%**	88%	75%	87%	91%	89%	84%	95%	79%

What needs to improve?

To continue to develop further improvement plans through the Listening into Action programme. The Trust is continuing to explore ways of delivering a more accessible and flexible training programme to assist with overall compliance rates.

How will we continue to monitor and report?

We will continue to conduct regular staff surveys. Staff have been encouraged through the Listening into Action initiative to use the 'Pulse Check' questionnaire tool to allow the organisation to better understand how they are feeling working for the Trust. This will give the Trust more insight to drive actions and changes.

Complaints

Why did we choose to focus on this?

The Trust recognises that complaints and concerns raised about our services represent a small proportion of the total number of contacts between staff and the public. Service users, relatives and carers provide a valuable perspective into how we provide care. By understanding why people complain, and the nature of the issues raised, we can endeavour as service providers to work in partnership with all our stakeholders to improve the quality of care and treatment.

What was our target?

The Trust aims to resolve problems which arise through internal mechanisms before a formal complaint is issued, and thereby to minimise the number of formal complaints received.

What did we achieve?

The following table shows the number of formal complaints received by all London Mental Health Trusts, as provided by HSCIC, ranked according to the population size of localities covered by each trust. Barnet Enfield and Haringey receive lower numbers of formal complaints based on population size than the majority of London trusts.

London Trusts	total complaints 2010-11	total complaints 2011-12	total complaints 2012-13	population by london borough *based on 2011 census*	2012-13 complaints rate per 1000 population
North East London NHS Foundation Trust	nil reported	174	169	959,200	0.18
Oxleas NHS Foundation Trust	110	179	161	796,000	0.20
Barnet, Enfield and Haringey Mental Health NHS Trust	251	215	220	923,800	0.24
Central and North West London NHS Foundation Trust	238	306	331	1,202,300	0.28
Camden and Islington NHS Foundation Trust	nil reported	121	151	426,400	0.35
South West London and St George's Mental Health NHS Trust	343	356	376	1,043,900	0.36
West London Mental Health NHS Trust	224	197	307	774,900	0.40
South London and Maudsley NHS Foundation Trust	551	555	551	1,230,700	0.45
East London NHS Foundation Trust	318	462	440	538,600	0.82
All london MH	**2035**	**2565**	**2706**	**7,895,800**	**0.34**

The most common category of complaint across the Trust continues to be dissatisfaction with clinical care and treatment followed by staff approach and attitude at both clinical and administrative levels. Poor communication in terms of providing accurate referral and aftercare information to both service users and carers appears as an issue across Service Lines.

Each complaint will be responded to individually and actions taken within the relevant team, or applied across services where relevant. Below are a few examples of learning shared across the organisation:

A number of concerns were raised by service users about the delays and cancellations of appointments in our Triage service. Following these issues being explored further, it was identified that a high rate of service users not attending their appointments had compounded the availability of appointments for other new referrals – resulting in a more assertive system being implemented to improve attendance and greater availability of clinics to new referrals.

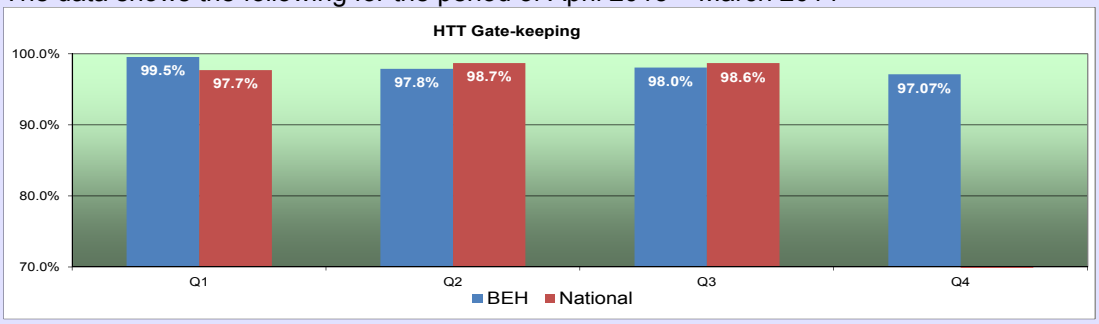
A service user did not feel that the purpose of Family Therapy Service meetings had not been discussed with them or their family, causing them anxiety. This issue was immediately picked up and addressed with the clinician involved to ensure greater communication and feedback was given to avoid such incidents happening again. The service has developed a information leaflet for all future users of the service and subsequent monitoring has shown improvement.

A service user's parents raised concerns that their son was moved on three separate occasions within a short period of their treatment. These concerns were shared with all staff to demonstrate how this incident affected the experiences of one service user. Greater communication is now happening between our in-patient staff and our bed management team to ensure that the services users' journey within our services is tracked and such disruption is not experienced again.

What needs to improve?	The Trust would like to improve the timeliness with which we respond to formal complaints, and have set high targets for response times. While we have made improvements to the complaints process to meet these challenging targets. The Trust acknowledges that there is still more to be done in this area and as such will be reviewing the themes associated with delays in the process and shall address these issues with appropriate action.
How will we continue to monitor and report?	The Complaints Team holds weekly Complaints Status Update meetings to track the progress of complaints responses from Service Lines. Service Line managers allocate suitably trained and experienced staff to investigate complaints. The duties of the allocated investigators include contacting complainants and drafting Service Line complaints responses. Actions from the weekly Complaints Team Status Update meetings are forwarded to the relevant Service Line Assistant Director and direct line manager in order to ensure timely completion of complaints within the deadline. Complaint reports, outstanding action plans and lessons learned are presented to monthly Service Line Serious Incident meetings and quarterly Service Line Deep Dive meetings.

Crisis Resolution Home Treatment Team Assessment

Why did we choose to focus on this?	The function of the Crisis Resolution Home Treatment Team (CRHT) is to provide intensive care and support in patients' homes as an alternative to acute inpatient admission. By providing an alternative to patients in crisis, gatekeeping allows the Trust to focus inpatient resources only where the greatest need is indicated, and allow patients to be treated within the least restrictive environment.
What was our target?	95% of inpatient admissions to be reviewed by the CRHT.
What did we achieve?	The Trust is currently gatekeeping 98.04% of 1735 admissions to inpatient wards in 2013-14. Q4 National data is not yet available. The following data is extracted from the patient record system and crossed checked with team managers to ensure all cases have been reviewed by the CRHT prior to admission. The data shows the following for the period of April 2013 – March 2014



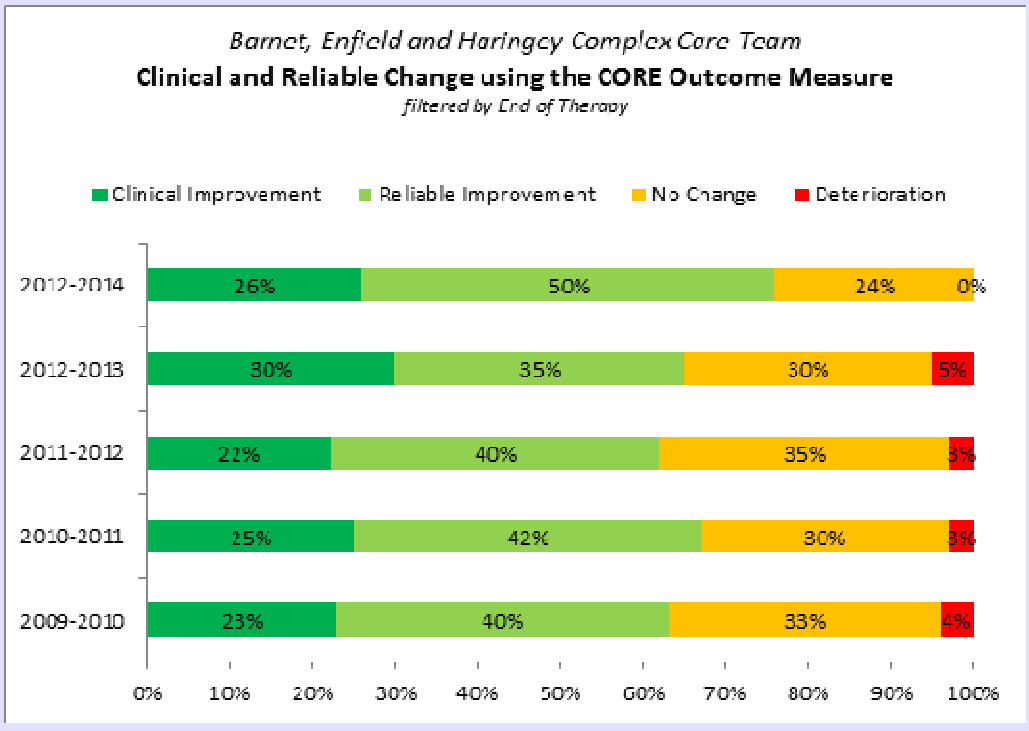
The following table shows the data published by the Trust to the Health Sector Compensation Information System from April to December 2012.

Proportion of admissions to acute wards that were gate kept by the CRHT teams	Q1 based on data submitted to HSCIC	Q2 based on data submitted to HSCIC	Q3 based on data submitted to HSCIC	Q4 based on data submitted to HSCIC
lowest	74.50%	89.80%	85.50%	data not yet available
BEH	99.52%	97.84%	98.02%	97.07%
Highest	100.00%	100.00%	100.00%	data not yet available
England	97.68%	98.67%	98.64%	data not yet available

What needs to improve?	Performance leads are working with managers to develop a more consistent recording system to monitor this activity.
How will we continue to monitor and report?	Performance reports will review this data monthly in operational management review meetings.

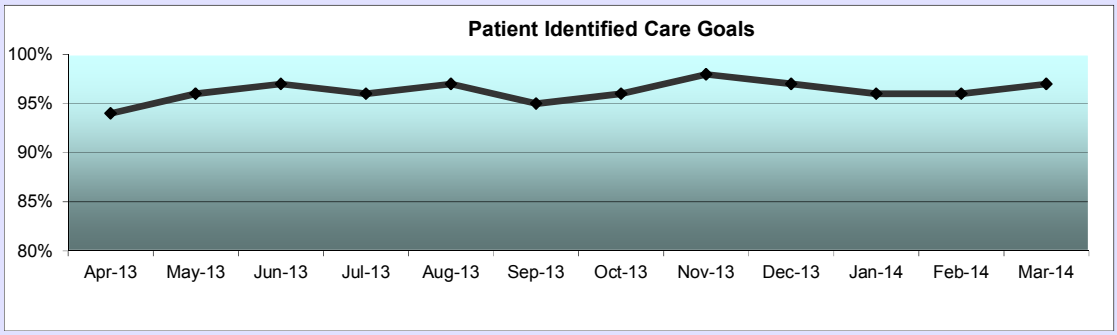
CLINICAL EFFECTIVENESS

Patent Reported Outcome Measures (PROMs) – *Key Priority*

Why did we choose to focus on this?	Patient Reported Outcomes are a valuable way for Trusts to understand the effectiveness of the treatment and care provided as reported by the service users themselves. PROMS are mandatory this year as a part of our CQUIN contract.
What was our target?	To develop and implement a programme to capture outcome data which can be reported against nationally accredited benchmark data when available.
What did we achieve?	We are currently using several tools to measure patient health outcomes, and have agreed to implement two nationally accredited patient reported outcome measure tools across mental health and community services. Outcomes are collected using the CORE 34 measure. This measure has high reliability and validity and is used across many different NHS services nationally. Recently it was the measure of choice in the National Audit of Psychological Therapies run by the Royal College of Psychiatrists. Outcome data is routinely collected at the start and end of treatment for all patients treated in this service who are receiving psychological therapy or receiving phased treatment as part of the Complex PTSD Stream or who are provided with treatment if the group programme in the MAP Stream. Data currently collected via a separate system for patients in the PD Stream. The following graph shows the percentage of clients who made clinical and reliable change during treatment within the Barnet, Enfield and Haringey Complex Care Teams, which is a service operating within the Severe and Complex Non-Psychotic Service Line of Barnet, Enfield and Haringey Mental Health Trust. 'Clinical improvement' refers to clients who have made sufficient improvement to no longer meet the threshold to be considered a clinical case. 'Reliable improvement' refers to those clients who have made a reliable change in their pre and post scores. 'No change' refers to those clients who have not made any measured change in therapy but also includes those clients who may have made a small change, which is not sensitive enough to be deemed statistically reliable (i.e. the result could have happened by chance). 

	Warwick-Edinburgh Mental Well-being Scale (sWEMWBS) was launched in Triage services in November 2013. Triage teams are receiving weekly performance updates to monitor compliance, and are currently meeting our internally agreed target of receiving feedback from 30% of patients. A health outcomes measure (EQ5D) was launched in Diabetes, Respiratory and Musculoskeletal services in November 2013, and we are currently meeting our internally agreed target of receiving feedback from 10% of patients.
What needs to improve?	Further roll-out of these measures to other services will be implemented in 2014-15. Analysis and interpretation of outcome data will need to be benchmarked against similar services through the payment by results steering group.
How will we continue to monitor and report?	Triage teams are receiving weekly performance updates to monitor compliance.

Patient Identified Care Goals

Why did we choose to focus on this?	Mental health service users have been an integral part of the development of our quality account. While benchmarkable outcome data is a national priority for all health services, our service users have expressed that every individual will have a unique and personal experience which can only be measured on an individual level. A standard was set following a stakeholder workshop to develop a measure which will identify if the plan of care agreed with service users contains individual and personal goals toward recovery.
What was our target?	To continue to develop and consistently deliver recovery based care with a target of 90% of all patients being supported to achieve individual recovery goals.
What did we achieve?	An audit based on 4572 patient records over the financial year indicated that 94% of patients had patient identified goals together with personal involvement in care planning. 
What needs to improve?	We will continue to monitor this aspect of care and continue to involve and encourage patients to take ownership and empower them to take responsibility and participate in their recovery.
How will we continue to monitor and report?	Monitoring will be maintained through the ward and community quality assurance process to ensure that this remains an important issue and scores remain high.

Emergency Readmissions

Why did we choose to focus on this?	This is a mandatory standard measure to address potentially avoidable readmissions into hospital. The Trust may be helped to prevent potentially avoidable readmissions by seeing comparative figures and learning lessons from incidents of readmission.
What was our target?	The Trust aims to maintain a standard of less than 5% of emergency readmissions to inpatient services within 28 days of discharge.
What did we achieve?	During 2013-2014 there were 45 emergency readmissions out of 1625 planned BEH's CCGs admissions (2.77%).
What needs to improve?	Continue to monitor in 2014-15
How will we monitor and report?	Performance is monitored through monthly service line performance meetings and at Board Committee level.

QUALITY STATEMENTS

During 2013 - 2014 Barnet Enfield and Haringey Mental Health NHS Trust provided eight NHS services in six service lines. BEH has reviewed all the data available to them on the quality of care in all eight of these NHS services. The income generated by the NHS services reviewed in 2013- 2014 represents 100% of the total income generated from the provision of NHS services by BEH for 2013-14.

National Audits

During 2013 - 2014 Barnet Enfield and Haringey Mental Health NHS Trust participated in 4 of 5 national clinical audits applicable to the services provided by the Trust (80%) and 1 of 1 National Confidential Enquiries applicable to the Trust (100%).

Prescribing Observatory for Mental Health (POMH) Audit Topic	Trust Participation		National Participation	
	Teams	Submissions	Teams	Submissions
Topic 13a: Prescribing for ADHD	0	0	374	5523
Report not yet received				
Topic 7d: Monitoring of patients prescribed Lithium	27	80	6306	883
Actions: Re-issue Lithium Bulletin and information on the NPSA lithium packs. Implementation of the Pharmacy Listening in Action project across the trust to ensure staff have access to the acute hospitals' pathology results so the blood tests can be copied and pasted into RiO.				
Topic 4b: Prescribing Anti-Dementia Drugs	2	60	420	9005
Report received in April 2014. Actions in development.				
Topic 10C: Use of antipsychotic medication in CAMHS	4	43	Not known	Not known
Report to be received in May 2014				

National Confidential Enquiry into Suicides and Homicides	On-going participation
Actions: Local Suicide dashboard created and monitored. On-going audit undertaken twice yearly in CRHT using national suicide prevention tool.	

Audit	Number of Participating Services	Therapist Questionnaire		Case Note Audits		Service User Questionnaires	
		Submissions	Minimum # of submissions	Submissions	Minimum # of submissions	Submissions	Minimum # of submissions
National Audit of Psychological Therapies for Anxiety and Depression	2	118	n/a	4999 (over 100%)	6 (guideline)	86	n/a
Actions: Report has been presented to teams and workshops in place to develop actions.							

Audit	Organisational Questionnaire Completed	Audit of Practice		Service User Questionnaires		Carer Questionnaires	
		Submissions	Minimum # of submissions	Submissions	Minimum # of submissions	Submissions	Minimum # of submissions
National Audit of Schizophrenia (report not yet issued by Royal College of Psychiatrists)	Complete	100 (100%)	100	47 (94%)	50	18 (72%)	25

Local Audits

Barnet Enfield and Haringey Mental Health NHS Trust conducts monthly quality assurance audits covering care planning, assessments, physical health, involvement of patients,

communication with referrers and information provided to patients and carers. These audits are completed by every clinical team on a monthly basis. Additionally, a programme of peer service reviews are conducted regularly across all services to inspect teams against the criteria issued by the care quality commission. This programme of audit work is supplemented by real time patient feedback, and a range of local audits covering medicines management, estates and facilities, health and safety, clinical policies, and service specific clinical criteria. The reports of 75 local clinical audits were reviewed by BEH in 2013– 2014.

Each audit is followed up with an action plan. A total of 1747 actions have been taken in response to findings from the quality assurance audits and service peer reviews. The following is an example of some of the actions Barnet Enfield and Haringey Mental Health NHS Trust has taken in 2013-14:

Audit	Actions Taken
Quality Audit	GP communications – nhs.net to fax guidance circulated and implemented in teams, Carers - carers strategy circulated for feedback from teams and stakeholders
Service Peer Reviews	improvements to team based clinical governance structures, development of improved supervision structures, review of fire drill and evacuation procedures in teams, training updated, information and notices updated, procedural checklists implemented
patient and carer experience internal real time feedback survey	you said we did posters in place, therapist led workshop in eating disorders developed user led agenda setting for clinical session
Patient Experience national survey	need for support with housing identified-DTOC working group initiated
GP satisfaction survey	development of new crisis service and triage teams, primary care academies
Staff survey	LiA team developed to address staff concerns
Suicide Risk Assessment	HTT teams restructured to provide direct crisis referral support
Seclusion Audit	Seclusion rooms no longer used for non-seclusion purposes
Medical Devices	Direct action taken when non-compliant
Observation	Datix updated to include content of observation tool. Minimum note keeping standards reissued.
Discharge, assessment and review letters Audit	review of template letters underway, implementation of NHS net email to fax process
Triangle of Care	proposal to include carers assessment training in mandatory clinical training

Care Quality Commission (CQC)

The Care Quality Commission is the independent regulator of health and social care in England and is tasked with inspecting health and adult social care providers to ensure they are delivering safe, effective, compassionate and high-quality care which meets the Essential Standards of Quality and Safety. The CQC also have responsibilities for monitoring the Mental Health Act and the services received by those detained under the act.

Barnet, Enfield and Haringey Mental Health NHS Trust is required to register with the Care Quality Commission and its current registration status is registered.

BEH has not conditions to its registration.

BEH is subject to periodic reviews by the Care Quality Commission.

BEH has participated in a special review of seclusion by the CQC during the reporting period.

The Trust received 19 Mental Health Act inspections from the CQC in the last financial year looking at all inpatient mental health services within the Trust with no major deviations from the act identified. Feedback from the visits is shared with teams to improve practice.

The Trust received ten regulatory inspections from the CQC in the 2013/2014 financial year assessing the Essential Standards of Quality and Safety across all six registered Trust locations, taking into account 20 teams. In these inspections 49 outcomes were reviewed with 37 of the outcomes found to be compliant. The CQC's approach over the last financial year significantly changed with more focused inspections. The inspections have identified areas of good practice within the Trust together with areas of variation and non-compliance. In all cases regulatory feedback has proven helpful in making improvements in the Trust.

Where areas for improvement have been identified, action plans have been developed in teams and service lines which are monitored until delivery of all actions. These plans are openly shared with commissioning groups and regulators. Plans are shared with other services and monitoring arrangements put in place to ensure the standards are met in all relevant areas. The CQC will revisit services to confirm the area of practice is compliant.

The following is an example of actions taken in response to CQC feedback:
The CQC identified issues in the District Nursing teams of Enfield Community Services in May 2013 including supervision arrangements and attendance at mandatory and specialist training in the teams. The teams created a robust action plan which was monitored through their quarterly deep dive meeting. The teams have since implemented a supervision structure within the service whereby staff receive 4-6 weekly management supervision and support through their handover meetings which occur regularly throughout the week. Staff also attended Clinical Supervision training offered through the Trust's training department. Specialist training has been provided to the teams including cannulation training, annual syringe driver updates and customer care training. Rates of attendance at mandatory training have also improved. The CQC returned to the District Nursing teams on 4th March and acknowledged the improvements which were made in the team since their last inspection and the teams were found to be compliant with the three outcomes which were inspected (Staffing, Supporting workers and Assessing and monitoring the quality of service provision).

The Care Quality Commission has taken enforcement action against BEH during 2013-14. Over recent months, our inpatient mental health services have been under enormous pressure. This has meant that, on occasion, we have had to use seclusion rooms on our mental health wards when a bed was not available and an urgent admission was required. This is not good clinical practice and this issue has recently been identified as a serious concern by the Care Quality Commission (CQC). Trust was issued with an enforcement notice in relation to Regulation 9 Outcome 4, in respect of the use of seclusion for non-seclusion purposes. The Trust immediately ceased this practice and has been compliant with this regulation since 10th December 2013 and has remained compliant up to 31st March 2014. Following a further visit from the CQC on 11 April 2014, the CQC has confirmed the Trust's compliance with regulation 9 outcome 4 and has rescinded the enforcement notice.

Research

Barnet Enfield and Haringey Mental Health NHS Trust has a strong tradition in supporting research. It continues to have research as core to the provision of high quality and innovative care for its patients. The Trust actively participates and supports research generated by its own clinicians as well as researchers from outside the organisation as well. The Trust has three full-time NIHR funded Clinical Research Officers. The Research and Development Department recruited one further part-time NIHR Research Nurse and will recruit two part-time Research Workers to support the recruitment of research studies in the

Trust.

The Trust has a continuously growing clinical trial portfolio. BEH was involved in conducting 39 clinical research studies approved by the ethics committee that related to mental healthcare provision during 2013 - 14; 21 portfolio and 18 non-portfolio studies. All 21 portfolio studies were funded; out of the 18 non-portfolio studies 6 were funded and 12 unfunded, which indicates a growing numbers of student research projects by BEH staff members.

The number of patients receiving NHS care provided by BEH in 2013 - 14 that were recruited during that period to participate in research approved by a research ethics committee was 687, this number has almost tripled compared to the recruitment numbers two years ago. 652 patients were recruited to portfolio studies; 35 patients to non-portfolio studies.

Peer-reviewed publications have resulted from our involvement in NIHR research, which demonstrates our commitment to the dissemination of research findings as well as a desire to improve patient outcomes and experience across the NHS.

For more information about the Research and Development department and recruitment opportunities, go to our Trust website: http://www.beh-mht.nhs.uk/Research-and-Development/

CQUIN

A proportion of Barnet Enfield and Haringey Mental Health NHS Trust income in 2013 - 2014 was conditional on achieving quality improvement and innovation goals agreed between BEH and NHS North Central London through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2013 - 2014 and for the following 12 month period are available on our website *(link to be added when final documents are uploaded).*

Hospital Episode Statistics

Barnet Enfield and Haringey Mental Health NHS Trust submitted records during 2013 - 2014 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was: 98.9% for admitted patient care; and 99.8% for outpatient care. The percentage of records in the published data which included the patient's valid General Medical Practice Code was 99.5% for admitted patient care; and 99.9% for outpatient care.

Information Toolkit

Barnet Enfield and Haringey Mental Health NHS Trust score for 2013 - 2014 for Information Quality and Records Management, assessed using the Information Governance Toolkit was Level 2. The Trust's Information Governance Assessment Report overall score for 2013-14 according to the IGT Grading scheme is as follows:

Version 11 (2013-2014)

Headlines:

Assessment Ref:	**ASS/108780**
Status:	**Published** (View History)
Audited:	**No**

Score:

Final Score:	**70%**	**Satisfactory**
Target Score:	**70%**	**Satisfactory**

A Clinical Coding Audit for Information Governance purposes took place in February 2013 and a number of recommendations were made to the Trust relating to admitted patient care

activity. Actions on these recommendations have been reviewed as below:

	Recommendations 2013:	Update on Actions 2012/13:
1	It is strongly recommended that staff either administrative or clinical assigning or inputting codes should receive NHS National Classification Service Standards Training in the rules and conventions of the classification. This should take effect immediately.	Staff who input clinical codes have attended the mental health training workshop as a minimum. The records manager has attended a 2-week training course related to ICD10 clinical coding standards and conventions. The Information Governance Manager has attended the 4 week foundation training course. Training provided by the Clinical Coding Academy. The clinical coder will attend the refresher training course when appropriate and has been encouraged to attend the full 4 week foundation course.
2	The Trust must revisit and review its policy on the use of discharge notifications as its source documentation used for coding. The Trust must develop a robust system that produces timely (7 days post discharge), accurate discharge summaries which will support the coding process. The discharge summaries should include all primary and secondary diagnosis that are relevant to the patient's episode of care.	Work is ongoing. The Trust have an action plan to capture all relevant diagnosis, which includes email communication to the clinicians from the Medical Director, the records manager quality checking data input by the coder, scrutinising the rio record for any gaps in information provided on the discharge documentation
3	The recording of ECT should be undertaken by the staff trained to the national clinical coding standards. It was made mandatory from 1st January 1999 (coding clinic November/December 1999). This should be discussed with software suppliers.	The Trust are in the process of reviewing the current electronic record system (RiO), clinical coding standards and conventions are being incorporated into the requirements with a new system
4	There should be more engagement with clinicians in order to validate the coded data and also to improve the documentation of co morbidities in the spell discharge summary.	The Medical Director is in the process of nominating a clinician who will meet with the coder on a regular basis, in the meantime the coder routinely communicates with the clinicians, e.g to clarify any issues
5	Those entering the data must ensure that all the relevant comorbidities are recorded. This is in line with Ref 88: Coding of Co-morbidities(Coding Clinic November 2012,V2.3)	The Trust have reviewed its clinical coding policy which now references Ref 88 and also includes an appendix by means of a prompt of co-morbidities

Payment by Results

Barnet Enfield and Haringey Mental Health NHS Trust was subject to the Payment by Results clinical coding audit during the reporting period as part of the Information Governance Toolkit annual submission and the error rate reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) was: Primary Diagnosis 6.56%.

To access the Barnet Enfield and Haringey Mental Health NHS Trust Clinical Strategy 2013-18 and Quality Strategy for 2013-16 go to: http://www.beh-mht.nhs.uk/?shortcutid=444372

TRUST Achievements…

Mental Health Trust and Met Police Partnership wins top award

An innovative and important partnership between Barnet, Enfield and Haringey Mental Health NHS Trust and the Metropolitan Police Service has been recognised with a prestigious policing award.

The team, which is made up of staff from the Trust and the police, was presented with the top prize for diversity at last week's Excellence in Total Policing Awards in recognition of their work to support people with mental health conditions. The multidisciplinary team of doctors, nurses and police officers has an important role to play in protecting high profile public figures, but their work also has a significant public health impact.

The Fixated Threat Assessment Centre (FTAC) consultant psychiatrist Dr Frank Farnham says that: *"by making an assessment of an individual the team is often able to put people in touch with their local mental health or primary care services. This early intervention allows people with mental health problems to be identified and provided with appropriate treatment much sooner than may have happened otherwise."*

Detective Chief Inspector Carol Kinley-Smith, who heads up FTAC, said: *"I am incredibly proud of the team. Mental health is a huge priority for the police at the moment, and this team is an excellent example of how effective partnership working can support both police and NHS objectives by protecting public figures and helping people get the care and support they need".*

National Police and Court Liaison/Diversion Pilot

The Trust has been successful in its bid to be the London pilot site and one of 14 sites nationally to trial the new operating mode for liaison and diversion services at police stations. The pilot will form part of a national evaluation, which will go towards the final business case to put to the treasury to release the funds to roll out the model nationwide. This will see the service which we already provide in Haringey, extend into the police stations of Enfield and Islington, provide a five day per week service at Highbury Magistrates Court and extend our delivery to all ages and those with assumed vulnerabilities. A similar service in Barnet is operated in conjunction with Central and North West London Foundation Trust.

Trust awarded University Status

Middlesex University has awarded 'University Affiliated' status to the Trust. The agreement will enhance the current partnership between the two organisations, demonstrating a strong commitment to education, research and development.

The agreement builds on the existing strong relationship between the University and the Trust, which has previously included opportunities for clinical placements for nursing students, bespoke and innovative educational projects for staff development, and evaluation and research projects on critical clinical practice questions.
Skills and knowledge at both organisations will be enhanced by the partnership, which will see clinicians from the Mental Health Trust working with Middlesex students and sharing their front line expertise, and Middlesex University experts providing training for staff at the Trust. This includes opportunities for Trust staff to gain university level qualifications for projects they carry out in the workplace.

Middlesex University Pro Vice-Chancellor and Dean of the School of Health and Education Jan Williams said: *"Middlesex University and the Trust have collaborated for a number of years on student placements, conferences and continuing professional development so we are delighted to have the opportunity to formally extend our partnership. We're looking forward to working together to respond to the challenges facing mental health and community health service users and staff, through research and development of innovative ways of working."*

Maria Kane, Trust Chief Executive said: *"Our relationship with Middlesex University is a crucial part of how we advance our research, develop our workforce and support the training of the next generation of NHS staff, so I am thrilled that we are able to strengthen our partnership through this agreement. We will be looking for new and innovative ways to work together to continue to improve the health and wellbeing of the community our Trust serves."*

Staff Achievements…

Denise is a top trainer

Denise Hall in our Workforce Development team was awarded trainer of the month for January by University College London Partners (UCLP) in acknowledgement of her sterling efforts in delivering dementia training across the Trust.

Denise, a skills trainer, delivers a range of training courses including the Trust's induction course said: *"I feel very honoured to have won this award. More importantly it recognises the work we are doing at the Trust to raise awareness about dementia."*

As part of her award Denise was presented with a gold project badge, a certificate of achievement and £250 to spend on items or initiatives related to delivering better dementia care in the Trust.

Trust clinician is also a top teacher …

A Trust clinician has been chosen as a 'top teacher' by students from the University College London (UCL) medical school.

Dr Robert Tobiansky, who works in psychiatry for the elderly, received the award after his students voted for him as one of the teachers who were particularly helpful or inspiring to them during their studies.

Throughout the year UCL students are given the opportunity to nominate their teachers and during 2012/13 over 1800 votes were cast and from there 70 award winners were chosen.

Karl takes tea with the Queen

Karl Sunkersing has been rewarded for his dedication to the NHS by being selected to attend a royal garden party at Buckingham Palace.

Karl, who is a trained psychiatric and general nurse, has worked for the NHS for 43 years. He currently works as the ECT co-ordinator and bed capacity manager at Chase Farm Hospital.

Oliver Treacy, Service Director for Crisis & Emergency, said: "*I am delighted that Karl was selected to attend a Royal garden party as it is recognition for the years of dedicated service that he has given to the NHS. He frequently goes beyond the call of duty and shows great empathy with all mentally ill patients, frequently giving up his own time to ensure that services are provided.*"

Karl Sunkersing (left) with Lynne Parry, who accompanied him to the garden party, with Oliver Treacy, Service Director

Joy Ihenyen has recently trained to become the Trust's first independent pharmacist prescriber. Following her training Joy worked as a general pharmacist at the Whittington before joining North Middlesex Hospital as a HIV pharmacist. She joined this Trust in 2006 as a mental health pharmacist.

Joy says: *"most of my work is ward based. It involves attending ward rounds with the multidisciplinary team and talking to patients about their medication. This is with a view to helping them understand what the medication does and the importance of taking them. I also do day to day clinical screening of new patients and ensure that the right medication is prescribed for the patient."*

Congratulations to staff nurse Amelia Bioku, who successfully achieved her MSc in Mental Health Studies with merit on 4 December 2013. Amelia, who works on Suffolk ward, said: *"I strongly believe it is essential for nurses to be knowledgeable, skilful and most importantly, to keep abreast of mental health nursing, in order to deliver safe and effective care based on evidence based practice. I would like to thank Sean Edwards, ward manager and those nurses who participated in the study for their support. I would also like thank my previous ward manager, Rey Bermudez who supported me with the funding."*

Ros Glancy, practice standards lead, said: *"Amelia's dedication and enthusiasm is really inspiring and we would like to wish her continued success for the future."*

Celebrating the work of Activity Co-ordinators

Staff and service users got together recently at Chase Farm to celebrate the work of the volunteer activity coordinators and thank them for the valuable work that they have done during the year. The activity coordinators are all volunteers who organise physical and other activities on the inpatient wards at Chase Farm. Paul McKevitt, Service Manager, said: "On behalf of the trust I would like to thank the activity coordinators for all of the valuable work they have done for the trust and our patients. They really support the ward staff by organising activities for the patients and as ex-service users themselves they are able to understand the issues and changes that the service users face. I would also like to thank Melina Back and Kate Holmes from EMU (Enfield Mental Health Users Group) for all of their hard work in establishing the activity coordinators network."

Paul McKevitt with Melinda Back and Kate Holmes

Celebrating our Commitment to Excellence Awards

Over 300 members of staff got together to celebrate the achievements of colleagues in the annual staff awards ceremony “Celebrating our Commitment to Excellence”. More than 80 people were nominated in the seven categories and the winners were announced on the night. Colleagues with 30 or more years of NHS service were also recognised.

Michael Fox, Trust Chairman, welcomed everyone to the awards ceremony saying: “*This event is a demonstration of the Trust’s on-going commitment to excellence. It is one way of saying thank you to all staff in what has been another challenging year for the Trust and the wider NHS*.”

During the evening members of the first 10 teams to take part in the Listening into Action programme were congratulated for their work. The teams, along with their sponsors, have been working hard to make improvements for the benefit of patients and staff.

Maria Kane gave a closing speech congratulating all of the award winners and acknowledging that the awards were just a snapshot of the good work that takes place throughout the Trust every day.

Audrey Carter

Compassion In Care Award

Audrey is a healthcare assistant on Avon Ward in Forensic. She is regarded as one of the back bones of the numerous successes on the ward. Audrey cares for every service user equally with respect and humanity.

Clinician of the Year

Bernie and Tanya from the ECS intermediate care team have been instrumental in the development of integrated services for admission avoidance and the older person’s assessment unit. Their contribution as the lead community clinicians has been exemplary providing leadership across the interface of primary and secondary care to improve the care for older people.

Bernie Sandford & Tanya Pugh

Sue Steward

Supporting Star

Sue supports staff in the dementia and cognitive impairment service in using RiO .She has developed systems and procedures for the teams to ensure the quality of data and compliance which has shown in the positive results in all performance reports and targets.

Innovation Award - *Multi Sensory Room*

Helen Blatchford and Despina Tzanidaki scooped the innovation award to install a special sensory area for children to use when visiting Cedar House at St Michael's Hospital in Enfield.

Manager of the Year

Helen Brindley, a manager in the Haringey complex care team, is fabulous at leading managerially and operationally, she is also clinically excellent. Helen is essential to the functioning of the service and well-being of the staff and clients

Diamond Team

During the year the Barnet Complex Care Team have overcome many challenges through strong clinical leadership and excellent team working.

Chief Executive's Award for Excellence

Catherin Marfelle, a healthcare assistant on Juniper ward, in forensic, is a resourceful and thoughtful person who everyone looks to for wisdom. She is often the first to identify problems and is not a person to ignore them if they interfere with the standard of work that she commits to.

The LiA Pioneers

The success of the first 10 Listening into Action (LiA) pioneering teams was recognised at the awards ceremony. Team representatives were presented with an award for their hard work on improvement projects. The projects range from enhancing services for older patients by creating a therapeutic space outside the Hawthorn Unit at Chase Farm to reinstating the Trust's direct access to pathology results. The teams are seeing the results of their hard work as changes are implemented across the Trust.

Statements from our Stakeholders

To be added

Glossary

BEH	Barnet Enfield & Haringey Mental Health NHS Trust
CCG	Clinical Commissioning Group: NHS organisations that have been authorised to commission healthcare services for their communities
CPA	Care Programme Approach: an assessment of needs with a mental healthcare professional, and to have a care plan that's regularly reviewed by that professional
CRHT	Crisis Resolution Home Treatment: to provide intensive care and support in patients' homes as an alternative to acute inpatient admission
CQUIN	Commissioning for Quality and Innovation: Key aim of the Commissioning for Quality and Innovation (CQUIN) framework for 2013/14 is to secure improvements in quality of services and better outcomes for patients, whilst also maintaining strong financial management
DTOC	Delayed Transfer of Care: A mental health delayed transfer of care occurs when a patient is ready to depart from acute mental health care and is delayed
ECS	Enfield Community Services
EQ-5D	A standardised instrument for use as a measure of health outcomes
HSCIC	Health and Social Care Information Centre
MH	Mental Health
MSK	Musculoskeletal
PCA	Primary Care Academy: offers training and support by Trust consultants to GPs on mental health, building relationships between primary and secondary care
PROMs	Patient Reported Outcome Measures: PROMs measures health gain in patients undergoing treatment. PROMs is an umbrella term that covers a whole range of potential types of measurement but is used specifically to refer to self-reports by the patient. Data may be collected via self-administered questionnaires completed by the patient themselves or via interviews.
RCGP	Royal College of General Practitioners
WEMWBS	Warwick-Edinburgh Mental Well-being Scale: Newly developed scale for assessing positive mental health (mental well-being). A 14 positively worded item scale with five response categories

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